



**Department of
Pediatrics**

POLICY AND PROCEDURE MANUAL

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POLICY ON ~ AWAY ROTATIONS

1. The resident must have completed 24 months of pediatric training.
2. The resident must be in full compliance with the following mandatory resident activities prior to receiving approval to do an away rotation:
 - a. Resident must attend a **minimum** attendance of three continuity clinics per month and all clinics must be logged into the ACGME website.
 - b. Resident must not be delinquent in conference attendance.
 - c. Resident must complete the required twenty PREP questions per month online.
 - d. Resident must complete all required online core curriculum modules based on his/her PGY level (AMA Modules).
 - e. Resident must complete all online faculty and peer evaluations via New Innovations.
 - f. Resident must complete all outstanding charts in medical records.
3. The resident must be deemed competent in all core competencies and in a supervisory role. This will be ascertained based on the resident's faculty and peer evaluations.
4. The resident must secure medical licenses and malpractice insurance and present proof of confirmation of the above at a minimum of two weeks prior to departure.
5. The resident must demonstrate the necessity of the away rotation to provide a specific clinical or research education experience not otherwise available at the home institution.
6. The resident should develop a list of written objectives prior to departure.
7. The resident should identify a preceptor in the host country or at the host institution.
8. The resident should orient him/herself with the host institution's policies and procedures prior to departure. If an international rotation, the resident should become familiar with the host country's climate, culture, politics, and health and safety issues.
9. If the resident is not fluent in the host country's language, arrangements must be made for translators.
10. The resident should secure travel documents before departure.

11. The resident should arrange housing and medical care for him/herself.
12. The resident must be formally evaluated by their appointed preceptor at the completion of the rotation, primarily to identify satisfaction of his/her objectives.
13. Upon returning, the resident should submit a written summary of his/her experiences to the program director and/or present an educational conference highlighting the experience.
14. The resident must receive prior approval from the program director and program coordinator prior to making any travel arrangements.



POLICY ON ~ CHIEF RESIDENT DUTIES

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

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

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

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

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

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

The clinical responsibilities of the chief resident are minimal. The chief residents will be allowed to take call for CHPA and or rotate as a "pretending" on the hospitalist service, if desired. All clinical work done on a faculty level will need to be co-signed by appropriate staff. Though the jeopardy system should limit the need for chief resident coverage of house staff absences, scheduling conflicts may arise that require the chief resident to cover a shift or service.



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

CHIEF RESIDENT RESPONSIBILITIES

- The Program Director and 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 (Chief A) 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 (Chief B) will remain away from the hospital and evacuate if a mandatory evacuation is called by the City of New Orleans. Chief B will assist with organization of the recovery team and communications during the code. He/she is also responsible for knowing the whereabouts of each resident, collecting/confirming alternate e-mail addresses/phone numbers, and staying in contact with the Program Director, co-chief, and residents.
- 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).
- **Code Grey Team**
 - One upper-level resident from each CHPA team (Purple/Green).
 - One upper-level Heme/Onc resident.
 - One upper-level resident from the collective subspecialty services will remain to care for all subspecialty patients (SSA and SSB).
 - *The "long" resident at the time of Code Grey activation will be selected.
 - Two PICU residents, including the resident on call the day Code Grey is activated and the resident on call the following day. If a cross-cover resident is scheduled, he/she will not be required to stay. In this case, the two PICU team members next scheduled to be on call will be activated.

- One CHNOLA NICU resident. This will be the on-call resident or the resident next scheduled to be on call.
- No residents will cover Touro NICU.
- Residents with special healthcare or personal needs that could be adversely affected by participating on the Code Grey Team will be considered on a case-by-case basis.
- The Chief Residents may appoint additional residents to the Code Grey team 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 Code Grey should notify the Chief Resident (Chief B) either by phone or e-mail as to their expected location during the Code. This will assist the Chief Resident in composing the Recovery Team.
- Every Resident must provide an emergency contact name/number and a non-LSU e-mail address at the beginning of the year and keep the chief residents updated to any changes in this information.

FAMILY MEMBERS

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

FOOD AND SHELTER

- The hospital will provide food for residents within its ability. There may be a nominal charge for food served during the Code.
- Residents should bring extra water and food just to be safe though.
- Residents should also bring extra bedding, towels and necessary clothes and toiletries. The call rooms and designated patient rooms will be available for the residents to use for sleeping.

- During the event of a vertical evacuation, some resident space (e.g. the resident lounge) may be needed for other hospital functions.

RECOVERY TEAM

- During a Code Grey, a recovery team will be created by the Chief Residents 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.



POLICY ON ~ CONTINUITY CLINIC

Clinic Attendance:

All residents are required to attend AT LEAST 36 clinics per academic year, an average of 3 clinics per month. This clinic number will be tracked on a monthly basis by the Compliance Committee. However, residents will only be penalized for low clinic numbers on a QUARTERLY basis. At the end each quarter, the resident should have the designated number of continuity clinics (see below). If the resident is not on track to meet the required number of continuity clinics for a designated quarter, he/she should attend additional make-up clinics when spots are available according to the chief resident missed clinic document. If the quarterly clinic number is low, a resident will be docked 10 professionalism points for that quarter. Please see the professionalism policy (2013 revision) for further clarification. Once residents have met the 36 clinics per year requirement, they are still expected to attend clinic on their assigned continuity day.

Quarter 1: 9 clinics

Quarter 2: 18 clinics

Quarter 3: 27 clinics

Quarter 4: 36 clinics

Patient Numbers:

In order to obtain an appropriate educational experience, residents should see an advancing number of patients per continuity clinic session: Interns = 3/clinic, 2nd years = 4/clinic, 3rd years = 5/clinic. Starting in July 2013, the TOTAL number of patients seen in clinic will be tracked on a quarterly basis. This number will be determined by multiplying the number of clinics attended by the end of each quarter and the average number of patients seen per clinic session. This can also be seen on the ACGME report as the “number of patient visits.” The goal number of patients to be seen by the end of each quarter is shown below.

	Interns(3)	2nd Years (4)	3rd Years (5)
Quarter 1:	27 patients	36 patients	45 patients
Quarter 2:	54 patients	72 patients	90 patients
Quarter 3:	81 patients	108 patients	135 patients
Quarter 4:	108 patients	144 patients	180 patients

The Compliance Committee will use this data to monitor and improve the continuity clinic experience but will not penalize residents if the numbers are low. However, residents with consistently low patient numbers will be addressed on an individual basis with action plans implemented as necessary.



POLICY ON ~ EDUCATIONAL DIDACTIC SESSIONS

PGY-1: All PGY-1 residents must attend **175 hours** of educational conferences (morning report, noon conference, grand rounds, clinical case conference, and professional sessions). **Annually**, if a resident fails to meet this goal, he/she must complete additional PREP questions based on the number of lectures that are missed at a 1:2 ratio. For example: If a resident attends only 160 lectures and is missing 15 lectures, then he/she must complete 30 additional PREP questions. These PREP questions must be completed by July 31st of the PGY-2 year.

PGY-2: The required attendance is based on the resident's performance on the ABP ITE in their second year. All PGY-2 residents who score at or above the national average must attend **150 hours** of educational conferences (morning report, noon conference, grand rounds, clinical case conference, and professional sessions). All PGY-2 residents who score below the national average must attend **175 hours** of educational conferences. Because the results of the exam are not released until October, the resident should plan accordingly to meet these requirements (i.e. if they performed poorly on the first year's ABP ITE, then they should attend enough conferences in July, August, and September to meet the goal of 175 hours.) If a resident misses the exam due to medical leave, the requirements will be based on the previous year's performance. If a resident fails to meet this goal, he/she must complete additional PREP questions based on the number of lectures that are missed at a 1:2 ratio. For example: If a resident attends only 140 lectures and is missing 10 lectures, then he/she must complete 20 additional PREP questions. These PREP questions must be completed by July 31st of their PGY-3 year.

PGY-3: The required attendance is based on the resident's performance on the ABP ITE. All PGY-3 residents who score at or above the national average must attend **125 hours** of educational conferences (morning report, noon conference, grand rounds, clinical case conference, and professional sessions). All PGY-3 residents who score below the national average must attend **175 hours** of educational conferences. Because the results of the exam are not released until October, the resident should plan accordingly to meet these requirements (i.e. if they performed poorly on the first and second year's ABP ITE, then they should attend enough conferences in July, August, and September to meet the goal of 175 hours.) If a resident misses the exam due to medical leave, the requirements will be based on the previous year's performance. If a resident does not meet these requirements by the completion of the third year, he/she will lose 10 professionalism points for quarter 4 and risk being reported to the Board of Pediatrics as unprofessional (see professionalism policy).

For all levels: QUARTERLY attendance of required conferences will be monitored by the compliance committee. Residents will be docked quarterly by 10 professionalism points for inadequate conference attendance. Additional PREP Questions will be assigned for deficiencies, as documented above.



RESIDENT ELIGIBILITY FOR SELECTION

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

House Officers must be:

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

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

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

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



POLICY ON ~ EVALUATION

- I.** Formative Evaluation: residents are evaluated by multiple assessors, in different settings utilizing multiple assessment tools over the course of residency. The faculty supervisor evaluates and documents the resident performance at the end of each rotation or at completion of the assignment. Peers who supervise and/or are supervised by a resident complete assessment tools as do medical students and nurses who work with the resident. These objective assessments of competence will measure a resident's knowledge, skills and attitudes in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the Pediatric Milestones.
- II.** Individual Learning Plans (ILP): Residents document an ILP and self-assessment annually under the guidance of the faculty advisor or program directors to assist with setting and tracking educational and professional goals.
- III.** Summative Evaluation: the Clinical Competency Committee (CCC) documents a summative evaluation for each resident semi-annually based on an active review of the formative evaluations, quarterly professionalism score, the American Board of Pediatrics in-training examination results and any other pertinent data. (See professionalism policy)
 - a. The CCC makes recommendations to the program director for resident progress, including promotion, remediation, and dismissal. (See grievance policy)
 - b. The CCC uses the Pediatric Milestones to ensure residents are able to practice without supervision upon completion of training.
- IV.** The Clinical Competency Committee: a select group of faculty members are appointed by the program director to collectively assess the clinical competency of each resident. The CCC is an essential component of a valid and reliable clinical evaluation system.
 - a. Structure
 - i. For each semi-annual report, there will be 3 meetings (one for each PGY level) held in November/ December for the 1st report and May/June for the 2nd report.
 - ii. Additional ad hoc meetings may be needed for any urgent intervention. The monthly Compliance Committee reviews all evaluations and if a resident exhibits "Critical Deficiencies" that may threaten the health and well-being of patients or the resident, the PD will convene the CCC for a formal assessment so that swift action can be taken to intervene and mitigate any harm. The PD may receive verbal or written evaluations from faculty, peers, medical students, patients or any solicited or unsolicited evaluations that would prompt

such a meeting.

- iii. The three associate program directors will serve as CCC Chairs (one for each PGY level) and are responsible for presenting summary recommendations to the PD.
- iv. The committee will consist of voting and non-voting members. Eight faculty members will serve as voting members; the 2 chief residents and program coordinator will attend the meetings and participate in discussion but serve as non-voting members. The PD will also attend as a non-voting member and with advice from the committee will ensure that the program's evaluation tools reflect the information required by the CCC in the deliberations of competence.
- v. Each faculty member will be assigned approximately 6 residents and they will review their assigned residents' files prior to the meeting and present a summary of their evaluations and assessment of their clinical skills. Each resident's progression will be noted during each CCC meeting by the program coordinator who will also record minutes of meeting. The final rating for each of the milestones will be determined by the committee as a whole, with the majority vote (over 50%) determining the rating. If there is a tie, the Committee Chair will serve as the tie breaker.
- vi. Committee Member Selection
 - 1. The PD will select faculty based on their dedication to medical education, willingness to serve, evidence of being reliable, possessing good interpersonal and communication skills and working knowledge of evaluation and assessment.
 - 2. CCC members are expected to dedicate approximately 20 hours a year in this role.
 - 3. CCC members will be reevaluated each year with members added/removed when needed and if job positions change.

V. Resident Enhancement and Corrective Action Plans:

- a. The formative evaluations are rated on a scale of 1-5 (novice, advanced beginner, competent, proficient, expert). It is generally expected that PGY-1's will achieve a level 2, PGY-2's will achieve a level 2-4, and PGY-3's will achieve a level 3-4 on all milestones by the end of their respective year. The summative evaluations are expanded to a 9-point scale to allow for half point ratings. Residents will otherwise be considered to have adequate progression based on the following scale:
 - i. PGY1: Rating of 2-4 (or greater) on the milestones evaluation form
 - ii. PGY2: Rating of 4-6 (or greater) on the milestones evaluation form
 - iii. PGY3: Rating of 6-9 on the milestones evaluation form
- b. If the resident is on target or ahead of projected performance, recommendations can be made to provide the resident with a guide to further enhance his or her development.
- c. If a resident's performance is rated below the expected level a formal corrective action plan will be developed by the CCC.

- i. The plan will be written out with specific recommendations and a timeline for the resident to demonstrate progression. This will be kept as part of the resident's file and a copy will be provided to the resident.
- ii. The CCC Chair will share the action plan with the Program Director for approval. Once approved, the plan will also be shared with the resident's faculty advisor and resident.
- iii. Working together the assigned faculty member and the CCC member will meet with the resident to review and enact the action plan. If the faculty member and CCC member assigned to the resident is the same individual, then one of the alternate CCC members assigned to that year will serve as the co-advisor for the action plan.
- iv. The resident's progression will be reassessed at subsequent CCC meetings or if needed ad hoc meetings based on the monthly Compliance Committee's recommendations.
- v. Additional requirements for Promotion
 1. In addition to clinical performance, other requirements must be met to be promoted as listed in Promotion Policy (including but not limited to: performance of required number of procedures, presentation at case conference and grand rounds, step III completion, participation in quality improvement project).

VI. If a resident's performance is repeatedly assessed below the expected level despite the corrective action plan the Committee Chair and Program Director will meet to determine the next step in corrective action. Dismissal, non-promotion, or additional training time may be recommended.

VII. All evaluations and documents related to a resident's performance are part of the resident record and are accessible for review during regular business hours in the residency office. A majority of evaluations are available on-line through the LSUHSC's New Innovations Evaluation system.



POLICY ON ~ GRIEVANCE PROCEDURES

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



POLICY ON ~ HOUSE OFFICER MOONLIGHTING

1. Moonlighting is defined as employment as a physician outside of the scope of the House Officer Program. All medical and non-medical type outside employment should be reviewed and approved by the program in accordance with the LSU System Permanent Memorandum – 11.
2. House officers must have written approval by the Program Director and/or Department Head before engaging in this activity. The Residency Office will maintain a moonlighting file of all the written approvals.
3. The Department of Pediatrics can withdraw permission for moonlighting if the resident's performance is substandard or any evidence of fatigue.
4. House Officers, while engaged in professional activities outside the scope of the program, are not provided professional liability coverage unless the services are performed at a public charity health care facility. For professional activities at Children's Hospital, residents must have additional malpractice coverage that is available through the Children's Hospital Finance Department.
5. Residents must abide by the guidelines for moonlighting times.
 - a. Residents cannot moonlight the day before or the day after a regularly scheduled call day.
 - b. Residents cannot moonlight during an every 4th night call rotation month.
 - c. Moonlighting activities cannot interfere with required rotation duties, which place restrictions on the timing of moonlighting activities. Moonlighting hours cannot conflict with the Resident Clinical and Educational Work Hours Policy (see policy) and are counted towards the 80-hour work-week limits. Residents must have 4 days off averaged over a 4-week period; must have 8 hours off between work and cannot work more than 24 hours consecutively.
 - d. Residents are limited to 5 weekday moonlighting calls/month
6. All moonlighting must be tracked in New Innovations' Work hours.
7. Moonlighting by interns and J-1 visa holders is not allowed.
8. All house officers must be **fully licensed** by the LA State Board to moonlight outside of the hospital e.g. have an unrestricted license, which usually means passing Step III and more restrictions for ECFMG holders.

**Please refer to the LSU GME House Officer Manual for additional moonlighting requirements/specifications.



POLICY ON ~ LEAVE

LEAVE

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

Job or Fellowship Interviews

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

Vacation leave

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

Sick Leave

House officers are permitted fourteen days including weekends of paid sick leave per year that may not be accumulated into subsequent calendar years and may only be used for the illnesses of the House Officer. As the American Board of Pediatrics requires 33 months of training for competence, sick leave in excess of 1 week (7 calendar days) during a resident's training will potentially delay a resident's completion date. Each individual case should be discussed with the Program Director and Program Coordinator. 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 scheduled 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.

Wellness Day Policy

Our residency program recognizes the occasional need for time off due to reasons other than an acute illness and has implemented a policy for residents to request time off based on these circumstances. In 2017, the Wellness Day was introduced as a mechanism to meet this need; however, the Wellness Day should not be abused and will be monitored by the chief residents. The chief residents will involve the Program Director, if needed.

- On paper, a wellness day will be entered as a **sick day**.
- **The resident must notify one of the chief residents of their need to take a wellness day, with a brief explanation as to why.** To protect your privacy, the chiefs do not need to know specific details but need to ensure the day is being used for an appropriate reason. In addition, the chief residents will determine if a back-up resident is needed to cover the resident's clinical responsibilities. Examples of appropriate reasons to take a wellness day:
 - Emotional exhaustion or being significantly overwhelmed to the point of it affecting your well-being and ability to care for patients.
 - To attend necessary healthcare appointments that would require you to have an entire day off.
 - Other life stressors that may fall into additional, unforeseeable categories
- Taking wellness days to leave for vacation early, prepare or leave for an extended weekend trip, attend an event for which the resident forgot to request time off, etc is not an appropriate use of the wellness day.
- The resident should still notify their team and/or attending physician of their absence PRIOR to the start of clinical duties so that patients can be appropriately divided and cared for. We would strongly encourage any communication with your attending to be done via a phone call.
- **The Chief Residents**
 - Will NOT discuss the specific reasons of a valid wellness day with the Program Director unless they feel your safety and/or well-being are in jeopardy.
 - Will discuss wellness day requests with the Program Director if they feel the reason is unwarranted and/or inappropriate.
 - Will notify the program coordinator of your absence so that it is properly documented for payroll, etc.
- Excessive and/or inappropriate use of the wellness day will be investigated and addressed by the chief residents and program director.



• **NON-RESIDENT – GENERAL BACKGROUND INFORMATION**

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

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

- 1) Insurance Coverage – Federal law requires that all J-1 personnel and their dependents have specific insurance coverage during their stay in the U.S. The minimum coverage required is: 1) medical benefits of at least \$50,000 per accident or illness, with a maximum \$500 deductible per accident or illness, 2) repatriation of remains coverage in the amount of \$7,500, and 3) coverage for any expenses associated with medical evacuation in the amount of \$10,000. (FYI, ECFMG will purchase the repatriation of remains coverage and the medical evacuation coverage once a person has been approved for sponsorship.)
- 2) Change in Status – It is strongly discouraged for an individual to travel to the U.S. in one status and then attempt to change to another status after entering the country. Very few of these requests are approved and, therefore, it is important the proper status be determined, and obtained, prior to coming to the U.S.
- 3) Important – If your visa status is J1 status, your employment is limited to established ACGME program sites for which ACGME letters of agreement are in place.

IMPORTANT ISSUES:

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

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

- a) Exact name(s) – Last name in CAPITAL LETTERS, first name, middle name
- b) Relationship
- c) Date of birth
- d) City and country of birth
- e) Citizenship
- f) Dates of expected visit

- 4) Licensure – It is the individual’s responsibility to always maintain a valid medical license from the Louisiana State Board of Medical Examiners (LSBME). Should a situation develop whereby medical licensure has not been renewed in a timely manner, the individual will be placed on leave of absence (without pay) until proof has been obtained from LSBME that the individual possesses a valid medical license. FYI: the LSBME requires successful completion of USLME Step 3 before issuing a renewal GETP beyond the first 24 months of training. If the FMG is applying for unrestricted licensure, completion of the FCVS profile through the Federation of State Medical Boards (FSMB) is also required.



POLICY ON ~ PROCEDURE AND CASE LOGS

1. All residents must keep a record of procedures performed on the New Innovations website and continuity clinic patients visits during their residency online at www.acgme.org
2. Each procedure should be recorded with a medical record number, date, and location the procedure was performed. It should also include who supervised the procedure and how well the resident performed the procedure.
3. A goal minimum number of procedures is suggested of PGY-1's: 5 attempts at lumbar puncture and intubation with 3 successful. Between Well Baby Nursery and Touro NICU rotations, attendance at a minimum number of 10 newborn deliveries is required of all residents.
4. Residents must demonstrate procedural competency by performing the following procedures and should seek out all opportunities to perform these procedures.
 - a. Bag Mask Ventilation
 - b. Bladder Catheterization
 - c. Incision and Draining abscess
 - d. Peripheral IV placement
 - e. Reduction of simple dislocation
 - f. Simple laceration repair
 - g. Simple removal of foreign body
 - h. Temporary splinting of fracture
 - i. Venipuncture
 - j. Umbilical catheter
5. Residents are required to complete 10 of these designated procedures prior to graduation.
 - i. Attending the delivery of a newborn
 - ii. Lumbar puncture
 - iii. Endotracheal intubation
6. Residents must be competent in the understanding of the indications, contraindications, and complications for the following: arterial line placement, arterial puncture, chest tube placement, circumcision thoracentesis
7. All patients seen in continuity clinic must be logged into the case log system. All information requested, such as age, gender, date of visit and diagnosis code must be entered. Residents must see progressive number of patients, with a goal minimum of 3 patients for PGY-1's, 4 for PGY-2's, and 5 for PGY-3's. All residents must attend 36 half day clinics/year.



POLICY ON ~ PROFESSIONALISM

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

Each resident will be granted **100 Professionalism Points** quarterly – based on the criteria below. For each criterion that is NOT MET, points will be subtracted. If a resident’s quarterly score is **less than or equal to 80, a warning will be issued**. If a resident **scores less than or equal to 80 in two quarters** in the same academic year, he/she will be **reported to the American Board of Pediatrics’ Annual Tracking System** as “Unprofessional”. Each resident’s progress will be monitored/recorded monthly by the Chief Residents and reviewed quarterly by the Compliance Committee.

Criteria	Points
Satisfactory evaluations from faculty members (a score of 2 or above in all parts of the professionalism domains of the monthly rotation evaluation)	10
Satisfactory evaluations from peers (a score of 2 or above in all parts of the professionalism domains of the monthly rotation evaluation)	10
Satisfactory evaluations from medical student evaluations (a score of 3 or above on “Treats medical students with courtesy and respect”)	10
Satisfactory evaluations from nurse evaluations (no rating of “Never/Poor” in the professionalism domains AND no comments about unprofessional behavior)	10
Satisfactory evaluations from patient evaluations (ratings of “yes” in all domains related to professional behavior) and timely submission of 2 evaluations/semester	10
Satisfactory reports from unsolicited sources (patients, families, hospital or department personnel including chief residents)	10
Appropriate attendance at the required number of continuity clinics (3 per month) and appropriate documentation of patient visits on the ACGME website (when assessed quarterly)	10
Daily documentation of Work hours on New Innovations (assessed monthly)	10
Attendance of the required number of educational conferences (when assessed quarterly)	10
Completion of 20 PREP questions per month (when assessed Quarterly – 60/Quarter), monthly board review quiz, biannual Observed H&P (PGY-1 only), AMA Modules and Compliance Modules (when assessed annually)	10
Professional Total Score	/100

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

Reporting to the American Board of Pediatrics (ABP)

An annual tracking system is conducted by the ABP in which the program director must submit a clinical competency rating and a professionalism rating. The clinical competency rating is based on the Clinical Competency Committee’s milestone ratings. Ratings for professionalism will be based on the professionalism scoring system as described above. If an unsatisfactory professionalism evaluation (score less than or equal to 80) is given for two quarters within the same academic year, this will be reported on this ABP annual tracking system. According to the ABP rules, a resident or fellow who receives an unsatisfactory evaluation for professionalism receives no credit for that year of training unless the program director provides evidence as to why a period of observation rather than a repeat year of training should be completed.

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

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

Referral to Campus Assistance Program

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

Assignment of Additional Clinical Duties

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

QUARTERLY attendance at the required number of continuity clinics (average of 3 per month); 60 PREP questions (20/month)

BIANNUAL completion of observed history and physical examination for PGY-1’s; submission of 2 patient satisfactions surveys

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

Failure to attend the required number of conferences each quarter will result in assignment of additional PREP questions. See policy for specific details.

Chief residents and program coordinators will track activities at the beginning of each month – date to be provided at the beginning of academic year. The program strongly advises residents to complete activities on a monthly basis, and chief residents will provide compliance data to residents each month for them to monitor individual progress. However, the residency compliance committee, including the Program Director, will meet quarterly to assess compliance. The program will not permit for any non-compliance with the required quarterly, biannual, and annual activities. If there is a scheduling conflict with night float coverage, a resident may be assigned night call in the PICU or note float as a substitute at the discretion of the program director and/or chief residents.



POLICY ON ~ REQUIRED SUBSPECIALTY EXPERIENCE

The residents are required to complete subspecialty rotations as they progress through their training. These subspecialties are split by the year.

PGY-1

- Endocrinology (1 month)
- Hematology/Oncology (1 month)

PGY-2

- Nephrology (1 month)
- Gastroenterology (1 month)
- Hematology/Oncology (1 month)

PGY-3¹

- Neurology (1 month)
- Cardiology (1 month)

Additional subspecialty experience is encouraged through the use of individual educational units

- Child psychiatry
- Infectious Diseases
- Allergy/Immunology
- Rheumatology
- Genetics
- Dermatology
- Ophthalmology
- Orthopedics & sports medicine
- ENT
- Pediatric surgery
- Pediatric radiology
- Nutrition

¹ Hematology/Oncology will be a traditional 1 month block. The remaining subspecialty rotations may be divided to accommodate schedule requests. However, the total time on the above subspecialty services will remain consistent for each resident based on PGY level.



POLICY ON ~ INDIVIDUAL EDUCATIONAL UNITS

The Pediatric RRC requires each residency training program to include a minimum of six individualized educational units (IEU'S) in its curriculum. The individualized curriculum must be determined by the learning needs and career plans of the resident and must be developed through the guidance of a faculty mentor.

The individualized curriculum should not be thought of as additional “electives” for the resident. The curriculum can be unique for each resident or designed as tracks within the program. The goal of the IEU is to provide experiences that will help residents be better prepared for the next steps of their careers after residency. Experiences can be inpatient, outpatient, research, or other. They may be repeated experiences, done previously in the program, or experiences that are at a higher level with less supervision (e.g. acting as a co-fellow on a subspecialty experience). The timing (year of training) should also be determined by the program. If the subspecialty experiences for the ‘three additional educational units’ are chosen based on needed experiences for the individualized curriculum, then they can count toward this requirement (a.k.a. ‘double counting’). An Educational Unit should be a block (four weeks or one month) or a longitudinal experience.

LSUHSC PEDIATRIC RESIDENCY PROGRAM’S INDIVIDUALIZED TRACKS

The Program Director, Associate Program Directors, Chief Residents, and/or Mentors will meet with each resident annually to determine his/her specific rotations for the upcoming year based on the resident’s expected career choice. Each pediatric resident will have **7 IEU’s** throughout the 3-year curriculum as outlined below. Each track must have at least 3 subspecialty rotations from the major or minor list and these can be combinations.

Primary Care Track			
PGY	Rotations	Comments	IEU #
1	Subspecialty OR Outpatient Pediatrics	ID highly recommended	1
2	Inpatient Pediatrics	Purple/Green Team	0.5
2	Subspecialty	**See suggestions below	1.5
3	Outpatient general pediatrics	Should be done at a private pediatrician’s office to simulate future practice, if applicable	1
3	Outpatient general pediatrics	-Emphasis on the business aspect of medicine i.e. billing, office management, etc. If possible, “mommy call.”	1
3	Subspecialty and Additional Well Baby Exposure	-Additional Well Baby time (ex. Nursery, lactation, Touro NICU) **See below for subspecialty suggestions	2
Subspecialty Recommendations: Orthopedics, Dermatology, ENT, Rheumatology, Genetics, Psychiatry, Neurology, Allergy/Immunology, Infectious Disease			

Hospitalist Track			
PGY	Rotations	Comments	IEU #
1	Subspecialty	**see suggestions below	1
2	Inpatient Pediatrics	Purple/Green Team	0.5
2	Subspecialty, Research, or additional Inpatient Pediatrics	**see subspecialty suggestions below	1.5
3	Inpatient Pediatric Rotation	-Purple/Green (minimum 0.5 IEUs if only completed 0.5 IEUs as PGY2) -Individualized hospitalist rotation to focus on team leadership, billing, QI, hospital systems, etc.	1.5
3	Subspecialty	**see suggestions below	1.5
3	Academic Medicine Rotation	Resident as Teacher and/or Research Rotation	1
Subspecialty Recommendations: Infectious Disease (minimum requirement = 2 weeks), Rheumatology, Allergy/Immunology, Pulmonology, Dermatology, Child Abuse, Hematology/Oncology Clinic, PICU			
Uncertain Track			
PGY	Rotations	Comments	IEU #
1	Options: Outpatient General Pediatrics, Subspecialty, or PICU/NICU	**see subspecialty suggestions below	1
2	Inpatient Pediatrics	Purple/Green Team	0.5
2	Subspecialty or ER	**see subspecialty suggestions below	1.5
3	Outpatient General Pediatrics	Consider a private pediatrician's office to simulate future practice, if applicable	1
3	Inpatient Pediatrics	Purple/Green Team	0.5
3	Subspecialty	**see suggestions below	2.5
Subspecialty Recommendations: ER, PICU, NICU, Infectious Disease, Allergy/Immunology, Rheumatology, Pulmonology, Nephrology, Heme/Onc Clinics, Cardiology, ENT, Dermatology, Radiology			
Emergency Medicine Track			
PGY	Rotations	Comments	IEU #
1	Subspecialty	**see suggestions below	1
2	ER		1
2	Academic Medicine Rotation	Resident as Teacher and/or Research	1
3	ER	Consider UMCNO for Trauma (advanced planning involved so notify PD/chief residents prior to 3 rd year)	1
3	PICU		1
3	Anesthesia		1
3	Subspecialty	**see suggestions below	1
Subspecialty Recommendations: Orthopedics, Radiology, Infectious Disease, ENT, Ophthalmology, Dental/OMFS			

PICU Track			
PGY	Rotations	Comments	IEU #
1	PICU and/or Subspecialty	**see subspecialty suggestions below	1
2	Inpatient Pediatrics	Purple/Green Team	0.5
2	Subspecialty	**see subspecialty suggestions below	1.5
3	PICU		1
3	Subspecialty	**see subspecialty suggestions below	2
3	Academic Medicine Rotation	Resident as Teacher and/or Research	1
Subspecialty Recommendations: *CICU, *Anesthesia/Sedation, Vascular Access Team, *Palliative Care, *Infectious Disease, Nephrology/Dialysis, Cardiology, Radiology, Pulmonology, Child Abuse, Additional Research (* = highly recommended)			
NICU Track			
PGY	Rotations	Comments	IEU #
1	NICU and/or Subspecialty	**see subspecialty suggestions below	1
2	Inpatient Pediatrics	Purple/Green Team	0.5
2	Subspecialty *Also consider CHNOLA NICU x 2 weeks	**see subspecialty suggestions below	1.5
3	NICU	Incorporate some overnight shifts/calls, could split between CHNOLA and Touro	1
3	Subspecialty	**see subspecialty suggestions below	2
3	Academic Medicine Rotation	Resident as Teacher and/or Research	1
Subspecialty Recommendations: Cardiology/CICU, Genetics, Anesthesia (procedures: intubation, line placement), Radiology, Maternal Fetal Medicine, Exposure to Prenatal Consults, Palliative Care, Neurology, Pulmonology, Research, PICU			
Subspecialty Tracks			
PGY	Rotations	Comments	IEU #
1	Subspecialty of Career Choice		1
2	Inpatient Pediatrics	Purple/Green	0.5
2	Subspecialty and/or Research Time	**See supplemental document for suggestions divided by desired fellowship	1.5
3	Subspecialty	Strongly consider additional NICU/PICU time, depending on career choice	1
3	Subspecialty	**See supplemental document for suggestions divided by desired fellowship	2
3	Academic Medicine Rotation	Resident as Teacher and/or Research	1

**The following pages provide a compilation of suggested Subspecialty IEUs and/or rotations based on the resident's chosen subspecialty and fellowship plan.

Suggested Electives for Residents Based on Career Path

From the Council on Pediatric Subspecialties

<http://www.pedsubs.org/about/index.cfm>

Below is a list of suggested (not mandatory) rotations that a resident should consider if they are planning to apply in a particular subspecialty. This is not meant to be an all-inclusive curriculum, but rather a list to create a program that fits a resident's individual needs.

Adolescent Medicine

There are no mandatory rotations for residents prior to Fellowship. A 2014 survey of Adolescent Medicine program directors was used to generate a list of suggested rotations to augment clinical expertise. The following recommendations were made: psychiatry - particularly outpatient (88%), sports medicine (82%), gynecology (76%), family planning (76%), substance abuse (58%), and endocrinology/obesity (53%).

Allergy-Immunology

- Allergy-Immunology (important to rotate in a clinic that sees both children and adults)
- Dermatology (very important)
- Rheumatology
- Consider ENT
- Consider nephrology and hematology-oncology
- Infectious disease

Cardiology

- PICU (not CICU) - critical skills
- Anesthesia - intubating and lines
- Pulmonary Medicine - coexisting lung disease/PHTN
- Pathology - cardiac if possible
- GI - particularly liver function and bowel motility
- Neurodevelopment – outcomes
- Nephrology - for associated renal dysfunction/medication/HTN

Child Abuse

- Radiology / Neuroradiology
- Trauma Surgery / Burn team
- Toxicology
- Forensic pathology
- Legislative Advocacy

Developmental-Behavioral Pediatrics

- DBP elective (in addition to required block rotation which may include rotations such as myelodysplasia, muscular dystrophy, neuromuscular, Fragile X, Downs or other sub-sub specialty clinics)
- Child psychiatry
- Child neurology
- Genetics
- Pediatric physical medicine and rehabilitation
- Community based primary care rotation

Experience with allied professionals such as psychologists, speech and language pathologists, audiologists, occupational therapists and physical therapists, medical social workers. In addition, advocacy experiences and experience with community-based agencies serving children and families would be worthwhile as would experiences in day treatment centers for children with special health care needs.

Endocrinology

- Endocrinology elective (inpatient and outpatient)
- Research month/elective
- Diabetes camp
- Rotations with diabetes experience (PICU, inpatient diabetes)
- Endocrine subspecialty clinic (longitudinal clinic if available)
- Genetics
- Adolescent Medicine

Gastroenterology

- Other medical subspecialties:
 - Allergy/Immunology - Food allergies, immunodeficiencies
 - Endocrinology - Growth, pubertal development, autoimmune endocrinopathies
 - Genetics
 - Rheumatology - Autoimmune disorders, joint disease associated with IBD, use of immunosuppression
- Other disciplines:
 - Pathology - Introduction to gross and microscopic pathology
 - Radiology - Fluoroscopy, CT, MR, nuclear medicine studies (IDA studies, gastric emptying studies)
 - Pediatric surgery
 - Speech pathology - Dealing with feeding issues

Hematology-Oncology

- Outpatient Pediatric Hematology/Oncology
 - To understand the treatment and experience of this patient population in the outpatient setting

- To better develop relationships with Pediatric Hematology/Oncology faculty for mentorship and recommendations
- Several of the following electives aimed at improving knowledge of the organ systems most commonly compromised in Pediatric Hematology/Oncology practice, whether secondary to disease or to toxicity
 - Cardiology
 - Dermatology
 - Gastroenterology
 - Immunology
 - Infectious Disease
 - Nephrology
 - Pulmonology
 - Radiology
 - Pediatric Pathology
 - Pediatric Radiation Oncology

Infectious Disease

- Infectious Diseases
- Radiology
- Orthopedics or another surgical subspecialty rotation
- Immunology (if available, not an allergy elective)
- Dermatology (if there is a robust consult service with exposure to dermatologic manifestations of infections and/or adverse drug reactions)
- Rheumatology
- Solid organ transplant/Bone marrow transplant

Nephrology

- Rheumatology
- Radiology
- Infectious Disease

Pulmonary Medicine

- Infectious Disease
- Gastroenterology
- Allergy/Immunology
- Respiratory Care rotation
- Cardiology
- PICU
- ENT
- Pathology (with emphasis on lung pathology)
- Radiology
- Anesthesia
- Sleep

Rheumatology

- The residents should have a solid background in General Pediatrics
- A rotation in Pediatric Rheumatology (this will be an away rotation for many residents)
- Allergy/Immunology
- Pediatric Nephrology
- Sports Medicine
- Dermatology
- Infectious Disease
- Hematology
- Immunology
- Research
- Physiatry/PM&R (if available)



POLICY ON ~ RESIDENT CLINICAL AND EDUCATIONAL WORK HOURS

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

I. CLINICAL AND EDUCATIONAL WORK HOURS

1. Work Hours

- a. Work 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. Work hours do not include reading and preparation time spent away from the work site.
- b. Clinical and educational work hours will be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and moonlighting.
- c. Residents will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- d. Work periods of PGY-1 residents will not exceed 16 hours in duration.
- e. Work periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous clinical and educational responsibilities in the hospital. Residents may be allowed to remain on-site to accomplish effective transitions of patient care; however, this period of time must be no longer than an additional four hours.
- f. Adequate time for rest and personal activities will be provided. Residents should have ten hours free of clinical and educational activities between scheduled work periods and must have eight hours free. After a 24-hour in-house shift, residents must have at least 14 hours free of clinical work and educational activities.

2. On-Call Activities

- a. In-house call will not occur no more frequently than every third night, averaged over a four-week period. For ICU rotations, residents will take

call every 4th night. During outpatient rotations as an upper level, residents may be assigned 1-3 cross covers per month. Interns will not participate in overnight call. For the emergency room rotations, residents will work 13 shifts per month.

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

II. EDUCATION, ALERTNESS MANAGEMENT AND FATIGUE MITIGATION POLICY

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

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

- D. If a resident should feel that fatigue may affect patient care or their transportation home, they may access the call rooms at any time for rest.
- E. Back up Call Policy: If a resident cannot perform their required duties, they must contact their supervising faculty member and the chief residents. A call system is created for use of needed replacement for the House Officer who is unable to perform their duties which is named Jeopardy Call. The Jeopardy Call schedule is created by the chief residents and distributed with the monthly call schedule. There is one upper level resident on Jeopardy Call every day as back up. The chief residents will determine if Jeopardy Call needs to be activated depending on the need of the residents' service or their responsibilities. The chief residents are responsible for notifying the Jeopardy Call Resident to report to work. The coordinator is also notified by the chief residents for proper documentation and monitoring of sick days.

III. MONITORING OF WORK HOURS AND HOUSE CALL

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

team or resident. The resident must provide the program director a written report describing this situation. The program director will track these episodes of additional clinical or educational responsibility.

IV. NIGHT FLOAT POLICY

- A. The night float system provides nighttime coverage for the four inpatient ward teams and occurs in two separate blocks: weekday night float occurring from Monday to Thursday night (4 nights in a row) and weekend night float occurring from Friday to Sunday night (3 nights in a row). Residents are rarely scheduled for more than 4 consecutive nights of night float. Weekday night float occurs in ½ month blocks whereas weekend night float may occur as an isolated weekend or two consecutive weekends. Residents are scheduled for 1-2 weekends of night float/month while on outpatient rotation months. There are at least two senior residents and one to two interns on night float at a given time to cover the four ward teams.
- B. Check-out between the day team and the night float team occurs promptly at 6:30pm for subspecialty teams and 7:00pm for ward teams. Each ward team and subspecialty grouping has a separate and consistent admit and floor call pager. Admit pagers are to be carried by the senior resident, and the floor pager is carried by either the senior or junior resident assigned to the team for the night. Patient lists should be accurately updated each day by both the day and night teams. Check-out to the day team occurs at 6:30 am for ward team and 7:00am for subspecialty teams, after which the night float residents are free of all other clinical duties unless needed during high patient volume times to assist in writing notes (residents are free of all clinical duties both the day before their first night float shift and the day after their last shift).
- C. Educational requirements: While on a two-week night float block, each group is required to complete 4-5 assigned night float curriculum modules. These modules will be discussed at a 1-hour evening session with one of the hospitalists. In addition, feedback on night float performance and handoff evaluation will occur during/after these sessions.

V. TRANSITIONS IN CARE

- A. Each ward team will conduct a structured handoff session of patient information at least twice each 24-hour period. This will occur when the day team signs out to the night float team in the evening and again when the night float team signs out to the day team in the morning.
- B. Each patient must be entered into a comprehensive patient list which includes but is not limited to patient identifiers, weight, diagnoses,

medications, allergies, pending labs or consults, new or anticipated problems, attending physician and guardian contact information, and resuscitation status (DNR) if applicable. The senior-most resident on the team is responsible for assuring the accuracy of this list on each shift. In addition, verbal face-to-face handoff will be conducted in an area where interruptions are less likely (resident lounge or conference room). The patient list is used as an adjunct to verbal handoff and as a reference throughout the shift. To minimize interruptions, a protocol has been adopted by both the hospital nursing staff and the residency program where pages to residents and are minimized during hand off times.

- C. Residents are trained annually on techniques for effective handoff and communication. This training occurs with an interactive session conducted by the program director or his/her designee.
- D. Contact information for each attending physician is kept on amion.com, the aforementioned list as well as with the hospital operator. Residents may at any time reference amion.com to determine the attending on call.
- E. If signs of excessive fatigue in the outgoing team are noted by the residents of the oncoming team, the chief residents should be notified immediately. Anyone who appears to be excessively fatigued will be immediately relieved of their duties and encouraged to nap in the call room prior to leaving the hospital.
- F. A member from each team will provide handoff to the night float team each evening. Members of each subspecialty grouping alternate remaining in the hospital to conduct handoff to the night float team. Also, any resident who is assigned to afternoon continuity clinic will not return to the hospital to handoff patients to the night team when possible
- G. The call schedule for individual residents is available online, with the hospital operator, and on each nursing unit at all times. Each team also has a “team pager” so that if any medical personnel are unsure which resident is responsible for the patient, the team may be reached easily by this route.

VI. LINE OF SUPERVISION POLICY

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

appropriately credentialed and privileged by each institution based on the Joint Commission of Hospital Accreditation Standards.

PGY-1

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

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

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

Chief Residents

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

Faculty/Attending Physicians

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

Prevent a Code Team (PACT)

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

Safety Issues

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

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

Program Director

The program director is responsible for responding to any trends or re-occurring concerns in regards to patient safety issues involving residents/fellows or attending physicians. The Program Director will address this issue with the resident. The Program Director will notify the Chair for any issues related to the LSUHSC faculty members and will report to the medical director of Children's Hospital for issues related to hospital operations or medical staff members who are nonmembers of the LSUHSC faculty.

Chair

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

Patients/families

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

Table of Supervision by PGY level

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

Definitions of various levels of supervision:

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



YEARLY PROMOTION CRITERIA

Residents' performance will be reviewed for promotion on a semi-annually basis by the Clinical Competency Committee. (See evaluation policy). In addition to clinical performance, other requirements must be met to be promoted as listed below:

I. PGY-1: For a resident to be promoted to PGY-2 all criteria must be satisfied.

Pass	Fail	Criteria
		Clinical skills and milestone ratings deemed at appropriate level by Clinical Competency Committee.
		USLME – Must sit for Step III
		Participation in Quality Improvement Curriculum with completion of required IHI Modules and additional QI expectations for PGY-1.

II. PGY-2: For a resident to be promoted to PGY-3 all criteria must be satisfied.

Pass	Fail	Criteria
		Clinical skills and milestone ratings deemed at appropriate level by Clinical Competency Committee.
		Presentation at one Clinical Case Conference
		USLME – Step III Pass
		Participation in Quality Improvement Curriculum, Quality Improvement Project, and additional expectations outlined for PGY-2 residents.

III.PGY-3: For a resident to graduate all criteria must be satisfied.

Pass	Fail	Criteria
		Clinical skills and milestone ratings deemed at appropriate level by Clinical Competency Committee.
		Participation in Quality Improvement Curriculum, Quality Improvement Project, and additional expectations outlined for PGY-3 residents.
		Presentation at one Resident Grand Rounds, M&M, or Journal Club
		Minimum number of procedures during 3 years of training: 10 attempts at LP and intubation. Attendance at a minimum 10 deliveries.



PROGRAM EVALUATION COMMITTEE (PEC)

Purpose: The PEC will provide a formal structure to be used in the systematic program evaluation, design and improvement.

Organization: Dr. Chelsey Sandlin, Program Director chairs this monthly committee which meets the first Wednesday of every month except November/December and May/June (due to the CCC Milestone reporting meeting). Members include: the Department Chair, Vice-Chairs, the associate program directors, current and rising chief residents, class representative from each residency program, Med-Peds program director, associate program director and chief residents, core faculty, Peds-EM program director, and program coordinators.

PEC Responsibilities: The PEC will participate actively in:

- Planning, developing, implementing and evaluating all significant activities of the residency program;
- Developing competency-based curriculum goals and objectives;
- Reviewing annually the program using the ACGME, LSUHSC, and departmental annual surveys completed by the faculty and residents;
- Documenting formal, systematic evaluation of the curriculum at least annually;
- Rendering a full, written, annual program evaluation (APE) to include a detailed action plan for program improvement;
- Assuring that areas of non-compliance with ACGME standards are corrected; and
- Presenting APE and action plan for program improvement to the LSU School of Medicine's Institutional Graduate Medicine Education Committee

Topics the committee will review including but not limited to:

- Past years' Action Plans
- Curriculum
- Didactic schedule
- Conferences
- Attendance
- Resident performance and progress
- In-service scores
- Core curriculum progress
- Milestones
- Evaluation summaries
- Scholarly activity/QI participation
- Graduate performance

- Board performance
- Post-graduate surveys
- Faculty development
- Program quality
- Evaluations of program by faculty, residents, etc.
- Program manual
- Review evaluations
- Accreditation requirements
- Rotation schedules
- Clinical and Educational Work Hours reports

Documentation of meeting: the Program Coordinator will record minutes for each meeting. The Program Director will submit a summary report to the DIO via New Innovations or any other means as requested.



POLICY ON ~ USE OF SOCIAL MEDIA

Background

- Physicians are utilizing digital forms of communication (e.g., texting, email, instant messaging), social networking sites (e.g., Facebook, Twitter) and online photo/video sharing technologies (e.g., You Tube, Instagram) with increasing frequency.
- These technologies offer great opportunities to improve patient outcomes with the ability to communicate instantaneously and reach a vast audience.
- At the same time, these advanced tools bring challenges to our profession in the form of ethical dilemmas regarding proper physician-patient relationship, privacy concerns, and the portrayal of physicians in a potentially negative manner.
- Resident trainees are at increased risk to the dangers in the use of these advanced means of communication as they transition from the acceptable “lay world” content of social media platforms to the constraints based on the tenets of ethical and professional boundaries.
- The same principles that guide verbal communication also apply to online communication, but it is vital to remember the potential permanence of online content even if removed from the original place of posting.
- This policy aims to guide the residents in their current role as well as in their future independent practice so that they may benefit from these technologies while conducting themselves in a responsible, respectful, and professional manner.

Specific Guidelines*

Interacting with Patients

Physicians are discouraged from interacting with current or past patients or patients’ families on personal social networking sites. All interactions between a physician and a patient or patient’s family should remain within the confines of this established professional relationship. If a physician interacts with patients using an online platform, it is advisable to use a professional site. Such interaction should nonetheless be approached with caution as the quality of the interaction may be less compared to a face-to-face communication.

Privacy/Confidentiality

Physicians should not discuss or post any comments, pictures, or videos of patients or patient related activities. Even if identifiers are removed, the potential for recognition is still present and such postings may be in violation of HIPAA laws.

Posting Content

Physicians should be mindful of any information posted on a personal social networking site that can be misinterpreted and taken out of its intended context. Seemingly innocent

pictures may be misconstrued as condoning of unhealthy behaviors (e.g., alcoholism, sexual promiscuity, or illicit drug use). At all times physicians are representing the medical profession and their employer/institution.

Professionalism

Physicians should not vent patient or work-related disappointments or frustrations online. They should not use vulgar language, disparaging remarks or content that could be viewed in any way disrespectful in any form of communication. Such unprofessional activity can undermine society's respect of physicians and thereby damage therapeutic alliances with patients.

Inter-professional Relationships

Physicians who serve as evaluators of trainees or students (e.g. attending and resident, resident and student) should maintain appropriate boundaries by avoiding digital friendships.

Discussion of Medicine Online

Using professional networks to share medical treatments and discuss interesting cases has many benefits. Physicians must ensure that these networks are secure with safeguards (e.g. password protected) to prevent access to non-members.

Disclosure

If a physician participates in a public online forum as an expert they must disclose accurately their credentials and any existing conflicts of interest.

Disciplinary Actions

Any violations of these rules, or other incidents of unprofessionalism, will be addressed by the LSUHSC Department of Pediatrics' Compliance and Clinical Competency Committees with appropriate disciplinary actions. State medical boards have authority to discipline physicians for any unprofessional behavior.

Other issues

1. Any post made by you must be viewed as your own and is not representative of LSUHSC or Children's Hospital.
2. Do not allow engagement in social networking sites to interfere with your clinical duties at work.
3. Any witnessed unprofessional behaviors must be reported to the Program Director or Chair of the Department of Pediatrics and/or any regulatory authority.

4. Physicians must be aware their online profiles, posts, pictures, and comments can adversely affect their future employment and medical career.

Recommended Safeguards

1. Utilize and familiarize yourself with the privacy settings on personal social networking sites.
2. Recognize the pitfalls of these privacy settings and the ability for unintentional viewers to see your posts.
3. Maintain separate personal and professional social media accounts online but realize that content on your personal site might still be accessed by patients, patients' families, colleagues, future employers, and lawyers.
4. Periodically check your online reputation by performing an Internet search of yourself.

*Adopted from Federation of State Medical Boards Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice. April 2012



POLICY ON ~ Patient Satisfaction Survey

1. All pediatric residents will be required to have **1 patient satisfaction evaluation completed per quarter.**
2. Surveys -
 1. One unsealed envelope will be placed in each of the resident mailboxes at the beginning of each Quarter. A box will be placed in the resident lounge with additional envelopes/surveys in case you need an additional one before the new quarter begins. Each quarter, a new envelope will be added to your box. In it, you will find:
 1. Instruction sheet
 2. Survey
 2. Please read the instruction sheet. You will write your name and rotations in the blanks on the form.
 3. Place the survey back in the unsealed envelope to provide to your patient family.
 4. Ask them to complete the survey, place in the envelope, seal the envelope, and return to you.
 5. Return the unsealed envelope to the coordinator or the chiefs.
3. **Who should complete your surveys?** You can ask any patient/family from any rotation and/or clinic to complete your survey. We suggest you have the surveys completed from different rotations. Consider asking your continuity clinic patients, as well.
4. It is the resident's responsibility to distribute and collect sealed survey envelopes from his/her patients and to submit them to the coordinator/the chiefs. This is to help individual residents ensure that an appropriate number of surveys are completed. A minimum of TWO surveys must be completed and submitted by December 15th and the additional TWO surveys must be submitted prior to June 15th. At that time, 10 professionalism points will be deducted at Q2 or Q4 if these requirements are not met.