LSU Health Sciences Center

SCHOOL OF MEDICINE AT NEW ORLEANS

Department of Medicine/Pediatrics

Policy & Procedure

House Officer Manual

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LSU MEDICINE/PEDIATRICS CURRICULUM AND GOALS & OBJECTIVES

The LSU Medicine/Pediatrics residency program is a 4-year program that provides comprehensive inpatient and outpatient didactic and clinical experiences in both Internal Medicine and Pediatrics that ultimately results in board-eligibility in both specialties. Residents rotate every four months and are promoted to supervisory residents after successfully completing eight months in each specialty.

Upon completion of the four-year residency program, residents are expected to have developed the knowledge and clinical skills essential for practicing Internal Medicine and Pediatrics both proficiently and competently in inpatient and outpatient settings. Graduated residents are expected to take and pass both specialty boards within 3 years of completing residency ***(see contractual agreement form)*.**

The components of training in internal medicine and pediatrics that constitute the Medicine/Pediatrics curriculum are derived from training that has been accredited as part of the core internal medicine program by the Residency Review Committee for Internal Medicine and the core pediatrics program by the Residency Review Committee for Pediatrics. The program functions as an integral part of both core programs with mandatory interaction between the core and combined programs at all levels of training.

Medicine/Pediatrics residents are required to complete 22 months of internal medicine rotations and 22 months of pediatric rotations. They must fulfill the Medicine/Pediatrics RRC requirements for required ward, subspecialty, emergency medicine, and intensive care rotations. At least 1/3 of the total internal medicine experience must involve ambulatory care.

Residents must attend at least 26 weeks and 36 half-day sessions of continuity clinic per year over the 48 months of training and must fulfill the minimal patient requirement for each level of training. PGY-I residents must see 54 adults and 54 pediatric patients (average 3 patients/week); PGY-II residents must see 72 adults and 72 pediatric patients (average 4 patients/week); PGY-III and PGY-IV residents must see 90 adults and 90 pediatric patients (average 5 patients/week) per year. Throughout their four years of residency training, residents must maintain an accurate log for tracking sufficient variety, acuity, and volume of continuity clinic patients.

The Program Director personally designs each resident's schedule to ensure a balanced, graded clinical experience that provides increasing competence and confidence while preventing undue repetition and fatigue ***(see sample schedule).***

The Medicine/Pediatrics program should be seamlessly intimately integrated into both of its parent categorical programs so that combined residents have the exact same inpatient and outpatient experiences as their categorical peers. Combined residents must attend the same conferences, morning reports, journal clubs, and Grand Rounds and satisfy the expected attendance requirements while rotating through each specialty.

Year	Medicine	Pediatrics
PGY-1	Med/Peds Ambulatory (1 month) Major Emergency Room (1 month) UH Ward (2 months) Cardiology (1 month) MICU (1 month) Touro Ward (1 month) Pulmonary (1 month)	Children's Hospital Wards (1 month) Well Baby Nursery (1 month) Heme/Onc (1 month) Development (1 month)
PGY– 2	Wards (2 months) Elective (1 month) Nephrology (1month)	Children's Hospital Wards (1 month) Well Baby Nursery (1 month) Neonatal ICU (1 month) Pediatric Emergency Room (1 month) Required Elective (2 months) Advocacy/NF (1 month) Ambulatory/vac (1 month)
PGY-3	Heme/Onc (1 month) Touro Wards (2 months) MICU (1 month) Cardiology (1 month) UH Wards (1 month) Elective (2 months)	Children's Hospital Wards (1 month) Required Elective (1 month) Pediatric ICU (1 month) IEU/NF (1 month)
PGY-4	Med/Peds Ambulatory (1 month) Ochsner-Kenner Ward (1 month) GMC/Palliative Care (1 month) Geriatrics (1 month)	Pediatric ER (1 month) Required Elective (1 month) Adolescent (1 month) Children's Hospital Wards (1 month) Advocacy/Community(1 month) IEU (1 month) vac/NF (1 month) Neonatal ICU (1 month)

In addition to attending required categorical meetings, combined residents must attend their own monthly Medicine/Pediatrics journal club and business meetings to foster a unique sense of identity, collegiality and unity among the combined residents, especially among those residents on opposite rotations.

The Medicine/Pediatrics Program Director must ensure compliance with the institutional and ACGME duty hour standards and monitor potential violations during transitions between specialty assignments ***(see duty hour policy).*** Residents and faculty must receive

education regarding recognizing signs of fatigue and sleep deprivation to prevent negative effects on patient care and learning.

The combined program director must document semiannual meetings with each resident to evaluate performance and to provide appropriate feedback. Documented quarterly meetings must be held with the core programs to ensure appropriate integration of training and supervision in each discipline.

The Program Evaluation Committee will convene in early Spring to assess the educational effectiveness of the Medicine/Pediatrics curriculum in achieving its specified goals and objectives. The Committee will be composed of at least 3 Medicine/Pediatrics faculty, coordinator, Chief Residents, and the Program Director who are responsible for performing a comprehensive review of the program by reviewing all program evaluations and will then develop an action plan to be submitted to the LSU GMEC that addresses any areas that require improvement. The Clinical Competency Committee will also meet in early Spring to make official recommendations to the Program Director for promotion or remediation of all residents (see Program Evaluation Committee and Clinical Competency Committee).

Competency-based, level-specific goals and objectives for each rotation are available via the Medicine/Pediatrics website for all residents and faculty to review. Faculty is required to review the goals and objectives with the residents at the start of each rotation **(*see Internal Medicine and Pediatrics Goals & Objectives*).**

Medicine/Pediatrics, Pediatric and Internal Medicine Policies and Procedure manuals are distributed to all residents electronically and contain information regarding duty hours, moonlighting policy, oversight policy, resident selection, resident evaluation, promotion requirements, and grievance/dismissal policy that comply with the institution's policies and procedures **(*see attached*).**

PROCEDURES:

Residents must maintain a log of adult and pediatric procedures. All residents and interns must log all pediatric RRC-required procedures and the ABIM-required medicine procedures using the computer-based New Innovations site.

EVALUATIONS:

Competency-based evaluations performed by faculty, peers, and self are completed via the computer-based evaluation system New Innovations. Nurse and patient evaluations are completed using paper evaluations and are completed during continuity clinics and select rotations. All resident evaluations are placed in individual portfolio binders that are locked safely in the Medicine/Pediatrics office. Residents can request to review their evaluations and portfolio at any time throughout their residency training.

In addition, residents have at least 2 evaluation tools to assess the successful attainment of each of the 6 competencies. The combined and categorical program directors are able to access the evaluations at any time to be used for promotion and/or remediation purposes. Residents can view their completed on-line evaluations at any time and are encouraged to do so to receive timely feedback. Residents must successfully complete the Medicine/Pediatrics RRC requirements to graduate and to become board-eligible in both specialties.

Unsatisfactory evaluations warrant immediate investigation by the Medicine/Pediatrics program director. The Medicine/Pediatrics program director must determine the circumstances surrounding the unsatisfactory evaluation and query the affected resident as well as involved faculty and residents. The Program Director will determine the required remediation and discuss the proposed action plan with both Internal Medicine and Pediatrics Residency Review Committees for further recommendations. Failure to improve the areas of concern may warrant repeating the rotation, extending the residency, or termination. The resident has the right to appeal the decision in accordance with grievance and due process procedures in the institutional policies and procedures manual.

VACATION:

Interns receive 3 weeks of vacation and PGY-II, III, and IV residents receive 4 weeks of vacation per year.

STEP III

ALL interns must take Step III by the end of their 16th month of residency and must pass Step III by June 30th of their PGY-II year. If a resident fails to either attempt to take Step III by the end of the16th month of residency, he/she will not be promoted to a supervisory resident status and will continue to function as an intern. Should the resident fail to successfully PASS Step III by the end of their PGY-II year on June 30th, he/she may be placed on probation, suspended without pay, or terminated for failure to comply with the official Medicine/Pediatrics policies and procedures. To apply for Step 3, go to the website at www.fsmb.org; click on Examination Services and then Step 3 Homepage. Be prepared for the cost - $705.00!

Health Requirement:

Incoming House Officers are required to provide proof of the following Immunizations / Vaccinations as conditions of employment:

- TB/PPD skin test within **2 months prior to start date**
- Rubella immunity proven by titer or documentation of two injections of MMR vaccine
- Mumps immunity proven by titer or documentation of two injections of MMR vaccine
- Measles immunity proven by titer or documentation of two injections of MMR vaccine

- Varicella (chickenpox) immunity proven by titer, two injections of varicella vaccine, or reliable history of past varicella infection
- Hepatitis B immunity proven by proof of antibodies to Hepatitis B or documentation of Hepatitis B vaccine
- Td/Tdap vaccination within the past 10 years

Continuing House Officers are required to provide ongoing documentation of the following immunizations to continue employment and be appointed to the next House Officer level:

- Annual TB/PPD skin test
- Maintenance of Td/Tdap vaccination as needed

Annual TB test results must be turned in on the specified LSU TB form within the House Officer Contract annually. All vaccination records will be maintained and monitored by the Student Health Department.

CONTINUING HOUSE OFFICERS: the annual TB test results must be submitted with the House Officer Contract annually. CONTRACTS WILL NOT BE APPROVED FOR RENEWAL BY THE GME OFFICE WITHOUT A COMPLETED TB TEST RESULT FORM ATTACHED TO THE CONTRACT.
http://www.medschool.lsuhsc.edu/medical_education/graduate/AgreementOfAppointment.asp

MOONLIGHTING:

(*see moonlighting policy*)

Moonlighting is not required and is not encouraged by the program. Approval of any and all moonlighting is entirely at the discretion of the Medicine/Pediatrics Program Director. Only residents that have successfully completed 16 months of training, passed USMLE Step III, and have a Louisiana medical license are eligible for moonlighting. Residents must be in good standing in both specialties with excellent evaluations. The resident must complete a Medicine/Pediatrics moonlighting approval form that documents the site(s), hours, and frequency of the moonlighting shifts. The resident must update the form each year and have the Program Director and the resident sign and date the form. Residents must comply with the ACGME duty hours and with the moonlighting policies of both Pediatrics and Internal Medicine.

Since moonlighting is an extracurricular activity approved by the Program Director, evidence of fatigue or interference with the ability of the resident to fulfill the duties of the educational program will result in immediate termination of all moonlighting privileges.

Residents with J-1 visas are prohibited from moonlighting. Residents can not moonlight during ICU and ward months.

SCHOLARLY ACTIVITY:

Medicine/Pediatric residents must participate in scholarly activity. Each resident must complete a minimum of 2 forms of scholarly activity by the end of their 4 years of residency. Scholarly activity may be in the form of abstracts, posters, publications, or local, regional, or national presentations. Residents are encouraged to participate on institutional committees; to attend local, regional, or national educational meetings; and to hold leadership positions.

Documentation of scholarly activity and awards are maintained in resident portfolios.

SUMMATIVE EVALUTION:

Upon completion of the program, a summative evaluation that verifies competency to practice independently is placed in the resident's permanent record and is accessible for review by the resident at all times. In addition, an evaluation of the resident's performance during the final period of education is included in the evaluation ***(see attached).***

BOARD CERTIFICATION:

All graduates are required to take both certifying examinations within three years of graduation. All interns must sign a letter of agreement signed by the trainee and the Program Director which states that the resident agrees to take both the IM and the Pediatric boards within three years of graduation. This requirement ensures compliance with the Medicine/Pediatrics RRC requirements that at least 80% of graduating residents take both boards.

The graduating residents will be notified of the cost of the certifying exams and the deadlines for registration for both boards as soon as the Program Director is notified by each board. Registration usually requires payment at least 8-10 months prior to the actual exam date. The ABIM exam takes place in mid-August and costs $1,280.00 and the ABP exam is scheduled in October and costs approximately $2,030.00. To register for the boards, visit www.abim.org and www.abp.org. Late registration for ABIM is $400.00 and for ABP, $305.00

Residents are informed of the costs and the proximity of the tests throughout their residency so they can prepare academically and financially in advance. Third and fourth year residents must create a study schedule and timeline to prepare for the boards. Residents are always encouraged to take both boards in the same year rather than delay taking either exam the following year.

Med/Peds Ambulatory Rotation

Goals and Objectives for Interns and Residents

Educational Purpose:

To provide residents with a comprehensive clinical experience treating common medical problems in variety of general and specialized ambulatory environments.

Teaching Methods:

Medicine/Pediatrics faculty teach the residents in the University of New Orleans student health clinic (UNO), Med/Peds continuity clinic and Luke's House Volunteer Clinic via one-on-one observation, mentoring, and teaching. Pediatric and adult subspecialists teach residents how to recognize and manage patients with medical problems unique to their specialties. Review of ambulatory topics relevant to specialty topics is encouraged prior to the rotation—see Ambulatory Rotation Goals and Objectives.

Mix of Diseases:

In addition to the general ambulatory environments provided by UNO, the Med/Peds clinic and Luke's House, residents also rotate through a number of specialty clinics including: dermatology, pediatric ophthalmology, adult/pediatric otorhinolaryngology, pediatric orthopedics, rheumatology, and HIV/ID. Subspecialty clinics are scheduled to maximize exposure to the disciplines that a resident has had the least experience in. UNO offers intensive exposure to management and anticipatory counseling of otherwise healthy young adults exploring new lifestyle habits. Luke's House attracts patients who are recently returned to New Orleans since Hurricane Katrina, many whom have chronic medical problems that have not been addressed since their evacuation three years earlier.

Patient Characteristics:

At UNO, patients range from part-time to full-time students aged 17-60 years of age. Many students have international backgrounds, varied socioeconomic backgrounds, and limited financial resources necessitating cost effective management practices. Luke's House is a free clinic for the community designed to care for patients with acute medical problems and to help establish medical homes for patients with chronic medical problems. Some patients are homeless and many have underlying mental diseases that complicate their medical problems. Pediatric and adult subspecialty clinics are set in private and hospital-based clinic environments.

Types of Clinical Encounters:

Clinical encounters increase proficiency in the following ambulatory problems and procedures:

1) Routine pap smears, breast exams and well-woman exams
2) Prescribing and counseling for sexually transmitted infections, contraception and sexual behaviors
3) Diagnosis and treatment of vaginitis, urethritis and other sexually transmitted infections with wet preps & KOH
4) Cryotherapy and management of genital warts, plantar warts and common warts, and molluscum contagiosum
5) Diagnosis and management of upper and lower respiratory infections with office based rapid tests and outpatient imaging
6) Office based management of asthma exacerbations with spirometry, peak flows, nebulizer treatments, outpatient imaging, and referral to the ER as necessary
7) Skin and soft tissue infections including I&D of MRSA abscesses, prescribing oral antibiotic choices, and admission criteria
8) Common office orthopedic complaints including basic suturing and splinting
9) Work or school physical exams
10) Age-appropriate immunizations for infants, adolescents, adults and elderly
11) Diagnosis and counseling for depression, anxiety, ADHD, and panic attacks with referral to psychiatry or behavioral counseling as needed
12) Diagnosis & treatment of hypertension, hyperlipidemia, and diabetes mellitus in the underserved, uninsured populations including outpatient interpretation of EKGs
13) Recognition and counseling of tobacco, alcohol and drug use/abuse including the "Five As"
14) Management of acne, psoriasis, eczema and atopic dermatitis
15) Management of retinopathy of prematurity, strabismus and myopia

Educational resources/Reading lists:

1) Managing Contraceptive Pill Patients - 12th Ed.- Dickey
2) Appleton & Lange's Current Medical Diagnosis and Treatment
3) The Sanford Guide to Antimicrobial Therapy 2008, 38th Edition
4) Color Atlas and Synopsis of Clinical Dermatology, 3rd Ed., Fitzpatrick et al
5) PDR
6) Up-To-Date
7) Med/Peds Ambulatory Curriculum readings

Method of Evaluation:

Residents are anonymously evaluated by the nurses on paper and on-line by faculty via computer-based evaluations on New Innovations.

INTERNS:

1. Interns should be able to see 3 to 4 patients per half-day. (Patient care)
2. Perform thorough H&P's based on the chief complaint (Patient care, Interpersonal skills)
3. Formulate a reasonable assessment and plan for acute care problems (STD, URI, UTI, depression/anxiety, orthopedic injuries, suturing/I&D, etc.) (Medical knowledge, patient care, Practiced-based learning)
4. Discuss treatment plan with the supervising physician who will then also assess the patient (Professionalism)
5. Achieve competence and confidence in performing routine well-woman exams, including but not limited to:
    a. Perform a comprehensive medical history focusing on sexual and gynecological history (Pap tests, any STI history and STI prevention, contraception history, menarche and menstrual history) as well as a thorough family history (Interpersonal skills, Patient care)
    b. Perform a complete physical including clinical breast exam, general physical, and complete pelvic exam with Pap screening and STI testing as warranted (Patient care)
    c. Become skilled at analyzing wet prep and KOH slides (Medical knowledge, Patient care)
    d. Interpret test results and discuss with patients any further testing needed (HPV testing, Colposcopy, etc) (Medical knowledge, Professionalism, Interpersonal skills, Patient care)
    e. Understand the basics of contraceptive methods and learn risks, benefits, and contraindications of hormonal contraception (Medical knowledge, Patient care)
    f. Perform gynecological exams with faculty supervision (Patient care)
6. Interview all patients with cultural and gender sensitivity (Professionalism, Patient care)
7. Maintain confidentiality in all patient encounters (Professionalism)
8. Gain proficiency in outpatient procedures including suturing, interpretation of spirometry, cryotherapy, interpretation of EKGs, punch biopsies, incision and drainage of abscess (Patient care)
9. Become familiar with the use of electronic health records in medical settings for prescribing and documenting medical problems and labs (Patient care, Systems-based Practice)
10. Mentor and assist medical students in the clinic (Practice-based Learning)

2nd YEAR RESIDENTS:

1. 2nd year residents should be able to see 5 or more patients per half-day (Patient care)
2. Perform all the skills expected of Interns (Patient care, Medical knowledge)
3. Perform accurate and focused history, physical exam, diagnostic evaluation, and treatment (Interpersonal skills, Patient care)
4. Appropriately utilize diagnostic tests to confirm the diagnosis (Systems-based Practice, Medical knowledge)
5. Counsel patients on disease process and recommend follow-up and specialist referral as appropriate (Interpersonal skills, Patient care, Systems-based Practice)
6. Discuss patients with the supervising physician who will then also assess the patient as necessary (Professionalism)
7. Formulate a comprehensive differential diagnosis based on patient complaint (Medical knowledge, Patient care)
8. Formulate a thorough, accurate treatment plan based on the most likely diagnosis (Patient care, Medical knowledge)
9. Choose the appropriate antibiotics or medication based on most likely etiology and most cost-effective approach. (Systems-based Practice, Patient care)
10. Utilize pharmacy resources pertinent to practice location to prescribe the most effective medication based on a patient's limited financial resources (Systems-Based Practice, Patient care)
11. Perform most office-based procedures with minimal faculty supervision (Patient care)
12. Clearly communicate risks and benefits of a procedure and potential side-effects of procedure or medication including obtaining informed consent (Communication skills, Patient care, Professionalism)
13. Communicate diagnosis, treatment, and follow-up using language appropriate to the patient's education and/or cultural background (Communication skills, Professionalism)
14. Utilize available resources to augment medical knowledge gaps to improve patient care, ie Up-to-Date, textbooks, journal articles (Practice-based learning)
15. Communicate effectively and respectfully with consultants, staff physicians, residents, and ancillary staff to maximize patient care (Professionalism, Communication Skills)
16. Encourage preventive health and effective counseling for male and female reproductive health, including sexuality, pregnancy, contraception, and STDs; smoking cessation, exercise (Patient Care, Practice-based Learning)
17. Utilize appropriate resources in the community to help uninsured patients receive appropriate care and follow-up (Systems-based Practice, Patient care)
18. Utilize pharmaceutical company "patient-care assistance programs" to help non-insured patients attain access to free or discounted medications for chronic conditions (Practice-based learning, Systems-based practice)
19. Without direct supervision, 2nd year residents will be able to perform thorough routine well-woman care with skills developed at intern level and additionally:
    a. Teach the patient how to perform self-breast exam (Patient care)

b. Manage contraception and address preventive health issues such as lipid and diabetes screening, cardiovascular risk assessment, etc. (Systems-based practice, Patient care, Medical knowledge)
c. Communicate "bad" news to patients and offer therapeutic interventions empathetically (Communication skills)

20. Mentor and assist interns and medical students in the clinic (Practice-based Learning)

3rd AND 4th YEAR RESIDENTS:

1. 3rd and 4th year residents should be able to see 7 or more patients per half day (Patient care)
2. Perform all the skills expected of interns and 2nd year residents (Patient care, Medical knowledge)
3. Residents should be able to multi-task and manage more than one patient at a time as well as appropriately refer for sub-specialist evaluation (Systems-based practice, Patient care)
4. Residents should perform routine well-woman care more efficiently than 2nd year residents (Patient care)
5. Residents should be able to supervise interns and medical students when needed (Patient care, Practice-based Learning, Communication skills, Medical knowledge)
6. Function autonomously and efficiently during patient interviews and exams, appropriately seeking faculty assistance when needed (Patient care, Communication skills, Practice-based Learning)
7. Utilize available computer resources to augment knowledge base and to optimize medical care (Practice-based Learning)
8. Inform patients of costs charged for medications and procedures in the clinic in advance, ie immunizations, steroid injections, bronchodilator treatments, I&Ds, cryotherapy (Systems-based practice, Communication skills, Patient care)
9. Independently perform clinic procedures including breast exams, pelvic exams, I&Ds, suturing, and administering bronchodilator treatments (Patient care)
10. Discuss indications, administration, and side effects of medications with patients and be fully knowledgeable of contraindications and drug interactions (Patient care, Systems-based practice)

Goals and Objectives
LSUHSC in New Orleans
Department of Medicine/Pediatrics
Combined Residency Training Program

Name of Rotation: **MED/PEDS AMBULATORY CONTINUITY CLINIC**

Rotation Description:
Continuity clinics are held one-half day each week throughout the four years of the Medicine/Pediatrics residency. It occurs in a private Medicine/Pediatrics clinics staffed by Med/Peds trained faculty. The private clinics primarily accept Medicare, Medicaid and third-party insurance. House officers follow, evaluate, and treat their own panel of patients during all four years of residency and are encouraged to refer patients from inpatient wards, urgent care, PER, MER, and the Well Baby/NICU rotations to their clinic for continuity of care.

In accordance with the Medicine/Pediatrics RRC requirements, **PGY-I** residents are required to see **54 adult and 54 pediatric patients/year**; **PGY-II** residents are required to see **72 adult and 72 pediatric patients/year**; and **PGY-III and IV** residents are required to see **90 adult and 90 pediatric patients /year.** All residents are required to attend a minimum of 26 weeks and 36 half-days of clinics per year. House officers are supervised by on-site faculty at all times who provide immediate feedback after each patient encounter. Clinic faculty must also complete verbal and written biannual evaluations for each resident and provide constructive, timely verbal feedback during each weekly clinic throughout the year.

Legend for Learning Activities (LA)
MR – Morning Report
FS – Faculty Supervision
CC – Case Conferences
DPC – Direct Patient Care
GR – Grand Rounds
CL – Core Lectures
GL – Guidelines Lectures
AMB – Ambulatory Topics
PREP – PREP Questions
MKSAP/PREP – Medical Knowledge Self-Assessment Program

Legend for Evaluation Methods of House Officers (EM)
FE - Faculty Evaluations
PDR–Program Director's Review (biannually)
360 – Patient and Nurse Evaluations
IE – In-service Exam

PR – Peer Review
AMB – Ambulatory Topics
CEX – Mini-Cex
R Aud – Resident Chart Audit of chart
F Aud – Faculty Chart Audit

Principal Educational Goals by Relevant Competency
The principal educational goals for residents on this rotation are indicated for each of the six ACGME competencies.
PGY-1/2/3/4 (Goals are for all levels unless indicated)

A. Patient Care - Principal Educational Goals

1. Take a complete medical history and perform a careful and accurate physical examination.
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP
EM: FE, PDR, 360, CEX, F Aud

2. Write concise, accurate and informative histories, physical examinations and progress notes.
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP
EM: FE, PDR, F Aud, R Aud

3. Define and prioritize patients' medical problems and generate appropriate differential diagnoses.
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, F Aud, R Aud

4. Develop cost-effective, evidence-based management strategies for ambulatory medicine patients.
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, F Aud, R Aud

5. Learn basic interpretation of x-rays, electrocardiograms, laboratory studies, and CT and MRI scans
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, CEX

6. Perform pelvic examinations, PAP smears, and endocervical cultures under supervision as well as other in basic office-based procedures including interpretation of EKGs, performing punch biopsies, performing incision and drainage and suturing of minor wounds
LA: DPC, FS
EM: FE, 360, CEX

7. Recognize the physical findings of acute and chronic medical illnesses.
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, CEX

8. Demonstrate a willingness and ability to help patients engage in strategies of disease prevention.
LA: DPC, FS, MR, AMB
EM: FE, 360, AMB, CEX

B. Medical Knowledge - Principal Educational Goals

1. Expand clinical knowledge of the basic and clinical sciences underlying the care of ambulatory medical patients.
LA: DPC, GR, FS, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB

2. Access and review the current medical literature and scientific evidence relevant to ambulatory medical care.
LA: DPC, GR, FS, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB

3. Understand the pathophysiology, clinical manifestations, diagnosis and management of medical illnesses seen by a general internal medicine/pediatrics physician in the ambulatory setting.
LA: DPC, GR, FS, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB

4. Recognize the indications for and basic interpretation of X-rays, electrocardiograms, pulmonary function tests, stress tests, CT and MRI scans, and laboratory studies.
LA: DPC, GR, FS, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, F Aud, R Aud

5. Learn the indications for and basic interpretation of standard laboratory tests, including blood counts, coagulation students, blood chemistry tests, urinalysis, body fluid analyses, and microbiologic tests.
LA: DPC, GR, FS, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, F Aud, R Aud

6. Become familiar with basic principles of disease prevention, including adult immunizations, cardiovascular risk assessment, prevention of cardiovascular disease, screening for cancer, prevention of osteoporosis and cessation of the use of tobacco, alcohol, and drugs. Peds topics include acne management, ADHD evaluation, urinary incontinence, evaluation of growth and development, iron deficiency anemia and adolescent HEADSS assessment.
LA: DPC, GR, FS, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, F Aud, R Aud

7. Appreciate the progress and evolution of chronic diseases over time.
LA: DPC, GR, FS, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR

8. Become familiar with the pathophysiology, clinical manifestations and non-operative management of common musculoskeletal conditions.
LA: DPC, GR, FS, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, CEX

9. Become familiar with the pathophysiology, clinical manifestations and medical management of common gynecological conditions such as vaginitis, dysmenorrhea, irregular menses and menopausal symptoms. Be able to interpret wet preps and KOH smears of vaginal and urethral discharge.
LA: DPC, FS, GR, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, CEX

10. Become familiar with the pathophysiology, clinical manifestations and medical management of common otolaryngologic conditions, such as acute and chronic sinusitis, allergic rhinitis, otitis media and externa, pharyngitis, and vertigo.
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, CEX

11. Become familiar with the pathophysiology, clinical manifestations and management of common ophthalmologic conditions and perform and interpret a fluorescein stain of the cornea.
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, CEX

12. Become familiar with the unique aspects of diagnosis, interpretation of tests and management of illnesses in a geriatric population.
LA: DPC, FS, GR, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB

13. Become familiar with the diagnosis, interpretation of tests and management of patients with pediatric and adult neurological diseases.
LA: DPC, FS, GR, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB

14. Become familiar with screening requirements and anticipatory guidance points for pediatrics patients at routine visits.

LA: DPC, FS, GR, MR, CC, CL, GL, MKSAP/PREP, AMB
EM: FE, IE, MR, AMB, CEX

C. Interpersonal Skills and Communication – Principal Educational Goals

1. Communicate effectively with patients and their families.
LA: DPC, FS, MR, GR, CC, CL, GL, JC, MKSAP/PREP
EM: FE, MR, 360

2. Communicate effectively with physician colleagues at all levels.
LA: DPC, FS, CC
EM: FE, PR, MR, 360

3. Present clinical information on patients concisely and clearly, verbally and in writing.
LA: DPC, FS, CC, MR
EM: FE, PR, MR, CC, F Aud, R Aud

4. PGY-1 Act as a role model for medical students.
PGY-2,3,4 Act as a role model for medical students, junior house officers, nurses and paramedical personnel.
LA: DPC, FS, MR, FS
EM: FE, MR, CC, 360

5. Learn to effectively document management choices, medical reasoning, counseling points, declined services.
LA: DPC, FS, MR
EM: FE, MR, CC, 360, F Aud, R Aud

D. Professionalism - Principal Educational Goals

1. Interact professionally toward patients, families, colleagues, and members of the health care team. Act as a role model for medical students.
LA: DPC, FS, MR, CC
EM: FE, PDR, PR, 360

2. Accept professional responsibility of patients' care as a primary care physician.
LA: DPC, FS, MR, CC
EM: FE, PR, PDR, 360

3. Develop an appreciation for the social, genetic, environmental, and economic cause of disease.
LA: DPC, FS, GR, MR, CC, CL, GL, MKSAP/PREP
EM: FE, IE, MR

4. Understand ethical concepts of confidentiality, consent, autonomy and justice in the outpatient setting.
LA: DPC, FS, GR, MR, CC, CL, MKSAP/PREP, AMB
EM: FE, IE, MR, PDR, AMB

5. Understand professionalism concepts of integrity, altruism and conflict of interest in the outpatient setting.
LA: DPC, FS, GR, MR, CC, CL, MKSAP/PREP
EM: FE, IE, MR

E. Practice-Based Learning and Improvement - Principal Educational Goals

1. Identify and acknowledge gaps in personal clinical knowledge and skills in the care of ambulatory patients.
LA: DPC, FS, MR, GR, CC, CL, GL, JC, AMB, MKSAP/PREP
EM: FE, IE, PDR, 360, AMB

2. Develop and implement strategies for filling gaps in clinical knowledge and skills.
LA: DPC, FS, MR, GR, CC, CL, GL, MKSAP/PREP
EM: FE, IE, PDR

3. Demonstrate a commitment to professional scholarship, including systematic and critical review of relevant print and electronic literature related to ambulatory medicine, integrating basic science with clinical medicine in light of the principles of evidence-based medicine.
LA: DPC, FS, MR, GR, CC, CL, GL, AMB, MKSAP/PREP
EM: FE, IE, PDR, AMB

F. Systems-Based Practice - Principal Educational Goals

1. Understand and utilize the multidisciplinary resources necessary to care optimally for ambulatory medicine patients.
LA: DPC, FS, MR, GR, CC, CL, GL, AMB, MKSAP/PREP
EM: FE, IE, MR, AMB

2. Effectively collaborate with other members of the health care team, including nurses, diabetes educators, social workers, occupational therapists, physical therapists, nutrition specialists, patient educators, speech pathologists, respiratory therapists, enterostomy nurses, and providers of home health services.
LA: DPC, FS, MR, GR, CC, CL, GL, AMB, MKSAP/PREP
EM: FE, PR, MR, AMB

3. Use evidence-based, cost-conscious strategies in the care of ambulatory medicine patients.
LA: DPC, FS, MR, GR, CC, CL, GL, AMB, MKSAP/PREP
EM: FE, IE, MR, AMB

4. Know when and how to request medical subspecialty and surgical consultations, and how best to utilize the advice provided.
LA: DPC, FS, MR, GR, CC, CL, GL, AMB, MKSAP/PREP

EM: FE, IE, MR, AMB

5. Consider the cost-effectiveness of outpatient and ambulatory diagnostic and treatment strategies.
LA: DPC, FS, MR, GR, CC, CL, GL, AMB, MKSAP/PREP
EM: FE, IE, MR, AMB

6. Know when to refer patients or consult specialists in adult or pediatrics speech/physical therapy, orthopedics, gynecology, otolaryngology, urology, neurology, and ophthalmology.
LA: DPC, FS, MR, GR, CC, CL, GL, JC, AMB, MKSAP/PREP
EM: FE, IE, MR, AMB

7. Develop familiarity and comfort using an electronic health record to send prescriptions, document medical conditions and vitals, and coordinate care.
LA: DPC, FS
EM: FE, AMB, F Aud, R Aud

8. Understand billing and coding documentation requirements for E&M visits for new and established patients and preventive care at all ages and select procedures and bill appropriately for services provided

LA: DPC, FS, CL
EM: FE, F Aud, R Aud

Ambulatory Yale Curriculum:

July:
Wk 1/2 Newborn Screening
Wk 3/4 Primary care of the Premature Infant

August
Wk 1/2 Newborn Exam and Counseling (Sleeping) - refer to Stanford Website for Newborn Exam
Wk 3/4 Common Newborn Questions (Colic, dental care, circumcision)

September
Wk 1/2 Infant Nutrition/Breastfeeding
Wk 3/4 Vision/Hearing Screens/Lead

October
Wk 1/2 Normal and Delayed Pubertal Development/Precocious Puberty
Wk 3/4 ADHD

November
Wk 1/2 Motivational Interviewing of The Adolescent Patient
Wk 3/4 DM Management

December
Wk 1/2 Depression/Anxiety

January
Wk 1/2 Fever in Children <36 months of age
Wk 3/4 Therapeutic Joint Injections and Evaluation of Joint Pain (Dr. Dasa)

February
Wk 1/2 HTN Mgt (Adults and Kids)
Wk ¾ Lipid Screening

March
Wk 1/2 Dermatology Vocabulary and Topical Medications
Wk 3/4 Liver Function Test Abnormalities in the Asymptomatic Patient

April
Wk 1/2 Iron Deficiency Anemia in Pediatrics
Wk 3/4 Office GU Exams and Counseling on Contraceptives

May
Wk 1/2 Dementia and Mental Status Evaluation in the Outpatient Environment
Wk 3/4 Pediatric Diarrhea Evaluation

June
Wk 1/2 Evaluation and Treatment of Low Back Pain
Wk 3/4 Evaluation of Pediatric Headache

LSU Internal Medicine/Pediatrics Lecture Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00-9:00	**IM and Peds Morning report●** (UH & Touro)	**IM and Peds Morning report●** (UH &Touro)	**IM and Peds Morning report●** (UH & Touro) **Peds Grand Rounds 1st, 3rd, 5th Wednesdays**	**IM and Peds Morning report●** (UH & Touro)	**IM and Peds Morning report●** (UH & Touro) Ambulatory Morning Report: 3rd Friday
9:00-10:00	**Morning report●** (OKMC)	**Morning report●** (OKMC)	**Morning report ●** (OKMC)	**Morning report●** (OKMC)	**Morning report●** (OKMC)
9:00 – 12:00	**Rounds, hospital duties, & clinics**	**Rounds, hospital duties, & clinics**	**Rounds, hospital duties, & clinics**	**Rounds, hospital duties, & clinics**	**Rounds, hospital duties, & clinics**
12:00	**Pediatric Core Conference**	**IM Clinical Case Conference** **Peds Core Conference**	**Pediatric Clinical Case Conference & M&M** (1st Wednesday); **Med/Peds meetings** (2nd & 4th)	**Pediatric Core Conference**	**Pediatric Core Conference** **Medicine Grand rounds**
1:00 - 3:00	**Hospital duties & clinics**	**Hospital duties & clinics**	**Hospital duties & clinics**	**Hospital duties & clinics**	**Hospital duties & clinics**
3:30 – 5:00pm	**IM Guidelines followed by MKSAP Review** (2nd & 4th Monday) Rm. 429 @ 1542		**IM Core Lectures** (weekly)		

2013 – 2014 LSU Internal Medicine/Pediatrics Academic Lecture Schedule

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● = Required attendance by ALL house officers on the medicine service

■ = All HO1's and HO2's required to attend *unless*:

1) *Post-call; 2) Vacation 3) ICU rotation; 4) Out-of-town rotation; 5) HO2 officer is the senior resident on the rotation*

Required attendance at 1 of 2 review sessions per month:

IM GUIDELINES & MKSAP REVIEW

Residents assigned to LSU Interim Hospital are expected to attend:

ALL CONFERENCES & IM GRAND ROUNDS

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

CONTRACTUAL AGREEMENT TO TAKE BOTH INTERNAL MEDICINE AND PEDIATRICS BOARDS

I, __________________________, HEREBY AGREE TO TAKE BOTH CERTIFYING EXAMS IN INTERNAL MEDICINE AND PEDIATRICS WITHIN 3 YEARS OF COMPLETING MY MEDICINE/PEDIATRICS RESIDENCY AT THE LSU HEALTH SCIENCES CENTER.

BY AGREEING TO TAKE BOTH CERTIFYING EXAMINATIONS, I ALSO ACKNOWLEDGE THE IMPORTANCE OF PASSING THESE EXAMINATIONS FOR BOTH PERSONAL ACHIEVEMENT AND COMPLIANCE WITH THE STANDARDS SET BY THE ACGME TO MAINTAIN ACCREDITATION OF THE LSU MEDICINE/PEDIATRICS RESIDENCY PROGRAM.

________________________________ ________________________________

Resident Date Program Director Date

Companion Document

The revised Program Requirements document for the Subspecialties of Pediatrics reflects a transition from a process orientation to one of outcomes. In order to provide assistance to Program Directors, this Companion Document includes some explanation and guidelines for the types of documentation that will be expected. The numeric designations refer to sections of the Program Requirements.

Goals and Objectives

Written goals and objectives are required for each learning experience. These must be level specific since you would expect more expertise as learners progress thorough fellowship training. Goals are broad statements of what the learner is expected to accomplish over time.

Objectives are specific statements about what the learner is expected to do. Learning objectives should begin with a verb. The choice of verbs is important as the verb gives an indication of the level of complexity of the task. For example, it is easier to "identify" or "explain" than it is to "apply" and "evaluate." The verb that one chooses also needs to be one that describes a measurable behavior. So verbs like learn or understand are not useful for writing learning objectives because it is difficult for an evaluator to directly observe whether the objective has been met. Responsibilities should not be confused with learning objectives and should not be included here. For example, "respond to the arrest team pager when you are on the ICU and ED rotations" is a responsibility and not a true learning objective. The level of detail of the learning objectives should be such that an evaluator would be able to say that a goal has been reached because the requisite set of behaviors needed to reach the goal have all been witnessed. The goals and objectives for each learning experience must be distributed to and reviewed with each learner.

ACGME Competencies

Practice-based Learning and Improvement

In order for fellows to adopt this competency as a life-long habit of practice, they should be guided in the process of reflection with the intent of identifying strengths, needed areas for improvement, and plans to implement strategies that will lead to practice improvement. Fellows should be paired with a faculty mentor with whom they can develop a meaningful relationship to guide them in this process. Faculty development is necessary to ensure that mentors have the needed skills to address the full scope of their responsibilities and function as a valuable resource to fellows. Mentors should meet with mentees a minimum of twice per year along with ongoing interaction via email, phone conversations, etc., during these intervals.

The process of self-assessment is most valuable when discussed with a mentor. The mentor should guide the fellow in reviewing evaluations from health care team members and patients to understand: 1) how one's performance /behavior can impact others, and 2) how to incorporate this feedback into future practice improvement. The fellow can then build on this self-assessment and reflective process by developing an individualized learning plan (e.g., documenting a minimum of three personal learning objectives to address identified areas of needed improvement and strategies to achieve the objectives). This plan should be updated at least annually with the final plan focusing on transition to the next phase of one's career and a plan for life-long learning. The "Fellow Center" of PediaLink provides a mechanism to guide fellows through a self-assessment and reflective process that culminates in documentation of their learning plan. In addition to knowledge content, it is critical that fellows demonstrate their ability to use technology to access scientific evidence, interpret the evidence they uncover, and then apply it to the care of their patients. The program must document that a fellow is able to perform these skills and that the faculty have a structured way of teaching and evaluating such skill. Having the fellows present at Journal Club or complete a critically-appraised topic are examples of ideal ways of teaching and assessing skills. Necessary components include faculty guidance, criteria for demonstrating competence that are transparent to both fellows and faculty, and documented achievement of competence using the established criteria.

The program must also document that fellows acquire the skills needed to analyze and improve the quality of their practice. Each fellow should engage in a quality improvement project/activity under the guidance of the faculty. The Plan-Do-Study-Act (PDSA) cycle, as described by Berwick, which can be completed in a minimum of two week cycles, provides a practical method for engaging fellows in this process. This requirement may also be met through fellow membership on a QI Committee. In this case there must be evidence of the fellow's active participation in the planning, implementation and analysis of an intervention on a practice outcome.

Programs must provide skilled teachers as role models who demonstrate the value of teaching students, residents, patients and families. Structured learning activities that address teaching skills should be incorporated into the curriculum. Fellows should have opportunities to practice these skills and in turn be evaluated in so doing so that feedback can be used to bring about ongoing improvement.

Interpersonal and Communication Skills

Effective written and verbal communication is critical to practicing the science of medicine; style and content of communication is critical to practicing the art of medicine.

Providing fellows a structured curriculum to address the needed skills as well as engaging them in interactive methods of learning, such as role modeling, role

playing, direct observation and feedback, etc., are necessary to enable them to become competent in this area. Based on the need for subspecialists to engage in the delivery of critical/complex and sometimes devastating information regarding diagnosis, process and treatment, particular attention must be given to teaching and assessing competence in conducting family meetings for these purposes. "On-the job" training without structured teaching and feedback is not sufficient.
Effective communication is a requisite skill for optimal functioning of the health care team. The ability to function as a both a member and leader of a team are critical skills for the subspecialist who works with referring physicians and agencies, patient and families, as well as other members of the health care system.
One effective way of evaluating communication is through review of the fellow's correspondence with other health care professionals. A structured process for review of written communication, particularly consults and letters to referring physicians is required. Ad hoc review of written communication does not meet this requirement. Timeliness of completion as well as quality of information provided should be assessed and a mechanism for delivering feedback to the fellow must be ensured. Documentation of competence should be included as part of the written evaluation process.

Professionalism

Medical ethics and professionalism should be emphasized in the didactic curriculum and modeled by the faculty in all aspects of their practice. A structured curriculum with meaningful venues for teaching that extend beyond the traditional lecture to include interactive learning (e.g., small group discussions of vignettes or case studies, computer-based modules, role plays, etc.) will meet this requirement.
Multi-source feedback that includes patients/families and allied health professionals is critical to the professional formation of fellows. Since the fellow will relate to each individual in a unique way it is important to have team members (including the patient and family as part of the team) contribute to the assessment of a fellow's professionalism. The program should provide a mechanism to ensure that patients/families and representatives of the health care team assess appropriate aspects of the fellow's professionalism and that this feedback is given to the fellows, preferably as aggregate data, that preserves the anonymity of the evaluators. These evaluations should supplement the evaluations of faculty and peers. A structured mechanism for dissemination and collection of evaluations as well as delivery of feedback to the fellows is required. Timeliness of feedback is also important particularly when there has been a breach of professionalism. A structured mechanism for timely documentation, such as the use of critical incidents or instant evaluations, should be in place. In cases where remediation is needed, the steps should include immediate feedback, the development of an action plan with the fellow that specifically addresses the infraction, ongoing monitoring of behavior, and an identified consequence if improvement is not demonstrated.

Systems-Based Practice

In order to best serve a patient population, one must develop a familiarity with the natural history and epidemiology of major health problems in the community. A background understanding of the health literacy of the community, along with knowledge of the cultural norms and health beliefs, will improve care delivery. This information becomes helpful in improving patient/family compliance as well. The program must provide a structured curriculum to address all of the elements of this competency as well as opportunities to apply this learning. Particularly relevant to subspecialty fellows is their ability to apply the elements of this competency (e.g., preventive care, resource allocation, cost-effective care, etc.) to help patients navigate the complexities of the health care delivery system.

A clinical setting that particularly lends itself to experiential learning and demonstration of the requisite skills is a continuity clinic setting where the fellow has an ongoing therapeutic relationship with patients. In addition, for three year fellowship programs, fellows must have exposure to the administrative aspects of the delivery of care appropriate to their subspecialty discipline. The required elements may be addressed by having fellows be active participants in division meetings and division conferences where these issues are discussed and solutions to identified problems developed and/or by participating with designated faculty in carrying out administrative responsibilities within the division.

Programs must provide a safe environment that encourages practitioners to identify weaknesses, deficiencies, and errors. The program must ensure that each fellow is actively engaged in activities, under the guidance of experienced faculty, to identify system problems/errors, and to develop and implement system solutions. Morbidity and mortality conference provides an ideal venue for a structured approach to the examination of system errors and the development of system solutions provided the interdisciplinary team that represents the system is involved and the fellow is an active participant in identifying and addressing the problems/errors.

Medicine/Pediatrics Residency Eligibility, Selection and Promotion Policy

First year House Officers must participate in the National Residency Matching Program (NRMP) and must meet the entire ACGME General requirement for selection of House Officers.

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.

4. Graduates of medical school's outside the United States who have completed a Fifth Pathway Program by an LCME-accredited medical school.

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 one level and passes the USMLE Steps 1 through 3 or COMLEX Steps 1 through 3.

House Officer selection criteria conform to the guidelines of the ACGME General Requirements. House Officer selection must comply with the institutional guidelines documented in the Graduate Medical Education Policies and Procedures Manual. Medicine/Pediatrics applicants send their applications through the Electronic Residency Application Service (ERAS) where the Medicine/Pediatrics Program Director, chief residents and coordinator review downloaded applicant files. Applicants invited for interviews meet with the Medicine/Pediatrics Program Director, chief resident, a faculty member and several residents. The Program Director, a Medicine/Pediatrics or Pediatrics faculty and a Medicine/Pediatrics chief resident will interview the applicant and fill out an evaluation form. The Program Director formally discusses the interviewed applicants with the Medicine/Pediatrics chief residents and involved faculty before finalizing the rank-order list. Selection criteria is based on application, curriculum vitae, personal statement, grades, board scores and letters of recommendation. House Officers are appointed for one year. The Program Director meets bi-annually with the House Officers to review their evaluations and individual learning plans. In the spring the Program Director convenes with the Clinical Competency Committee which makes official recommendations for each residents regarding the progress of each resident, including promotion, remediation, or dismissal. The Program Director uses the recommendations of the Clinical Competency Committee to determine whether the residents have successfully satisfied all criteria for promotion to the next PGY level.

LSU Health Sciences Center

Internal Medicine/Pediatrics Residency Program Resident Duty Hours Policy

The LSU Internal Medicine/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. Didactics and clinical education have the highest priorities 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 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.

   a. Duty hours will be limited to 80 hours per week averaged over a four-week period, inclusive of all in-house call activities, internal moonlighting and external moonlighting.

   b. Residents will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

   c. Minimum Time Off between Scheduled Duty Periods:

      1) All interns and residents must have 8 hours free of duty but should have 10 hours free of duty between scheduled duty periods.

      2) PGY II residents are considered “intermediate” residents and must have at least 14 hours free of duty after 24-hours of in-house duty.

   d. EXCEPTION to the 8/10 hour duty periods: Residents in their final years of residency (PGY III and IV) may occasionally stay on duty to care for their patients or return to the hospital with less than 8 hours free of duty. The program director must monitor these circumstances to ensure an appropriate educational rationale.

II. On-Call Activities

a. In-house call will not occur more frequently than **every third night.** For inpatient IM and pediatric NICU and PICU rotations, residents take every 4th night call. During outpatient rotations as an upper level, residents can be assigned 4–5 call nights, but are not allowed any extra duties in the NICU. Residents will have 2 call free months throughout their four years of training. For the pediatric emergency room rotations, residents will work at least sixteen 8-hour shifts. For adult ER rotations, residents work 12-hour shifts but are still required to attend their continuity clinics since the residents will not be scheduled shifts on those days.

b. Maximum Duty Period Length

   1. Continuous on-site duty, including in-house call, will not exceed 16 consecutive hours for interns
   2. Residents PGY-2 and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
      I. **24 + 4 Rule**: Residents may remain on duty for up to four (4) additional hours to participate in the transfer care of patients, to maintain continuity of medical care, and to participate in didactic activities, if time permits.
      II. No new patients will be accepted after 24 hours of continuous duty.
      III. Examples of work schedules: If the resident's workday starts at 7:00am, they must leave by 11:00 am post call. If the workday starts at 8:00am, they must leave by 12:00 pm post call.
   3. **EXCEPTION** to 24 + 4 rule: Residents who **voluntarily** remain beyond their scheduled duty period to care for a **single** patient must provide a justification for staying to the Program Director via e-mail within 24 hours in every circumstance. The resident must hand over the care of all of other patients to the team responsible for their continuing care.

   4. Only 3 justifications for extensions of duty are acceptable:

A) Required continuity for a severely ill or unstable patient

B) Academic importance of the events transpiring

C) Humanistic attention to the needs of patient or family

5. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

III. All employees of LSUHSC must comply with the Chancellors Memorandum 37 which is the LSUHSC Fitness for Duty Policy. This memorandum requires all LSUHSC employees to report to work fit and safe. It defines unsafe/impaired behaviors, the requirement for self or supervisor referral to the Campus Assistance Program, and the steps taken thereafter.

IV. Although faculty should model professional behaviors and standards that encourage residents to be fit for duty, the residents must assume responsibility and accountability for proactive behaviors that promote fitness for duty.

A. Wisely manage their time before, during, and after clinical assignments.

B. Recognize, address, and report impairment in self and peers.

C. Prioritize patient safety and welfare.

D. Report duty hours accurately, timely, and honestly.

III.Moonlighting *(see also the Medicine/Pediatrics Moonlighting Policy)*

a. The residency program will ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

b. Both external and internal and external moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s), i.e., internal moonlighting must be counted toward the 80-hour weekly limit on duty hours.

c. Residents must not schedule moonlighting activities that will cause them to exceed any of the duty hour requirements particularly the 80-hour maximum weekly limit.

d. House officers must carefully track and record their internal and external moonlighting to ensure they do not exceed the 80-hour work week requirement.

e. Residents who violate duty hour policies due to inappropriate moonlighting will be subject to disciplinary

action including but not limited to loss of moonlighting privileges.

IV. Monitoring of Duty Hours

a. Residents must enter duty hours in New Innovations https://www.new-innov.com for all rotations throughout the academic year for all pediatric and adult rotations.

b. Residents who fail to log duty hours or who log erroneous duty hours are subject to disciplinary action by the program.

V. Monitoring of Fatigue and Sleep Deprivation

a. Faculty will receive education on the signs of sleep deprivation both at the Medicine/Pediatrics monthly faculty meetings and via the Med/Peds website and Policy & Procedure manual available for view at all times.

b. Faculty will document monthly on the resident evaluation forms if there are any signs of fatigue.

c. The Pediatrics Program Director or designee as a member of Children's Hospital Infection Control and Quality Assurance Committee will receive quarterly reports on needle stick injuries, sentinel events, and adverse patient outcomes.

d. Residents will self-report on their biannual self-assessments the following: number of traffic violations, accidents; reports of any needle sticks; reports of any adverse patient outcome or significant medication errors. These assessments will be reviewed with the Program Director during the biannual reviews and appropriate action plans will be developed if needed.

VI. Residents' Responsibilities:

a. Enter duty hours in New Innovations accurately and timely.

b. Notify the respective chief residents and Program Director within 24 hours if the duty hours are violated with the explanation of the circumstances that led to the violation. The Program Director will keep track of all duty-hour violations and make program changes should there be an excessive number reported.

c. Complete the self evaluations at the biannual review that include sleep deprivation questions.

VII. Medicine/Pediatric Chief Residents' Responsibilities:

a. Notify the program director about any potential violations that should be rectified immediately

b. Remind residents at the monthly Medicine/Pediatrics business meetings to complete duty hours log in New Innovations and to be more proactive and responsible about compliance with duty hours.

c. The Medicine/Pediatrics chief residents will collect quarterly resident questionnaires that include compliance with duty hours. They will present all violations to the Internal Medicine and Pediatrics Residency Review Committees.

d. During monthly Med/Peds business meetings, Medicine/Pediatrics chief residents will discuss significant IM and Pediatric duty hour violations which are then presented to the respective IM and/or Pediatrics Residency Review Committee to develop potential solutions.

TRANSITIONS OF CARE

The institution and program recognize the importance of effective, efficient, and informative "hand offs" that minimize medical errors, promote patient safety, and produce the most optimal outcome for patient care. The program has developed the following safeguards to ensure effective transitions of care between residents.

1) Resident schedules with accurate faculty and resident contact information for each rotation will be clearly posted on both New Innovations and the patient information sheet that resident use during hand-offs.
2) Residents and interns will be evaluated by faculty (for residents and/or interns) and residents (for interns) during internal medicine and pediatric wards, and pediatric night float rotations: a) to ensure a structured hand-off process that facilitates continuity of care and patient safety; b) to assess the accuracy and thoroughness of information during the transfer of care; c) to assess the competency of residents in communicating with team members
3) The Medicine/Pediatrics, Pediatrics, and Internal Medicine Program Directors will give lectures to new interns during orientation that focus on anticipatory guidance and preventative measures.
4) The interns receive education material about transitions of care during the institutional orientation.
5) The residents must read and successfully complete the institutional core module on transitions.

The content of the transition document should include the following relevant, accurate and significant patient information that will ultimately improve overall patient care by the "on-call" team.

1) Name and valid contact numbers of all team members including attending physician, resident, and intern (valid contact numbers: beeper/ home/cell)
2) Patient demographics (full name, age, sex, DOB, room number, medical record number, number of family members that wish to be contacted)
3) Code status of patient
4) Active medical problems; relevant past medical history
5) Current medications, allergies, consultants
6) Pending labs, radiographs, tests, and results to be checked by on-call team
7) Disposition (home/hospice/discharge/rehab)
8) **Anticipatory Guidance** for issues/concerns over next 12-24 hours
9) Plan/"To Do" List

A sample template was placed on a pocket card and distributed to all house officers during orientation.

LSU MEDICINE/PEDIATRICS MOONLIGHTING POLICY

1. Moonlighting is not required and is not encouraged by the program. Approval of any and all moonlighting is entirely at the discretion of the Medicine/Pediatrics Program Director.

2. Only house officers who have successfully completed 16 months of training, passed USMLE Step III, and have proof of medical licensure in Louisiana in their file are eligible for moonlighting.

3. House officers must be in satisfactory academic standing in both specialties and have excellent evaluations documented in all rotations.

4. The resident must complete a Medicine/Pediatrics **Moonlighting Approval Form** that documents the location of the activity, time commitment (hours per week), and frequency of the moonlighting shifts. This form must be updated each year and signed and dated by both the Program Director and the resident.

5. House officers must provide proof that any and all malpractice coverage will be provided by you and/or the institution where moonlighting takes place. Residents must comply with both the institutional duty hour policies as well as the moonlighting policies of both Pediatrics and Internal Medicine.

6. Since moonlighting is an extracurricular activity approved by the Program Director, evidence of fatigue or interference with the ability of the resident to fulfill the duties of the educational program will result in immediate termination of all moonlighting privileges.

7. Moonlighting is not permitted during weekdays between 7am – 4pm.

8. House officers cannot moonlight during ICU and ward months.

9. Neither the weekly call schedule nor weekend rounds will be modified to accommodate moonlighting commitments.

10. House officers may never use their temporary MCLNO DEA number outside the MCLNO-New Orleans system. Inappropriate use may result in arrest, fines, and disciplinary action by the program director.

11. House officers are prohibited from moonlighting in weight loss and pain clinics.

12. All moonlighting that occurs within the residency program both internal at the sponsoring institution AND external moonlighting must be counted toward the 80-hour weekly duty hour requirement.
    1. Residents must not schedule moonlighting activities that will cause them to exceed any of the duty hour requirements particularly the 80-hour maximum weekly limit.
    2. House officers must carefully track and record their internal and external moonlighting to ensure they do not exceed the 80-hour work week limit.

13. Residents who violate duty hour policies due to inappropriate moonlighting will be subject to disciplinary action including but not limited to loss of moonlighting privileges.

14. **All interns and house officers with J-1 visas are prohibited from moonlighting.**

15. House officers subpoened for activities related to moonlighting must use their vacation time or 1 in 7 days off to fulfill the subpoena. All call or clinics must be made up for the resident(s) covering for you.

PEDIATRICS MOONLIGHTING POLICY

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 if there is evidence of fatigue.

4. House officers 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 the Children's Hospital Finance Department.

5. Residents must abide by the following moonlighting guidelines:

a. Residents cannot moonlight the day before or the day after a regularly scheduled call day.
b. Residents cannot moonlight during an every 4th night call rotation month.
c. Moonlighting activities cannot interfere with required rotation duties.
d. 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.
e. Residents are limited to 5 week day calls/month

6. Monitoring of activities will be performed formerly at the monthly Pediatrics Residency Review Committee meetings.
7. Moonlighting by 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.

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

LSU MEDICINE/PEDIATRICS MOONLIGHTING APPROVAL FORM

I, ________________________, attest to the fact that I am moonlighting at the following location(s). I have been informed that moonlighting is a privilege which is completely predicated on my academic standing and requires written permission from my Program Director. Moonlighting activities cannot violate ACGME work force hour requirements and cannot take place during regular residency working hours, particularly during ward and ICU rotations. Proof of malpractice coverage must be provided and placed in the file before any moonlighting can occur.

I must receive written permission to moonlight at any additional locations in the future, and I will document additional moonlighting opportunities on this form. I must update this form annually and carefully read the Medicine/Pediatrics Moonlighting Policy. I understand that my moonlighting privileges may be removed or limited at any time by my Program Director for either personal or professional reasons.

Moonlighting site(s) and average number shifts/month (specify duration of each shift):

1. ___________________________ Approved: ___________
2. ___________________________ Approved: ___________
3. ___________________________ Approved: ___________
4. ___________________________ Approved: ___________

Supervision for LSU Medicine/Pediatrics House Officers

INTERNS

Interns must be supervised by senior level residents (2nd, 3rd, 4th, 5th year), fellows, and faculty during all patient encounters. Residents must take in-house call with interns and personally review each history and physical, diagnostic and treatment plan, and order set with the intern(s). Interns should direct any questions during clinics, call and rounds to residents, fellows, or faculty. All patients admitted by interns must be interviewed and examined by the supervisory resident and faculty. Residents and faculty must co-sign intern notes in the chart. Interns must be directly supervised during all invasive diagnostic and therapeutic procedures.

RESIDENTS (2nd, 3rd, 4th)

Medicine/Pediatrics residents assume a supervisory role after completing eight months of each specialty to ensure adequate competency in each specialty. Residents are responsible for teaching medical students and interns during both inpatient and outpatient rotations. Residents must take in-house call with interns and personally interview and examine all patients admitted by the intern. Residents must assist interns in accurate documentation, including history & physicals, orders, and consultations. Residents must teach interns how to perform procedures accurately and must supervise interns during all procedures. Residents must delegate patient care responsibilities to interns in a graded fashion to provide a challenging, yet balanced educational experience that is not service-oriented.

Residents must demonstrate leadership during all clinical rotations. They should review their goals and objectives before each rotation with faculty. Residents should be proficient in the 6 competencies and duty hours policies and be proactive about enforcing the policies with the team.

All progress notes and new admissions must be reviewed and signed by fellows or staff. When residents admit new patients with or without the intern, they must discuss the diagnosis and treatment with the fellow or attending on call. Rounds must be conducted with fellows and/or staff to ensure graded competency and confidence at each level of training. Fellows and faculty must interview, examine, and write a note on all patients managed by the resident during inpatient and outpatient rotations. Residents should direct all questions and concerns regarding patient management to fellows and faculty. Although faculty is encouraged to provide both mid-month and end-of-the-month feedback, residents should proactively seek such feedback from peers, fellows, and faculty. Procedures that have been performed many times do not require supervision;

however, procedures new to the resident should be directly supervised by fellows or staff, with procedures notes written for all procedures.

CHIEF RESIDENTS

Medicine/Pediatrics chief residents are 4th year residents who function in both resident and administrative capacities. During their clinical rotations, they function like all supervisory residents and oversee students and interns in all aspects of patient care, including writing notes, history & physicals, writing orders, procedures, education, and supervision.
Administratively, the chief residents serve as a liaison between residents and the faculty. They manage minor administrative issues within the residency, but report major problems involving residents, faculty, policies, and curriculum to the Medicine/Pediatrics Program Director.

FACULTY

A. *Supervision of Residents:*

Faculty assigned to each participating site must possess the documented qualifications to instruct and supervise all residents at that location. They must demonstrate strong interest in education of residents and must devote sufficient time to fulfill their supervisory and teaching responsibilities. They must be educated to recognize the signs of fatigue and sleep deprivation and apply the policies in the P&P to prevent and counteract the negative effects on patient care and learning. Faculty must comply with the duty hour standards for interns and faculty to prevent excessive reliance on residents to fulfill service obligations. Finally, faculty must role model and exhibit professional standards of behavior that is conducive to the personal and professional development of each resident.

Faculty are ultimately responsible for the oversight of all patient care activities as well as supervision and education of interns and residents. They are directly responsible for the medical management of all patients and the overall educational experience of each team member. They must ensure the accuracy and thoroughness of patient assessments and therapeutic plans by interviewing and examining patients and reading the progress notes in the chart. Prior to each rotation, faculty must review the level-specific, competency-based goals and objectives with the team to ensure each member understands the individual and team goals. They should provide each resident with a graded level of responsibility for patient care, progressive responsibility for patient management, teaching, administration, and leadership based on the level of resident training and the variety and breadth of clinical experiences.

Faculty should always be available 24/7 for all questions regarding patient care. Faculty should provide daily and mid-month formative feedback to interns and residents and discuss the final summative evaluation with each resident at the end of the rotation. During these feedback sessions, faculty should address any patient care issues that must be corrected prior to promotion to the next level of training.

B.***Communication with Attending Physicians*:**

Although faculty and residents collectively have responsibility for the safety and welfare of patients; however, the attending physician is ultimately responsible for the patient's care. Thus, the program must ensure that appropriately credentialed faculty provide appropriate supervision of residents in all patient care activities to ensure patient safety and resident education. Faculty should supervise the management of patients either directly or indirectly based on the level of training of the resident (see below). Residents are instructed to call the attending physician at any time if they have any questions or concerns about the patients. However, if fellows are rotating on the service and are directly involved in the management of the patient ie in the ICU, the resident should first call the fellow on-call to provide him/her with a meaningful educational experience necessary during fellowship.

Residents, however, MUST communicate with the appropriate supervising faculty in unique circumstances that require immediate attention including:

1) Transfer of patients to the ICU
2) Impending death or death of a patient
3) Discussion of end-of-life issues ie DNR, palliative care, hospice
4) Family wishes to speak to the attending physician
5) Significant or unexpected deterioration in patient status
6) Any uncertainty regarding diagnosis and/or management
7) Difficulty attaining timely subspecialty or specialty consultants
8) Unanticipated invasive, diagnostic procedure or surgery

C.Staff-Resident Roles

Prior to the beginning of all ward rotations, the ward attendings receive specific instructions electronically that highlight faculty teaching and administrative expectations. The ward rules require that faculty ensure both the staff and residents/interns properly introduce themselves to all patients and fully disclose their respective medical roles regarding the management of the patients. Faculty and residents will be evaluated for compliance with the required patient-physician introduction.

D.Levels of Supervision:

The following chart documents the level of resident supervision expected at each level of training to ensure graded authority and responsibility throughout training. Faculty and senior residents or fellows serving in a supervisory role must be cognizant of delegating portions of care to residents based on the needs of the patient and the skills of the individual resident or intern to assist in their progress toward greater independence. Ultimately, residents should be able to manage patients independently and competently without supervision by the completion of their 4th year.

PGY	Direct by Faculty	Direct by senior residents	Indirect but immediately available - faculty	Indirect but immediately available - residents	Indirect available	Oversight
I	All educational rounds: Inpatient wards, including ICU; checking out patients in subspecialty & continuity clinics, PER/MER; Simulation & procedure skills fairs Select observed mini-history and physicals; hand-offs; pap smears; some invasive procedures; observing specific communication skills in clinic or wards with difficult	Performance of invasive procedures; end-of-life issues; transfer to the ICU; pronouncing patients; delivering bad news; hand-offs; checking orders for accuracy and thoroughness ; assessing critically ill patients on the floor or ICU; management of difficult patients	All rotations during routine work hours from 8am-5pm in clinic and wards after educational rounds are completed	Performing history and physical exams in clinic, ICUs wards; writing orders; assessing patients on the floor; calling consultants	24/7 during wards; during regular clinic hours 8am-5pm; invasive procedures; end-of-life issues; pronouncing patients; delivering bad news; transfer to ICU; discussing patient care issues esp the accuracy of dx and mgt	QI projects

	patients, peers, or consultants; delivering bad news, etc					
II	All educational rounds: Inpatient wards including ICU; checking out patients in subspecialty & continuity clinics, PER/MER; Simulation & procedure skills fairs Select observed mini-history and physicals; hand-offs; pap smears; some invasive procedures; hard-offs; observing specific communication skills in clinic or wards with difficult patients, peers, or consultants; delivering bad news, etc	Performance of invasive procedures; end-of-life issues; transfer to the ICU; hand-offs; pronouncing patients; delivering bad news; checking orders for accuracy and thoroughness; assessing critically ill patients on the floor or ICU; management of difficult patients	All rotations during routine work hours from 8am-5pm in clinic and wards after educational rounds are completed	Performing history and physical exams in clinic, ICUs, and wards; writing orders; assessing patients on the floor; calling consultants	24/7 during wards; during regular clinic hours 8am-5pm; invasive procedures; end-of-life issues; pronouncing patients; delivering bad news; transfer to ICU; discussing patient care issues esp the accuracy of dx and mgt	QI projects
III	All education rounds: Inpatient wards including ICU; checking out patients in subspecialty & continuity		All rotations during routine work hours from 8am-5pm	Performing history and physical exams in clinic, ICUs, and wards; writing	24/7 during wards; during regular clinic hours 8am-5pm; invasive procedures;	QI projects

	<u>clinics,PER/MER; Simulation & procedure skills fairs</u> ***<u>Select observed mini-history and physicals; pap smears; hand-offs; some invasive procedures; observing specific communication skills in clinic or wards with difficult patients, peers, or consultants; delivering bad news, etc</u>***		***<u>after educational rounds are completed</u>***	***<u>orders; assessing patients on the floor; calling consultants</u>***	***<u>end-of-life issues; pronouncing patients; delivering bad news; transfer to ICU; discussing patient care issues esp accuracy of dx and mgt</u>***	
<u>IV</u>	***<u>Inpatient ward rounds including ICU; checking out patients in subspecialty & continuity clinics, PER/MER; Simulation & procedure skills fairs</u>*** ***<u>Select observed mini-history and physicals; pap smears; hand-offs; some invasive procedures; observing specific</u>***		***<u>All rotations during routine work hours from 8am-5pm after educational rounds are completed</u>***	***<u>Performing history and physical exams in clinic, ICUs and wards; writing orders; assessing patients on the floor; calling consultants</u>***	***<u>24/7 during wards; during regular clinic hours 8am-5pm; invasive procedures; end-of-life issues; pronouncing patients; delivering bad news; transfer to ICU; discussing patient care issues, esp the accuracy of dx and mgt</u>***	***<u>QI projects</u>***

	communication skills in clinic or wards with difficult patients, peers, or consultants; delivering bad news, etc					

PROGRAM DIRECTOR

The Medicine/Pediatrics Program Director must ensure the Residency Supervision Policy is actively enforced during all internal medicine and pediatrics rotations. Should the Program Director discover that noncompliance exists on either an internal medicine or a pediatrics rotation, she will determine the exact violation and confer with either categorical program director to resolve the issue. Further deliberation with the appropriate residency education committee may also be required

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. Education and annual 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.

LIAISON AND OVERSIGHT POLICY

According to the ACGME Common Program Requirements, the program director must "oversee and ensure the quality of didactic and clinical education in all sites that participate in the program." This requirement includes: "selecting and supervising the faculty and other program personnel at each participating institution; appointing a local site director accountable for resident education; monitoring resident supervision at all participating sites; implementing policies and procedures consistent with institutional and program requirements for duty hours and working environment, including moonlighting; and enforcing institutional grievance and due process procedures."

The Medicine/Pediatrics residency program adheres to this ACGME policy. The program director makes all resident schedules for each academic year. Categorical chief residents make all call schedules that comply with the institutional work force hours. The program director monitors the volume and type of admissions and work force statistics for each site to ensure adequate training and compliance at all sites. The Medicine/Pediatrics program director meets monthly with the Internal Medicine Residency Education Committee and with the Pediatrics Residency Education Committee to discuss compliance with duty hours, resident issues, results of competency-based evaluations, and educational goals at each site. Effective July 2007, the internal medicine hospitalists at Ochsner Medical Center-Kenner and Touro Hospitals, Dr. Najy Masri and Dr. John Amoss, respectively, will also attend the Internal Medicine Residency Education Committee monthly to ensure adequate communication between program directors and hospitalist directors in regard to achieving educational goals and objectives. Since the Program Director must "provide back-up support systems when patient care responsibilities are unusually difficult or prolonged" and must "adjust schedules to mitigate excessive service and/or fatigue," these regularly scheduled meetings will facilitate efficient solutions to such problems.

Medicine/Pediatrics house officers meet monthly at their own business meeting to discuss significant medicine and pediatric issues so that the Medicine/Pediatrics program director can bring these salient issues to the appropriate Residency Education Committee for discussion. The pediatric residency program also holds monthly housestaff meetings which are attended by all categorical and Medicine/Pediatrics residents to discuss resident concerns, announcements, important issues or updates. Combined residents meet biannually with the Medicine/Pediatrics program director to review their portfolios, procedure logs, competency-based evaluations, and compliance with duty-hour requirements.

Grievance Procedures/Dismissal Policy

1. The Internal Medicine/Pediatrics Residency Program follows the guidelines set forth by the LSUHSC Institutional Graduate Medical Education Guidelines which are documented in the House Officer Manual for appeals and due process. All incoming house officers are given copies of the Graduate Medical Education Guidelines at orientation and are encouraged to become familiar with them.

2. **There are several additional steps to facilitate the process. First, the Medicine/Pediatrics chief residents and/or Program Director counsel residents who have personal and/or professional difficulties.** The Medicine/Pediatrics Program Director is directly involved in both Residency Review Committees and Competency meetings that review residents with academic, personal or professional problems that require immediate swift attention. The Program Director must counsel the resident and offer appropriate remediation that will provide assistance for academic, professional or personal deficiencies. The Program Director personally discusses the formal recommendations for remediation with the resident of concern and outlines a specific time frame for accomplishing the expected outcome. In addition, the resident can be offered available resources such as Campus Assistance if the problem warrants psychiatric or crisis intervention. Failure to achieve the expected outcome may warrant probation or dismissal.

3. **Minor problems are first discussed with the Program Director to facilitate a reasonable solution.** For most minor first offenses no formal recommendations are made. Residents, however, will be referred to the Campus Employee Assistance Program if the Program Director and/or Clinical Competency Committee feel that the house officer's professional performance may be impaired by substance abuse, mental illness, or other treatable issues. Also, residents are encouraged to self-refer if they deem necessary.

4. For repeat offenses or more serious offenses, the case is discussed with the Residency Review Committee involved to discuss potential solutions and/or recommendations for remediation. At all times, the resident may appear in person or in writing before a Clinical Competency Committee to appeal the decision of the Program Director and Residency Review Committee. If the resident's issue has a potential impact on patient care or safety, the resident may be reassigned to a rotation where his or her actions will not endanger patients or other workers while the case is under review.

5. **Failure to comply with recommendations or to satisfy remediation expectations can result in probation or dismissal after a final set of meetings with the Program Director and the members of the Clinical Competency Committee. The resident is encouraged to appeal if there are any questions.**

6. **Probation and dismissal** are viewed as final options for the following reasons: a) repeated violations of any of the 6 competencies; b) insubordination; c) conduct detrimental to patient care; d) unprofessional conduct; e) revocation or suspension of license; f) violation of federal and/or state laws, regulations, or ordinances;. g) failure to comply with policies, rules and regulations of the House Officer Training Program or other facilities where the House Officer is trained.

7. **If an adverse action such as probation or dismissal is taken, the Chairmen of both Internal Medicine and Pediatrics departments and the Associate Dean of Graduate Medical Education must be notified.**

8. Residents have the right to due process and can appeal the decisions of the Clinical Competency Committee as outlined in the institutional GME Houseofficer Guidelines. The resident must be notified of his/her due process as outlined in the House Officer manual and Graduate Medical Education Policies and Procedures Manual.

DUE PROCESS

All communication regarding due process will occur by either official campus email, certified letter, or hand delivery (revised 12/15/2009). Dismissals, non-reappointments, non-promotion (revised 6/21/2007) or other adverse actions which could significantly jeopardize a House Officer's intended career development are subject to appeal and the process shall proceed as follows:

Recommendation for dismissal, non-reappointment, or other adverse action which could significantly threaten a House Officer's intended career development shall be made by the Program Director in the form of a Request for Adverse Action. The Request for Adverse Action shall be in writing and shall include a written statement of deficiencies and/or charges registered against the House Officer, a list of all known documentary evidence, a list of all known witnesses and a brief statement of the nature of testimony expected to be given by each witness. The Request for Adverse Action shall be delivered in person to the Department Head. If the Department Head finds that the charges registered against the House Officer appear to be supportable on their face, the Department Head shall give Notice to the House Officer in writing of the intent to initiate proceedings which might result in dismissal, non-reappointment, summary suspension, or other adverse action. The Notice shall include the Request for Adverse Action and shall be sent by campus email, certified mail to the address appearing in the records of the Human Resource Management, or may be hand delivered to the House Officer (revised 12/15/2009).

Upon receipt of Notice, the House Officer shall have five (5) working days to meet with the Department Head and present evidence in support of the House Officer's challenge to the Request for Adverse Action. Following the meeting, the Department Head shall determine whether the proposed adverse action is warranted. The Department Head shall render a decision within five (5) working days of the conclusion of the meeting. The decision shall be sent by campus email, certified mail to the address appearing in the records of the Human Resource Management, or hand delivered to the House Officer and copied to the Program Director and Academic Dean (revised 12/15/2009).

If the House Officer is dissatisfied with the decision reached by the Department Head, the House Officer shall have an opportunity to prepare and present a defense to the deficiencies and/or charges set forth in the Request for Adverse Action at a hearing before an impartial Ad Hoc Committee, which shall be advisory to the Academic Dean. The House Officer shall have five (5) working days after receipt of the Department Head's decision to notify the Academic Dean in writing or by email (revised 12/15/2009) whether the House Officer would challenge the Request for Adverse Action and desires an Ad Hoc Committee be formed. If the House Officer contends that the proposed adverse action is based, in whole or in part on race, sex (including sexual harassment), religion, national origin, age, Veteran status, and/or disability discrimination, the House Officer shall inform the Academic Dean of that contention. The Academic Dean shall then invoke the proceedings set out in the Section entitled "Sexual Harassment Policy" of

this Manual. The hearing for adverse action shall not proceed until an investigation has been conducted pursuant to the Section entitled "Sexual Harassment Policy."

The Ad Hoc Committee shall consist of three (3) full-time clinical faculty members who shall be selected in the following manner:

The House Officer shall notify the Academic Dean of the House Officer's recommended appointee to the Ad Hoc Committee within five (5) working days after the receipt of the decision reached by the Department Head. The Academic Dean shall then notify the Department Head of the House Officer's choice of Committee member. The Department Head shall then have five (5) working days after notification by the Academic Dean to notify the Academic Dean of his recommended appointee to the Committee. The two (2) Committee members selected by the House Officer and the Department Head shall be notified by the Academic Dean to select the third Committee member within five (5) working days of receipt of such notice; thereby the Committee is formed. Normally, members of the committee should not be from the same program or department, In the case of potential conflicts of interest or in the case of a challenge by either party, the Academic Dean shall make the final decision regarding appropriateness of membership to the ad hoc committee. (revised 7-1-2005) Once the Committee is formed, the Academic Dean shall forward to the Committee the Notice and shall notify the Committee members that they must select a Committee Chairman and set a hearing date to be held within ten (10) working days of formation of the Committee. A member of the Ad Hoc Committee shall not discuss the pending adverse action with the House Officer or Department Head prior to the hearing. The Academic Dean shall advise each Committee member that he/she does not represent any party to the hearing and that each Committee member shall perform the duties of a Committee member without partiality or favoritism.

The Chairman of the Committee shall establish a hearing date. The House Officer and Department Head shall be given at least five (5) working days notice of the date, time, and place of the hearing. The Notice may be sent by campus email, certified mail to the address appearing in the records of the Human Resource Management, or may be hand delivered to the House Officer, Department Head, and Academic Dean. Each party shall provide the Committee Chairman and the other party the following documents: a witness list, a brief summary of the testimony expected to be given by each witness, and a copy of all documents to be introduced at the hearing at least three (3) working days prior to the hearing.

The hearing shall be conducted as follows:

The Chairman of the Committee shall conduct the hearing. Each party shall have the right to appear, to present a reasonable number of witnesses, to present documentary evidence, and to cross-examine witnesses. The parties may be excluded when the Committee meets in executive session. The House Officer may be accompanied by an attorney as a nonparticipating advisor. Should the House Officer elect to have an attorney present, the Department Head may also be accompanied by an attorney. The attorneys for the parties may confer and advise their clients upon adjournment of the proceedings at reasonable intervals to be determined by the Chairman, but may not question witnesses,

introduce evidence, make objections, or present argument during the hearing. However, the right to have an attorney present can be denied, discontinued, altered, or modified if the Committee finds that such is necessary to insure its ability to properly conduct the hearing. Rules of evidence and procedure are not applied strictly, but the Chairman shall exclude irrelevant or unduly repetitious testimony. The Chairman shall rule on all matters related to the conduct of the hearing and may be assisted by University counsel.

The hearing shall be recorded. At the request of the Dean, Academic Dean, or Committee Chairman, the recording of the hearing shall be transcribed in which case the House Officer may receive, upon a written request at his/her cost, a copy of the transcript will be provided.

Following the hearing, the Committee shall meet in executive session. During its executive session, the Committee shall determine whether or not the House Officer shall be terminated, or otherwise have adverse actions imposed, along with reasons for its findings; summary of the testimony presented; and any dissenting opinions. In any hearing in which the House Officer has alleged discrimination, the report shall include a description of the evidence presented with regard to this allegation and the conclusions of the Committee regarding the allegations of discrimination. The Academic Dean shall review the Committee's report and may accept, reject, or modify the Committee's finding. The Academic Dean shall render a decision within five (5) working days from receipt of the Committee's report. The decision shall be in writing and sent by campus email or certified mail to the House Officer, and a copy shall be sent to the Department Head and Dean (revised 12/15/2009).

If the Academic Dean's final decision is to terminate or impose adverse measures and the House Officer is dissatisfied with the decision reached by the Academic Dean, the House Officer may appeal to the Dean, with such appeal limited to alleged violations of procedural due process only. The House Officer shall deliver Notice of Appeal to the Dean within five (5) working days after receipt of the Academic Dean's decision. The Notice of Appeal shall specify the alleged procedural defects on which the appeal is based. The Dean's review shall be limited to whether the House Officer received procedural due process. The Dean shall then accept, reject, or modify the Academic Dean's decision. The decision of the Dean shall be final.

A House Officer who at any stage of the process fails to file a request for action by the deadline indicates acceptance of the determination at the previous stage.

Any time limit set forth in this procedure may be extended by mutual written agreement of the parties and, when applicable the consent of the Chairperson of the Ad Hoc Committee.

MEDICINE/PEDIATRICS PROCEDURES AND TECHNICAL SKILLS POLICY

Medicine/Pediatrics residents must fulfill the Pediatric RRC procedure requirements and the ABIM procedure requirements for board certification in Internal Medicine and Pediatrics for two important reasons: **1)** to fulfill future credentialing requirements and **2)** to ensure proficiency with technical skills expected of internists and pediatricians. These educational experiences should be graduated so residents can build and maintain skills throughout their residency training. The program director must have documentation to confirm the competency of each resident for each required procedure.

Documentation of procedures must specifically include the patient's medical record number, date of procedure, direct supervisor, indication for the procedure, and complications associated with the procedure. Residents must document instruction in the performance of procedures to include indications, contraindications, complications, and accurate interpretation of procedure results. As part of procedural competence, residents must be able to obtain informed consent; and for pediatric procedures, residents must be able to address the pain associated with the procedures. Residents log in their procedures in New Innovations under "Cases".

The American Board of Internal Medicine no longer requires a specific number of directly supervised, successfully performed procedures but recommends 3 to 5 as the minimum since confirmation of competence is not credible with fewer procedures. Residents, however, should be supervised until they can demonstrate the necessary skill for independent practice.

To assist residents with competence and confidence in developing proficiency in performing invasive procedures, a biannual procedure skills fair sponsored by the Internal Medicine department will be held biannually. The fair primarily focuses on teaching four major procedures: lumbar puncture, airway, interpretation of dysrhythmias and application of ACLS protocols, and ultrasound-guided central line placement.

Residents must demonstrate proficiency in the following procedures as recommended by both the Internal Medicine RRC:

1. **<u>Central Venous Line Placement</u>**
   Indications: Administer fluids/meds when no peripheral access, administer hyperalimentation solutions, measure CVP, insertion of Swan-Ganz catheter or transvenous pacemaker. Contraindications: infection at site, coagulation disorder. Limitations: thick neck, obesity. Complications: pneumothorax, hemothorax, hydrothorax, hematoma, catheter misplacement, air embolism, catheter embolism.

2. **Lumbar Puncture**

Indications: Suspected meningitis, encephalitis, meningeal carcinomatosis or leukemia, tertiary syphilis, staging lymphomas, evaluation for Guillain-Barre syndrome, multiple sclerosis, dementia in selected cases, pseudotumor cerebri, suspected subarachnoid hemorrhage, introduction of drugs. Contraindications: infection at site, increased intracranial pressure, severe coagulation disorder, CNS mass lesion. Limitations: difficult in spine disorders, elderly with severe osteoarthritis. Complications: spinal headache, trauma to nerve roots, herniation.

3. **Thoracentesis**

Indications: Pleural effusion of unknown cause, relief of dyspnea caused by large pleural effusion. Contraindication: clotting disorder, low platelets, uncooperative patient or patient with severe cough or hiccups. Complications: pneumothorax, hemothorax, infection, hypotension, pulmonary laceration, vasovagal episode, puncture of liver or spleen, air embolism, subcutaneous emphysema.

4. **Abdominal Paracentesis**

Indications: Determine cause of ascites, evaluation for possible peritonitis, relief of dyspnea, abdominal pain or discomfort from tense ascites. Contraindications: coagulation disorder, bowel distension, infection at site. Limitations: patient must be still, small amounts of ascitic fluid may be difficult to aspirate-get ultrasound. Complications: hypotension/shock, persistent leakage of fluid, bleeding, perforated bowel, peritonitis.

5. **Arthrocentesis**

Indications: unexplained effusion, remove hemorrhagic effusion in traumatized joint, steroid injection, evaluate antibiotic response with infectious arthritis, and remove purulent fluid in distended infected joint. Contraindications: infection at site. Limitation: joint must be still. Complications: infection, hemorrhage, tendon rupture, nerve palsy.

6. **Arterial Puncture**

Indications: Arterial – to monitor blood pressure during use of potent vasoactive agents and for frequent blood gas analysis; venous - to obtain blood culture, chemistry panels for analysis. Contraindications: poor arterial circulation with poor ulna artery collateral flow, coagulation disorders, infection at site. Complications: arterial - thrombosis, embolism, hemorrhage, infection; venous – thrombophlebitis.

7. **Nasogastric Intubation**

Indications: ventilatory support, facilitate suctioning, trauma patients with possible cervical spine injury. Contraindications: absence of respiratory

distress, oxygen saturation <90%. Limitations: careful with neck injuries, obesity. Complications: esophageal intubation, insertion in main bronchus, tube obstruction, spinal cord injury, aspiration.

8. Pap smear and endocervical culture

Indications: early detection of cervical dysplasia/carcinoma-in-situ/high-grade carcinoma. Contraindications: history of complete or partial hysterectomy not due to cancer, patient refuses to consent. Complications: mild, temporary pelvic discomfort, mild cervical bleeding.

9. The following procedures should also be logged:

a. arterial line placement
b. elective cardioversion
c. endotracheal intubation
d. skin biopsy
e. cryosurgical removal of skin lesions
f. temporary pacemaker placement
g. ambulatory EKG interpretation
h. treadmill exercise testing
i. soft tissue and joint injection
j. interpretive skill in ambulatory blood pressure monitoring
k. interpretive skill in CXR
l. interpretive skill in spirometry

10. **Advanced Cardiopulmonary Resuscitation** offered each year by the emergency medicine department.

For a subset of procedures, ABIM requires all candidates to demonstrate competence and safe performance by means of evaluations performed during residency training. The set of procedures and associated competencies required for each are listed below.

To help residents acquire both knowledge and performance competence, ABIM believes that residents should be active participants in performing procedures. Active participation is defined as serving as the primary operator or assisting another primary operator. ABIM encourages program directors to provide each resident with sufficient opportunity to be observed as an active participant in the performance of required procedures. In addition, ABIM strongly recommends that procedural training be conducted initially through simulations. At the end of training, as part of the evaluation required for admission to the Certification Examination in Internal Medicine, program directors must attest to each resident's knowledge and competency to perform the procedures. ABIM does not specify a minimum number of procedures to demonstrate competency; however, to assure adequate knowledge and understanding of the common procedures in internal medicine, each resident should be an active participant for each procedure five or more times.

Competency is required in the following procedures:

	Know, Understand and Explain				Perform Safely and Competently
	Indications; Contraindications; Recognition & Management of Complications; Pain Management; Sterile Techniques	Specimen Handling	Interpretation of Results	Requirements & Knowledge to Obtain Informed Consent	
Abdominal paracentesis	X	X	X	X	
Advanced cardiac life support	X	N/A	N/A	N/A	X
Arterial line placement	X	N/A	X	X	
Arthrocentesis	X	X	X	X	
Central venous line placement	X	X	N/A	X	
Drawing venous blood	X	X	X	N/A	X
Drawing arterial blood	X	X	X	X	X
Electrocardiogram	X	N/A	X	N/A	
Incision and drainage of an abscess	X	X	X	X	
Lumbar puncture	X	X	X	X	
Nasogastric intubation	X	X	X	X	
Pap smear and endocervical culture	X	X	X	X	X
Placing a peripheral venous line	X	N/A	N/A	N/A	X
Pulmonary artery catheter placement	X	N/A	X	X	
Thoracentesis	X	X	X	X	

Top

Credit in Lieu of Standard Training for Internal Medicine Candidates

Procedures for which all residents must develop ***both knowledge competency and performance competency:***

1. Draw arterial blood
2. Pap smear and endocervical culture
3. Draw venous blood
4. Place IV line
5. ACLS

Both the ABIM and the Internal Medicine RRC agree that all internists should achieve these competencies early in training either in medical school or in residency.

PEDIATRICS REQUIREMENTS

The Pediatric RRC requires that all Medicine/Pediatrics residents be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. In addition, residents must complete training and maintain certification in both Pediatric Advanced Life Support and the Neonatal Resuscitation, including simulated placement of an intraosseous line.

Residents must be able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results.

Residents must demonstrate procedure competency by performing the following pediatric procedures:
(a) Bag-mask ventilation
(b) Bladder catheterization
(c) Giving immunizations
(d) Incision and drainage of abscesses
(e) Peripheral intravenous catheter placement
(f) Venipuncture
(g) Neonatal endotracheal intubation
(h) Lumbar puncture
(i) Temporary splinting of fracture
(j) Reduction of simple dislocation
(k) Simple laceration repair
(l) Simple removal of foreign body
(m) Umbilical catheter placement
(m) Developmental screening test;
(n) Procedural sedation;
(o) Pain management;
(p) Reduction and splinting of simple dislocations/fractures.

Residents must be competent in the understanding of the indications, contraindications, and complications for the following skills during pediatrics:

(a) Arterial line placement
(b) Arterial puncture
(c) Chest tube placement
(d) Circumcision
(e) Endotracheal intubation of non-neonates
(f) Thoracentesis

During their pediatric rotations, Medicine/Pediatrics must be able to provide compassionate, appropriate, and effective care for the treatment of health problems and the promotion of health. Residents must demonstrate the ability to:

a. Gather essential and accurate information about the patient
b. Organize and prioritize responsibilities to provide safe, effective, and efficient care
c. Provide transfer of care that ensures seamless transitions
d. Interview patients and families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease
e. Perform complete and accurate physical exams
f. Make informed diagnostic and therapeutic decisions that result in optimal medical judgment
g. Counsel patients and families
h. Develop and carry-out management plans
i. Provide effective health maintenance and anticipatory guidance
j. Provide appropriate role modeling
k. Provide appropriate supervision

POLICY ON WEEKEND/HOLIDAY SWITCHOVER on PEDS

This policy applies to PICU and NICU teams only and does not apply to the 6 day winter holiday blocks. The goal of these changes is to improve continuity of care around switchover time and to ensure a smooth transition from one team to another.

1. All residents/interns that are not either post-call or coming off a shift in the PER that has ended within the past 10 hours are required to show up for work at the usual time (7AM), write notes and round with the team. After rounds, those who are not on call may leave.
2. For those residents/interns who are post call on a ward or ICU team, you will stay on that service to help the incoming residents/interns get acquainted with the patients, write notes and round with the team. The post-call residents/interns will not see any new patients during this period and must leave at 1PM. Therefore, if you are post-call you do not need to report to your new team/elective for that day. Should this added time create problems with duty hour requirements (i.e., greater that 80 hour average work week or elimination of the residents only golden weekend for that month) arrangements will be made to ensure compliance (i.e., residents/interns will leave early on another day that month to make up for the hours).

In order to facilitate a smooth transition and optimize continuity of care around switchover time it is ***essential*** *that all residents/interns coming onto a ward or ICU service receive sign-out on the patients they will be acquiring. For residents, the incoming resident(s) should contact the current resident(s) on the day prior to switchover and should have a plan in place to account for any patients who are admitted overnight. Interns should likewise get in touch with their new upper level on the day prior to switchover.*

Resident Evaluation Policy

1. At the end of each month rotation all faculty must log onto New Innovations and complete a competency-based evaluation for each resident on his/her service. The faculty must meet with each resident on the service to evaluate them in each of the following categories: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice. In the event of an unsatisfactory evaluation, the resident must discuss the evaluation with the program director. At all times, the resident may appear in person or in writing before a clinical competence committee to review an unsatisfactory annual evaluation.

2. Residents are comprehensively evaluated by faculty, nurses, patients, peers, and themselves throughout the year. Peer and faculty evaluations are anonymous via New Innovations.

3. Residents must also attain 8 mini-clinical examination forms completed each year, 4 internal medicine and 4 pediatrics, to document directly observed clinical competency.

4. Continuity clinic preceptors must evaluate residents biannually both verbally and in writing.

5. Nurses in select areas will evaluate residents: NICU, PICU, UNO Student Health, Touro wards, Pediatric Hematology-Oncology, Gold team, Silver team, continuity clinic.

6. Medical students who rotate in Pediatrics evaluate supervisory residents anonymously.

7. Biannual review
    a. Performed confidentially twice a year with Medicine/Pediatrics Program Director
    b. Review individual resident self-assessments with reflection on current and future goals
    c. Review all internal medicine and pediatric evaluations
    d. Review in-training examinations
    e. Discuss individual personal and professional goals with the program director
    f. Develop action plans to address areas of concern

Sleep Fatigue: Prevention, Identification and Management

The residents and faculty recognize the importance of educating both faculty and residents about alertness management and fatigue mitigation strategies to minimize medical errors that increase morbidity and mortality. All residents receive a laminated pocket card with strategies to help mitigate fatigue and minimize medical errors that compromise patient safety. The Medicine/Pediatrics website also posts the following fatigue mitigation and alertness strategies that residents can refer to at all times.

Facts

- Most residents cite "too little sleep"
- Average person needs 8.2 hours/night
- However, insufficient time may be spent in deep or restorative sleep on call
- If on call, residents may be interrupted by other residents, anxiety about beeper call, anticipation of sleep interruption
- Energy (circadian) lows between 3-7 am and 3-5 pm
- Disruption in sleep leads to "sleep debt"
- Sleep debt may occur rapidly
- Sleep debt requires several consecutive full night's sleep for adequate recovery

How does sleep fatigue effect medical performance?

- In-service training scores lower
- ER residents performed fewer components of history and physical
- IM residents less accurate in EKG interpretation
- Surgical residents required more time than usual to perform simulated skills and committed more errors
- Surgical residents 45% more post-operative complications
- Declined cognitive and procedural abilities in pediatric residents
- Decay in empathy, professionalism, empathy and alertness

How does sleep fatigue affect me?

- Increased risk of personal injury and accident
- Increased use of alcohol or other agents in order "to cope"
- Increased motor vehicle collisions (49% of pediatric residents noted "falling asleep at the wheel")
- Sleeping 5 hours or less increases crashes 4.5 times
- Crashes most commonly occur in the morning and mid-afternoon

Warning Symptoms and Signs of Sleep Deprivation

- Repeated yawning and dozing off during conferences
- "Microsleeps"
- Increased tolerance for risk
- Passivity - feeling like you just don't care
- Inattention to details
- Rechecking work constantly
- Restlessness and irritability with staff, colleagues, family
- Difficulty focusing on patient care
- Decreased cognitive functions
- Increased errors
- Difficulty sleeping
- Time pressure + Fatigue= Major Risk for Error
- Sleep inertia: confusion and dysfunction that occurs upon awakening from sleep
- The disorientation may also include a period of amnesia for the period of awakening

To minimize the effect of sleep inertia:

- Get out of bed
- Stand up
- Turn on the lights
- Try to nap every 12 hours

Prevention/Treatment/Management

- Recognition is key!
- Limit moonlighting
- Reduce nonessential tasks and enhance learning during clinical time
- Faculty should help residents identify co-existent medical or emotional issues that may affect sleep
- Enlist residents in combating issues with sleep fatigue
- Set priorities for "time off": Protect your recovery time! You cannot cram it all into a 24-hour off day!
- Be smart about schedule swapping

SLEEP/FATIGUE MITIGATION/ALERTNESS STRATEGIES:

1) Strategies for healthy sleep for PRE-CALL Residents:
    - Aim for 7-9 hours per night – sleeping <7 hrs/day can lead to sleep deficit
    - Catch-up sleep on days off – if sleep 7 or less hrs/d during the week, you need to sleep 9 hours or more on both Saturday and Sunday to catch up.
    - Keep a routine

- Avoid alcohol to help you sleep
- Avoid stimulants to keep you up
- Avoid heavy meals within 3 hours of sleep
- Adequate exercise but avoid 3 hours before sleep
- Healthy diet
- Sleep hygiene – sleep same time every day
- Relaxation rituals before sleep (bathe, read, watch TV etc.)
- Protected sleep time
- Light exposure when awake

2) Alertness Management Strategies for ON CALL Residents:

- Nap whenever you can –
  - 1-2 hour nap prior to 24 hr on call
  - 15 min naps q 2-3 hrs improves performance between 2am and 9am
- Nap during circadian lows – BEST Circadian Window: 2pm-5pm and 2am-5am
- Duration of Nap: >30 min and < 2 hours
- Strategic consumption of coffee (t1/2 3-7 hrs); know your own alertness/sleep pattern
- Tell your resident or faculty if you are too sleepy to work!

3) Safe Habits for POST CALL residents:

- Safe Driving
  - Consider distance to the hospital
    - Avoid driving if tired – instead take a taxi or other available transportation
    - Either nap for 20 minutes or consume 1 cup of coffee 30 minutes before driving
    - Lowest alertness 6 am-11am after being up all night
    - If drowsy while driving, pull over to a safe location and take a nap
    - Warning signs – it only takes 4 seconds to have an accident!
      - Trouble focusing on the road
      - Can't keep eyes open
      - Nodding
      - Yawning repeatedly
      - Drifting from lane to lane
      - Closing eyes at stoplights
      - Not remembering driving the last few miles
      - Missing signs/exits

Remember:

1) Caffeine: NOT A SLEEP SUBSTITUTE
    - Effects within 15 to 30 minutes
    - Only a temporary help
    - Adverse effects: disrupts sleep quality, causes tolerance, diuresis and irritability
2) Most people need 8 hours of sleep per night; significant cognitive declines occur with just one night of missed sleep full.
3) Full recovery from sleep deficit usually takes 2 nights!
4) Other medications and drugs:
    - Sleep medications only after medical/sleep consultation
    - Avoid alcohol for sleep
    - Avoid over the counter stimulants

ALERTNESS/FATIGUE MITIGATION MANAGEMENT STRATEGIES

During both the Medicine/Pediatrics intern orientation and the institutional orientation at the end of June just prior to the beginning of residency, the Program Director and the DIO, respectively, address the issues of recognizing the signs of fatigue, sleep management and alertness management and fatigue mitigation strategies. These strategies are placed on the Medicine/Pediatrics website for 24-hour access and will be sent electronically to all residents at the beginning of each rotation to remind the residents of these easily implementable strategies. Additionally, the institution provides a laminated pocket-card with alertness/fatigue mitigation management strategies for all new interns during their institutional orientation in June.

The institution also requires that all residents must successfully complete fatigue and fatigue mitigation strategies modules with a passing score of at least 80% by the end of their intern year which is tracked by both the program coordinator and the institution.
During the Medicine/Pediatrics faculty meetings, the Program Director reviews the policies regarding fatigue and alertness management and fatigue mitigation strategies with core faculty. The faculty members also receive e-mails that highlight these strategies at the beginning of each ward rotation to remind them of the strategies recommended by the program and institution to prevent morbidity associated with fatigue. Since fatigue can adversely affect both patient care and learning, residents are encouraged to either take strategic naps or utilize the back-up call schedule in cases of extreme fatigue; however, they should notify their team in advance if possible.

STRATEGIC NAPPING

For shifts exceeding 16 hours, residents are encouraged to take strategic naps especially between the hours of 10pm through 8am to combat the adverse effects of fatigue and sleep deprivation. Such napping should not be scheduled but should be based on patient needs and resident fatigue. At least annually, all faculty and residents receive instruction from the Program Director to both recognize the signs of fatigue and sleep deprivation and to provide acceptable solutions for the degree of fatigue/sleep deprivation. For example, faculty can either instruct the house officers to nap in the hospital call rooms or go home if warranted. Residents must also successfully complete the on-line Alertness Management and Fatigue Mitigation modules that specifically emphasize strategic napping to be promoted to the PGYII year. The successful completion of these modules with an 80% passage rate is monitored by the institution and program coordinator.

Residents must also track the number of hours of strategic napping while on-call and comment on its benefit if any with mitigating fatigue and improving patient care. During biannual resident evaluations, residents comment on the frequency of medical errors or motor vehicle accidents associated with fatigue and what measure(s) could have been taken to prevent the errors.

BACK-UP CALL SCHEDULE POLICY

A monthly jeopardy call-schedule is available on-line for both internal medicine and pediatrics in case of unforeseen resident emergencies that preclude them from fulfilling their assigned duties either prior to call or during call. Residents scheduled for jeopardy call are usually on subspecialty rotations that are not excessively rigorous and that primarily involve outpatient clinics with no call. The resident must first notify the respective Chief Resident and the Medicine/Pediatrics Chief Resident that they will not be able to fulfill their patient duties and should include the relevant circumstances and the estimated duration of his/her absence. The Chief Resident then calls the appropriate resident or intern scheduled for jeopardy call to inform him/her of the change in the work assignment to ensure that patient care is never compromised by the absence of a resident. The Chief Resident also notifies the members of the team including the faculty of the temporary change in the resident assignment.

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

Resident Name:________________________ Date:________________
Level: PGY 1

Residents' performances 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.
		Pediatrics conference attendance (morning report, noon conference, grand rounds): 13 conference hours per month
		Internal medicine conference attendance: 90%
		Medicine/Pediatrics journal club and business meeting attendance: 90%
		Has taken USMLE Step III by the 16th month of residency and/or has passed Step III by the 18th month of residency
		Presentation at 5 morning report conferences
		Completion of 100% of all monthly Prep questions
		Completion of Internal Medicine and Pediatrics procedure log
		Completion of work force hours on New Innovations
		Completion of Continuity Clinic log Weeks: _________; Adults: ________; Pediatrics:________
		Portfolio is updated and complete
		Medical Records are complete at all hospitals
		Satisfactory performance on 8 Mini-Clinical Examination (4 adults and 4 pediatrics)

		Completion of at least 4 Graduate Medical Education Modules, one of which must include Sleep Deprivation/Fatigue with >80% passage rate
		Completion of Nurse Evaluations – total of 6
		Completion of Patient Evaluations – total of 6
		Participation in Quality Improvement project(s)
		Participation in Patient Safety project(s)

*Reason for failure – Check one:
________________Unsatisfactory performance on 2 rotations – no promotion
________________Unsatisfactory performance on 1 rotation – remediation before promotion

Comments:

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

MEDICINE/PEDIATRICS PGY-2 PROGRESS & PROMOTION RATING FORM

Resident Name:___________________________ Date:___________________
Level: PGY 2

Residents' performances 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.
		Pediatrics Conference attendance (morning report, noon conference, grand rounds): 13 conference hours per month
		Internal Medicine conference attendance: 90%
		Medicine/Pediatrics Journal Club/Business Meetings: 90%
		Successfully passed Step III by June 30th
		Completion of at least one of the required scholarly activities
		Presentation at one Clinical Case Conference (optional)
		Completion of 100% of all monthly Prep questions
		Completion of Internal Medicine and Pediatrics procedure log
		Documentation of work hours in New Innovations
		Completion of Continuity Clinic log Weeks: _________; Adults: _______; Pediatrics:_________
		Completion of 8 mini-Clinical Exam Forms (4 pediatrics and 4 adults)
		Portfolio is updated and complete

		Medical Records are complete at all hospitals
		Completion of at least 8 Graduate Medical Education Modules with >80% passage rate
		Completion of Patient Evaluations – total of 6
		Completion of Nurse Evaluations – total of 6
		Participation in Quality Improvement project(s)
		Participation in Patient Safety project(s)

*Reason for failure – Check one:
_________________Unsatisfactory performance on 2 rotations – no promotion
_________________Unsatisfactory performance on 1 rotation – remediation before promotion

Comments:

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

MEDICINE/PEDIATRICS PGY-3 PROGRESS & PROMOTION RATING FORM

Resident Name:___________________________ Date:____________________
Level: PGY 3

Residents' performances 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-4 all criteria must be satisfied.

Pass	Fail	**Criteria**
		Satisfactory performance on all evaluations by faculty.
		Pediatrics Conference attendance (morning report, noon conference, grand rounds): 13 conference hours per month
		Internal Medicine conference attendance: 90%
		Medicine/Pediatrics Journal Club/Business Meetings: 90%
		Presentation at one Clinical Case Conference
		Completion of 100% of all monthly Prep questions
		Completion of Internal Medicine and Pediatrics procedure log
		Documentation of work hours in New Innovations
		Completion of Continuity Clinic log Weeks:_________; Adults: __________; Pediatrics:__________
		Completion of 8 mini-Clinical exam forms (4 pediatrics and 4 adults)
		Portfolio is updated and complete
		Medical Records are complete at all hospitals
		Completion of at least 8 Graduate Medical Education Modules with >80%

		passage rate Completion of Patient Evaluations – Total of 6
		Completion of Nurse Evaluation – Total of 6
		Participation in Quality Improvement project(s)
		Participation in patient safety project(s)

*Reason for failure – Check one:
________________Unsatisfactory performance on 2 rotations – no promotion
________________Unsatisfactory performance on 1 rotation – remediation before promotion

Comments:

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

MEDICINE/PEDIATRICS PGY-4 PROGRESS & PROMOTION RATING FORM

Resident Name:__________________________ Date:___________________
Level: PGY 4

Residents' performances 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.
		Pediatric conference attendance (morning report, noon conference, grand rounds): 13 conference hours per month
		Internal Medicine conference attendance: 90%
		Medicine/Pediatric Journal Club/Business meeting: 90%
		Completion of 2 forms of scholarly activity
		PowerPoint presentation at Medicine/Pediatrics Journal Club
		Presentation at one Clinical Case Conference (IM or Pediatrics)
		Completion of 100% of all monthly Prep questions
		Completion of procedure log
		Documentation of work hours in New Innovations
		Medical Records are complete at all hospitals
		Completion of Continuity Clinic log Weeks:_________; Adults:_________; Pediatrics:_______
		EBM presentation

		Completion of 8 Mini-Cex (Observed H & P) - 4 adults and 4 pediatrics
		Portfolio is updated and completed
		Completion of Patient Evaluations – total of 6
		Completion of Nurse Evaluations – total of 6
		Participation in Quality Improvement project(s)
		Participation in Patient Safety project(s)

*Reason for failure – Check one:
_________________Unsatisfactory performance on 2 rotations – no promotion
_________________Unsatisfactory performance on 1 rotation – remediation before promotion

Comments:

Faculty, Rotation, Peer Evaluation Policy

Every month residents are sent anonymous evaluations of fellows, faculty, rotations, and peer evaluations through New Innovations that they must complete. These evaluations are compiled at the end of the year and are presented to the Residency Evaluation Committee, Clinical Competency Committee, Program Evaluation Committee, and individual faculty. These evaluations help improve the quality of existing rotations and provide essential feedback to faculty and fellows in regard to their abilities as role models, educators and clinicians. The evaluations are then used to facilitate careful selection of those faculty deemed worthy of teaching residents and students to ensure optimal education during all rotations.

POLICY ON NON-TEACHING PATIENTS

Residents are not permitted to manage non-teaching patients in any hospital or clinic except in the case of an emergency. A non-teaching patient refers to any patient who is a "private" patient and is not on a designated teaching service and/or does not fulfill the educational requirements for that particular residency as set forth by the Medicine/Pediatrics RRC and the ACGME.

For example, Medicine/Pediatrics residents can not be asked to admit primary surgical or psychiatric patients since the Medicine/Pediatrics RRC requirements do not permit residents to assume primary management of those specialty patients to fulfill their educational goals and objectives.

Policy regarding Census/Admission Caps

1.Total number of admissions per call night per upper level intern for each inpatient team at the LSU Interim Hospital: 5 new admissions and 2 inpatient transfers for a maximum of 7 patients.

2. Total number of admissions per call night per upper level resident for each inpatient team at the LSU Interim Hospital: 10 new admissions and 4 inpatient transfers for a maximum of 14 patients.

3. Maximum team census for 1 resident and 1 intern: 14 patients

4. Maximum team census for 1 resident and > 1 intern: 20 patients

5. In the event of a census cap, patients will be admitted to the other 3 teams in an alternating fashion in the order that they are admitted. The 1st cap admission will go to the "sister" service. Any remaining admissions will go to the other 2 teams beginning with the team that is furthest from call. For instance, Team 1 will admit any cap admissions to Team 3, then Team 4 and then Team 2. This cycle will then be repeated if necessary.

6. Night Float residents are there to help with admissions from 8pm to 7am, and are to stay for morning report when the post call team is presenting a patient that was admitted overnight. Residents on General Medicine Consults will admit patients from 7am through 12noon to enable the team on call to round without interruption.

HURRICANE "CODE GREY" POLICY

LSU RESIDENTS AT 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).
- 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) 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 or pets are allowed.

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.

LSU RESIDENTS AT UH, TOURO & OCHSNER-KENNER HOSPITAL

Program Director(s) and Chief Resident(s) responsibilities:

The residency program director(s) and chief resident(s) are responsible for declaring Code Grey status after being informed by hospital administration or department chairs. The chief residents will assure that an adequate number of housestaff are on duty at each hospital. The chief residents will identify the on call teams and will provide this information to the medical director via fax or if after hours via phone and fill out the on call form. The program director(s) or designees and chief resident(s) will be stationed at LSU Interim Hospital where they will coordinate the call teams, supervise delegation of hospital admissions, and assist in appropriate shelter for residents and their immediate families.

Firm Teams. When code grey is declared, all 4 firm teams will report to the LSU Interim Hospital and meet with the chief residents regarding their assignments. The firm team on call at University the day code grey is called and the other firm team on call the next day will be required to remain on site. The other members of the firm teams may not leave without checking out with the chief residents and must be immediately available after conditions have stabilized to relieve the other team members. The 4 firm teams remaining on site made up of 4 residents and 4 interns will cover all the LSU medicine patients at the LSU Interim Hospital. Any changes with other housestaff for coverage must be approved by the chief residents. The firm teams will also manage any LSU subspecialty inpatients with assistance from the subspecialty fellow and staff. The subspecialty teams must create a patient list for the chief residents and firm teams.

Touro. NO housestaff will take call during Code Grey at Touro.
Ochsner-Kenner. No housestaff will take call during Code Grey at Ochsner-Kenner.

Other Hurricane information
The chief residents may call additional housestaff as needed to provide coverage in the event of a disaster. If there are special circumstances that would prohibit a resident from taking hurricane call (pregnancy, illness etc) then he or she must notify the chief resident who will make the final decision after discussing with the program director.

All housestaff are to notify the medical director's office of their arrival. During the Code Grey the medical director has final authority and responsibility for all assignments for all of the medical staff. Call rooms will be assigned by the medical director. Assigned physicians will be allowed to park 1 (one) vehicle on campus. Family members will be limited to immediate family only (spouse/significant other and children). Absolutely no pets will be allowed. Food, clothing, medications, blankets, pillows, and water are the responsibility of the individuals. The hospital will do its best to supply food and water but in an extended disaster this may not be possible. The LSUHSC campus facilities will not be available as an emergency shelter for anyone including faculty, staff, students or the general public in the event of a hurricane. This will be strictly enforced by the University Police. Only essential and approved persons/personnel will be allowed on campus. All parking garage privileges will be suspended at all locations for the duration of the emergency. Emergency/Disaster parking will be available for essential personnel only with appropriate passes and approvals.

In all cases, once the hurricane activation has been cancelled, all LSU Internal Medicine residents and faculty assigned to the LSU Interim Hospital, Ochsner Kenner Regional Medical Center, and Touro Infirmary inpatient services are expected to return to their respective hospitals to assist in the management and disposition of patients in the hospital and in the clinics.

Louisiana State University Health Sciences Center at New Orleans response plan for weather related emergencies can be found in the below link:
http://www.lsuhsc.edu/no/administration/cm/cm-51.aspx

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

Final Evaluation of Medicine/Pediatrics Graduates

Name: __________________________ Date: ____________________

1. Goals/Employment after Graduation:
   ____

2. Address and Contact Numbers (Personal and Professional):

   (H)_______________________________
   (W)____________________________

   ____
   ____

3. Board Preparation: (Circle)

   MKSAP IM MEDSTUDY PEDS MEDSTUDY PREP

4. Which Board will you take first? (Circle) IM Peds Both

5. Do you plan to take both boards? (Circle) Yes No

   a. If no, please specify the reason(s).

   ____

6. Do you feel your 4-yr training at LSU has prepared you for your future employment?
   a. If no, please explain. Circle: Yes No

7. Quality Improvement Project completed: Yes No

Topic:

8. Please rate your clinical rotations using the following scale:
   (a=poor; 2=fair; 3=good; 4=very good; 5=excellent)

INTERNAL MEDICINE

Inpatient: Touro:
UH:
Kenner:

MICU: UH:
Kenner:
Touro:

MER:

Med/Peds Ambulatory:

Subspecialties:

Geriatrics:

General Medicine Consults:

Palliative Care:

OVERALL INTERNAL MEDICINE RATING:

PEDIATRICS

Inpatient: Children's:
Purple:
Silver:
Gold:
Heme/Onc:

PICU:
NICU: Children's:
Touro:

PER:

Adolescent:

Well Baby:

Subspecialties:

Development:

OVERALL PEDIATRICS RATING:

CONTINUITY CLINIC:

FAVORITE ASPECT(S) OF RESIDENCY:

____

____

LEAST FAVORITE ASPECT(S) OF RESIDENCY:

____

____

CONSTRUCTIVE COMMENTS:

___

___

___

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

SUMMATIVE INTERNAL MEDICINE/PEDIATRICS EVALUATION

Dr. ______________________________ has successfully completed the requirements mandated by the RRC for Internal Medicine/Pediatrics. He/She has demonstrated proficiency in the six major areas of competency as required by the ACGME which includes patient care, medical knowledge, practice-based learning and improvement, interpersonal/communication skills, professionalism, and systems-based practice. He/she possesses the knowledge and clinical experience to practice both specialties with sufficient competence to enter practice without direct supervision.

________________________ ________________________

Program Director Date Resident Date

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

Yearly Program Evaluation of the LSU Medicine/Pediatrics Program

Use the following Likert scale to rate the following items:
1 = Poor; 2 = Below Average; 3 = Average; 4 = Good; 5 = Excellent

1. **Hospitals**

	Children's	Touro	Kenner	UH
a. Call Rooms				
1. Cleanliness				
2. Accessibility				

	Children's	Touro	Kenner	UH
b. Food 24/7				
c. Quality of Ancillary Services (clerical/secretarial/phlebotomy)				
d. Quality of Nursing				

Compliance with work force hours

	Children's	Touro	Kenner	UH
e. 16 max shift as intern				
f. 80 hrs / wk max				
g. 1 in 7 off				
h. At least 10 hrs between shifts				
i. More than q 3 day call				
j. 24 + 4 max shift as resident				

	Children's	Touro	Kenner	UH
k. Resources (computers, radiology, office space)				
l. Quality of resident teaching/supervision				
m. Quality of faculty teaching				
n. Faculty Supervision				
o. Faculty availability				
p. Faculty awareness of work force hours				
q. Availability of consultants (ENT, Ortho)				

r. Written feedback at end of rotation

Children's

i. **Continuity Clinic (Please use the Likert Scale above)**

	Children's	Touro	Kenner	UH
s. Quality of teaching				
t. Frequency feedback				
u. Adequate staff to resident ratio				
v. Sufficient volume of adults				
w. Sufficient volume of children				
x. Quality of nursing				
y. Ancillary support				
z. Faculty supervision				
aa. Varying acuity				
bb. Variety of diagnoses				
cc. Is continuity achieved?				

3. **IM Conferences (when applicable)**

	Touro	Kenner	UH
1. MKSAP Review			
2. Clinical Guidelines			
3. Core Lecture			
4. Grand Rounds			
5. Clinical Case Conference			
6. Morning Report			
7. Journal Club			
8. M & M			

4. **Pediatric Conferences at Children's (Use the Likert Scale above)**

1. Core lectures
2. Morning Report
3. Clinical Case Conference
4. Grand Rounds
5. Board Review
6. Journal Club

7. M & M

5. Have you read and completed the **Med/Peds moonlighting policy** and received approval for moonlighting by the Med/Peds Program Director **before** moonlighting?

6. Have you received Goals and Objectives in both IM and Pediatrics for each rotation? If not, have you asked the Med/Peds coordinator for them?

7. **Medicine/Pediatrics**

a. Journal Club ☐
b. Business Meeting ☐
c. Recruitment Party ☐
d. Biannual Evaluations ☐
e. Cohesiveness of the program ☐
f. Sufficient balance of subspecialty, wards, ICU ☐
g. Research opportunities ☐
h. Availability of Program Director ☐
i. Approachability of Program Director ☐
j. Sense of integration with categorical programs ☐
k. Sense of unique identity as Med-Peds ☐
l. Sufficient representation among categorical programs ☐
m. Leadership ☐
n. QI projects ☐
o. Simulation Fair (Biannual) ☐
p. Fair and equal treatment by: **IM:**_________________
Peds: _______________
Med/Peds: ___________

7. Do you feel that your grievances are appropriately addressed by the Med/Peds Program Director? If not, please explain.

8. Use Likert Scale to rate the overall effectiveness of the Med/Peds curriculum **(0=Poor; 1=Fair; 2= Average 3= Good; 4=Excellent):**

a. effectively educate you in *both* Internal Medicine and Pediatrics ☐
b. preparation for the progressive rigors of internship and/or residency, especially when transitioning from intern to supervisory resident. ☐
c. prioritize education over service ☐
d. address importance of compliance with duty hours ☐
e. educate residents about fatigue and sleep deprivation ☐

9. Please identify any strengths and weakness that need to be addressed ASAP. ***Please realize that your comments are designed to strengthen our program and make necessary changes to enrich your educational experiences!!***

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

LSU Medicine/Pediatrics Graduate Survey

1. Years of Medicine/Pediatrics Residency: ____________

2. Did you take and/or pass your Boards?
   a. Pediatrics
   b. IM
   c. If you didn't take one or both boards, why not?
   ____
   ____

3. What is your current employment? (Circle)
   a. Hospitalist
   b. Urgent Care
   c. Emergency Room
   d. Private Practice
      i. Adults only
      ii. Peds only
      iii. Both Adults and Peds (% of each):
   e. Subspecialty (please specify): ____________________
   f. Academia
   g. Fellowship (specify):____________________________

4. Are you part-time, full-time, or not working? _______________

5. How well did the Med/Peds curriculum prepare you for your current job? (Circle)
   a. Excellent
   b. Very Good
   c. Average
   d. Below Average
   e. Other ___________

6. How would you rate the overall effectiveness of the residency program in preparing you for following using the Likert scale below:
   A=Excellent B=Very Good C=Good D=Fair E=Poor

   a. Procedures (LP, central line, circumcision, thoracentesis, paracentesis, arterial line, I&D)
   b. Inpatient Pediatrics
   c. Inpatient Internal Medicine
   d. Outpatient Pediatrics
   e. Outpatient Internal Medicine
   f. Subspecialty expertise
   g. Management of ICU/critically ill patients
   h. Fellowship training
   i. Urgent Care/Emergency Medicine
   j. Combined Medicine/Pediatrics practice
   k. Academia

Please circle the number that best describes your opinion.

Not at All Moderately Very
1 2 3 4 5 6 7

I am satisfied with the quality of my residency education.

1 2 3 4 5 6 7

My residency training prepared me:

To work effectively in various health care settings (Systems Based Practice)
1 2 3 4 5 6 7

To work in inter-professional teams to enhance patient safety and to improve quality of patient care (Patient Care, Systems Based Practice)
1 2 3 4 5 6 7

To perform thorough assessments of my patients (Patient Care)
1 2 3 4 5 6 7

To use medical knowledge to provide the most up-to-date patient care (Patient Care, Medical Knowledge)
1 2 3 4 5 6 7

To critically appraise evidence from scientific studies to continually improve/update patient care practices (Practice-Based Learning, Patient Care)
1 2 3 4 5 6 7

To assess the effectiveness of my patient care practices (Practice-Based Learning)
1 2 3 4 5 6 7

To communicate effectively with patients and their families (Patient Care, Communication/Interpersonal Skills, Professionalism)
1 2 3 4 5 6 7

To work effectively with other health care professionals (Interpersonal/Communication Skills, Professionalism)
1 2 3 4 5 6 7

To practice in an ethical manner (Professionalism, Patient Care)
1 2 3 4 5 6 7

To practice in a culturally competent manner (Patient Care, Professionalism)
1 2 3 4 5 6 7

To identify ways in which delivery systems affect patient safety (Systems-Based Practice, Patient Care)
1 2 3 4 5 6 7

To use system resources to provide comprehensive and cost-effective care (Systems-Based Practice, Patient Care)
1 2 3 4 5 6 7

List the three **BEST** aspects of your LSU Med/Peds residency training.

1.
2.
3.

List the 3 **WORST** aspects of your LSU Med/Peds residency training.

1.
2.
3.

List 3 **constructive and proactive** ways to improve these weaknesses.

1.
2.
3.

Thank you for participating in this survey which is designed to improve the quality of our LSU Medicine/Pediatrics Residency Program. Your honest and candid responses are greatly appreciated.

Please return the completed survey no later than ________________________.
Return the survey in the enclosed self-addressed envelope or mail to:

Vilma Cervantes
Medicine/Pediatrics Program Coordinator
1542 Tulane Avenue, 4th Floor, Room 441A
New Orleans, LA 70112
Phone: (504)568-3792

LSU Health Sciences Center
SCHOOL OF MEDICINE AT NEW ORLEANS

Faculty Evaluation of the Medicine/Pediatrics Program

Please use the Likert Scale to rate the LSU Medicine/Pediatrics Program.
(1 = Poor; 2 = Average; 3 = Good; 4 = Very Good; 5 = Excellent)

1. **MEDICAL KNOWLEDGE**
   Demonstration of effective Medicine/Pediatrics conferences (journal club, comprehensive medicine morning report, continuity clinic ambulatory conferences) to educate and to prepare the residents for in-service exams and ABP/ABIM exams

2. **PATIENT CARE**
   a. *Effectiveness of the resident schedule and curriculum to ensure diverse and comprehensive exposure to outpatient and inpatient diseases and their management*
   b. *Demonstration of resident competency in providing holisitic, compassionate, and comprehensive care*

3. **INTERPERSONAL/COMMUNICATION SKILLS**
   Effectiveness of the program to help residents develop essential communication skills with their peers, ancillary staff, faculty, and patients for delivering comprehensive, superior health care in both inpatient and outpatient settings

4. **PROFESSIONALISM**
   Effectiveness of the program to facilitate the acquisition of essential values of professionalism such as altruism, accountability, excellence, duty, service, honor, integrity and respect for others

5. **PRACTICE-BASED LEARNING & IMPROVEMENT**
   Effectiveness of the program to encourage and to teach residents to learn from their mistake(s), to facilitate the learning of others, and to use evidence-based medicine for optimizing patient care

6. **SYSTEMS-BASED PRACTICE**
   Effectiveness of the program to teach residents how to optimize inpatient and outpatient care for both insured and uninsured patients by using the available resources in the various clinics and hospitals

7. **SENSE OF UNITY AMONG RESIDENTS**
8. **FACULTY SATISFACTION WITH CURRICULUM**
9. **MORALE OF FACULTY**
10. **SENSE OF RESIDENT SATISFACTION WITH EDUCATION**
11. **Please make recommendations to help improve the quality of the curriculum**.