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OUR MISSION

Mission Statement, Department of Pediatrics

*With our KU partners, our mission is to optimize the health and well-being of children and their families through excellence in patient care, education and research.*

Mission Statement, Pediatric Medical Education Division

*The mission of the Education Division is to provide a culture of learning, to facilitate the journey of becoming competent clinicians, maintaining high standards of professional behavior and dedication to life-long learning.*

Program Goals

Pediatricians are responsible for promoting health and treating disease and injuries in infants, children and teenagers. To do so means caring for the child as well as parents and families and their communities too.

Our residents will be trained to provide family-centered care that is evidence based and compassionate. They will learn to identify problems that may cause ill health in children and to determine treatment plans to alleviate these problems by using their skills and those of colleagues. Included in caring for children are the following expectations the Program expects all residents and faculty members to uphold:

- **Dedication** to putting the patient first
- **Possession** of a life-long desire to learn and improve
- **Continuous** use of evidence based medical practices and quality improvement
- **Communication** skills that enhance the patient-physician relationship
- **Willingness** to advocate for patients in an increasingly complex medical system
- **Desire** to carry out the professional responsibilities of a pediatrician

The curriculum of the KU Pediatrics Residency Program is designed to assist physicians in acquiring the knowledge, skills, attitudes, and clinical judgment necessary to meet these expectations. Residents show progress towards meeting these goals by demonstrating continuous improvement on the in-training exam offered by the American Board of Pediatrics. Successful completion of the Pediatrics Board Examination is a goal for each resident. A wide variety of educational and clinical experiences will be available during training to help you accomplish this goal.

Throughout residency, you will learn the non-testable skills- how to work together, how to teach, how to communicate with patients and other health care professionals, how to critically look at a problem and work to solve it, and how to develop the professionalism expected of physicians. You will have opportunities to learn about advocacy, ethics and the business side of medicine. Additionally, based on your future career plans be they fellowship, academic medicine or private practice, there is flexibility in the curriculum to allow individualization of your training in order to prepare you for your practice beyond residency. Such experiences are vitally important if our graduates are to meet the ever-changing demands of pediatric practice.

Together with your fellow residents, students and faculty, work hard, enjoy what you do and never forget that you make a difference in the lives of children. On behalf of the entire staff of the Pediatric Medical Education Center (PMEC), welcome!!
ACADEMIC

ACGME Core Competencies

1) Competence in patient care:
Residents must be able to provide family-centered patient care that is developmentally and age appropriate, compassionate, and effective for the treatment of health problems and the promotion of health.

2) Competence in medical knowledge
Residents must demonstrate knowledge about established and evolving biomedical, clinical and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care and the education of others

3) Competence in practice-based learning and improvement
Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices

4) Competence in interpersonal/communication skills
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates

5) Competence in professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

6) Competence in systems-based practice
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

Residents are expected to develop these skills and attitudes over the course of residency. To that end, the evaluation of resident performance is based on milestones showing growth towards competency with behavioral anchors including emerging skills, near competent, competent and expert. First year residents are not expected to be competent in areas such as medical knowledge or patient care however many will be already competent in professionalism and communication. Before graduation a resident must have achieved competence in all six areas.

The Program also evaluates whether or not pediatric residents are competent to supervise others, to act with limited independence, and whether they can reasonably be expected to pass the board examination. The development of competence is dependent not only on a resident’s ability to act independently but also on their ability to work interdependently with other members of the health care team including medical students, peers, faculty, allied health, nursing and the community.

Additional information on the ACGME General Competencies under Evaluation can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
NAS- The Next Accreditation System

In 1999, the ACGME introduced the six domains of clinical competency to the profession, and in 2009, it began a multiyear process of restructuring its accreditation system to be based on educational outcomes in these competencies. The result of this effort is NAS, scheduled for phased implementation in July 2013. The aims of NAS are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME’s movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.

Pediatric Milestones

A key element of NAS is the measurement and reporting of outcomes through the educational milestones, which is a natural progression of the work on the six competencies. In each specialty, the milestones result from a close collaboration among the American Board of Medical Specialties certifying boards, the review committees, medical specialty organizations, program director associations and residents.

The Pediatrics Milestone Project included the development of more than 50 milestones. Twenty-one milestones were chosen to be reported on starting in 2013-2014. The evaluation tools used by the program have been adapted to facilitate assessment of residents using the milestone behavioral anchors as proposed by the Pediatric Milestones Working Group. Here is an example for how the milestones look.

**Competency: Patient Care**

**Milestone 1: Gather essential and accurate information about the patient**

*Level 1: Remedial* (typical of graduating medical student)

Either **gathers too little information or exhaustively gathers information following a template** regardless of the patient’s chief complaint, with each piece of information gathered seeming as important as the next. Recalls clinical information in the order elicited, with the ability to gather, filter, prioritize, and connect pieces of information being limited by and dependent upon analytic reasoning through basic pathophysiology alone.

*Level 2: Emerging Skills* (typical of a resident during early residency)

Clinical experience allows linkage of signs and symptoms of a current patient to those encountered in previous patients. Still relies primarily on **analytic reasoning** through basic pathophysiology to gather information, but has the ability to link current findings to prior clinical encounters allows information to be filtered, prioritized, and synthesized into **pertinent positives and negatives**, as well as **broad diagnostic categories**.

*Level 3: Near Competent* (typical of a resident during late residency)

Advanced development of pattern recognition that leads to the **creation of illness scripts**, which allow information to be gathered while simultaneously filtered, prioritized, and synthesized into **specific diagnostic considerations**. Data gathering is driven by **real-time development of a differential diagnosis early** in the information-gathering process.

*Level 4: Competent* (level of a graduating resident)

**Well-developed illness scripts** that allow essential and accurate information to be gathered and **precise diagnoses to be reached with ease and efficiency** when presented with most pediatric problems, but still relies on analytic reasoning through basic pathophysiology to gather information when presented with complex or uncommon problems.

*Level 5: Expert* (level of a practicing pediatrician)

**Robust illness scripts** and instance scripts (where the specific features of individual patients are remembered and used in future clinical reasoning) lead to **unconscious gathering of essential and accurate information in a targeted and efficient manner when** presented with all but the most complex or rare clinical problems. These illness and instance scripts are robust enough to enable discrimination among diagnoses with subtle distinguishing features.
Pediatric Milestones to Report on Semi-Annually

A. Patient Care
   1. Gather essential and accurate information about the patient
   2. Organize and prioritize responsibilities to provide patient care that is safe, effective, and efficient
   3. Provide transfer of care that insures seamless transitions
   4. Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment

B. Medical Knowledge
   1. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems

C. Practice-Based Learning and Improvement
   1. Identify strengths, deficiencies and limits in one’s knowledge and expertise
   2. Identify and perform appropriate learning activities to guide personal and professional development
   3. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
   4. Incorporate formative feedback into daily practice

D. Interpersonal and Communication Skills
   1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
   2. Demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions

E. Professionalism
   1. Humanism, compassion, integrity, and respect for others; based on the characteristics on an empathetic practitioner: Humanism
   2. A sense of duty and accountability to patients, society, and the profession: Professionalization
   3. High standards of ethical behavior which includes maintaining appropriate professional boundaries: Professional Conduct
   4. Self-awareness of one’s own knowledge, skill, and emotional limitations that leads to appropriate help-seeking behaviors
   5. Trustworthiness that makes colleagues feel secure when one is responsible for the care of patients
   6. The capacity to accept that ambiguity is part of clinical medicine and to recognize the need for and the utilize appropriate resources in dealing with uncertainty

F. Systems-Based Practice
   1. Coordinate patient care within the health care system relevant to their clinical specialty
   2. Advocate for quality patient care and optimal patient care systems
   3. Work in inter-professional teams to enhance patient safety and improve patient care quality
2011 ACGME Requirements-Resident Supervision

A. **Supervision of Residents**
   - In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.
   - This information should be available to residents, faculty members, and patients.
     - **Inpatient**: Patient information sheet included in the admission packet and listed on the “white board” in each patient room
     - **Outpatient**: Provided during introduction verbally by residents and/or faculty
   - Residents and faculty members should inform patients of their respective roles in each patient’s care.
   - The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

B. **Methods of Supervision**
   - Some activities require the physical presence of the supervising faculty member.
   - For many aspects of patient care, the supervising physician may be a more advanced resident or fellow.
   - Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician in his/her “final years of training”, either in the institution, or by means of telephonic and/or electronic modalities.
   - In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.
   - The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
   - The program director must evaluate each resident’s abilities based on the following specific criteria and when available should be guided by specific national standards-based criteria.
   - Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents
   - “Residents in their final years of training” or fellows should serve in a supervisory role of PGY 1 and “intermediate residents” in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow

C. **Levels of Supervision Defined**: To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision established by the ACGME.

1. **Direct Supervision**: This means the supervising physician is physically present with the resident and patient.
2. **Indirect Supervision A (with direct supervision immediately available)**: This means the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
3. **Indirect Supervision B (with direct supervision available)**: This means 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.
4. **Oversight**: This means the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
<table>
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<tr>
<th>PERIODIC REQUIREMENTS</th>
<th>RRC APPROVED LICENSED INDEPENDENT PRACTITIONER SUPERVISOR (PR VI.D.1)</th>
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</thead>
<tbody>
<tr>
<td>Physician assistants, nurse practitioners, psychologists, physical and occupational therapists, speech and language pathologists, dieticians/nutritionists, counselors, and audiologists are just some of the providers who see their own patients and may serve as teachers and/or supervisors for residents as appropriate in ambulatory (i.e. school-based health centers, child development clinics) and inpatient (i.e. NICU) settings. Some states may have regulatory rules that won’t allow LIPs to supervise residents.</td>
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<th>OPTIMAL CLINICAL WORKLOAD (PR VI.E.)</th>
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<td>This depends on all the factors listed in the requirement. The program director must make an assessment of the learning environment with input from the faculty and residents. Minimum patient loads should usually be five on the general inpatient unit, and four in PICU and NICU. However, there may be situations in which lower patient loads may be acceptable. Programs will need to justify lower patient loads with evidence such as severity of illness indicators or other factors.</td>
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<tr>
<th>MEMBERS OF THE INTERPROFESSIONAL TEAM (PR VI.F.)</th>
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<tr>
<td>Nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and language pathologists, audiologists, respiratory therapists, psychologists, and nutritionists are examples of professional personnel who may be part of the inter-professional teams.</td>
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<tr>
<th>COMPETENCIES TO ALLOW PGY1 RESIDENTS TO PROGRESS TO INDIRECT SUPERVISION (PR VI.D.5.a)(1)</th>
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<tr>
<td>PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available.</td>
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<tr>
<th>DEFINING RESIDENT LEVELS “INTERMEDIATE LEVEL” &amp; “FINAL YEARS OF TRAINING” For establishing the minimum rest period between duty periods (PR VI.G.5.b&amp;c)</th>
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<tr>
<td>PGY-2 residents are considered to be at the intermediate level.</td>
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<tr>
<td>PGY-3 residents are considered to be in the final years of education.</td>
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<th>CIRCUMSTANCES WHEN RESIDENTS IN THEIR FINAL YEARS OF EDUCATION MAY REMAIN OR RETURN IN &lt; 8 HOURS (PR VI.G.5.c)(1))</th>
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<tr>
<td>The majority of RRCs defined these circumstances as “required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family, however, the Pediatric RRC determined that there are no circumstances under which pediatric residents may stay on duty without eight hours off.</td>
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<tr>
<th>DEFINED MAXIMUM NUMBER OF CONSECUTIVE WEEKS AND MAXIMUM NUMBER OF MONTHS PER YEAR OF IN-HOUSE NIGHT FLOAT (PR VI.G.6.)</th>
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<td>Residents should not have more than one consecutive week of night float and not more than four total weeks of night float per year.</td>
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<tr>
<th>PROGRAM-SPECIFIC GUIDELINES FOR CIRCUMSTANCES AND EVENTS IN WHICH RESIDENTS MUST COMMUNICATE WITH APPROPRIATE SUPERVISING FACULTY (PR VI.D.5)</th>
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<tr>
<td>see following PGY level charts and in the Resident Supervision Policy in the Pediatric Residency Policies Manual. Residents must communicate with supervising faculty for admissions, transfers of patient to a higher level of care and for end-of-life decisions.</td>
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<tr>
<th>SOURCE OF SPECIFIC CRITERIA AND/OR SPECIFIC NATIONAL STANDARDS-BASED CRITERIA USED TO EVALUATE EACH RESIDENT'S ABILITIES (PR VI.D.4.a)</th>
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<tr>
<td>The Pediatric Milestones outline the specific criteria for resident abilities. At this time, there are goal milestones (Level 3.5-4 learner) for residents to attain prior to graduation. Nationally identified milestones thresholds for decisions such as promotion to supervising resident have not yet been identified. Several multi-center studies are underway in order to determine national standards-based criteria based on the pediatric milestones. General standards for promotion from PGY level to PGY level for the KU Pediatrics residency program are outlined in the Pediatric Residency Handbook.</td>
</tr>
<tr>
<td>LEVEL of SUPERVISION</td>
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| DIRECT               | Procedures: All procedures until signed off as competent to perform independently.  
Procedures residents must be able to perform: bag-mask ventilation, neonatal endotracheal intubation, peripheral IV placement, venipuncture, umbilical catheter placement, lumbar puncture, bladder catheterization, GYN exam, wound care and simple laceration repair, incision and drainage of abscess, giving immunizations, developmental screening, procedural sedation, pain management, temporary splinting of simple injuries, simple removal of foreign body  
Procedures residents must understand and may perform: circumcision, arterial line placement, arterial puncture, chest tube placement, endotracheal intubation of a non-neonate, thoracentesis  
Rotations: PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available on all clinical rotations or services. Supervision can be by a more senior resident. |
| INDIRECT A (with direct supervision immediately available) | Procedures: Once signed off as competent, any of the above listed procedures.  
Rotations: PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available. Supervision can be by a more senior resident.  
Common Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, rapid responses, code blues or other pediatric emergency activations, DNR or other end of life decision (further examples of outlined in the Resident Supervision policy in Pediatric Residency Policy Manual. |
| INDIRECT B (with direct supervision available-as determined by program specific RRC guidelines PR VI.D.5.a).(1)) | PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available. |
**Intermediate Level Residents**

<table>
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<th>LEVEL of Supervision</th>
<th>Activities/Procedures (as defined by RRC* &amp; Program)</th>
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<tr>
<td>Direct</td>
<td>Procedures: Any procedure not previously signed off as competent at the end of the PGY 1 year</td>
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</table>
| Indirect A (with direct supervision immediately available) | Procedures: Umbilical catheterizations, neonatal intubations, conscious sedation  
Rotations: NICU, CMH-ED |
| Indirect B (with direct supervision available) | Rotations: Continuity Clinic, Outpatient Subspecialty Clinics, PICU-KU, Term Nursery, Inpatient Pediatrics, Call  
Common Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, rapid responses, code blues or other pediatric emergency activations, DNR or other end of life decision (further examples of outlined in the Resident Supervision policy in Pediatric Residency Policy Manual.) |
| Oversight (with direct supervision available) | Rotations: Community Medicine-community sites (observational only, no direct patient care), Home Call (Mommy Call) |

**Residents in Final Years of Training**

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<th>LEVEL of Supervision</th>
<th>Activities/Procedures (as defined by RRC* &amp; Program)</th>
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<tbody>
<tr>
<td>Direct</td>
<td>Procedures: Any procedure not previously signed off as competent at the end of the PGY 2 year</td>
</tr>
</tbody>
</table>
| Indirect A (with direct supervision immediately available) | Procedures: Umbilical catheterizations, neonatal intubations, conscious sedation  
Rotations: NICU, ED-CMH, PICU-CMH |
| Indirect B (with direct supervision available) | Rotations: Continuity Clinic, Outpatient Subspecialty Clinics, PICU-KU, Term Nursery, Inpatient Pediatrics, Call  
Common Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, rapid responses, code blues or other pediatric emergency activations, DNR or other end of life decision (further examples of outlined in the Resident Supervision policy in Pediatric Residency Policy Manual.) |
| Oversight (with direct supervision available) | Rotations: Home Call (Mommy Call) |

Additional information on the Supervision Policy can be found in the Pediatric Residency Policies and Procedures Manual and the University of Kansas Graduate Medical Education Policy and Procedure Manual.  
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
# 2011 COMMON PROGRAM REQUIREMENT WORKSHEET

## RESIDENTS’ PARTICIPATION IN PATIENT SAFETY PROGRAMS (ANNUAL) (PR VI.A.3)

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<tr>
<td>Institutional quarterly Patient Safety Conference</td>
<td>Pediatric Department Patient Safety and Quality Improvement Conference</td>
</tr>
<tr>
<td>GME Core Competency Conferences</td>
<td>Program Transitions of Care education &amp; process education</td>
</tr>
<tr>
<td>Resident PGY-1 orientation: Take Action course synopsis &amp; Resident Handovers group sessions</td>
<td>ICAP Grant: Interprofessional Collaborative Acute Care Practice in Pediatrics</td>
</tr>
<tr>
<td>Resident education in patient safety &amp; quality GMEC subcommittee</td>
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<tr>
<td>PSN reporting mechanism</td>
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<tr>
<td>Risk Management CHALK online modules including professionalism, fatigue and substance abuse</td>
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<tr>
<td>TeamSTEPPS dissemination</td>
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<tr>
<td>Institutional Transitions of Care education &amp; process education</td>
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## RESIDENTS’ PARTICIPATION IN INTERDISCIPLINARY CLINICAL QUALITY IMPROVEMENT PROGRAMS (ANNUAL) (PR VI.A.3)

<table>
<thead>
<tr>
<th>Institutional:</th>
<th>Program:</th>
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<tbody>
<tr>
<td>Institutional quarterly Patient Safety Conference</td>
<td>Interdisciplinary Program PBLI projects (use PBLI template)</td>
</tr>
<tr>
<td>GME Core Competency Conferences</td>
<td>Resident PBLI projects and PDSA cycle QI projects</td>
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<tr>
<td>Resident PGY-1 orientation: Take Action course synopsis &amp; Resident Handovers group sessions</td>
<td>Department QI monitoring</td>
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<tr>
<td>Resident education in patient safety &amp; quality GMEC subcommittee</td>
<td>Department Patient Safety Conference</td>
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<tr>
<td>PSN reporting mechanism</td>
<td>Departmental M&amp;M conferences</td>
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<tr>
<td>Risk Management CHALK online modules</td>
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## BACK UP SYSTEM WHEN CLINICAL CARE NEEDS EXCEEDED RESIDENTS’ ABILITY (PR VI.C.2)

<table>
<thead>
<tr>
<th>Institutional:</th>
<th>Program:</th>
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</thead>
<tbody>
<tr>
<td>Institutional GME Manual Policy statement</td>
<td>Pediatric Departmental Call Schedule-online or posted</td>
</tr>
<tr>
<td>KUH Hospital Links online on-call system</td>
<td>Pediatric Residency Policy Manual description of continuity coverage for fatigued resident</td>
</tr>
<tr>
<td>Team updates of O2 Team in Epic</td>
<td></td>
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<tr>
<td>Resident Orientation-Duty Hour &amp; Supervision discussions</td>
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## SCHEDULES THAT INFORM ALL TEAM MEMBERS OF ATTENDING/RESIDENTS CURRENTLY RESPONSIBLE FOR EACH PATIENT’S CARE (VL.B.4) & RESIDENTS & FACULTY INFORM PATIENTS OF THEIR ROLES IN CARE (VL.D.1.B)

<table>
<thead>
<tr>
<th>Institutional:</th>
<th>Program:</th>
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<tbody>
<tr>
<td>KUH admission Handout to patient with description of level of caregivers</td>
<td>RRC-defined designation of licensed independent practitioner in GMEC Resident Supervision template in pediatric residency handbook and policy manual</td>
</tr>
<tr>
<td>UKP clinic handout of caregiver definitions</td>
<td>Program supervision policies updated to include new supervision requirements</td>
</tr>
<tr>
<td>KUH Oncall system in Hospital links</td>
<td>Program specific on-call schedule mechanisms</td>
</tr>
<tr>
<td>O2 “patient care team” accuracy</td>
<td>Picture roster</td>
</tr>
<tr>
<td>Bedside whiteboard</td>
<td>Business cards given to patients with names/titles</td>
</tr>
</tbody>
</table>
**DESCRIBE HOW CLINICAL ASSIGNMENTS DESIGNED TO MINIMIZE PATIENT CARE TRANSITIONS** (PR VI.B.1)

**Institutional:**
- Annual Program Outcomes Assessment and Action Plan Report (Annual Program review) checkbox
- Monthly call schedules

**Program:**
- chill your hands
- ED C
- O2 Electronic Handoff

**EDUCATION & IMPLEMENTATION OF STRUCTURED HAND-OVER PROCESS** (PR VI.B.2)

**Institutional:**
- Residents’ orientation video & small group sessions
- Residents’ SIGNOUT Template pocket card
- EPIC O2 Signout instrument
- Online module about handoffs/transitions of care
- O2 Electronic Handoff

**Program:**
- Scheduled face-to-face handoff meetings specified
- Program specific education
- Handoff process described in pediatric residency handbook

**FATIGUE, SLEEP DEPRIVATION AND MITIGATION EDUCATION** (PR VI.A.5.e & VI.C.1.a), INCLUDING EDUCATION OF PROFESSIONAL RESPONSIBILITY TO APPEAR FOR DUTY RESTED/FIT (VI.A.1)

**Institutional:**
- GME online Fatigue Education Module modification
- Resident Orientation- Duty Hour & Supervision
- Institutional Policy statement
- SIGNOUT cards

**Program:**
- Pediatrics specific fatigue education
- Pediatric Residency Policy Manual statements in professionalism and duty hours

**FATIGUE MITIGATION PROCESSES, CONTINUITY OF CARE IF UNABLE TO PERFORM DUTIES AND SLEEP/TRANSPORTATION FOR FATIGUED RESIDENTS** (VI.C.1-3)

**Institutional:**
- KUH on-call online system (Hospital Links)
- Resident Orientation (Duty Hour & Supervision talk)
- Resident Council education
- GMEC education
- Department call rooms & Swing Call room
- Fatigue Transportation service (GME Manual guidelines section)
- Faculty Fatigue on-line learning modules

**Program:**
- Duty hours fatigue file including fatigue transportation incidents & explanation box for 24hr and 8hr rule violations- monitored by PD)
- Department of Pediatrics call schedule
- Pediatric Residency Policy Manual describes continuity process
- Team updates of O2 Team in Epic

**MONITORING PATIENT CARE PERFORMANCE INDICATORS** (VI.A.5.g)

**Institutional:**

**Program:**
- Department of Pediatrics QI requirements/measures
- KUH QI report requirements/measures
- UKP QI report requirements/measures
- Patient 360-degree surveys/evaluations

**FACILITIES**
- Secure room or lockers
- Sleeping Rooms – segregated by Gender
- Shower/Bath
Performance Expectations

The Pediatric Residency Program has criteria for advancement/promotion of residents. The final decision of whether to promote or graduate a resident is determined by the Program Director with advice of the Pediatric Clinical Competency Committee and the faculty of the Department. As noted in another section of this manual, regular evaluation of and feedback to every resident is required from teaching faculty who supervise residents.

The criteria for advancement, eventual graduation, and approval to sit for the certifying examination of the American Board of Pediatrics is based upon satisfactory achievement of the following:

1) **Clinical competence** - fund of knowledge, clinical performance (rotation evaluations), clinical judgment, knowledge of limitations, doctor-patient relationships

2) **Professional behavior** - working relationships with others, acceptance of responsibility, punctuality, and reliability

3) **Technical skills** - procedural competence and experience, appropriate documentation in the medical record including completeness and timeliness

Level Specific Performance Expectations

**Pediatric Level 1:** The PGY 1 junior resident will be responsible for the care of their assigned patients under the supervision of a senior resident or faculty member.

- **Inpatient rotation responsibilities:** completion of an admission H&P containing a complete history, physical examination, developmental assessment, differential diagnosis and management plan; maintenance of the daily ongoing medical record; and entry of discharge summary into O2 which should be done at the time of discharge but which must be done within 48 hours of discharge

- **Outpatient rotation responsibilities:** care of patients as assigned by their senior or faculty member

- **Teaching responsibilities:** at this level teaching is directed primarily to patients and families as well as to medical students assigned to the same rotation.

**Pediatric Levels 2 and 3:** The PGY 2 and PGY 3 senior residents will assume progressive responsibility for all patients and more junior residents and medical students on the services he/she is supervising. Successful promotion to the PGY2 level means that a resident may assume inpatient senior resident on-call responsibilities after hours and on weekends. This distinction means that the resident has demonstrated the ability to function without the direct supervision of a more senior resident or faculty member.

- **Inpatient rotation responsibilities**
  - *Floor:* This rotation has two supervisory residents, a Clinical Senior and a Consult Senior. The junior most senior resident will typically serve as the Clinical Senior however residents may alternate these roles by switching mid-month.
    - **Clinical Senior Primary Responsibilities**
      - Supervise the day to day patient care done by juniors and medical students
    - **Consulting/Teaching Senior Primary Responsibilities**
      - Assist Clinical Senior as service needs demand
      - Complete pediatric consultations within 24 hours of receiving the consult
      - Teach the medical students and junior residents
Shared Senior Resident Responsibilities
- Monitor the duty hours of all members of the team
- Communicate with primary care physicians
- Assist junior residents with completion of daily work including teaching them the organizational skills needed to complete work completely yet in a timely manner

**NICU/PICU:** These seniors will assume the responsibilities of the Clinical and Consulting Senior as outlined for the rotation as well as any other responsibilities appropriate for the rotation.

- **Outpatient rotation responsibilities:** Specialty rotation seniors will serve as liaison between the subspecialty attending and the inpatient teams. These residents will serve in a consulting capacity, but may assist in patient care as needed.
- **Teaching responsibilities:** Senior residents are expected to teach patients and families as well as medical students and junior residents in both formal and informal settings.

**Resident Responsibilities and Criteria for Advancement**

Residents will assume progressively increasing responsibility for patient care according to their level of training, their ability and their experience. The level of responsibility accorded to each resident will be determined by the teaching staff.

**PGY 1 Responsibilities:** The PGY 1 junior resident will provide patient care under the supervision of senior residents and attending physicians. They are given graduated responsibility for patient care based on training received during the course of residency as well as the experience and knowledge gained by each resident.

Junior Residents will:
1. Study/Read during down times on each rotation. It is expected that PGY 1 residents will be self-directed learners, including continuing education outside of the structured educational program.
2. Completion of monthly board study requirements as determined by the ITE
3. Assist fellow residents- it is not a matter of IF you will be asked to help a colleague but WHEN
4. Write complete admitting medical histories and perform physical examinations, to include developmental assessments and growth charts
5. Generate a differential diagnosis and management plan for each patient
6. Discuss with the supervising resident and/or attending the history and/or physical findings and present a diagnostic and therapeutic plan
7. Record daily progress notes after assessment of patient and modify notes based on further examination of the patient and discussion with the attending and/or supervising resident
8. Write orders for patient care based on the plan
9. Provide daily care of patients including procedures and follow up of x-rays and lab results
10. Develop discharge plan including prescriptions, home health care, and follow up along with the attending and/or senior resident
11. Complete the discharge summary **within 48 hours of discharge**
12. Closely work with the students, participate in their bedside teaching and follow patients with them
13. Communicate with the patient, the family, attending, other health care professionals on the treatment team and the referring physician as delegated
14. Participate in inpatient junior call as per schedule
15. Active participation in all required resident conferences and other educational conferences including presenting MTC when assigned
16. Provide on-going care as the primary physician to continuity clinic patients, be available to patients at all times during office hours, and arrange coverage for patients when unavailable
17. Registration, preparation and completion of USMLE/COMLEX Step 3 should be completed before December 30th of the PGY 1 year.
18. Other expectations as outlined in “Performance Expectations”
PGY 1 Criteria for Advancement

1. Satisfactory performance of the above responsibilities as assessed by faculty evaluations and 360 degree evaluations during clinical rotations in the PGY 1 year
2. Show evidence of ability to manage common/routine medical problems and conditions
3. Satisfactory performance with appropriate documentation of common technical procedures such as venipuncture, lumbar puncture, tracheal intubation, placement of UAC or UVC, developmental screening, hearing and vision screening, injections, wound care including suturing
4. Knowledge of pediatric literature and ability to gather information from library sources
5. Conference attendance as per Conference Attendance Policy
6. **Completion** of USMLE/COMLEX Step 3
7. Journal Club presentation

Performance Evaluations for PGY 1 Residents

The Pediatric Clinical Competency Committee will review resident performance in December and June. Decisions to not renew contracts or to not promote will be made before March 1st whenever possible in accordance with the Institutional policies. Additional reviews may be needed for residents experiencing academic or professional difficulties.

PGY2 Responsibilities: Senior level residents will supervise PGY 1 level residents, students and other trainees in inpatient and outpatient settings. Senior residents will be given increased responsibility based on training and demonstrated ability.

Senior Residents will:
1. Read/Study during down times of each rotation. It is expected that PGY 2 residents will be self-directed learners, including continuing education outside of the structured educational program.
2. Completion off monthly board study requirements as determined by the ITE
3. **Assist fellow residents- it is not a matter of IF you will be asked to help a colleague but WHEN**
4. Participate in daily patient care and be responsible for:
   a. monitoring the patient care related activities of PGY-I residents and medical students including H&Ps, daily notes, order writing and discharge planning
   b. independent gathering of information by history and physical examination and generation of a concise senior note for all admissions and daily where appropriate
   c. assessment of clinical and laboratory data
   d. appropriate management of patients
5. Discuss with the PGY 1 and/or attending the history and exam and assist the PGY 1 resident in developing diagnostic and therapeutic plans
6. Take senior call after hours and on weekends and be the admitting resident during that time
7. When on an elective rotation, act as liaison between that subspecialty and the senior resident on the floor. Make daily contact with the inpatient senior after clinical assessment.
8. Case presentations at morning report when on inpatient services
9. Assume a supervising role on the inpatient and outpatient services as needed
10. Assume increasing teaching responsibilities of students and PGY1 residents
11. Communicate regularly with the patient, the family, the attending, consultants, and the referring physician
12. Provide on-going care as the primary physician to their continuity clinic patients, and be available to their patients at all times during office hours and arrange coverage for their patients when they are unavailable
13. Active participation in all required resident conferences and other teaching conferences including presenting MTC when assigned
14. In the absence of the PGY1 resident, the senior resident is responsible for completing admission H&Ps, daily notes and the discharge summary within 48 hours of discharge
15. Participate in School of Medicine and Department of Pediatric department activities such as student precepting, Problem-Based Learning small groups, QA/QI projects, and pediatric committees
16. Other expectations as outlined in “Performance Expectations”

PGY2 Criteria for Advancement

1. Satisfactory performance of the above responsibilities as assessed by faculty evaluations and 360 degree evaluations during the clinical rotations
2. Show evidence of ability to manage increasingly complex medical problems using appropriate consultants
3. Work efficiently and cooperate with the health care team, avoid iatrogenic problems, anticipate and prevent impending problems, and recognize additional co-existing problems
4. Assess level of patient satisfaction with patient care delivered
5. Further documentation of procedures with the addition of IV placement, gynecological examination, and foreign body removal
6. Conference attendance as per Conference Attendance Policy
7. Satisfactorily performance of Floor, FTN, NICU and PICU at level expected of a senior resident.
8. Patient Quality and Safety Conference presentation
9. Meet licensing requirements as deemed necessary by the Kansas State Board of Healing Arts
10. Successful renewal of Neonatal Resuscitation Program and Pediatric Advance Life Support training

Performance Evaluations for PGY 2 Residents

The Pediatric Clinical Competency Committee will review resident performance in December and June. Decisions to not renew contracts or to not promote will be made before March 1st whenever possible in accordance with the Institutional policies. Additional reviews may be needed for residents experiencing academic or professional difficulties.

PGY3 Responsibilities

1. All PGY3 residents should be aggressively studying for Boards via independent and group study. It is expected that PGY 3 residents will be self-directed learners, including continuing education outside of the structured educational program.
2. Completion of monthly board study requirements as determined by the ITE
3. Assist fellow residents- it is not a matter of IF you will be asked to help a colleague but WHEN
4. Assume a supervising role on the inpatient and outpatient services
5. Demonstrate the ability to function as an independent clinician with the ability to manage simple to complex problems and conditions and direct/assess day-to-day patient care
6. Act as consultant to the other departments
7. Actively participate in all required resident conferences and other educational conferences including presenting MTC when assigned
9. Teach junior residents and students how to diagnosis and manage commonly seen general and subspecialty problems
10. Provide on-going care as the primary physician to their continuity clinic patients, and be available to their patients at all times during office hours and arrange coverage for their patients when they are unavailable
11. In the absence of the PGY1 resident, the PGY 3 resident is responsible for completing the discharge summary within 48 hours of discharge and must ensure that all discharge summaries are completed at the end of each rotation
12. Communicate regularly with the patient, the family, and the referring physician
13. Participate in School of Medicine and Department of Pediatric department activities such as student precepting, Problem-Based Learning small groups, QA/QI projects, and pediatric committees
14. Other expectations as outlined in “Performance Expectations”
Criteria for Graduation from the Program
1. Satisfactory performance of the above responsibilities as assessed by faculty evaluations and 360 degree evaluations during the clinical rotations
2. Recertification of Basic Life Support, Neonatal Resuscitation Program and Pediatric Advance Life Support training
3. Conference attendance as per Conference Attendance Policy
4. Documentation of experience in all required procedures.
5. Presentation of a Senior Scholarly Conference
6. Documented satisfactory performance in each of the six core competencies

Performance Evaluations for PGY 3 Residents
The Pediatric Clinical Competency Committee will review resident performance in December and June. Additional reviews may be needed for residents experiencing academic or professional difficulties.

Residency Completion Certificate
Resident certificates may include the awardees’ previous degree earned with the name (John Doe, D.O., Sally Jones, M.D.). The previous degree must match the official degree earned and shall not be converted to equivalent degrees. For foreign medical institutions, the official degree conferred is verified by searching the Foundation for Advancement of International Medical Education and Research database. This database is endorsed by the Educational Commission for Foreign Medical Graduates.

Evaluation forms can be found in Forms through Blackboard. Additional information on the Evaluations can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Performance Improvement Plans (PIPs)
The Performance Improvement Plan (PIP) is a faculty level of concern regarding a resident. These detailed, milestone based action plans are created to address specific areas of concern in a resident’s performance. The PIP will include one or more required clinical, educational or professional/personal activities assigned to provide residents with opportunities to improve in specifically identified areas. The PIP will also include increased feedback from faculty and the Program.

This intervention is documented in the resident’s peer review file but is not reportable to GME, the boards or to licensing/credentialing organizations. The PIP is used solely as an early intervention process so that performance concerns do not escalate to the level of failed rotations, appearance before the Academic and Professionalism Committee, warning status or probation. Non-compliance or inability to meet the required outcomes may lead to these reportable interventions by the Program.
Professionalism

A special note about Professionalism. This is a very broad competency and is intimately woven within the other five. When a resident has a negative interaction with a patient, is that Interpersonal and Communication Skills or Professionalism? Both. When a resident is not ready to present their conference on time is that Practice-Based Learning and Improvement or Professionalism? Both. Part of your growth in training will be to develop the professionalism expected of pediatricians.

Professionalism is defined by demonstrating commitment to carrying out professional responsibilities and in adherence with ethical principles. Residents are expected to demonstrate compassion, integrity, excellence, altruism, and respect for others; responsiveness to patient needs; respect for patient privacy; accountability to patients, society and the profession; honesty and dependability; and sensitivity and responsiveness to a diverse patient population including but not limited to gender, age, culture, race, religion, disabilities and sexual orientation.

We know that residency is stressful and the hours can be long and this kind of environment is guaranteed to produce lapses in professionalism. Such lapses will be addressed immediately with residents. Sometimes this involves meeting with an attending, your advisor, the Pediatric Chief or a Program Director. We also use Professionalism calls as detailed in the Pediatric Residency Policies and Procedures Manual. These calls are assigned to residents who have inconvenienced a colleague or patients because of a lack of professionalism. For example, if you forget to double check the clinic schedule and miss a continuity clinic that then must be covered by your peers, you will get a professionalism call.

The University of Kansas School of Medicine projects an image of professionalism within our community. To raise awareness of professionalism within the KU medical community, KU has undertaken a “Professionalism Initiative.” The full initiative can be reviewed at:
http://www.kumc.edu/school-of-medicine/fafd/professionalism-initiative.html

Additional information on Professionalism can be found in the Pediatric Residency Policies and Procedures Manual as well as information Additional information on the Professionalism Initiative under Resident Code of Professional and Personal Conduct can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Blackboard, Education Plans and Advising Program

Blackboard

The Pediatric Residency Program utilizes the Blackboard Learning Management System for all educational activities. Blackboard can be located through the KUMC home page on the Education tab, then Blackboard.
https://bb.kumc.edu/

The two major components of the curriculum on Blackboard are the structured reading program with accompanying board-style PREP questions from the AAP and the curriculum for each of our rotations.
Individualized Learning Plan (ILP)

At the start of each academic year, residents will be expected to complete an ILP through the American Academy of Pediatrics’ Pedialink website: http://pedialink.aap.org The ILP includes two important activities: a self-assessment of milestone based development in the six competency domains and goal setting.

In setting goals for the year, residents self-critique their strengths and weaknesses and set 3-5 learning goals for the year using the SMART goal template (Specific, Measurable, Attainable, Realistic and Timely.) Goals should be specific and include at least a basic plan for how to meet them. The Program Director and Advisors will review each ILP and give feedback on the goals as well as other suggestions to help the resident successfully meet their goals. At the end of the year, residents will reexamine their ILP and comment about their progress or lack of toward meeting their goals. The Program shares the American Academy of Pediatrics’ vision that early career experiences with goal setting will set the stage for the life-long learning as a pediatrician.

Faculty Advisor/Mentors

Each resident will be assigned a faculty advisor or mentor, usually a General Pediatrician or Behavioral-Developmental Pediatrician, for their junior year. (Appendix A) Although some would define these terms differently, for the purpose of our Program, the terms are interchangeable. If over the course of residency the resident chooses to switch advisors or add a specialty advisor, such changes are permitted with the approval of the Program Director. Residents are also encouraged to utilize additional faculty advisors depending on their interests and career goals.

Advisors are expected to meet with the resident at least bi-annually to review the resident's progress and evaluations. At the fall meeting, the advisor will review the resident’s performance on the In-Training Exam in order to assist with the development of a boards study plan. This meeting will be documented on the Advisor-Advisee Meeting Form found in Pediatric Forms on Blackboard. Besides formal meetings, advisors are also available to discuss any issues or concerns that arise of either a professional or personal nature.

A primary goal of our academic advising program is to assist residents in the development of meaningful educational plans that are compatible with professional and personal goals. Academic advising should be viewed as a continuous process of self-reflection, feedback and improvement. Such advising is only the beginning of the life-long learning and improvement process physicians do over the course of their careers.

The ultimate responsibility for making informed decisions about goals and educational plans rests with the individual resident. The academic advisor assists the residents as outlined below.

Resident Guidelines- What we expect the residents to do

- Seek out their advisors regularly in addition the two required yearly meetings. Residents are responsible for contacting the advisor to set up a mutually agreeable meeting time. Residents are expected to be on time for advising meetings.
- Come to advising meetings having reviewed their quarterly reviews/evaluations and having prepared initial or ongoing plans of study
- Meet deadlines for study plans
- Check their campus mailboxes and e-mail accounts
Advisor Guidelines – What you can expect your advisor to do

- Establish a positive collegial relationship with the resident characterized by mutual respect and caring
- Provide effective advising services for professional and personal development
- Be accessible via email, office hours, and advising meetings. It is the resident’s responsibility to contact advisors for a meeting and the advisor’s responsibility to be prompt for the appointment.
- Discuss expectations related to academic integrity and professionalism
- Assist the resident in developing a study plan and follow up to ensure residents are achieving goals
- Conduct at least semi-annual meetings to review academic progress and update study plans. Meetings that require documentation should take place in October (establish study plans based on ITE performance) and April (re-evaluate study plans and address areas of concern).
- Assist the resident with the development of their ILP through Pedialink
- Assist the resident in identification of strengths as well as areas in need of improvement
- Provide support and feedback on resident scholarly presentations
- Be a role model of exemplary behavior, including active participation in teaching, research and clinical responsibilities
- Demonstrate the value of lifelong education

Structured Reading Program, Board Preparation and SIPR
(Specialized Intensive Pediatrics Review)

All residents are encouraged to develop an ongoing board study plan for the duration of their residency training. However, some residents need more focused, directed and supervised board preparation.

Scores on the July In-Training Exam strongly predict the likelihood of passing boards; a score at or above national average for PGY level predicts a 90% chance of passing boards on the first attempt. Because of this correlation, the program uses the ITE scores to determine the amount of board preparation oversight for an individual resident. The ITE exam is only one indicator of academic performance and promotion or continuation in the program is based on overall academic performance, however, failure to comply with the requirements of SIPR may warrant corrective actions.

The ITE exam is only one indicator of academic performance and promotion or continuation in the program is based on overall academic performance, however, failure to comply with the requirements of SIPR may warrant corrective actions.

Structured Reading Program (all Residents)
All pediatric residents participate in a structured reading program throughout residency. The key components of the reading program are the following:

- Structured reading program including but not limited to:
  - Weekly readings in Nelson’s Textbook of Pediatrics (PGY 1s and 2s) or in Pediatric MedStudy (PGY 3s)
  - Readings from sources such as Pediatrics in Review
- Weekly PREP questions based on reading assignment done in Blackboard
- Independent review of the Med Study Board Review or other board review videos
- Mock ITE exam to be taken in the spring.
Board Preparation for Residents at or Above National Average on ITE for PGY Level

PGY 1 Residents at or above national average for PGY level

*Expectations of residents in this group:*

1. Participation in the structured reading program
2. Meet with the educational specialist in class group as assigned by a program director
3. Develop a board study plan that is monitored at least twice a year by a program director
4. Mock ITE Exam
5. Will be allowed to schedule an international rotation in the PGY 2 year

PGY 2 Residents at or above national average for PGY level

*Expectations of residents in this group:*

1. Participation in the structured reading program
2. Meet with the educational specialist in class group as assigned by a program director
3. Develop a board study plan that is monitored at least twice a year by a program director
4. Mock ITE Exam
5. Will be allowed to schedule an international rotation in the PGY 3 year

PGY 3 Residents at or above national average for PGY level

*Expectations of residents in this group:*

1. Participation in the structured reading program
2. Develop a board study plan that is monitored at least twice a year by a program director
3. Mock ITE Exam
4. Will be allowed to participate in locums if the score on the ITE predicts a probability of a first time pass rate of 80% or greater

Specialized Intensive Pediatrics Review

SIPR residents participate in the structured reading program as outlined as well as other activities including but not limited to the following:

- Analysis of knowledge gaps on medical knowledge examinations such as the ITE
- Learning style analysis and test taking strategies with a program director
- Additional support institutional educational specialists through Student Support and Counseling Services.
  Contact: Alice Carrot, Director of Educational Support Services. There are three ways to schedule an appointment with a learning specialist. You may call (913) 588-6580, go to G116 Student Center during regular office hours, or email directly at acarrot@kumc.edu.
- Group board review activities
- Additional practice board examinations
- Additional faculty mentoring

Board Preparation for Residents Below National Average on ITE for PGY Level

PGY 1 SIPR Residents below national average for PGY level

*Expectations of residents in this group:*

1. Participation in the structured reading program
2. Meet individually with a program director to discuss learning style, test taking strategies and ITE performance by December
3. Meet with the educational specialist in class group or individually as determined by a program director
4. Develop a focused, detailed, and goal oriented board study plan monitored at least twice a year by a program director.
5. Take the Mock ITE Exam and any other practice examinations as determined by the program
6. Will not be allowed to schedule an international rotation in the PGY 2 year unless performance on the Mock ITE demonstrates improvement to the national average for PGY level or significant improvement over the ITE as determined by the Program Director
PGY 2 Residents below national average for PGY level

Expectations of residents in this group:
1. Participation in the structured reading program
2. Meet individually with a program director to discuss learning style, test taking strategies and ITE performance by December
3. Meet with the educational specialist in class group or individually as determined by a program director
4. Participate in group board review sessions as assigned by a program director.
5. Develop a focused, detailed and goal oriented board study plan monitored at least twice a year by a program director.
6. Take the Mock ITE Exam and any other practice examinations as determined by the program
7. Will not be allowed to schedule an international rotation in the PGY 3 year unless performance on the Mock ITE demonstrates improvement to the national average for PGY level or significant improvement over the ITE as determined by the Program Director.
8. Participation in a board review course in the summer of PGY 3 year mentored by the program directors.

PGY 3 Residents below national average for PGY level

Expectations of residents in this group:
1. Participation in the structured reading program
2. Meet individually with a program director to discuss learning style, test taking strategies and ITE performance by December
3. Meet with the educational specialist in class group or individually as determined by a program director
4. Participate in group board review sessions as assigned by a program director
5. Develop a focused, detailed and goal oriented board study plan monitored at least twice a year by a program director.
6. Take the full Mock ITE Exam and any other practice examinations as determined by the program
7. Will not be allowed to participate in locums.
8. May be required to enroll in post-graduation Board Review Course.
Electives

Electives outside of specialty and general pediatric electives offered at KU (Appendix B) fall into several categories:

1) Subspecialty rotations offered at Children’s Mercy (see below)
2) Subspecialty rotations completed at KU but in which resident desires additional exposure (individualized curriculum)
3) Specialty rotations in departments at KU outside of Pediatrics (individualized curriculum)
4) Special scholarly activity projects (see below)
5) Out-of-town rotations
6) International rotations
7) Other individualized curriculum

Out of Town and International Elective Rotations

Residents are responsible for setting up these rotations on their own. These rotations require approval of the Program Director at least six months in advance. It is preferable that these rotations be scheduled at the time that the master schedule is created in so far that there are outpatient months in the master than can easily be switched when such outside and international rotations are confirmed.

Out of town rotations should be scheduled at least 4 months in advance and international rotations must be scheduled at least 6 months in advance. Please follow the appropriate rotation checklists for these rotations.

In general, the following apply to these both out of town and international rotations:

- The resident must provide a written description of the rotation, including its location, and name and contact information for the supervising physician. The supervising resident will be responsible for completing an evaluation for the experience.
- After approval of the rotation by the program director, the resident will be responsible for making all necessary arrangements, including obtaining a permanent medical license or training permit at his/her own expense in the appropriate state. Malpractice insurance from the Institution will be in effect.
- The resident will be responsible for meeting with the Program Director to create goals and objectives for the experience at least 1 month prior to the rotation. Included in this planning should be a schedule of clinical and didactic experiences and clinical responsibilities.
- The resident must complete the out of town or international rotation checklist at least 1 month prior to the rotation.
- All paperwork must be completed and signed off on by the Program Coordinator at least 1 month prior to the rotation or the rotation may be canceled.
- Vacation policy and the mandatory three weeks minimal attendance apply as per other electives
- All duty hour reporting requirements are in effect for out of town and international rotations
- Contact with the program while outside of Kansas City
  - While on out of town elective, the resident will be expected to check email daily.
  - While on an international elective, the resident will be expected to check email or to call in at least weekly.
Additional Information and Conditions for International Rotations

- A one-time $1000 International Travel Grant is available for select international health experiences. There are a limited number of these grants available per year. Residents in their final year of training will have priority in awarding of the grant should there be more requests than grants available in a year.
- Upon completion of an international rotation, residents are expected to give a formal presentation about their experience.
- The conditions for international travel for training purposes are as follows:
  - Submit a travel request to the Travel Audit Office irrespective of the travel-funding source. The travel request must be submitted at least four weeks prior to the travel date. Workers Compensation benefits cannot be extended for any overseas rotations without an approved travel request.
  - The resident must contact the Director of the Office of International Programs, at least six months in advance of any planned overseas travel as part of a KUMC residency program, at 588-1480.
  - Travel to any country on the US State Department Travel Warning List is discouraged under the auspices of any KUMC Program, and will be handled on a case by case basis.
  - Telephone Nurse Manager, Department of Occupational and Environmental Medicine to review those inoculations required in the foreign countries which the traveler will be visiting.

Additional information on International Travel can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. [http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html](http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html)

Individualized Curriculum (IC)

Starting with the Class of 2016, training requirements in Pediatrics include 6 educational units of an individualized curriculum. The individualized curriculum must be determined by the learning needs and the career plan of each resident and must be developed through the guidance of a faculty mentor. There may be up to 3 months of overlap between the individualized curriculum and specialty pediatric requirements.

Individualized curriculum experiences may be block experiences or longitudinal experiences. For IC rotations that already have associated schedules and goals and objectives, the resident will be responsible for meeting with a program director at least 1 month prior to the rotation to personalize the experiences to meet the resident’s IC goals. For IC rotations that are new experiences, the resident will be responsible for meeting with a program director at least 2 months prior to the rotation to create a clinical and educational schedule to meet the goals and objectives set by the resident.

Residents will be expected to complete the appropriate Individualized Curriculum Checklist for every IC rotation. Additional information about IC can be found on Blackboard.

Children’s Mercy Rotations (Required and Elective/IC)

In order to rotate to Children’s Mercy Hospital, residents will need at temporary Missouri license and a Missouri DEA. The Program Coordinator will begin this application process for July 1st of the PGY 1 year shortly after the completion of the Master Schedule for the next year. Please respond to requests to sign licensure forms in a timely manner so that you are licensed well in advance of any rotations to CMH. Both license and DEA will be renewed prior to the PGY 3 year.

Requests for CMH rotations: CMH rotations will be requested at the time requests for rotations are being accepted for the preparation of the next year’s master schedule. Requests for CMH electives based on the master are submitted to CMH who notifies us what is available. Changes are made in the master to accommodate as many CMH elective requests as possible.
General Information

- All paperwork must be completed and signed off on by the Program Coordinator at least 60 days prior to the rotation or the rotation or you may not be able to do the rotation. This must be done before EACH CMH rotation!
- Vacation policy and the mandatory three weeks minimal attendance apply as per other electives
- All duty hour reporting requirements are in effect while on rotation at Children’s Mercy
- CMH rotations require a written set of goals and objectives. If there are not specific goals for a given elective month, the resident will be responsible for meeting with a program director to create goals and objectives for the experience at least 1 month prior to the rotation.
- Rotations available at both KU and CMH: Whenever possible, the resident should take subspecialty rotations at KU first if the rotation fulfills a required subspecialty requirement.
- Conference attendance: Residents are expected to attend conferences at CMH with CMH residents and are excused from conferences at KU.
- Clinic attendance: Residents will continue to have continuity clinics scheduled by the KU Chief in conjunction with the CMH Chiefs.
- Day off requests: It may be possible to request days off from the CMH ED and CMH PICU rotations if done well in advance of the rotation and prior to the creation of those schedules. Requests for multiple days off or days off consecutively are NOT likely to be granted. Requests from CMH Chiefs for days off may be responded to directly with a CC to the KU Chief. Any other requests or changes should be made on your behalf by the KU Chief. If in doubt about communication with CMH, go through the KU Chief!
- Other conflicts: The KU Chief will notify the CMH Chiefs of other conflicts in schedule such as the ITE or Pediatric Retreat in order for those absences to be taken into account in scheduling the KU residents.
- Sick Days or other unscheduled absences: Any absence from a rotation at Children’s Mercy Hospital must be reported to the CMH Chief as soon as possible via pager. The KU Chief must also be notified. Days missed due to illness or other unscheduled absences will need to be made up.

Resident Research and Scholarly Activity

The Department Research Committee oversees all resident research. All residents will be expected to participate in a scholarly activity during residency. These activities will be as varied as residents and may include quality improvement projects, case reports, protocol guidelines, clinical research, basic science research, educational research, etc... Some residents may participate in a formal research month or do their research during off time. For scheduled research time, a product such as an abstract, a paper, a poster presentation, a platform presentation or a guidebook is required. In order to receive credit for any research time, a research mentor must complete an evaluation of your time doing the research activities. More information about the research expectations is available from the Research Committee.

Resident Scholarly Activity

All residents will participate in scholarly activities during residency. The Director of Resident Research is the primary liaison for resident scholarly activity. Scholarly activities may include Case Reports, Quality Improvement Projects, Basic Science research and any number of additional forms of scholarly activity.
Required Resident Scholarly Activity

Residents are required to complete a scholarly activity that can be done in either a 2 or 4 week educational unit, longitudinally or on the residents own time if needed. Details for the required research educational unit will be available from the Research Committee.

- Develop a general research/scholarly activity idea and find a mentor. Submit the general idea and the mentor name to the Director of Resident Research and Research & Scholarship Committee at least three months in advance of the start of the elective date.
  - Examples of research/scholarly activity: QI projects, clinical research, basic science research, case reports, educational research, etc...
- Written goals and objectives for the project(s) are required for all scholarly activity educational units
- At least two months prior to the start of the elective, the resident must submit a research plan and all pertinent information to the Research & Scholarship Committee in time for this information to be reviewed at a Committee meeting prior to starting research activity.
- Meet with mentor regularly to document progress, problem solve, cover learning objectives, etc.
- Present findings of research educational unit at Grand Attending Rounds during the Research & Scholarship GAR presentations

Elective Research Individualized Curriculum

The Research Committee has created a structured research month for resident who wants to learn more about research. The following are basic requirements for Research Electives.

- Advanced preparation for the Research Educational Unit is strongly suggested. All research rotations will be monitored and overseen by the Department of Pediatrics Research Committee.
- Develop a general research idea and find a mentor. The resident is responsible for identifying the appropriate faculty member to supervise and evaluate the month. Submit the general idea and the mentor name to the Director of Resident Research and the Research & Scholarship Committee at least three months in advance of the start of the elective date.
- At least one month prior to the start of the elective, the resident must submit a 5 page document detailing the research plan and all pertinent information to the Research & Scholarship Committee in time for this information to be reviewed at a Committee meeting prior to starting the research activity.
- The goal is for the resident to be able to complete the research project, and exit with a meaningful outcome by the end of the research experience be it a 2 week or 4 week elective.
- Meet with mentor to document progress, problem solve, cover necessary learning objectives, etc.
- Present findings of research month at Grand Attending Rounds as above
Evaluations

Resident Evaluations

Progress through the residency is determined by a resident’s increasing ability and competence, not time spent in individual rotations. Each rotation includes an evaluation and critique of the resident's performance by the attending faculty member.

Monthly Faculty Evaluation of Residents, 360° evaluations including evaluations from support staff/nursing, patients and peers, In-Training Exam scores, self-evaluations, attendance at conferences, review of the resident continuity clinic numbers, plus any additional formative evaluations, letters, critical incidents or awards are kept in the resident’s portfolio and reviewed at least twice a year by the Pediatrics Clinical Competency Committee. Residents also meet with the Program Director Semi-Annually to review all aspects of training including evaluations.

The Pediatric Clinical Competency performance reviews are the basis for the summative assessment of overall performance and generally determine the committee's recommendations concerning remedial work or probationary status, where necessary, as well as contract renewal and promotion. Final decisions on the committee’s recommendations rest with the Chairman of the Department of Pediatrics. The final performance reviews are written and included in the confidential file. Residents will be asked to sign their performance reviews as evidence of their receipt of this feedback.

Faculty Evaluations of Residents

In addition to daily feedback on performance, faculty will provide in-person feedback to each resident at the mid-point of each monthly rotation. If faculty members do not offer face-to-face feedback, it is the right and responsibility of the resident to ask for such feedback. Any difficulties obtaining feedback should be brought to the attention of the Program Director. Faculty members are also expected to complete timely written monthly feedback in the form of the electronic Faculty Evaluation of Residents. These evaluations are available to the resident to review as soon as they are completed.

360° Evaluations: Peer, Nursing, Patient and Medical Student

Residents evaluate each other on a monthly basis using the Peer Evaluation. These results are collated in aggregate twice a year for review by the CCC and shared with each resident during their semi-annual meetings with the PD.

Residents are evaluated by nursing staff on inpatient, PICU, NICU, FTN, and acute care at the end of every rotation using the Nursing Evaluation. Additional nursing evaluations may also be done by advanced practice nurses and other allied health professionals. These evaluations are reviewed twice a year by the CCC and shared with the resident at their semi-annual meetings with the PD.

Residents are evaluated by patients in the continuity clinic using the Patient Evaluation. These evaluations are gathered throughout the year and reviewed twice a year by the CCC and shared with the resident at their semi-annual meetings with the PD.

Residents are evaluated by medical students each clerkship using the SOM Evaluation of a Resident. These evaluations are reviewed by the Pediatric Chief, the Program Director and the Clerkship Director at the end of each clerkship so that group and individual feedback can be provided. The evaluations are also reviewed twice a year by the CCC and shared with the resident at their semi-annual meetings with the PD.
**Resident Evaluations of Faculty**

Residents will evaluate all faculty members quarterly. Attending physicians, consultants, mentors, lecturers, and preceptors all contribute to resident evaluations. Each faculty member’s evaluations are summarized twice a year in an aggregate report so as to maintain resident anonymity. The aggregate evaluation report for January-June rotations is prepared for the Program Director by the Residency Coordinator in August and for July-December rotations in February. The PD reviews the aggregate evaluations and prepares a summary Faculty Teaching Evaluation for each faculty member. These evaluations are shared with the faculty member and the Chair as part of the Annual Faculty Review process. Individual faculty members may review these evaluations with the PD as well. Outside of the calendar year evaluation period, the Residency Coordinator screens resident evaluations of faculty for issues warranting the immediate attention of the Program Director.

**Resident Evaluations of Rotations**

Residents evaluate each rotation at the end of the experience. Aggregate data is shared with the division director or rotation head once a year as part of the continuous curricular review process. This process includes the review of one year’s worth of rotation evaluations, ITE/Board scores and other measures. A summary of that review is prepared and brought to a small group of faculty including the rotation director and residents in order to set goals for rotational improvement for the next improvement cycle. The Residency Coordinator screens rotation evaluations for issues warranting the immediate attention of the Program Director.

**Resident Evaluations of the Program**

Residents will evaluate conferences and educational activities. Residents also evaluate the Residency Program at the end of the academic year. Aggregate data from these evaluations is reviewed by the Pediatric Program Evaluation Committee as part of the Annual Program Evaluation (APE) process. The APE report is shared with the Graduate Medical Education office as well as the Department of Pediatrics.

*Pediatric Residency Evaluations* can be found in *Pediatric Forms* on Blackboard.

Additional information on *Resident, Faculty and Program Evaluation* can be found in the *University of Kansas Graduate Medical Education Policy and Procedure Manual*. [http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html](http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html)

**Resident, Faculty, Rotation and Program Concerns**

Issues raised in all of the above evaluations are taken very seriously by the Program leadership. There are a number of examples where this feedback has brought about significant and sometimes immediate changes in the structure of the Program in both educational and patient care arenas. The critical incident form can also be used to document these concerns.

In addition to formal evaluations, residents are encouraged to bring up any concerns about the residency at any time. Only by addressing problems in a timely manner can the high standards of the residency Program be maintained. So that residents do not feel intimidated or fear retaliation for expressing concerns about the Program, a variety of group and individual forums for addressing concerns exist in the Program. The Program Directors, Residency Coordinator and Pediatric Chief meet with all the residents on a weekly basis and additionally with each class individually once a month.

Residents are welcome to bring concerns to the Program Director or Associate/Assistant Directors, Department Chair, Advisors, Residency Coordinator, Pediatric Chief, or Resident Class Representatives on Pediatric Residency Committee at any time. Outside of Pediatrics, issues may be raised with the Designated Institutional Official or the GME office or the Resident Ombudsman.
Conferences

Core Curriculum

Schedule: Monday noon-1pm, Tuesday noon-1pm, and Thursdays noon-1pm, One Friday per month noon-4pm
Location: 2001 Miller Building or ZIEL Simulation Lab
Attendance: Residents - see Pediatric Residency Attendance Policy, REQUIRED
Scheduling: Pediatric Chief
Advisor: Pediatric Chief, Program Director
Format: The topics of the Core Curriculum will be selected from the Nelson's Essentials of Pediatrics, Faculty survey, In-Training Examination results, and American Academy of Pediatrics PREP Content Specifications. July-August will be a review of emergency topics (what to do on call) that is repeated yearly. Board Review takes place in June. The other 8 months include the gamut of pediatric and pediatric subspecialties. Topics may repeat in an 18 month cycle. Topics will be presented in a case-based format with board review questions incorporated as often as possible. Residents are expected to be active participants in their learning by asking questions and participating in topic discussions. The weekly schedule will be distributed one week in advance so that residents can read about each topic in advance of the lecture. Core lectures are recorded and archived for later review.
Evaluation: Residents will be asked to evaluate each conference. The results will be reviewed by the PD and Chief and shared with presenters as part of faculty development in the area of teaching skills.

Children’s Mercy Didactics

Schedule: Fridays 1:15pm-5:15pm, one Friday afternoon per PGY level as scheduled by CMH
Location: CMH Housestaff Conference Rom
Attendance: All residents on designated Fridays. Missed conferences must be made up by reviewing the conference recordings.
Format: Various topics based on PGY level.

Grand Attending Rounds

Schedule: First Friday of the month noon-1pm
Location: 2001 Miller Building
Attendance: Faculty, residents, and students - see Pediatric Residency Attendance Policy
Scheduling: PMEC Administrative Assistant. Each division is required to present one (1) Grand Attending Rounds per year. Divisions are encouraged to collaborate on a case presentation.
Advisor: Associate Program Directors
Format: Case-based conference focused on collaborative inter-professional experiences targeted to improve clinical teams, communication and patient safety. The presentation will consist of a well-constructed and concise case. The faculty member facilitates the case discussion with input from other health professionals, including relevant individuals from other departments. Patients chosen for presentation may be from any area general, subspeciality, neonatal, etc. The patients may be chosen from either inpatient or outpatient services. The presentation should focus on how the team worked together for the best care of the patient or how additional collaboration would have been beneficial. Grand Attending Rounds are recorded and archived for later review.
Evaluation: Audience members will evaluate the conference
**Morning Teaching Conference**

Schedule: Monday, Tuesday, Wednesday, and Friday 7:30-8:00am  
Location: Monday 3001 Miller, Tuesday and Wednesday 1001 Miller  
Attendance: Residents - see Pediatric Residency Attendance Policy  
Scheduling: Pediatric Chief  
Advisor: Associate Program Director and MTC Resident Representatives  
Format: Appendix C  
Evaluation: Audience members will evaluate the conference

**Pediatric Grand Rounds**

Schedule: Thursday 8:00-9:00am  
Location: Clendening Auditorium  
Attendance: Entire Pediatric Department - see Pediatric Residency Attendance Policy  
Scheduling: Faculty Members of the Grand Rounds Committee  
Coordinator: Joint KU-CMH Grand Rounds Committee  
Format: Presentations by faculty and guest speakers on current pediatric topics of interest. Grand Rounds lectures are recorded for later review.  
Evaluation: Audience members will evaluate the conference

**Ethics Conference**

Schedule: Monthly, Wednesday noon-1pm  
Location: 2001 Miller Building  
Attendance: Entire Pediatric Department - see Pediatric Residency Attendance Policy  
Scheduling: Pediatric Chief  
Advisor: Kathy Davis, PhD  
Format: Ethics Conference seeks to expose the pediatric residents, faculty, and interested others to ethical questions impacting our field as well as to generate lively debate. For each conference a timely reminder and short reading (e.g., article, etc.) will be sent out. Ethical questions will be presented and discussed. The goal is not necessarily to resolve the question; how we approach these ethical concerns and attempt to make our own decisions is equally important. The use of "case analysis" as an example of a tool to frame the debate will be taught and utilized.

**Palliative Care Conference**

Schedule: Quarterly, Wednesday, noon-1pm and as needed  
Location: 2001 Miller  
Attendance: Typically residents only  
Scheduling: Pediatric Chief  
Advisor: Emily Riegel, MD  
Format: Palliative Care Conference seeks to expose pediatric residents to the growing specialty of pediatric palliative care. Some conferences will discuss typical scenarios that arise in this field while others will focus on actual palliative care cases in our own clinical practice.
Continuity Clinic Curriculum (PEAC) Conference

Schedule: Core session monthly for PEAC, noon-1pm  
Location: 2001 Miller Building  
Attendance: Residents, and students - see Pediatric Residency Attendance Policy  
Scheduling: Pediatric Chief  
Advisor: Directors of Continuity Clinic  
Format: Continuity Clinic Curriculum topics for the preceding month will be discussed allowing residents an opportunity to ask questions, to deeper their understanding of the concepts covered in these online curriculum and to discuss how to apply this new knowledge to patient care.  
Evaluation: Audience members will evaluate the conference

GME Core Competency Conference

Schedule: Monthly on Tuesday 6:30am-7:30am or noon-1pm  
Location: AM sessions: School of Nursing Auditorium, PM sessions: Sudler Auditorium  
Attendance: Pediatric residents  
Format: Various topics focused on the six competencies of interest to all residents at KUMC. GME Core Competency lectures are recorded and archived for later review.

Resident Conferences

The Pediatric Chief will develop a schedule for the year for all resident conferences. Residents are responsible for planning and preparing their assigned conference to present on the date assigned. Residents should begin preparation for their conferences well in advance of their scheduled presentation date so as to allow sufficient time to review the content to be presented and for PowerPoint presentations to undergo editing. If it becomes necessary to reschedule a conference, the Pediatric Chief and the residency coordinator must be notified. The resident may be responsible for finding a colleague to trade conference dates. Senior Resident Conferences and Journal Club are recorded and archived for later review.

Senior Scholarly Presentation

Schedule: Wednesday 12:00 noon-1pm  
Location: 2001 Miller Building  
Attendance: All faculty and residents - see Pediatric Residency Attendance Policy  
Advisors: Designated Associate Program Director with an additional Clinical Advisor to be identified by the resident as needed  
Objective: Third-year residents will develop a “state of the art” understanding of a specific topic or area of research and synthesize this information into a presentation. The Senior Scholarly Presentation provides an opportunity for residents, with the help of the faculty mentors, to further develop their use of medical literature and its clinical relevance as well as to improve teaching and presentation skills.  
Format: All presentations will include the following:  
- Purpose and rationale for the presentation  
- Current literature review  
- Application to current practice (clinical relevance)  
- Recommendations for additional research needed  
Process:  
6 weeks prior to presentation: APD approval of the topic  
4 weeks prior to presentation: APD approval of outline of the presentation and timeline for completion  
1 week prior to presentation: Submit final slides to APD for review  
The presentation is formal and well-rehearsed. The presentation is based on slides and/or paper handouts, which may be copies of selected pages from books or journals, or original charts or other figures drawn by the presenting resident. Any required copyright must be secured by the resident. Presentations are audio recorded and archived for later review.
Evaluation: The APD will evaluate the resident teaching/presentation skills. This evaluation will include preparatory work and the practice session. The clinical advisor will complete an evaluation of the resident’s accuracy and clinical content the day of the presentation. The resident will provide an electronic copy of the PowerPoint to the PMEC. Residents will NOT be allowed to post-pone presentations except for medical emergencies. Residents who receive an unsatisfactory evaluation will be required to complete another Senior Scholarly Conference or a component of the Senior Scholarly Conference activity as determined by the conference advisors in order demonstrate mastery of the learning objectives.

**Patient Safety and Quality Improvement Conference**
Schedule: Wednesday noon-1pm
Location: 2001 Miller Building
Attendance: All faculty and residents - see Pediatric Residency Attendance Policy
Advisors: Designated Associate Program Director
Objective: The goal is to teach patient safety and quality improvement concepts, as well as foster greater communication between disciplines, in the setting of case discussion.
Format: The resident will present a concise summary of the clinical case, as well as, any background material relevant to the discussion; such as guidelines and other markers of standard of care. Then, using the Patient Safety Matrix lead a systematic discussion of system and communication issues. The focus will NOT be on individual errors but on system problems encountered in our clinical practice. At the end of the conference, the resident will write up a summary of the suggestions for QI projects resulting from the discussion and submit it to the advising faculty member. It is expected that these ideas will become QI projects for the residency program.
Process:
- **6 weeks prior** to presentation: APD approval of the case
- **4 weeks prior** to presentation: APD approval of outline of the presentation and timeline for completion
- **1 week prior** to presentation: Submit final slides to APD for review
Evaluation: The APD will evaluate the resident teaching/presentation skills. This evaluation will include preparatory work and the practice session. The APD will also evaluate the resident’s accuracy and clinical content the day of the presentation. The resident will provide an electronic copy of the PowerPoint to the PMEC. Residents will NOT be allowed to post-pone presentations except for medical emergencies. Residents who receive an unsatisfactory evaluation will be required to complete another Patient Safety Conference or a component of the Patient Safety and Quality Improvement activity as determined by the conference advisors in order demonstrate mastery of the learning objectives.

**Journal Club (not applicable to PGY 1 residents in 2016-2017)**
Schedule: Wednesday noon-1pm
Location: 2001 Miller
Attendance: Residents and Faculty - see Pediatric Residency Attendance Policy
Advisor: Mike Rapoff, PhD
Objective: The program’s required evidence-based medicine exercise, Journal Club, emphasizes scholarship and critical thinking regarding the current literature in clinical pediatrics. The forum gives the presenting resident and the audience an opportunity to closely examine and debate the merits of a single journal article in view of its relation to its background literature and with respect to established evaluative criteria in medical statistics and research design.
Format: The Journal Club is presented in three parts.
1) The presenting resident describes the problem, summarizes competing schools of thought and the immediately relevant background literature, summarizes the main paper, and states an opinion (e.g., regarding the adequacy of the study design, the validity of the conclusions, the degree to which the authors met their objectives, etc.). The presentation focuses on issues of research design and statistical adequacy, and the validity of controversial findings.
2) The Faculty Advisor and any guest experts comment on the paper and the problem in general.
3) The discussion is opened to the floor, with emphasis on critical evaluation and implications for clinical practice and future research. The conference coordinator will complete a conference evaluation for the presenting resident.

Process:

- **At least 6 weeks prior** to presentation: Article approval is completed. In consultation with Dr. Patton, the resident will choose an original research article, typically a main article, from a peer-reviewed journal such as *Pediatrics, Journal of Pediatrics, NEJM* published within the last 12 months. The paper is chosen either because it involves findings that challenge current practice, or because it involves an unusual or somewhat difficult research approach that the presenting resident would like to learn.

- **4 weeks prior** to presentation: Ongoing meetings with Dr. Patton are required to work through this scholarly activity. These meetings are to be scheduled during the month prior to presentation. The presenting resident studies the main article and at least one closely related article to which it refers, paying particular attention to questions of statistical and research design and the validity of controversial findings.

- **1 week prior** to presentation: Submit final slides to Dr. Patton for review.

- **Week of** presentation: Practice session with Dr. Patton.

Evaluation: Dr. Patton will evaluate the resident’s teaching/presentation skills. This evaluation will include preparatory work and the practice session. Dr. Patton will also evaluate the resident’s competence in appraising current literature. The resident will provide an electronic copy of the PowerPoint to the PMEC. Residents will NOT be allowed to post-pone presentations except for medical emergencies. Residents who receive an unsatisfactory evaluation will be required to complete another Journal Club or a component of the Journal Club activity as determined by the conference advisors in order demonstrate mastery of the learning objectives.

**Other Residency Meetings**

**Core Announcements**

Schedule: Thursdays noon-1pm
Location: 2001 Miller
Attendance: Residents on KU campus and via ITV at Prairie Village
Format: Weekly Core Announcements will be shared with the residents by the PD and other members of the leadership team. Time will be dedicated to addressing new or ongoing resident concerns. Program updates from O2 Superusers and GMEC Resident Council will be done at this time along with any other updates from resident led initiatives.

**Class Meetings**

Schedule: Fridays noon-12:45pm
Location: 2001 Miller
Attendance: Residents attending CMH Didactics that afternoon.
Advisor: Dr. Lisa Gilmer
Format: Class specific topics will be covered on a monthly basis.
Routine Admission Procedure for Transfers *(Appendix D)*

The admitting senior resident should promptly and courteously process any admission requested from the KUMC transfer center, the pediatric clinic or the Emergency Department. Outside referring physicians will access the transfer center at 1-877-738-7286. The senior resident will be paged to **913-588-9999** to call the transfer center back. Both the senior resident and the appropriate attending (typically the PICU attending) will be on the line with the referring physician and the transfer center. Inside referring physicians may access the senior resident on the admit pager, 917-3333. Please refer to the full protocol for handling transfers.

The following is helpful information to gather on all transfers.

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Patient age/DOB</th>
<th>Patient contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referring physician</td>
<td>Referring institution</td>
<td>Referring phone number/address</td>
</tr>
<tr>
<td>Admitting diagnosis</td>
<td>Admitting physician/service</td>
<td>Admission date</td>
</tr>
</tbody>
</table>

The referring physician must be called soon after the admission, frequently during the hospital stay, and at discharge by the faculty and supervising resident. Internal referring physicians may be contacted by email. It is the responsibility of the senior resident to make sure that this happens.

**Documentation/Charting**

The hospital chart is one of the most important documents you will regularly encounter in your personal and professional life. Don't forget that the original impetus for complete and accurate medical charting was not a legal requirement for documentation or a way to bill for physician time, but rather to facilitate communication - to allow progress, ideas, thoughts, plans and goals to be noted for future reference. As you know, review of a patient's previous hospital or outpatient record can yield an enormous amount of information and save time, money delay, and inappropriate intervention. The accurate recording of the patient's hospital course is paramount to good medical care.

**O2 (Optimal Outcomes)**

Implementation of our electronic medical record has already dramatically changed the way students, residents and attending physicians document patient care. You will receive training on O2 as part of orientation but your peers will be the most helpful teachers to show you how to maximize the potential of O2. Regular emails on how to maximize O2 and announcements on new features of the system are regularly sent to providers. Additionally, there are resident Super Users who are program specific experts on the EMR available to help.

**Admission Orders**

Most patients will be admitted using the General Pediatric Order/Term Nursery/PICU/NICU order sets, however, there are a number of specific order sets as well for conditions such as fever in infant < 3 months, asthma exacerbation, CF, fever and neutropenia, gastroenteritis/dehydration, video EEG, pyloric stenosis, bronchiolitis, chemotherapy and sickle cell crisis. Please use a diagnosis specific order set whenever possible. They were designed to standardize practice following the evidence-based medicine. Standard order sets help to provide optimal patient care that is safe of and of high quality.
History and Physicals (assign the note type as H&P)

The hospital chart (both paper and electronic versions) is a legal document and you should understand some of these ramifications. Your notes must accurately record the patient's daily progress, including thoughts and plans discussed on rounds. Gratuitous comments, editorial comments or negative references to other treatments are usually not useful, especially when these comments imply fault and should not be included in notes. Mistakes can happen. Addendum notes should be written to explain any errors in other notes. Your notes will be routed to the appropriate attending for Edit/Cosign. Medical students are expected to write notes daily. Please read these notes and provide feedback to the students.

There are several Pediatric H&P templates available on O2. Use the one that is the most appropriate. The admission note is required within 24 hours of admission. Usually the junior resident completes the admit H&P. The senior resident must have at least a brief admitting note that must include a history of present illness, physical exam, and assessment/plan. The admission H&P should be completely filled out including lab and x-ray results that sometimes must be added in after the H&P has been completed. Medical students are expected to complete an H&P too however this is separate from that of the residents.

Progress Notes (assign the note type as Progress Note)

Progress notes are required daily and are usually written by the junior resident. The students are also expected to write daily progress notes. A day of discharge note should also be written in the chart, as the final discharge summary might not be available to health professionals should the patient require care soon after hospital dismissal. The day of discharge note should be a brief SOAP note like other daily notes. The discharge summary will include a recap of the hospitalization, plans for home health care and follow-up clinic visits, dismissal medicines, and note of who the referring doctor is.

Procedure Notes (assign the note type as Procedure Note)

Residents are expected to write a procedure note after each procedure. If a consent form was required, a procedure note is needed (ex- lumbar puncture, circs). Deliveries also require a procedure note.

Patient Orders in O2OM [O2 Order Management]

All orders on patients admitted to the pediatric services are to be written primarily by senior residents except in emergencies or other unforeseen circumstances. A resident must cosign all orders written by medical students. Orders will be written in concert with the overall plans for the patient outlined by the attending and senior residents. Although the admitting team usually writes the admission orders, other teams such as the urgent care team may assist with this in order to facilitate an admission. When writing orders on a patient not already on the unit, the final order should be to “notify the pediatric resident when the patient arrives in the unit.” This eliminates the problem of a patient arriving on the floor and the admission team not being aware of it.

Any stat order should be verbalized to the appropriate patient nurse and to the unit clerk for immediate attention. Stat pharmacy orders should be faxed directly to the pharmacy by the ordering physician.

Verbal and Telephone Orders

The use of verbal orders and telephone orders is strongly discouraged and their use is appropriate only in circumstances when the resident is unable to leave a patient care situation in order to personally write the order. All verbal and telephone orders must be signed within 24 hours per hospital policy. Any physician member of the team can sign these orders. Best practice is to check charts while rounding.
Consultations

Pediatric consultations are another part of the medical record and are also done in O2.

For consults to the general pediatric team, services will page the Admitting Resident on the 917-3333 pager. The Consult Senior or the Clinical Senior if necessary will inform the General Attending about the consult. The resident and the attending may proceed with the consult together or the resident may be asked to complete the consult and present back to the attending to staff the consult.

For consults to pediatric specialties, if there is a resident on the service, that resident will usually begin the consult and then discuss it with the faculty who will staff the consult. When an inpatient pediatric service consults another service, the consult form must be filled out completely with a question for the specialist and signed by the attending. Some consultants are called into the specialists directly by the residents while the unit clerk calls others in. Current practices change so consult with the senior resident about which way to proceed.

Specifics about Pediatric Consults: Pediatric ICU consults are placed on almost every pediatric patient admitted to the PICU by other services such as Trauma and Neurosurgery. These consults are to the PICU service only and a second consult to the Inpatient General Pediatrics team is needed when patients are transferred out of the PICU. It is helpful for the PICU team to remind our surgical colleagues of this given the idea of switching services from ICU to floor is not something that occurs on surgical services.

All patients under the age of 17 admitted to a service besides Pediatrics, Family Medicine or Ob-Gyn, must have a pediatric medical consult. This can be to the PICU team, the General Pediatrics team or to a Pediatric Subspecialist. Frequently Behavioral Pediatrics is consulted as well but that should not be the only pediatric consult- a medical consult is a requirement of the hospital medical staff rules. On the other side, any patient over the age of 17 admitted to Pediatrics requires a consult to an adult service such as General Internal Medicine or an Internal Medicine Specialty service.

Discharge Summaries

Hospital rules demand that all discharge summaries be completed in O2 within 48 hours of discharge on all admissions including newborns however it is strongly requested that they are completed on the day of discharge.

The habit of early completion of charting will prevent otherwise irritating intrusions into your busy schedule or even a limitation on your patient privileges. If you are having difficulty meeting completion deadlines, contact Medical Records. You may edit your discharge summaries electronically and you are encouraged to do so especially with your first summaries. Unsigned orders or notes will also be sent to you to sign electronically in ChartMaxx.

When you have a delinquent discharge summary, both you and the Program Director will receive an email notification from Medical Records with a warning of possible suspension. Failure to promptly take care of the delinquent summary will result in your immediate suspension from all clinical duties until your discharge summaries are completed. All email responses to Medical Records should be copied to the Program Director.

Note of Caution: Delinquent medical records are not only a problem during residency (clinical time missed under a suspension must be made up) but such incidents will be reported as suspensions on all future employment verifications and licensing requests. Often these requests do not differentiate a suspension for delinquent medical records from more serious offences such as academic or professional probation.
Role of the Caregiver

Upon admission to the Pediatrics Unit, the PICU, and the Full Term Nursery families receive a Care Team handout with pictures of the attending physicians and residents who will be taking care of their child. This information also includes the following descriptions for the caregiver roles.

Faculty, Attending, Medical Staff

These terms all mean the same thing and refer to the expert leader of your child’s care. These doctors carry the primary responsibly for your care and have been recruited from all over the world to provide your child with the best possible treatment. Faculty physicians have completed college, medical school (4 years) and then training in a residency program (3 years.) Some Faculty have had even further advanced training in one or more fellowships after residency (3 years.) All Faculty physicians have a license to practice medicine from the Kansas State Board of Healing Arts. Almost all faculty physicians are also Board Certified by the American Board of Medical Specialties. Some faculty members are still in the process of becoming board certified as this process can take years. These doctors provide care for patients and provide supervision and teaching for Resident Physicians and Medical Students as University of Kansas School of Medicine professors.

Resident and Fellow

Residents have completed college and medical school. These doctors have come from all over the world to train for 3 years in Pediatrics at the University of Kansas School of Medicine. To be accepted into a residency program is a competitive process with some programs getting over a 100 applications for each position. Residents in the first year have been referred to as “interns” or “juniors” while residents in their second and third years have been referred to as “seniors.” Fellows have completed a residency program and participating in advanced training in a medical subspecialty. Both Residents and Fellows are licensed to practice medicine by the Kansas State Board of Healing Arts. Residency and Fellowship training programs also include research into state-of-the-art medical advances. The interactions between Resident/Fellow supervision, clinical training and medical research is what makes the University of Kansas Hospital a premier “Teaching Hospital” and “Academic Medical Center.” All Resident patient care is supervised by a more senior Resident, Fellow or Faculty physician.

Medical Students

Medical Students have completed and are training to become physicians. They have competed with several hundred applicants to become a medical student at the University of Kansas School of Medicine to earn their MD and become a doctor. Medical Students most commonly spend time in the Hospital and Clinics during their two final years of medical school. All Medical Student participation in patient care is closely supervised by licensed doctors (i.e., Faculty, Fellows, Residents.) In their final year of training, Medical Students decide which medical field they wish to pursue as a career. They complete for positions in residency programs both at the University of Kansas School of Medicine and all over the nation. Occasionally medical students from other medical students rotate alongside the University of Kansas School of Medicine students.

Additional information on the Role of the Caregiver can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Ethics Committee/Patient Rights

With increasing medical sophistication, the ethical questions that surround a patient’s care often overwhelm the medical decisions. All of you have been involved in wrenchingly complicated problems by this time in your training and this will only continue. Remember that in even the most complicated ethical situation, the first and most important step is to talk with the patient and family. Only through full communication with the appropriate decision-maker can you address honestly, thoroughly and expediently the issues that have been raised.

Fortunately, we are not alone. There are other people willing and able to assist. There is a Pediatric Ethics Committee that meets monthly to discuss ongoing issues and is available to consult for ethical questions for both inpatients and outpatients. Our pediatric social workers also help with these difficult cases. The chaplain services consist of full-time Protestant and Catholic ministers. Other denominations have clergy on call to respond to patient requests. The hospital Office of Legal Counsel can advise on legal issues concerning patient care. The hospital has put together an Ethics Manual covering many other issues of ethical concern regarding the activities of physicians. This should be read and consulted often as you mature as a doctor.

Clinical Services: Inpatient

For all clinical services, detailed Goals and Objectives outlining educational and clinical experiences and expectations are available on Blackboard.

General Pediatrics Floor

There is one resident inpatient team consisting of two senior residents (PGY 2 and PGY 3) and two PGY 1 residents. There are two attending teams who supervise patient care on the general pediatrics floor. All Hematology-Oncology patients are admitted to the Pediatrics Heme-Onc service under a Pediatric Hematologist-Oncologist. All general pediatrics patients and all other pediatric subspecialty patients are admitted to the Gen Peds service under a General Pediatrician.

Patients will be divided amongst the PGY 1 residents by the senior residents. Patients will also have a medical student assigned to them by the seniors. There are no caps in pediatrics. PGY 1 residents are expected to serve as the primary care giver for at least 5 patients at a time, on average. Service size is not limited by the number of beds on the Pediatrics Unit either as patients, especially adolescents and surgical patients may be placed on other units. However if the volume and or acuity warrants, decisions on patient caps are at the discretion of various attending physicians.

The PGY2 will typically be the Clinical Senior. This resident will manage patients on the floor working closely with the juniors. This resident should be checking orders and answering questions for the junior residents and medical students as they pertain to patient care. The PGY3 will typically be the Consult/Teaching Senior. This is a teaching role and this resident should be teaching the medical students and juniors on a regular basis. This senior will also be the consultant for other services such as the ED and surgical services. When the seniors are at the same level, the roles may be assigned at the start of the month and switched on a weekly or midmonth basis.

Both seniors are expected know all the patients on the floor. Obviously, these roles may blur somewhat during the busiest clinical months of the year. The most important aspect of these roles is teamwork and communication with each other.
The Pediatric Inpatient Service practices Family Centered Rounds (FCR). This includes a huddle with the multidisciplinary team in the morning as well as rounding at the bedside with the patient and family at the center. All members of the care team including physicians, medical students, nurses, pharmacists and social worker are present in the room for these rounds. Both patient care and teaching are done with the patient. FCR improve communication both within the care team and with the families and increases patient satisfaction.

PGY 1 residents will do 3 months of inpatient. PGY 2 residents will do 1-2 months of inpatient, the first one paired with a PGY 3 co-senior when possible and 6 weeks of Night Service. PGY 3 residents will do 1-2 months of inpatient. Evaluations are done as a group by the Inpatient Pediatric Attending (IPA) Group.

**KU Pediatric Intensive Care Unit**

The Pediatric ICU service is responsible for all patients admitted to PICU Service as well as most of the other pediatric patients admitted to the PICU such as trauma patients concurrently with those services. PGY 1 residents will not be assigned to the PICU but are expected to participate in admissions to the PICU while on call, particularly during the final inpatient rotation of their junior year. PICU patients may be admitted to the PICU or other ICUs as needed. The PICU team will be responsible for all critically ill children on their service no matter what unit they are in. The Pediatric Procedure Room is also located in the PICU and the PICU senior will assist with pediatric procedures and sedations when patient care responsibilities permit.

PGY 2 residents will do one month of KU PICU. PGY 3 residents may also do an additional 2-4 weeks in the PICU as well as 4-6 weeks of PICU Night Service. Evaluations are done by the Pediatric Critical Care physicians.

**Children’s Mercy Pediatric Intensive Care Unit**

PGY 3 residents will complete the second required PICU month in the PICU at Children’s Mercy. During this rotation, residents will be expected to perform at or above the level of a PGY 2 CMH resident. This rotation includes 2 week of PICU night service. The CMH Chief Resident will provide the schedule for the month. Prior to rotating to the CMH PICU, residents will have completed the following prerequisites: Cardiology rotation, KU PICU, supervisory inpatient experience, and the PICU on-line learning modules. The evaluations are done by the CMH Critical Care educational liaison.

**Pediatric Surgery**

The Pediatric Surgery service at KU covers the gamut of general pediatric surgical cases. This subspecialty rotation provides an excellent range of experiences for pediatric residents. During this rotation, the Pediatric Resident will learn to recognize and diagnose common surgical problems, evaluate post-operative outcomes, determine when to refer a patient to a Pediatric Surgeon and will be given the opportunity to see the pathology directly in the operating room.

The Pediatric Resident is expected to be involved in the care of all patients on the Pediatric Surgical service including primary care responsibility for patients in rounds, in the pediatric surgery clinic and in the OR. Presence in the surgical clinic is an essential and required component of the rotation and probably the most valuable aspect of the rotation, allowing pre-and post-operative assessments of real-life situations that the resident will most likely see later in his/her practice. Scrubbing in on the cases is optional, but strongly encouraged. Residents will attend Pediatric Surgical Conferences.
Neonatal Intensive Care Unit

The NICU service will consist of two residents in various combinations of PGY 1 and PGY 2 residents. Neonatologists are the attending physicians. Neonatal Nurse Practitioners serve a diverse role, including teaching, 24/7 patient care and supervision where permitted and when needed. This is not a supervisory rotation for PGY 2 residents. Senior residents are expected to mentor and teach the junior residents in the NICU but supervision will be provided by the Neonatologists or NNPs.

PGY 1 residents will do two months in the NICU and PGY 2 residents will do one month. Evaluations are done by the Neonatologists.

Full Term Nursery

The FTN service will have one senior resident every month and 1-2 PGY 1 residents one of whom may be a Family Medicine PGY 1 resident. General Pediatricians will serve as the attending physicians. A Pediatric Nurse Practitioner serves the nursery in a diverse role including teaching and patient care supervision.

PGY 1 residents will do one month in the FTN and PGY 2 residents will do one month. PGY 3 residents may also do an additional 2-4 weeks in the FTN.

Clinical Services: Outpatient

For all clinical services, detailed Goals and Objectives outlining educational and clinical experiences and expectations are available on Blackboard.

KU Emergency Medicine Services

Our Emergency Department is staffed by both EM trained faculty as well as IM, FM and Med-Peds trained faculty. Residents will be assigned to see patients by the attending. Although the ED serves pediatric and adult patients, every effort will be made to have pediatric patients seen by the pediatric resident. The focus of the ED triage process when there is a Pediatrics resident on should be for the pediatric resident to see all the children. To that end, Pediatrics residents may be asked to manage several patients at once so as to serve as many pediatrics patients as possible. Pediatric residents should also actively see pediatric patients in the Fast Track area of the ED. When seeing adult patients, keep in mind there are lessons to be learned from adults too. The ED is a particularly busy place for gynecology cases, lacerations and simple injuries requiring casting and splinting that are similar in adults and children and which provide opportunities for required procedures. Likewise, the ED is a good place for procedures such as IV starts, venipuncture, arterial sticks and bladder catheterizations. Just step up and do them!

Follow-Up Care from ED: To ensure good follow up of patients from the ED when follow-up care in the pediatric outpatient clinic is recommended, the resident in the ED should email the residents in Same Day Sick about patients that were told to follow up in clinic. Although this email should be brief, it should include any information that is needed for good follow up such as treatments rendered and any tests to follow up. The Same Day Sick resident should reply to the ED after seeing the patient to complete the feedback loop. This is an excellent way to improve the quality of care for patients initially seen in our ED.

Particular note should be made of any Pediatric Cardiology, Nephrology or Pediatric Hematology/Oncology patients. When such patients present, the faculty member on call for that service (the page operator has the faculty coverage schedule) is to be immediately notified via pager that their patient is in the ED regardless of the time of day or night. Do not arrange for patients’ management and disposition until the above subspecialist on-call has been consulted.
When there is not a pediatric resident in the ED and often times when there is, the ED staff may page the pediatric admitting resident to consult. Such consults should be attended to as soon as possible and when completed, discussed with the General Pediatrics staff either in person or by phone so that a disposition can be determined. Only when the ED patient is seen by the General Pediatrics can the visit be billed but even when not staffed in person, the consult should be filled out and note made that the case was discussed with staff.

PGY 1 residents will do one month in the KU ED. PGY 2 or 3 residents will do one month at the CMH ED.

**Same Day Sick (also known as Urgent Care and Acute Care)**

The Same Day Sick Clinic serves children who are sick or who have minor injuries. Occasionally when the continuity clinics are full, well children may also be scheduled in this clinic. There is usually a senior resident and one to two PGY 1 residents assigned to the clinic. Often there is also a Family Medicine PGY 1 resident scheduled as well. The clinic is staffed by General Pediatricians.

Although patients can walk in to this clinic, appointments are strongly encouraged. Injuries seen are usually minor- sprains and strains. More serious injuries may be seen and evaluated but casting and suturing cases are sent to the ED. Illnesses seen run the gamut from rashes and ear infections to serious asthma exacerbations, thus residents must be prepared for anything. There is capability for limited labs in clinic such as strep and urinalysis, while other lab specimens can be sent to the main lab. Residents will call the families with all labs and x-ray results. There is also capability for minor procedures such as incision and drainage as well as cryotherapy. The clinic begins at 8:00am and the last patient of the day is accepted at 4:30pm. During the lunch hour, the clinic is staffed by faculty physicians so that residents can attend conference. At least one resident is responsible for staying in clinic until the last patient has been discharged at the end of the day.

**Center for Child Health and Development (formerly the Developmental Disabilities Center/DDC)**

The CCHD is a training, service and research facility represented by the disciplines of developmental pediatrics as well as audiology, speech pathology, psychology, special education, physical therapy and occupational therapy, nursing, social work, nutrition and neurology. The CCHD provides multi-disciplinary evaluations of neurodevelopmental disorders or children with special health care needs.

**Other Rotations**

Each rotation has goals and objectives available on Blackboard. Some rotations require a pre and/or post-test while other rotations require either a special project or presentation. It is the responsibility of the resident to meet with the faculty member in charge of the rotation at the start of the rotation to discuss any and all rotation requirements. **All rotational requirements MUST** be completed by the Monday following the last day of the rotation. Any exceptions to this requirement must be approved by the rotation director and communicated with the PMEC.

Rotation schedules are included with the goals and objectives and residents should look over these at least a month in advance in order to identify any rotation conflicts with continuity clinic as early as possible. It is the responsibility of the resident to notify the rotation director of any conflicts for the month (clinics, vacations, board examinations) prior to the start of the rotation. Continuity clinics are moved for recurring specialty conflicts (i.e. resident on Cardiology is moved off Tuesday clinic because Tuesdays are outreach cardiology clinics) as much as possible but it is the ultimate responsibility of the resident to identify and help plan strategies for other needed clinic changes.
Rotation Requirements

All rotation requirements as well as most of the rotational educational resources are available on Blackboard. Residents should review Blackboard for the upcoming rotation at least a week before the rotation begins as there may be requirements that must be completed before the first day of the rotation.

Rotational requirements are educational and clinical activities that complement the clinical service component of each rotation. Rotational requirements assist the evaluating faculty in determining the level of competency in areas such as technical skills, compassion, use evidence-based medicine in clinical decision making, and level of medical knowledge. Rotational requirements are to be completed during the rotation. When rotational requirements are not done in a timely manner, evaluations of the resident’s performance are delayed.

Expectation for Rotation Requirement Completion: The expectation is that all rotation requirements will be due by 8am on the Monday following the final weekend of the rotation (senior switch day). The program coordinator will send an email notice to any resident with outstanding requirements allowing until 8am Wednesday morning. The program coordinator will send the names of residents with outstanding requirements to the Pediatric Chief by noon on Wednesday at which time Completion of Rotation Requirements policy will go into effect.

Excused Extensions for Rotation Requirement Completion: If unable to complete rotational requirements by the above deadlines, residents may email the Pediatric Chief before the Monday morning deadline to request an extension. The email should include a reason for the request and a planned date for submission of the rotation requirements. Requests due to not managing time within the given rotation will rarely be excused.

In the circumstance when the resident is physically unable to complete requirements the week they are due such as rotating to an out of town rotation or being on vacation, the resident will be expected to complete the activities in the above manner the first Monday they are available.

Additional information on the Completion of Rotation Requirements can be found in the Pediatric Residency Policies and Procedures Manual.

Continuity Clinics (Appendix E-Template and Appendix F-Scheduling Rules)

The continuity clinic is designed to provide each resident the experience of providing longitudinal, continuous and comprehensive pediatric care over the duration of their three-year training period. Continuity Clinic permits the opportunity of delivering both acute and chronic care as well as well child supervision and anticipatory guidance. Each resident's panel of patients will be accrued from a variety of sources, which may include hospital discharges, newborns discharged from the nurseries, patients seen in the ED or Same Day Sick, and patients who had previously been followed by a resident completing training. The schedulers will make every effort to maintain resident patient panels. Residents are encouraged to give their business cards to their patients so that the patients may identify them as their primary care provider.

Continuity for patients and residents will be enhanced by the maintenance of a designated continuity clinic half-day as much as possible during a given year. Each half-day is assigned a general pediatrician who serves as the preceptor for that clinic. This attending will also evaluate the resident’s performance either at the quarter or semester. That preceptor will be responsible for that clinic unless it conflicts with attending time or time or out of office time. A primary clinic can be at KU MOB (Medical Office Building) or at the Prairie Village office so long as at least 36 clinics in no fewer than 26 weeks are done at the same location.
Organization: Practices are structured as follows:

KU MOB: Monday, Tuesday, Wednesday, Thursday and Friday afternoons

Prairie Village: Monday, Tuesday, Wednesday and Thursday afternoons, occasional Fridays

- **Afternoon Clinics:** At MOB and PV, the first patient is scheduled at 12:45pm for 3rd year residents and 1:00pm for first and second year residents. The resident should be ready to see the patient no later than 1:00pm. Patients are expected to arrive on time for their appointments. The clinic template is based on 30 minute appointments. An exception is made for newborns (< 2 months.) These patients worked into the schedule even if late. Afternoon clinic is usually completed by 5:00pm.

- **On didactic days,** residents with clinic at PV should pick up their lunch to go in 2001 Miller at 11:30am in order to allow sufficient travel time to PV in order to watch didactics from the resident work room or conference room.

**Resident Numbers**

- **PGY 1 Residents** are expected to see an average of 3 patients during a clinic. There are 6 patient slots on PGY 1 templates. Residents will start the year with abbreviated templates and work up to 6 patients. For the second half of the year, a 7th appointment slot is added at the end of the clinic template. Use of this add on slot must be approved by the resident.

- **PGY 2 Residents** are expected to see an average 4 patients per clinic session. There are 6 patient slots on PGY 2 templates. There is an additional 7th appointment slot added at the end of the clinic template. Use of this add on slot must be approved by the resident.

- **PGY 3 Residents** are expected to see an average 5 patients per clinic session. There are 8 patient slots on PGY 3 templates. There is an additional 9th appointment slot added at the end of the clinic template. Use of this add on slot must be approved by the resident. Occasionally a second half day per week clinic is added during rotations when this is possible in order to get clinic numbers up.

**Schedules:** Clinic schedules are prepared by the Pediatric Chief. Calendars are regularly distributed via email and are available in the Physician Scheduler system as well as on Google Drive. Schedules are prepared as far in advance as possible and are typically open three months ahead. For that reason, it is very important for vacation requests to be submitted as early as possible so that clinics can be closed without bumping patients. Residents are responsible for being in clinic as assigned and for checking that their clinics are canceled for vacation, LOA, and rotation conflicts. If a resident has a conflict with a clinic after patients have been scheduled they may be asked to find alternative appointments for patients that may including asking a colleague to cover the scheduled clinic or the opening of an alternate clinic for the resident with the conflict. These circumstances arise when residents do not check the clinic calendars for each and every possible conflict (post call, vacation, tests, certification classes, rotational conflicts, etc….). Failure to be in clinic and failure to notify the Pediatric Chief of conflicts after the clinics are opened will result in professionalism calls.

Clinics will be moved or cancelled as needed for specific rotations, conflicting clinics, redistribution of clinics on busy days and vacations. Other cancellations needed by residents for other reasons are to be made at least two months in advance and only with the permission of the Pediatric Chief. All communication regarding clinic changes should be made via e-mail. Changes made less than 2 months in advance cannot be guaranteed. Timely return of vacation requests will help to assure that clinics are closed when residents are on vacation. Last minute changes and cancellations of clinic after distribution of the clinics for the quarter should be avoided whenever possible. Last minute absences for circumstances such as personal or family illness should be reported as early as possible to the Residency Coordinator who will work with the Pediatric Chief and the Continuity Preceptors to arrange for coverage for the absent resident.

All residents are required to do at least 36 clinics in no fewer than 26 weeks. For this reason, clinics are cancelled for only selected rotations including: any rotation too far a distance from KU, Night Service, NICU and PICU will have 2 clinics in the month, and CMH PICU will have 2 clinics per month. Residents rotating to CMH for other rotations will typically have weekly clinic during subspecialty rotations. Residents will have 2 clinics while in the ED at KU and CMH. Projections for clinic numbers are done in December and again in March so as to have time to make changes in the schedule in order to assure compliance with the expectations for continuity clinic.
Continuity Clinic Preceptor Responsibilities: The preceptor should be physically present in the clinic at the designated starting time. The preceptor is expected to be immediately available to the residents for the duration of the clinic. Faculty members are not to see their own scheduled patients. The preceptor will oversee clinic flow to make sure that appointment schedules are met as closely as possible.

The faculty preceptor must see every patient seen by residents in their first six months of residency training. During that first six months of training, the preceptor must discuss every patient with the resident and see every patient to repeat the key elements of the history and physical. For residents past the first six months of training, the preceptor should review patient management decisions and content of anticipatory guidance provided by the resident physician prior to the patients leaving the clinic.

Faculty members are responsible for completing the charge documentation on all patients but resident participation in coding and billing is strongly encouraged. Faculty will review resident charts, document their findings, attest the resident note and complete final coding and billing in a timely fashion.

Resident Responsibilities: Continuity Clinic is to take precedence over all other clinical activities. Each resident is expected to arrive in clinic at the appropriate starting time and remain there as long as there are patients to be seen. Resident will huddle with their clinic nurse to discuss scheduled patients, determine plans for late patients and plan for any potential clinical issues. The management of each patient is to be discussed with the clinic preceptor prior to the patients leaving the clinic and before initiating treatment. Charting on continuity clinic patients must be completed on the day of the visit to ensure availability of records for on-going care.

Following up of lab results is a shared responsibility of the preceptor and the resident. Labs will be sent to both the resident and the attending through O2. Any critical results will be called to the faculty physician. It is the expectation that residents respond to lab results in their in box within 48 hours of a result note. The resident will document their assessment of the labs (ex. normal or not) and the follow up needed (ex. called parent to start iron.) The resident will follow up all results with the families and document these conversations in the result notes. Result notes should be routed to the attending of record as well as the resident’s nurse. For labs where the resident is unsure of how to proceed, the result note can document that (ex. abnormal TSH, will route to Dr. Maalouf.) resident’s responsibility to discuss all lab values with the preceptor and to notify the family of the results.

Patient Logs: The IDX scheduling software maintains a log of all patients seen including the date of service, the age and the chief compliant. However, in order to capture all diagnoses and conditions seen in continuity clinic, residents are encouraged to maintain a listing of their continuity clinic patients on paper or in an electronic database such as O2. Every effort should be made to update this list weekly at the end of each clinic session.

Patient Phone Calls: The triage nurse in clinic handles the bulk of patient calls during the day but residents provide telephone advice to patients during regular operating hours when needed. All resident messages will be routed to their O2 in basket. More urgent phone calls will be paged to the residents. Residents are expected to check their O2 in basket daily as well as respond to pages in a timely manner. Failure to respond to an O2 message or page from nursing may result in the Pediatric Chief or Program Director being contacted. Patient communication is part of the professionalism competency and failing to do so in a timely manner will result in a professionalism call.

Overbooking of Clinic Schedules: A note about the overbooking of patients, residents may not overbook another resident’s clinic. A resident may overbook only his or her own clinics. There is a built-in add on slot at the end of each clinic template which should be used first when overbooking clinics. To overbook additional patients, ask the scheduler to pull up a given clinic so that that overbooked patient can be placed in an appropriate slot (i.e. not between siblings.) Do not double book patients! Double booking is scheduling 2 patients in the same appointment slot. When you overbook a patient, the message line for that patient when your schedule is printed will read “per Dr. X” to remind you that you gave permission to overbook. Clinics may also be overbooked directly by Program Director. This will be done in order to accommodate nursery follow-ups primarily but may
also be necessary during the busy school physical season. When such appointments are made, the comment section will always read “per PD.” Any problems with scheduling should be brought to the attention of the PD.

*Late Policy:* Patients are expected to arrive on time for their appointments. If patients arrive after their scheduled appointment time, the triage nurse may be asked to evaluate the appropriateness of the visit and will determine where to schedule the late patient—Continuity Clinic, Same Day Sick or a later clinic. The exceptions to the last policy are infants < 2 months of age. These infants will be seen no matter how late. They will be told that they will have to wait until their provider finishes with other patients.

*Continuity Clinic Curriculum:* The Director of Continuity Clinic in coordination with the program directors and Pediatric Chief are responsible for the educational curriculum of continuity clinic.

*Directly Observed H&Ps:* First year residents will have three of their clinic visits directly observed by their clinic preceptor over the course of the first semester. Senior residents will have one clinic visit directly observed during the first semester.

*Continuity Clinic Evaluations:* These evaluations are completed once a semester on each resident by the small group of preceptors assigned to each of the clinic sites as residents will work with each member of the preceptor group during a semester. The Continuity Clinic Attending group will meet to complete the Continuity Clinic Evaluation. *(Appendix T)*
Call and Night Service

All residents will regularly take part in the in-house schedule. Senior residents will also take part in the home call schedule.

Every effort will be made to keep the call schedule fair as far as the number of calls, number of weekend calls, and number of holidays worked. Because this balance is difficult to achieve on a monthly basis, this parity is examined over the course of the academic year. **The call schedule will never be equal, to do so would take away the flexibility that residents appreciate; fair is the goal.** The Pediatric Chief is responsible for the call schedule. Any questions about the fairness of the call schedule should be addressed to the Chief. A preliminary call schedule will be made available at least 2 months in advance. Any questions or problems with the schedule at that time will be the responsibility of the Chief to fix. Once this schedule is made final, any changes are the responsibility of the involved residents, not the Chief. Such changes need to be sent to the Pediatric Chief as well as to the General Pediatrics Administrative Assistant via email or by phone so that the necessary changes in the on-line call schedule can be made. If changes are made at the last minute after hours or over the weekend, please call the switchboard operators directly to notify them of the changes.

Floor/PICU and Night Service

The residents assigned to Floor or PICU Call are responsible for the work up any new patients admitted to the floor and PICU and they handle any emergencies arising in the hospital.

**Evening checkout starts between 5:00pm-5:30 pm depending on time of year and patient census.** All daytime residents are expected to be present unless arrangements have been made for an early inpatient pair and a late inpatient pair for checkout. When there are two seniors on at night, PICU and Floor check out happen separately. When there is a junior and a senior on at night, the PICU senior should be present for Floor check out. When possible, the General Pediatric and PICU attending physicians should be present for evening checkout as well. Efficient and quality check out is essential for a successful night. Checkout is a standardized process with verbal and written transfer of patient information based on structured mnemonics. **(Appendix N)** Checkout should take approximately 30 minutes.

Night Service is the program’s way of improving continuity of care and it is counted toward required inpatient time. There is no continuity clinic scheduled during night service rotations. Residents are also excused from in-person Core conference however they are expected to view 50% of the missed recorded conferences. The Night The floor and PICU seniors along with a float senior will cover call on Friday night and over the weekend.

The Night Service residents are an essential part of the floor team and PICU team taking care of the patients at night. By seeing patients nightly and being alert at night, you may pick up things missed by the day team (a late consult, a late lab or x-ray). This may get patients discharged earlier by being more aggressive with changing respiratory treatments (for an asthmatic) or tapering pain meds (for a sickle cell patient). This is a scheduled rotation and unlike being "on float call" for a night. It is your job to admit a patient as if it is your own and move their care forward. When you come on, go around and say hi to families and talk to nursing staff just as the day team does in the morning. Night service is not just watching patients overnight until the day team is back on!

The Night Service residents should also check out with the attendings on their service by phone if there are any questions or clarifications needed from checkout. Night Service residents will be expected to discuss all admissions with the appropriate attending at some point prior to morning checkout. All admissions must be discussed with the attending on service at the time of admission.
While on any call, float or night service, you must documentation your activities in O2. This includes all exams and conversations with families. This documentation allows for better communication with the day team. A short note is to be written on each chart. This may be either a brief status note for a patient who was quiet overnight (“Chart reviewed. Patient seen and no concerns at this time”) or a progress note for a patient who required intervention (“Notified by nursing of fever. Patient seen, etc” in SOAP format). The Night Service residents should conduct “Midnight” rounds as well. This is a chance to make sure all is well on the floor, that any daytime tests and studies have been reviewed, any late staffed consults have been reviewed, and all orders for morning tests and studies have been written and that patients are progressing toward discharge. It is also a chance for parents who cannot be at the hospital during the day to talk to the team face to face. Expect that all attendings- PICU, General Pediatrics and Heme-One, will call in at some point in the evening to check in on patients if you haven’t called them.

**Morning checkout starts at 6:00am.** All daytime residents are expected to be present unless arrangements have been made for an early inpatient pair and a late inpatient pair for checkout. It is not acceptable for the Night Service residents to remain in house longer than needed because the day teams arrive late for checkout. The sickest patients should be presented first to whichever members of the day team are present. Checkout should not be repeated for late comers. Checkout should take no longer than 1 hour. Prolonged morning checkout is an issue for the Night Service residents who must have 10 hours between shifts, a longer break is preferred.

**NICU**

Neonatal Nurse Practitioners cover overnight and weekend call hours for the NICU. Although not regularly assigned to take call in the NICU, the NICU residents may stay into the evening for imminent deliveries or other patient care/educational activities provided all duty hour restrictions are observed, in particular the 10 hour between shifts rule. For example, if a resident leaves the NICU at 8pm, they cannot return the next morning until 6am. Residents may also have the opportunity to take overnight call as the discretion of the neonatologists.

Residents in the NICU will checkout patients to the NNP at 4:30pm each night. Residents are expected to arrive for morning check out no later than 6:30am and 6:00am is preferred.

**FTN**

There is no provider assigned for overnight and weekend coverage for the FTN. The protocol for coverage of patients in the FTN after 4:30pm and on weekends is as follows:

- The FTN attending is contacted for routine low-risk admissions and patient care questions until 9pm.
- For admission orders on newborns after 9pm, the Senior Resident on Call is paged to place those orders.
- For non-emergent patient care questions, the FTN attending should be called first. If in their opinion a pediatrician needs to assess the infant, the Senior Resident on Call will be paged to assess the infant and communicate findings to the FTN Attending.
- For emergent patient care questions or issues, the on-call NNP will be paged to assess the infant and communicate findings with FTN Attending and NICU Attending if needed.
- The NNP’s provide cross coverage at night for FTN deliveries. If there is a delivery situation that requires additional providers (twins or other multiples), the Senior Resident on Call may be paged to assist with that delivery.

See *Pediatric Policy Manual* for details regarding supervision of resident.
Answering Service/Home Call

KU Pediatrics provides nighttime, weekend and holiday phone coverage for all of its primary care patients. Senior residents are assigned to Home Call/Mommy Call at night and on weekends and holidays as part of the backup system. Home calls start at 4:30pm and are taken by the resident assigned to home call until 9pm at which time they are sent to the senior resident on call for the floor who is responsible for calls until 8am. On weekends and holidays, the home call resident takes calls from 8am-12pm. Residents receive these calls on their pagers unless other arrangements have been made with the page operators. The Inpatient Attending is typically the faculty backup for home calls. The page operators will have this schedule so if you need faculty back up for a home call, call the operators to confirm who “On Call” faculty member is. Residents on Home Call are encouraged to page this attending for triage questions they cannot answer or to handle calls beyond the resident’s capabilities. The attending on the floor is back up for any calls that come to the on call resident after 10pm. Residents will be expected to provide appropriate telephone management, including referral to an ED or urgent care clinics on all calls. **Resident must document all calls in O2 by 8:00am the following morning.** If a faculty PCP is identified, the phone encounter should be routed to that provider for review and sign off. If no PCP is identified of if the PCP is a resident, route the phone encounter to the Pediatric Chief as well as the resident PCP.

*See Pediatric Policies and Procedures Manual for Answering Services Guidelines, Daytime and Nighttime*

Back Up System

The program uses several back-up systems in place for when the clinical care needs exceed a resident’s abilities.

1) Jeopardy Call Schedule: There is a senior level resident assigned to Jeopardy Call every day of the week. If a resident calls in sick for an overnight or weekend call shift, this person is activated to assume responsibility for that shift. If the clinical care needs exceed a team’s abilities in terms of volume or acuity, this resident is activated to come in and help any team during the time when the clinical care needs require it. This may include assisting both day and night teams. The program will work to mitigate other pulling of residents to cover services for planned and predictable daytime shortages of residents. It is the expectation that the faculty will provide this type of coverage.

2) Pediatric Chief: The Chief is available 24/7 by pager unless on vacation in which case the Program Director is available, to help problem solve back-up issues.

3) Attending Physicians: There is an attending physician assigned to every team, day and night, who is available by phone at any time.

4) Program Director: The Program Director is also available if the above measures have not been successful in mitigating situations where clinical care needs exceed a resident’s abilities.
Communication with Referring Physicians-External and Internal

Referrals are a large and very important part of the service provided by this Department. The attending physician is responsible for accepting all patient transfers. These referrals frequently come from physicians outside the KU Medical Center, in greater Kansas City or Kansas and Missouri. Timely communication with referring doctors is essential. A recurring complaint about our hospital is that referring doctors seldom hear what is going on with the patients they send here. If our Department is going to continue to provide outstanding service to outside doctors, we must keep them informed. A referred patient is not a "dump." Most referring physicians are conscientious practitioners who recognize a problem beyond their abilities and appropriately send their patients to us. Even if the patient would not have been admitted from our own clinics, as the tertiary care center for eastern Kansas, it is our responsibility to thank our referring physicians for sending us their patients and to inform them that it is our pleasure to take care of their patients. The same attitude applies to patients admitted from the ED and from clinic.

Whereas most external referrals for admission go through the Transfer Center, internal admissions both from urgent care and specialty clinics go through the 917-3333 pager. There is an additional protocol for our specialists for planned admissions. This protocol includes sending an email to the attending, nurse manager and senior residents with all the pertinent information about the patient. However, there are times when a specialty patient will just “show up.” In these cases, contact the appropriate attending.

At the time of any admission, the admitting team will obtain from the patient the primary care physician’s name and phone number. It is appropriate for the senior resident to contact the PCP regarding the admission. **Internal referring physicians and PCPs may be contacted by email but outside physicians should be called.** This is to let the patient's doctor know that his or her patient has arrived and to clarify any questions or priorities that may have arisen after your workup. It is also wise to contact the doctor periodically during the prolonged admission to keep him/her updated. A referring doctor should also be made aware of any significant changes in their patient’s clinical status. There is nothing more embarrassing for a PCP than to be unaware of the death of his or her patient. Residents will also contact the referring physicians at discharge to provide more timely information for follow up. Some attending physicians may wish to make the phone calls to outside PCPs. Who does the contacting is less important than the contact being made. Discuss with your attending who will take responsibility for this task. **Remember, you can never keep the PCP too informed.**

**ADMINISTRATIVE**

**Kansas Licensure/Step 3 Policy**

All residents are required to apply for a temporary license to practice medicine in Kansas prior to beginning practice at the University of Kansas Medical Center. In order to get licensed by July 1st, new residents will be expected to submit all necessary paperwork by the deadlines set by the PMEC. Failure to do so may result in your license not being issued by July 1st. If such a delay is the fault of the resident, the resident may be required to use vacation and sick time for the days not worked between July 1st and the day they become licensed. Residents upon receipt of license have full legal authority to authenticate death certificates. Your license, both temporary and permanent will be kept in your portfolio in the residency office.

Licensure and Step 3: The temporary license is not sufficient licensure to practice outside of KUMC. Residents must have passed USMLE/COMLEX Step 3 in order to obtain a permanent license.

*See Pediatric Policies and Procedures Manual for Step 3 Policy.*
DEA

Your DEA certificate is good for approximately 3 years. You will receive a “fee exempt” DEA that can only be used for writing prescriptions on educational rotations. If you would like an unrestricted use DEA, you are responsible for the fee of ~$550. You are responsible for renewing your certificate before it expires, which can be done with the help of the residency coordinator. Your DEA is tied to your practice location so as you graduate and begin practice or further training elsewhere, you will need to change your address with the DEA.

A copy of your current DEA license must be provided to the PMEC to be kept in your portfolio. If a pharmacy calls to request your DEA number the residency coordinator will page you with the request. The residency office will not give out your DEA number over the phone. The triage nurse in clinic will also have your DEA number and may give that information when needed by a pharmacist. Current Kansas Medicaid policy requires physicians’ DEA number for all prescriptions. More information can be found at the DEA website: http://www.deadiversion.usdoj.gov/index.html

NPI

The National Provider Identification number (NPI) is used by the government to track physicians nationally and by the State of Kansas to track prescription writing. This number will stay with you for your entire medical career. The Program will assist you in obtaining this number at the start of training. Any changes in your status (name, address, practice information, licensure) need to be reported within 30 days of the date of change. These changes may be made at https://nppes.cms.hhs.gov/NPPES.

BLS, NRP, PALS, ATLS

Basic Life Support, Neonatal Resuscitation, and Pediatric Advanced Life Support are required for all pediatric residents and Acute Trauma Life Support is required for senior level pediatric residents. These requirements are met through regularly offered courses given by nursing education at KU as well as through courses in the community. The Program will pay for your initial certification for each of these classes. The Program will also pay for your first recertification course typically taken at the end of your second year if taken through KU or outside only if due to an internal scheduling conflict. If you choose to take these courses outside of KU for other reasons, the Program will reimburse only as much as the KU course would have cost.

Once signed up for a course, you are expected to attend. Cancellations made less than 48 hours in advance are charged to the Program. Residents will be responsible for reimbursing the Program for any classes rescheduled less than the 48 hours required for cancellation with refund. It is the expectation that residents will pass all courses on the first attempt. If a resident is unable to pass the course or course exam requiring a second course or repeat exam be taken, the resident will be responsible for the cost of the repeated course or exam. The repeat course or exam, like late cancellations, is a personal expense. Educational funds may not be used to cover repeat test or class costs. Please prepare adequately for each course!!

Certification lasts for two years so you will need to renew your certifications at some point during residency. Keep your eyes open for announcements about registration for recertification courses. A copy of your current cards must be given to the residency coordinator and kept in your portfolio in the PMEC.
Code Blue Pager/Trauma Pager/Pediatric Emergency Activation Pager

Code Blue Pagers are to be used for emergency pages only. They are NOT to be used for routine pages. Residents must carry their personal pager in addition to the code pager. The Pediatric Code Blue Pagers are custom-tuned to the same frequency. This allows the page operators to activate all pagers simultaneously. This pager will alert residents to pediatric code blues as well as all traumas. Pages on trauma patients who are 21 years of age and older may be disregarded. The Pediatric Resident on Call is expected to attend all Pediatric Traumas, Pediatric Code Blues and Pediatric Emergency Activation pages.

During check out, the pagers should be checked for functionality and transferred to the appropriate residents. Never leave a code pager sitting in a work area or call room. Each code blue pager should be on a member of the team day and night.

Personal Pagers

Upon receipt of your pager, please change the personal message to identify yourself as the owner of the pager. Pagers should be with you and on at all times. There are situations when you will need to be reached despite being out of the hospital be it your day off or post call. Although this does not happen often, it may happen especially when you are on an inpatient rotation. When you are not available (vacation, out of town rotation) the message on the pager should be changed to indicate that you are out of town until a given date and instructions provided for calling the PMEC for questions. When you are unavailable for shorter periods of time, change the message on your pager to indicate that you temporarily cannot answer pages but that you will be checking your voice mail. **It is never appropriate to just turn your pager off!**

Text paging is preferable to voice or numeric paging as it gives the receiver more information about the need to respond and the sender. For example, you will receive text page reminders about conferences. Nurses will usually text page about a patient and will ask for call back. Instructions on pager functions are included in Appendix G.

*Expectations for Pager Availability:* Residents are expected to be on-site or be available by pager during office hours every weekday. If not on campus and paged to return to work, residents are expected to be able to return to campus promptly. Residents are also expected to be available in an emergency on weekends as well. Therefore, any day that a resident intends to be unavailable by pager should be requested as a no call request or other leave such as vacation or CME to the Pediatric Chief. If you are paged because it is believed you could be available and you are not available, that may be counted as a vacation day.

*Forgotten Pager:* If you get to work and realize that you have forgotten your pager, it is crucial that you notify the PMEC including the Residency Coordinator and the Pediatric Chief as well as the attending for that day. You will need to provide an alternate way for the program to reach you (cell phone) should that be needed.

*Lost or damaged pagers:* If you lose or damage your pager, it is your responsibility to replace it at cost $50.00. Educational funds may not be used to cover the cost of lost or damaged pagers. If your pager stops working due to normal wear and tear, a replacement pager may be provided. If you experience problems with your pager, take it to the Pager Warehouse located in the basement of the hospital (B314) to have it checked. If you have questions regarding operation of the pagers, detailed instruction booklets are available at the Pager Warehouse and on line at [www.kumc.edu/information-resources/pagers.html](http://www.kumc.edu/information-resources/pagers.html).
Resident Communication-Email and Mailboxes

In addition to being available by pager, unless on vacation, **residents are expected to check their email messages at least daily.** This includes time when on outside rotations as other facilities will typically have computer access. Most residents also have email access available on their smart phones. On an international rotation, computer and phone access to email may not be available and arrangements for communication with the Program should be made prior to prior to departure. Email is the primary means of communication not only from the Program (Program Director, Residency Coordinator and Pediatric Chief) but it is also the primary mode of communication from the department (Chair and other faculty members), School of Medicine and Hospital.

**Failure to read and respond to emails in a timely fashion is unprofessional behavior and may result in disciplinary action.**

Although secure, the email system at KU is monitored regularly by the IT department. Your KU email account should be used for work or educational business. If you are using your work email for an excessive amount of personal business, you should set up an additional personal email account. Email communication within the medical center and hospital are protected by firewalls, however communication outside of the campus is not protected. If you choose to communicate with patients by email, be sure to use the” [secure]” heading in your subject heading line. This will encrypt any message you send out and protect your patient’s information. Also, it is important to discuss with patients what is appropriate to communicate by email (diet and behavior questions) and what is not (sick questions.)

Residents also have assigned a mailbox located on the 2nd floor in Miller. Items such as correspondence and journals will be placed in the resident mailboxes. Residents are expected to check their mailboxes on a regular basis. If cannot reasonably return to check your mailbox regularly, arrange for a colleague to check your box for patient care items that need attention. Your mailbox is not a storage unit. If you want to keep something long term, please keep it in your locker, not in your mailbox.

**Pediatric Medical Education Centers- 4th Floor Miller and Ground Floor Miller**

Both PMECs provide space for residents to gather and to study.

**PMEC:** The 4th floor PMEC includes the offices of the Residency Coordinator, the Program Directors and the Pediatric Chief. Also includes the offices of the Student Clerkship Coordinator and Clerkship Director. There is space for gathering, working and several computers however this is an office area so please respect others as they work. This is a shared space for both residents and medical students.

There is a refrigerator, coffee machine, water machine and a microwave. A variety of snack foods are available for residents only. The PMEC is open during work hours. For safety reasons, the PMEC is locked during night and weekend hours. A lock box key is available for access in the evenings during the week and on weekends. Please make sure the PMEC is locked if you use it during these non-business hours. Although medical students on the Pediatric Clerkship may use the PMEC during the day, access after-hours is for residents only. If the privilege of using the PMEC is abused (left messy, books go missing, computers are not treated well) then the PMEC will only be open during work hours.

**Resident Lockers:** Each resident will be assigned a locker in the PMEC. You are responsible for the locker key. If your key is lost, you will be responsible for a $25.00 replacement fee. Educational funds may not be used for this expense.
Check-Out Materials: There are many resources available for residents to check out in the PMEC including pediatric board review materials as well as rotational required materials such as textbooks. Some materials are checked out for a few days and others may be checked out for an entire rotation. Residents are expected to return all checked out materials to the PMEC by the check in date. Items checked out for a rotation will be due on the last Friday of the rotation for seniors and on the last Tuesday of the rotation for juniors. DO NOT handoff materials directly to the next resident; please check all materials back into the PMEC.

Residents will be financially responsible for all materials checked out from the PMEC. Any materials lost or damaged to the point where they are not usable by other residents while checked out will need to be replaced at the resident’s expense. Educational funds cannot be used to replace lost or damaged checked out materials.

PMEC Annex: The ground floor PMEC provides a space for residents to meet, work and use the computers. There are three desktop computers, boosted WiFi access and a printer in this space. There is a conference table and room for small meetings in this space as well as a large screen on which to project. During business hours, this space is to be used for work and study. After hours, residents will be able to use this space for relaxation. This space does not include a refrigerator, microwave or food. Residents are invited to bring food and beverage into the PMEC annex but are expected to clean up after themselves. This space is primarily for resident use but may be used by PMEC staff for meetings. The space is accessible via a lock box key at all times. Please make sure the PMEC is locked if you are the last to leave.

Resident Duty Hours

Duty hours include all clinical and academic activities related to the residency program (patient care, administrative duties related to patient care, provision of transfer of care, in-house on call, and scheduled academic activities. Duty hours do not include reading and preparation time spent away from the duty site. Prior to leaving for vacation or other personal time, residents are expected to record their duty hours for the time they will be gone.

Hours per week and Shift Length
• Residents must not be scheduled for more than 80 hours per week, averaged over four weeks
• When residents take call from home and are called into the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit
• Any task related to performance of duty, even if performed at home, count toward the weekly duty hour limit
• Locum tenens time must be counted toward the weekly duty hour limit
• Required research time must be counted toward the weekly duty hour limit however optional research time does not need to be counted
• PGY 1 Residents: maximum shift length is 16 hours (no exceptions)
• PGY 2 and PGY 3 Residents: following a 24 hour call, 4 additional hours for patient handoff and education are permitted for a maximum shift length of 28 hours

Days/time off
• Residents must have at least one full (24 hour) day out of seven free of patient care duties, averaged over four weeks
• Residents should have a minimum rest period of 10 hours between duty periods, and must have a minimum rest period of 8 hours and must have 14 hours off following a 24 hour call
  o Should is so important that an appropriate educational justification must be offered for its absence.
On-Call responsibilities

- Residents must not be assigned in-house call more often than every 3rd night, averaged over 4 wks
- Senior Level Residents Only: Continuous time on duty (call) is limited to 24 hours
- Residents may not assume responsibility for any new patients after 24 hours
- At home call is not subject to the every third night limitation, however, at home call must not be so frequent as to preclude rest and reasonable personal time for each resident
- Backup support systems must be provided when patient care responsibilities are unusually difficult or prolonged or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care

Post-Call responsibilities

- Additional duty time of up to four hours is permitted for continuity of care (rounds, handoffs) and educational activities (lectures and conferences)
- Total duty time allowed for performance of residency duties in the hospital or clinics is limited to 28 hours; after that time, the resident is required to leave the hospital/clinic

Pediatric duty our polices are available in the Pediatric Policies and Procedures Manual

EPIC, O2 and Other Secure Databases

Residents will receive training on the computer system through the hospital. In order to access the system, the resident will need to have a log in and password. In order to prevent a breach in security, a password is not to be shared or used by another staff member to access the computer system. Penalties for such breaches in the HIPAA security policy may result in a formal reprimand and possibly termination. The O2 system can be accessed from home at http://access.kumed.com/Citrix/Access/auth/login.aspx.

Any personal computer or handheld device that will be used to access Protected Health Information (PHI) needs to follow KU Mobile Device Security Policies (see http://www2.kumc.edu/security/MobileSecurity/index.html for more detail.)

O2 In Basket: Management of the O2 in basket is a key component of communication via the EMR. Residents are expected to check their in basket daily and to respond to lab or other alerts within 48 hours copying those results the appropriate attending and nurse. Your O2 In Basket should be covered by a colleague during planned vacations.

Procedure Logs

Residents will log procedures in one of several possible electronic databases including the MedHub system or in an electronic database of their own design. The latter must be organized by procedure and able to be printed out when needed by the Program. It is the resident’s responsibility to track their procedures and to develop a method for entering them (i.e. - keep them in a small notebook and enter monthly.)
The Resident Agreement

The resident will enter into an agreement with the University of Kansas Medical Center to participate in a graduate medical education program yearly.

Additional information on The Resident Agreement and Severance of the Resident Agreement can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://gme.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Leave

The following descriptions of leave are not intended to be all inclusive. If a resident has extenuating circumstances and requests an exception to any of these policies, they must meet with the Program Director to discuss the request. Exceptions to the leave policies may be granted at the discretion of the Program Director based on the circumstances presented within the limitations of the institution and the American Board of Pediatrics.

Call activities missed due to any type of leave will be made up and paid back whenever possible so that the distribution of call responsibilities is as equitable as possible.

Additional information on Leaves (bereavement, military, etc…) can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Request for Leave Form and Deadlines for Leave Requests are available in the Pediatric Forms on Blackboard.

Leave and Impact of Length of Residency

The American Board of Pediatrics requires that each resident satisfactorily complete 33 months of 36 months of residency training in order to sit for the Pediatric board exams. Residents have three weeks of vacation per year for a total of nine weeks for the duration of training. Residents also have up to 10 days of sick leave per year for a total of 30 days or four weeks for the duration of training. If a pediatric resident took the maximum time off for both vacation and sick days, it would equal 13 weeks or three months and one week. Any additional time away from training requires that the resident make up training time at the end of their three years in order to complete residency and to sit for boards.

It is possible for a resident to take time off for a variety of leaves including maternity leave without having to extend residency training. However to do so, you must satisfactorily complete 33 months of training. However, it may not be in the best interest of the resident parent, baby or program to do so. Please see details under Parental Leave.
Sick Leave

Residents receive a total of ten working days per year of sick leave. These days will not carry over into the next year and do not accumulate. If a resident misses three consecutive days of a clinical assignment, a doctor’s excuse will be required. At the discretion of the Program Director or Pediatric Chief, a doctor's excuse may be required for other absences.

The procedure for reporting a sick day is:
1. Notify the Pediatric Chief: The Chief must know about the sick day as soon as possible in order to handle any coverage issues.
2. Page Attending.
3. E-mail the following people: Program Coordinator (for written documentation and duty hour reporting reconciliation), Attending (for coverage and possible make up of clinical or educational activities) and Pediatric Resident (for written documentation of the sick day)
4. Failure to follow the absence notification protocol will result in a Professionalism Call. Repeated violations of the notification protocol or failure to notify the program of a sick day at all may result in referral to the Academic and Professionalism Committee.

It is the policy the GME office to allow sick time to be used for self, spouse or children. The Program allows sick time to also be used in the care of sick parents and other extended family if discussed and approved by the Program Director.

Educational Days

PGY 1 Residents will be permitted up to 3 educational days for their Step 3 exam including a rest/travel day before the day of the test and the days of the test. PGY 2 and PGY 3 Residents will be permitted up to 5 educational days for attending activities such as professional meetings (presentation or attendance), pediatric board exam preparation, and fellowship interviews.

These activities should be done during outpatient months whenever possible. Educational days taken during inpatient rotations may need to be scheduled days off from the rotation instead of Educational Days. For most rotations, no more than a week of time can be missed and still have enough clinical time thus educational days and vacation may not be possible in the same month. Educational days off must be approved by the Chief.

Professional Leave

Residents will be provided with paid professional leave at the discretion of the Program Director in situations where the resident is in the due process phase of a fair hearing or if relieved of clinical or patient care duties for reasons of suspension or probation.

Vacation

Each resident will be granted a total of three weeks (15 working days) vacation per academic year (July 1st - June 30th). Any vacation day not taken during this period will be lost as vacation days cannot be accumulated from year to year. Vacations must be requested through the Physician Scheduler system. The Pediatric Chief will approve or disapprove all vacation requests in the manner prescribed by the Program. In cases where there are questions, the Program Director’s decision on whether to grant the vacation request or not will be final.
Vacations are typically scheduled for a 5-day period of a Monday – Friday. Residents will have one end weekend off and all attempts at giving the resident both weekends off will be made by the Pediatric Chief but cannot be guaranteed. Additional vacation days are not given if a holiday falls within your week of vacation. Special circumstances for taking vacation longer than 5 consecutive days (i.e., the last week of one month and the first week of the following month) or shorter vacations than 5 days must be discussed with and approved in advance by the Pediatric Chief and Program Director.

It is advisable not to take time off during required rotations or during rotations done only once during residency. Rotations affected by this are adolescent, behavioral-developmental pediatrics and the 4 required subspecialty rotations. One alternative is to repeat part of that rotation during another month so as to receive the full educational value and credit for that rotation. Additionally, residents are expected to complete at least 15 days of rotational assignments to receive credit for that rotation. Any other days away in a month with scheduled vacation such as holidays, CME, sick, etc… will require additional time on that rotation for it to count. On rotations such as these, shorter vacations will be considered so as to not have time to make up.

Vacations are typically not allowed in December because of the special holiday schedule unless prior approval is received from the Program Director. Also, vacation will not be granted without advanced approval by the Program Director for the first two weeks of July, the last two weeks of June (except for graduating residents), and while on the Inpatient Services (PICU, NICU, Floor) or during Emergency Medicine rotations. Vacation for senior residents while in the Full Term Nursery may be allowed pending coverage by other residents or nurse practitioner. Junior residents may take vacation while in the nursery. Unless there are special circumstances, only one resident on a service may be on vacation at a time and the total number of residents on vacation at the same time is also limited and at the discretion of the Pediatric Chief.

It is common practice to not schedule a resident for night call the weekend before and after their vacation, if possible. However, having both weekends of a vacation off is NOT guaranteed! If the resident is on a service where they have weekend obligations (such as the inpatient services), it is the responsibility of the senior resident on the service to arrange weekend coverage, which may include the resident. Additionally, because of weekend coverage in the nursery, vacations while in the nursery will have only one weekend off.

Residents are expected to be on-site or be available by pager during office hours every weekday. If not on campus and paged to return to work, residents are expected to be able to return to campus promptly. Residents are also expected to be available in an emergency on weekends as well. Therefore, any day that a resident intends to be gone from the hospital and unavailable by pager should be requested as a vacation day unless he/she is attending an educational or teaching activity outside the region. Prior to leaving for vacation or other personal time, residents are expected to record their duty hours for the time they will be gone and change the message on their pager to reflect their unavailability.

All vacation requests are made through the on-line Physicians Scheduler system and must be made by the deadlines set by the Pediatric Chief. It will be the responsibility of the Chief to assure that there is adequate coverage of all services during requested vacations. Should more residents request a given week of vacation than can be gone; the Chief will work with all parties to try to solve the problem. If a dispute remains, the Program Director is ultimately responsible for granting vacation days.

There are a number of programs that assign all vacation days to residents so that ability to request vacation days is a privilege for our residents. Ongoing problems with vacation disputes may result vacations being assigned.
**Personal Leave (Leave Without Pay)**

A resident may request up to three months (12 weeks) per year of leave without pay for illness, serious health condition, disability of the resident or the resident’s immediate family, or the birth or adoption of a child. The decision to grant such leave is at the discretion of the Program Director but denial of a request for leave is a grievable matter. Residents are expected to spin down any unused paid time off such as vacation or sick time prior to starting other FMLA time.

“Immediate family” is defined as child, parent or spouse of the resident related by blood, marriage or adoption.

“Serious health condition” is defined as an illness, injury, impairment or any physical or mental condition that requires inpatient medical care or continuing treatment by a health care provider.

Personal leave taken for reasons of illness or serious health condition may be taken intermittently (except in the case of Parental Leave detailed below) so long as aggregate personal leave does not exceed three months per year. Stipend payments to the resident will be suspended during periods of personal leave. Residents will continue to receive other benefits during personal leave. However, there is a cost to continue health insurance during personal leave.

All residents should inform the Program Director in writing of their leave plans as soon as they know they will need to take time off. Training time missed for personal leave may need to be made up at the end of the thirty-six months of residency training. The resident will receive full salary and benefits during the extended training period. **For any FMLA qualifying absence including parental leave even if only sick and vacation time is being used, the resident will be expected to complete the FMLA checklist.**

When possible, the resident must give the Program 30 days-notice of the intent to take leave for foreseeable events. For other events, the resident must provide notice as soon as reasonably possible.

**Parental Leave (Maternity and Paternity)**

After vacation, Parental Leave is the most common form of leave requested by Pediatric Residents and as such deserves special attention.

The American Academy of Pediatrics recommends that “regardless of gender, residents who become parents should be guaranteed 6-8 weeks, at a minimum, of parental leave with pay after the infant’s birth. In addition, in conformance with federal law, the resident should be allowed to extend the leave time when necessary by using paid vacation time or leave without pay.”

This recommendation must be taken in light of the duration of training board eligibility/certification requirements and the leave policies of the institution. Leave for birth or adoption cannot be taken intermittently; if both spouses are members of the resident staff, their combined total leave for birth or adoption is limited to three months/12 weeks per year.

Residents becoming pregnant, adopting a baby or whose significant other is pregnant, should inform the Program Director in writing of their leave plans as soon as possible. The resident must give 30 days-notice of the intent to take leave for foreseeable events such as childbirth, adoption, or necessary medical procedures. However, if the birth, adoption, or medical treatment requires leave to begin in less than 30 days, the resident must provide notice as soon as reasonably possible. The resident may also be required to periodically provide a status report and statement of intent to return from leave specifying the anticipated date of return.

Residents must draw down all **PAID** leave while on FMLA. If the maximum number of vacation and sick leave days for the year has been used, the resident’s FMLA leave will be unpaid.
The challenge of using all five weeks of vacation/sick leave all once leaves no other time off during the academic year including time needed during pregnancy for time off for appointments or possible pregnancy complications or after delivery for well-baby checkups or baby illnesses.

The typical schedule for residents following the birth or adoption of a child is the following:

- Residents use 5 weeks of vacation/sick time for parental leave (this is PAID FMLA time)
- Residents then complete 5 days of CME time (providing they have not yet used it during the year), typically board review or 1 week of individualized curriculum with educational or research activities
- After 6 weeks, residents will resume all clinical activities including call and clinic
- Any sick time used during pregnancy will be subtracted from the five weeks above starting with sick time and will reduce the amount of time that can be taken as PAID FMLA after delivery.

Residents may choose to add on additional UNPAID FMLA time up to a total of 12 weeks (paid plus unpaid time=12 weeks) following the above schedule to extend their parental leave. Any time off beyond the above schedule will need to be made up at the end of residency.

Additional information on FMLA Leave can be found in the University of Kansas Human Resources website. [http://www.kumc.edu/human-resources/benefitsrewards/family-and-medical-leave-act.html](http://www.kumc.edu/human-resources/benefitsrewards/family-and-medical-leave-act.html)

**No Call Requests**

The program allows residents to submit no call requests for each monthly schedule. These requests are honored by the Pediatric Chief as much as possible but excessive numbers of requests or extremely call limiting requests that result in the schedule being difficult to create may mean the elimination of no call requests for all residents. All no call requests should include a reason for the request. Requests may be granted based on a priority basis if many are made for the same time period. For example, a request for no call because of role in a wedding will likely be given priority over a request for no Friday calls without a reason. Appropriate no call requests are at the discretion of the Pediatric Chief.

**Other Unofficial Time Out of the Office**

Residents are expected to be available by pager during office hours Monday through Friday unless on officially scheduled time off such as vacation, CME or other approved leave.

There are circumstances where you might be able to be out of town and not be on official time off. For example, during an ED rotation you might have two or more days in a row without a scheduled shift. You would be able to be out of town during that time but however the requirement is that residents be available by pager Monday through Friday unless on an approved leave. Respectful of your time off, the program will allow such unofficial time off however the Pediatric Chief must be made aware that you are unavailable.

Failure to notify the program that you are unavailable by pager during unofficial time off will result in a Clinical Professionalism Call and possible referral to the Academic and Professionalism Committee.
Benefits

Additional information on Benefits under Resident Agreement can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. [http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html](http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html)

Pay Periods and Paydays

Pay periods are biweekly. Your first payday will be on July 15, 2016 for the pay period 6/19/2016-7/2/2016 and on Friday of each succeeding 2-week period for salary earned during the preceding pay period.

**2016-2017** Stipends are as follows:

- PGY1 - $51,993
- PGY2 - $53,783
- PGY3 - $55,524

Medical Insurance

Health insurance coverage for the resident begins the first day of the calendar month following the first 30 days of employment as required by the State of Kansas. Residents may add spouse and dependents to their health insurance however the institution does not cover the premiums for spouses and dependents. Medical insurance start date is **August 1, 2016**. Residents are strongly encouraged to investigate COBRA coverage or other private, short term health insurance during this mandated waiting period.

Link to health insurance information: [http://www.kdheks.gov/hcf/seph/Active-2016-Book.htm](http://www.kdheks.gov/hcf/seph/Active-2016-Book.htm)

Disability

The University of Kansas will provide all residents with long-term disability insurance coverage. The disability insurance premium will be paid by the University of Kansas Medical Center. Each resident at orientation will be provided with a copy of the disability insurance pamphlet. The University of Kansas will offer a short-term disability insurance plan, at cost for all residents. Short-term disability covers temporary loss of income due to a disability. Each resident at orientation will be provided with a copy of the disability insurance pamphlet.

Professional Liability

The State of Kansas provides professional liability coverage and tail coverage for residents for acts committed while caring out their program responsibilities.

Kirmeyer Fitness Center

The Department of Pediatrics will reimburse you half of the annual membership fee at the fitness center if enrolled before October 1st.

Parking

The Department provides pediatric residents Bluff Garage parking. Additional information on parking is available through parking services at 8-5175 or the web at [http://www.kumc.edu/parking/](http://www.kumc.edu/parking/).
White Coats/Scrubs/ID Badges/Dress Code

The hospital provides a limited number of white coats and scrubs for your use. Scrubs are to be laundered by the hospital using a card-based checkout process. If you choose to purchase a nicer white coat, you may use your education fund to cover that cost. Additionally, the program will cover the cost of embroidering your name and KU Pediatrics on one coat.

You should be aware that it is official hospital policy that ID be worn above the waist at all times. If you attempt to access a hospital unit without your ID badge, you will not be allowed. The full hospital dress code follows as an appendix. On the whole, dress for the Department is slightly more casual than other departments such as Internal Medicine. Please note that when causal days such as Jeans Days are being held in the clinic, this attire is still not permissible for those working in the hospital. When in doubt, follow the lead of senior residents or faculty members.


Access to Meals

Meal cards are provided to residents who are on overnight call. The daily allowance is $16.00. Meal allowances do not carry over from month to month. Meal cards are distributed on July 1st and residents will retain the card until graduation. Meal cards may be used at the Hospital Cafeteria, Java City in the MOB, the Cambridge Cafe or Elements for Life.

The Hospital Cafeteria is located on the ground floor of the hospital near the main entrance and serves hot meals, sandwiches, salads, snacks and drinks. Hours are from 6:30am-8:00pm Monday-Friday and 7:00am-6:30pm weekends and holidays. Vending machines are available 24 hours a day just outside the cafeteria.

Elements for Life is located at the entrance of the hospital cafeteria and offers snacks, drinks and convenience foods 7:00am-1:00am Monday-Friday and 6:00pm-1:00am on weekends.

Library

The Dykes Library for the Health Sciences is located across 39th Street north of the hospital. The Department pays the library fee for all residents. Any library fines, however, are the responsibility of the resident and it is possible for your graduating diploma to be withheld until library fines are paid in full. Educational funds may not be used to pay for library fines. Comprehensive information about the library is available on Pulse http://www.2.kumc.edu/ir/dvkes/about.htm.

American Academy of Pediatrics Membership

The Kansas Chapter of the AAP pays for half of the membership to the AAP for all residents and the Department pays for the other half of your membership. AAP membership includes a subscription to PREP study material, Pediatrics in Review and Pediatrics. These publications will start arriving in January of your first year. Other free educational offerings are available throughout the year so watch out for emails from the Academy.
Educational and Board Exam Reimbursement Funds

- PGY 1 Residents: $750.00
- PGY 2 Residents: $1,000.00
- PGY 3 Residents: $1,500 educational fund and $500 board reimbursement fund*

*$500 for successful completion of boards if taken the year of graduation

The educational funds are not accumulated and must be used for approved educational purposes. Allowable expenses may include Pediatric Certification exam, text books, subscriptions and journals, computer programs, electronic resources such as CDs and DVDs, permanent DEA, medical equipment, computers and software, smartphone (initial purchase cost only and only one device will be reimbursed over three years) and research expenses. Educational funds may also be used to cover expenses travel and board for meetings and fellowship interviews.

_A special note about computing devices:_ The program will reimburse the purchase cost a basic computing device such as an iPad, a tablet PC, a laptop or other computer **ONCE** during residency. Accessories, replacement or updated devices will not be reimbursed in subsequent years.

_Exclusions:_ Educational funds may not be used for expenses already paid for once by the department such as repeat certification courses if the resident fails the course, repeat Step 3 exams if initially failed or for fines such as parking tickets or library fines.

All items submitted for reimbursement are subject to approval by the Program Director. If you have any questions if something will be reimbursed or not, please inquire before making the purchase. Reimbursements forms may be obtained in the PMEC in the box of forms outside of the coordinator’s office. Each request MUST be accompanied by an original receipt (copies of receipts will not be accepted).

Receipts for purchases must be submitted no more than 60 days after the purchase in order to be reimbursed. Reimbursement for Step 3 exam taken after Match Day will not be subject to the 60 day rule. Only Step 3’s taken after Match Day will be reimbursed. All receipts must be submitted to the Residency Coordinator by May 1st.

See _Educational Fund Reimbursement Form in Pediatric Forms_ on Blackboard.

Moonlighting and Locum Tenens Policy

_Moonlighting:_ The Pediatrics Residency Program does not permit moonlighting activities. Unapproved employment outside of the University of Kansas Medical Center may result in suspension from the training Program. Senior resident participation in Locum Tenens is at the discretion of the Program Director.

_Locum Tenens:_ As of 7/1/12, the Kansas Locum Tenens program requires all residents and fellows to purchase their malpractice insurance for temporary coverage and provide a notice of basic coverage form. Rural Health will provide assistance with the process as needed. Residents and fellows will be given an additional $200 for each coverage for the purpose of reimbursement for insurance.

See _Moonlighting and Locum Tenens Policy_ in the **Pediatric Policies and Procedures Manual**

Additional information on _Moonlighting and Locum Tenens_ can be found in the **University of Kansas Graduate Medical Education Policy and Procedure Manual**.

http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Resident Impairment, Fatigue and Stress

Satisfactory performance includes the absence of significant impairment (impaired function of a resident to a degree that it is causing less than satisfactory performance, and/or the impaired function, if not corrected or is uncorrectable and is likely to lead to future unsatisfactory performance) due to physical, mental, or emotional illness, personality disorder, fatigue, stress or substance abuse. Every effort will be made to reasonably accommodate those individuals with conditions or impairments that qualify as a disability under applicable law, provided that accommodation does not present an undue hardship for the Department, the Medical School, or venues of training. Residents will nevertheless be required to satisfactorily meet the Department's forgoing performance criteria, requirements, and expectations of the Pediatric Residency Program. The Kansas Impaired Physician Program is available for anonymous reporting at http://www.ksbha.org/contacts/impairedprovider.shtml.

Additional information on the Resident Impaired Physician and Substance Abuse Policy, Alcohol/Drugs/and Tobacco, Prevention of Illegal Drug and Alcohol Use and Resident Fatigue and Stress can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Legal-Malpractice

Malpractice is an unfortunate fact of life. While honest mistakes and even poor outcomes will happen, it is the hope and goal of the Department and the Program that through effective instruction, close supervision and compulsive personal habits actual malpractice will be rare to nonexistent. No discussion of malpractice begins without the admonition to foster good communication with your patients. A large percentage of lawsuits results from simple failure to keep a patient or family informed about diagnosis, prognosis, plans and realities. A relationship built on consideration and respect avoids many problems and even allows for forgiveness of mistakes and adverse outcomes. Such a relationship does require time - but this is time well spent. The hospital has patient advocates who are often approached by the patient or family with complaints or concerns. These individuals are usually able to identify problems in communication that can be expeditiously managed.

There is a Risk Management Coordinator operating out of the Office of Legal Counsel for the hospital and another for the School of Medicine. These people can advise you before a problem becomes serious enough to consider malpractice. Most suggestions are common sense but worthy of implementation. If you find yourself, a colleague, an attending or other professional person engaging in activities that may eventually be considered malpractice, it is your moral and legal responsibility to report this activity. You can approach another attending, the Chairman or Vice-Chairman of the Department, the risk management coordinator or the hospital lawyers. However, for your own protection (as well as the involved individuals and the hospital) tell someone.

When an Attorney calls for Faculty or Resident (usually MD or DO or PhD) notify Amy Sokol, University Risk Manager, Legal Counsel at 8-7283 or email asokol@ku.edu. Ms. Sokol will get in touch with KU Hospital risk management as needed including Deb Jackson, Senior Director of Risk Management, KUH and/or Dan Peters, KUH General Counsel

Should a lawyer or paralegal contact you for comments regarding a patient’s care, do not respond. Report the incident immediately to the PMEC who will direct you to the appropriate office. The Department has legal counsel on retainer available on short notice if necessary for appropriate advice on how to handle such requests.

On occasion, you may be contacted by the news media regarding the status of a patient admitted to the hospital. Usually, they respect the patient's privacy by not badgering hospital employees who may know the health status. In any case, do not feel any obligation to answer the reporter's questions. Please refer these questions to your attending or to the Office of University Relations.
Types of Risk Management Reviews

There are three types of reviews that are conducted by the University and KU Hospital that residents may be asked to participate in.

1) Risk Management Review
   - Investigate and document circumstances
   - Work with facility attorneys and/or liability carrier to establish probable cause, scope of liability, and potential financial losses- where possible, mitigate liability risk
   - Identify risks that could lead to future liabilities of this type and implement corrective actions
   - Residents would be accompanied by University Legal Counsel

2) Peer Review/Performance Management
   - Fulfill the legal obligation of the organized medical staff and the facility to ensure that physicians and professional staff are adequately trained and are competent to perform their duties
   - Determine if a standard of care has been violated
   - Determine if additional action is warranted
   - Residents may be accompanied by University Legal Counsel

3) Root Cause Analysis (RCA) also known as Deep Dives
   - Obtain information about how the system lost control so that preventive actions can be taken to improve the future safety and reliability of the system
   - These are peer-reviewed and nondiscoverable and as such although Legal Counsel might be present, they are not there to officially represent the resident
   - Resident may be accompanied by the Program Director or other member of the residency leadership team however that person is only there to observe and support the resident
   - When these occur, Hospital risk management notified Amy Sokol who will contact the Program Director so that they can notify the resident and assist with schedules changes to accommodate the RCA.

Additional information for the Risk Management and Disaster Policy can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Other Helpful Websites

Additional information may be found in the following resources:

KU Graduate Medical Education Website
http://gme.kumc.edu/

Accreditation Council on Graduate Medical Education Website
http://www.acgme.org/acgmeweb/

KU Graduate Medical Education Residents Policy and Procedural Manual
http://www.kume.edu/school-of-medicine/gme/policies-and-procedures.html

Department of Pediatrics website
http://www2.kumc.edu/kids/

American Academy of Pediatrics website
www.aap.org

The Kansas Chapter of the AAP website
http://www.kansasaap.org/wordpress/

American Board of Pediatrics website
https://www.abp.org/

National Resident Matching Program (for fellowships)
http://www.nrmp.org/
Appendix A: Advisors

Dr. Osama Almadhoun
  Wail Tfankji, PGY 3

Dr. Grace Brouillette
  Sarah Orr, PGY 1
  Amanda Osterloeh, PGY 2
  Julianne Schwerdtfager, PGY 3

Dr. Jennifer Dioszeghy
  Morgan Eidson, PGY 1
  Mary Nguyen, PGY 1

Dr. Kathy Ellerbeck
  Kelstan Ellis, PGY 3

Dr. Steve Lauer
  Anton Luckoff, PGY 1

Dr. Mike Lewis
  Katie Rha, PGY 1
  Neha Puar, PGY 2

Dr. Lore Nelson
  Jacob Hessman, PGY 1
  Dani Bar-Zion, PGY 2

Dr. Katie Petelin
  Abu-Nasser, PGY 1
  Mandi Menard, PGY 3

Dr. Beth Pitts
  Sarah Kirkpatrick, PGY 2
  Melanie Leveille, PGY 2
  Stephanie Srur, PGY 3
  Rebecca Tusken, PGY 3

Dr. Ryan Smith
  Melike Bozkanat, PGY 2
  Brittany Slagle, PGY 3

Dr. Carissa Stanton
  Leslie De La Fuente-Carrasquillo,
  PGY 1
  Amanda Prosser, PGY 2

Dr. Heather Von Bevern
  Allek Kelm, PGY 2
  Moshe Prero, PGY 3

Dr. Joy Weydert
  Obehioye Okojie, PGY 2
  Meenal Gupta, PGY 3
Appendix B: Pediatric Rotations and Educational Liaisons

Adolescent Pediatrics  Dr. Lore Nelson
Allergy/Immunology  Dr. Selina Gierer
Behavioral/Developmental Pediatrics  Drs. Kathy Ellerbeck and Maura Wendland
Cardiology  Dr. Kenn Goertz
Child Psychiatry  Dr. Sharon Cain
Community Pediatrics  Drs. Katie Petelin and Kourtney Bettinger
Continuity Clinic  Drs. Katie Petelin and Whitney Pressler
Critical Care  Dr. Apurva Panchal
Dermatology (CMH)  Dr. Amy Nopper
Emergency Medicine  Dr. David Lisbon
Endocrinology  Dr. Angela Santiago
ENT  Dr. Daniel Bruegger
Gastroenterology  Dr. Osama Almadhoun
Genetics  Dr. Jyoti Panicker
Hematology/Oncology  Program Directors, Pediatric Chief
Individualized Curriculum  Dr. Mary Ann Jackson
Infectious Diseases (CMH)  Dr. Mike Lewis
Inpatient Pediatrics  Dr. Joy Weydert
Integrated Medicine  Dr. Heather Von Bevern
Junior Ambulatory  Dr. Chaitali Mahajan
Neonatology  Dr. Sandeep Riar
Nephrology  Dr. Kathy Davis
Palliative Care  Dr. Kurt Schropp
Pediatric Surgery  Dr. Lisa Gilmer
Neurology  Dr. Ann Davis, Dr. Apurva Panchal
Pulmonology  Dr. Carol Lindsley
Radiology  Dr. Grace Brouillette
Research
Rheumatology
Same Day Sick
Sports Medicine
Appendix C: Morning Teaching Conference Format

Who: Residents and medical students on the floor, PICU and FTN along with their attending faculty members as well as any resident on a KU based outpatient rotation are expected to attend. Residents on both inpatient and outpatient rotations will be assigned MTC dates. The Pediatric Chief will prepare the calendar for MTC.

When: 7:30am-8:00am on Mondays, Tuesdays, Wednesdays and Fridays

Where: 1001 or 3001 Miller

Why:
1) RRC requirement for at least 3 teaching rounds per week for inpatient service (IPC and P)
2) Patient based presentations (PK)
3) Targeting knowledge and skills required of a general pediatrician including an emphasis on the appropriate use of subspecialists (MK and SBP)
4) Correlation of pathophysiology of disease will be stressed
5) Other areas to be addressed include: interpretation of clinical data, cost-effective medicine and appropriate use of technology (PBLI), and disease prevention

What: Attendance will be taken and peer evaluations of presentations will be done to document content and to provide feedback to presenters

Format
MTC is an exercise focused on a variety of skills such as history taking, differential diagnosis development, diagnostic work up and therapeutic management. Each case is unique in which of these areas is the focus but most MTC will focus on the work up and management as that is the area where discussion between residents and faculty yield good learning. Residents are expected to submit their MTC case to the MTC Advisors at least 24 hours prior to the presentation.

The presenting resident should make the focus of the MTC (history, workup, management) known to the audience at the start of the conference and an appropriate amount of time devoted to each section based on the focus for the given topic. Residents are encouraged to use the white board and to make the presentation active.

First 5-10 minutes (Assigned Resident)
On Mondays, interesting cases admitted over the weekend will be presented. On Tuesdays and Wednesdays, the case presentation should be of very recent case or a recent case chosen for specific teaching points. The topics and teaching points to be discussed should be discussed with the appropriate attending(s) at least a day before the teaching conference. This should relay only the initial signs, symptoms and findings for the case. If the case focus is on history, then this section may be longer.

Second 10-15 minutes (Resident/Student discussion facilitated by assigned resident)
Interactive segment during which a differential diagnoses list would be generated as well as a list of potential next investigative and therapeutic steps. The residents and students in the audience would be involved in this part of the presentation. If the case focus is on differential and initial work up, this section should be longest.

Third 5-10 minutes (Assigned Resident)
Closure of the case including briefly stating what was found in the patient, what the pertinent test results showed, what diagnosis was reached and how the patient was initially treated. If the case focus is on managements, this section may be longer.

Last 5-10 minutes (Assigned Residents and Faculty)
Learning or take-home points of the presentation reviewed and a board question or two is presented if appropriate.
Appendix D: Transfer Center Protocol

Service or Type of Patient:

Patients less than or equal to 17 years of age requiring transfer for medical/surgical management (except trauma)

1. Upon request for patient transfer to a pediatric service:
   a. Page the PICU attending.
   b. Page the senior admitting resident at 917-3333 and notify them of request for pediatric transfer

2. Arrange conference call with the referring physician, resident and PICU attending to discuss the case and decide if transfer to KU Hospital (KUH) is appropriate.
   a. If the KUH attending physician feels that the patient should be admitted to the PICU, the pediatric critical care attending should be paged and conference into the call. Now follow the Pediatric ICU Protocol.

3. Determine bed availability:
   a. Contact the appropriate charge nurse to determine if a bed is available for the transfer while the physicians remain on the line.
   b. If a bed is available, the referring physician is notified that the patient is accepted for transfer. The physicians can discuss any further care of the patient while still at the referring facility, as well as the mode of transport.
   c. If a bed is not available contact the Nursing Director, Maternal/Child, (M-F) or Nursing Administrative Coordinator (from 1700 to 0700, weekends and holidays) to assist in determining bed availability

4. If a bed is not available at KUH, the transfer center will aid the referring physician in identifying an alternative site for transfer of the patient.

5. At this point, the admitting resident and PICU attending can disconnect from the conference call.
   a. If the patient is going to the inpatient service, the resident on call should notify the inpatient attending or the heme-onc attending of the admission. This can be done at the time the patient transfer is accepted and must be done after the patient arrives and the team has assessed them.

6. The transfer center will notify admitting and will arrange the details of transfer with the referring facility.

7. When the patient is ready to transfer, the referring facility should call the KUH Transfer Center, which will connect them with the charge nurse on Pediatrics/PICU for nursing report.

8. The transfer center will notify the referring facility and the senior pediatric resident (917-3333) upon arrival of the patient at KUH.

Any difficulties with the Transfer Center should be reported to the attending physician at the time of the incident in order to handle that particular patient and to Dr. Lauer in order to address the problem in general.
Appendix E: Continuity Clinic Assignments 2016-2017

KU- Medical Office Building Clinic Site
   PGY 1  De La Fuente, Luckoff, Orr, Rha,
   PGY 2  Bozkanat, Kelm, Kirkpatrick, Leveille, Okojie, Puar
   PGY 3  Ellis, Gupta, Schwerdtfager, Tfankji

KU-Prairie Village Clinic Site (Mon, Tues, Wed and Fri afternoons)
   PGY 1  Abu-Nasser, Eidson, Hessman, Nguyen
   PGY 2  Bar-Zion, Osterloh, Prosser
   PGY 3  Menard, Prero, Slagle, Srur, Tusken

Clinic location assignments will stay consistent throughout the year. The clinic day of the week may change based on clinical rotations, the number of residents in a given clinic session and preceptor availability. There are a limited number of preceptors at each site allowing for preceptor continuity over the year.

Typically there will be 3 residents in a half day clinic. The maximum number of residents in one clinic session is 4 per preceptor.

<table>
<thead>
<tr>
<th>1st and 2nd Years</th>
<th>Maximum- 7 patients</th>
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<tr>
<td>1:00pm</td>
<td>ANY</td>
</tr>
<tr>
<td>1:30pm</td>
<td>ANY</td>
</tr>
<tr>
<td>2:00pm</td>
<td>NNB slot/switches to ANY slot same day</td>
</tr>
<tr>
<td>2:30pm</td>
<td>ANY</td>
</tr>
<tr>
<td>3:00pm</td>
<td>FREEZE/THAW one week before clinic</td>
</tr>
<tr>
<td>3:30pm</td>
<td>ANY</td>
</tr>
<tr>
<td>3:45pm</td>
<td>FROZEN- only resident can okay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3rd Years</th>
<th>Maximum- 9 patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:45pm</td>
<td>ANY</td>
</tr>
<tr>
<td>1:15pm</td>
<td>ANY</td>
</tr>
<tr>
<td>1:45pm</td>
<td>NNB slot/switches to ANY slot same day</td>
</tr>
<tr>
<td>2:15pm</td>
<td>ANY</td>
</tr>
<tr>
<td>2:45pm</td>
<td>FREEZE/THAW one week before clinic</td>
</tr>
<tr>
<td>3:15pm</td>
<td>ANY</td>
</tr>
<tr>
<td>3:45pm</td>
<td>ANY</td>
</tr>
<tr>
<td>4:15pm</td>
<td>ANY</td>
</tr>
<tr>
<td>4:30pm</td>
<td>FROZEN- only resident can okay</td>
</tr>
</tbody>
</table>
Appendix F: “Rules” for Continuity Clinic Schedules

Initial template for clinics is created for upcoming year
- KU PM Clinics: Mon, Tues, Wed, Thurs and Fri with 4 residents maximum (prefer 3)
- PV PM Clinics: Mon, Tues, Wed, Thurs and some Fri with 3 residents maximum

Expectations for Day of Clinic
- Day of clinic will vary depending on the rotation the resident is on
- Day of clinic may also vary within the same rotation depending on resident availabilities and clinical conflicts as outlined below
- Clinic calendars must be checked very closely

Floor
- Seniors: Clinics on different days/times from each other (Mon or Tues clinic)
- Juniors: PM clinics on different days from each other, when possible (Wed or Fri Clinic)
- Both: 1 clinic per week except no clinic week of CMH didactic

PICU Senior
- PM clinics (typically Wednesday clinic)
- 1 clinic per week except no clinic week of CMH didactic

NICU
- Seniors: PM Clinic on different day than Junior(s)
- Juniors: PM clinics on different days from each other, when possible
- 1 clinic per week except no clinic week of CMH didactic

FTN
- Junior: Clinic on different day/time from senior

Night Service Residents
- Will not have clinic while on nights

ED KU and ED CMH
- 2 clinics during 4 week blocks, 3 clinics during 5 week blocks
- Chief will add to the schedule after ED schedule final available from both KU EM and CMH Chiefs

Same Day Sick and Community
- Seniors and Juniors: Clinics on different days/times from each other
- SDS senior will have different clinic from PICU senior

CMH PICU
- No clinic first week of rotation and during week of nights
- 2 clinics during 4 week blocks and 3 clinics during 5 week blocks
- KU and CMH Chiefs will coordinate clinic schedule
- First patient scheduled at 1:20pm

Junior Ambulatory
- Schedule worked out after all above changes are made and based on call schedule; goal is to have 5-6 ½ days per week of clinics (continuity, junior ambulatory, urgent care)
- Schedule done by Pediatric chief
Specialty Clinics (subject to change if subspecialty clinics change)

- Adolescent: **must** have Fri PM
- Allergy: best clinic day is **Wed PM, Friday PM**
- Behavioral-Developmental: best clinic day **Monday PM**
- Peds Cardiology: best clinic day is **Wed PM**
- Peds Endocrine: best clinic days **Tues AM, Friday PM**
- Peds GI: best clinic days **Wed PM, Friday PM**
- Peds Heme/Onc: **must** have Tues PM or Wed PM
- Peds Nephrology: best clinic days **Mon AM, Wed PM, Fri PM**
- Peds Surgery: **must** have clinic **Tues or Wed PM or Fri PM**
- Peds Rheumatology: best clinic days **Tues PM, Wed PM**
- Community: **no Wed; best Tues PM, Fri PM**
- For other conflicts including CMH Specialty rotations, it is up to the resident to notify the Chief about the clinic conflict at least three months in advance in order to move or close clinics.

Clinic Redistributions

- Numbers of residents in ½ day clinics should be balanced
- Residents will be redistributed so that there are at least 2 residents in a given clinic

Out of Town Rotations- all clinics cancelled

Vacations/Locums- clinic cancelled at least three months in advance

Holiday Block- clinics cancelled during Holiday Block if clinic numbers are met

Prairie Village Clinics

- Should have at least two, and not more than three residents scheduled. There may be clinics with only one resident on rare occasions.
- Clinics must be maintained at PV throughout the year so as to have 36 ½ days of clinic at that site

KU MOB Clinics

- Should have at least two, and not more than four residents scheduled. There may be clinics with only one resident on rare occasions.
- Clinics must be maintained at MOB throughout the year so as to have 36 ½ days of clinic at that site

Third Year Senior Clinics- cancelled the last week of the academic year if clinic numbers are met

Second Clinics for 3rd Years

- Additional clinics may be needed to meet patients per clinic numbers or when extra experience in the continuity clinic is needed or desired.
- May open at a location opposite that of primary clinic when desired
- Second clinics during outpatient elective months only
  - Only during months when specialty clinics permit 2nd clinics
  - Only schedule after all above clinics including Junior Ambulatory have been scheduled
  - Any ½ day of continuity clinic will count toward their total number of clinics
  - When clinics are otherwise full, do not schedule 2nd clinics

Clinic goals is 36 ½ day sessions per year in no fewer than 26 weeks per year

- December check: goal of ~18 ½ days of clinic per resident thus far
- February check: target for 36 ½ days or more of scheduled clinic

All continuity clinic rules subject to change as clinical schedules change.
Appendix G: Pager Commands and Instructions

Dial your pager number, enter 0 then enter your personal access code.

<table>
<thead>
<tr>
<th>Message Retrieval</th>
<th>Pagesaver Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Delete Message</td>
<td>14 Retrieve Numeric Messages</td>
</tr>
<tr>
<td>3 Play Message</td>
<td>3 Play Newest Message</td>
</tr>
<tr>
<td>4 Play Oldest Message</td>
<td>4 Play Oldest Message</td>
</tr>
<tr>
<td>5 Replay Message</td>
<td>5 Replay Message</td>
</tr>
<tr>
<td>6 Forward Message</td>
<td>2 Delete Message</td>
</tr>
<tr>
<td>7 Time &amp; Date</td>
<td>7 Time &amp; Date</td>
</tr>
<tr>
<td>8 Skip Back</td>
<td></td>
</tr>
<tr>
<td>9 Undelete All</td>
<td></td>
</tr>
<tr>
<td>0 Pause</td>
<td></td>
</tr>
<tr>
<td>* Help</td>
<td></td>
</tr>
<tr>
<td># Disconnect</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Update Greetings</th>
<th>Access Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 To Update Greeting</td>
<td>Default code is 1998</td>
</tr>
<tr>
<td>30 Begin Recording</td>
<td></td>
</tr>
<tr>
<td>1 End Recording</td>
<td></td>
</tr>
<tr>
<td>40 Playback</td>
<td></td>
</tr>
<tr>
<td>* Help</td>
<td></td>
</tr>
</tbody>
</table>

**Page Forward:** Allows you to manually forward your pages to another pager

Dial your pager number
Enter “0”
Enter your four digit access code
Enter “16” to access page forward menu
Enter “6” to select pager number to be forwarded to
Enter the pager number

**Page Absence:** Enables your pager to “not accept calls” and gives a verbal message that you are not accepting calls.

Dial your pager number
Enter “0”
Enter your four digit access code
Enter “8” to activate or deactivate this feature

**Groupwise Paging**
(913) 917-#### @myairmail.com
Internet paging: go [http://myairmail.com](http://myairmail.com) or KUMC online directory at [http://www.kumc.edu](http://www.kumc.edu)

**Direct Dial Paging**
ON CAMPUS – Dial 9 (to access outside line), then 917####
OFF CAMPUS – Dial the seven digit pager number. (Include the 913 area code if out of area.)

**Numeric Pages:** Enter your call back phone number, press #, and then hang up.
**Alphanumeric Pagers:** Enter your call phone number or voice message, press #, and then hang up.

To speak to the pager operator, dial 588-5155
Appendix H: Procedures

Residents must be able to competently perform all medical, diagnostic and surgical procedures considered essential for the area of practice.

**Group 1:** Residents must be able to competently perform procedures used by a pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results. Residents must demonstrate procedural competence by performing the following:

- Bag-mask ventilation
- Bladder catheterization
- Giving immunizations (SQ, ID, IM)
- Incision and drainage of abscess
- Lumbar puncture
- Neonatal endotracheal intubation
- Peripheral intravenous catheter placement
- Reduction of simple dislocation
- Simple laceration repair, wound care
- Simple removal of foreign body (nose, ears)
- Temporary splinting of fracture
- Umbilical catheter placement (UAC and UVC)
- Venipuncture

*All Group 1 procedures are documented throughout residency.*

**Group 2:** Residents must complete training and maintain certification in Pediatric Advanced Life Support, including simulated placement of an intraosseous line, and Neonatal Resuscitation.

**Group 3:** 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
- Endotracheal intubation of non-neonates
- Thoracentesis

*All Group 3 procedures are documented throughout residency.*

**Group 4:** Residents must be able to competently perform procedures used by a pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results. Residents must demonstrate procedural competence by performing the following:

- Developmental screening (Junior Ambulatory)
- Hearing screening (JA)
- Inhalation medications (JA)
- Tympanometry and audiometry (JA)
- Vision screening (JA)
- Gynecologic exam (Adolescent)
- Pain management (PICU)
- Procedural sedation (PICU)

*Group 4 procedures are documented at various points in the residency program as identified above.*

**Procedure Logs**

All procedures must be logged into MedHub. Logs will be reviewed semi-annually as part of the CCC process.
Appendix I: Faculty Roster

**Allergy/Immunology**
Sadia Hayat, MD  
Selina Gierer, MD, Chief  
John Martinez MD

**Behavioral Pediatrics**
Martha Barnard, PhD, Chief  
John Belmont, PhD  
Amanda Bruce, PhD  
Ann Davis, PhD  
Steve Lassen, PhD  
Eve-Lynn Nelson, PhD  
Susana Patton, PhD  
Mike Rapoff, PhD  
Brenda Salley, PhD  
Jane Sosland, PhD  
Maura Wendland, PhD

**Developmental Pediatrics**
Kathryn Ellerbeck, MD

**Endocrinology**
Angela Lennon, MD, Chief

**Gastroenterology**
Osama Almadhoun, MD, Chief  
Chantal Lucia Casadonte, MD

**General Pediatrics**
Kourtney Bettinger, MD  
Laura Blasi, MD  
Grace Brouillette, DO  
Kathy Davis, PhD  
Jennifer Dioszeghy, MD  
Lisa Gilmer, MD  
Steve Lauer, MD, PhD  
Mike Lewis, MD  
Kayla Maalouf, MD  
Lore Nelson, MD  
Katie Petelin, DO  
George Phillips, MD, Chief  
Beth Pitts, MD  
Whitney Pressler, MD  
Pam Shaw, MD  
Ryan Smith, MD  
Heather Von Bevern, MD  
Joy Weydert, MD  
Meghan Adams, PNP  
Molly Drake, PA  
Sallie Page-Goertz, PNP  
Stephanie Painter, PA

**Hematology-Oncology**
Jyoti Panicker, MD, Chief  
Thomas Loew, MD  
Nancy Potter, NP  
Melissa Stein, NP  
Anne Stanton, NP

**Infectious Diseases- CMH ID**
Mary Anne Jackson, MD  
Robyn Livingston, MD  
Russell McCulloh, MD  
Angela Myers, MD  
Doug Swanson, MD

**Neonatology**
Krishna Dummula, MD  
Chaitali Mahajan, MD  
Vishal Pandey, MD  
Amie Slaughter, NNP

**Nephrology**
Sandeep Riar, MD, Chief

**Neurology- CMH Neuro**
Keith Coffman, MD  
Gina Jones, DO  
Jean-Baptiste Le Pichon, MD

**Pediatric Surgery**
Kurt Schropp, MD, Chief

**Rheumatology**
Jordan Jones, MD  
Carol Lindsley, MD, Chief
Appendix J: Pediatric Training Roadmap Class of 2019

Educational Units (EU) are composed of block or longitudinal experiences. Each EU must include a minimum of 32 half-days of scheduled activities. 6 EUs are dedicated to each resident’s Individualized Curriculum.

<table>
<thead>
<tr>
<th>PGY 1</th>
<th>3 Educational Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient General Pediatrics/Heme-Onc</td>
<td>2 EU</td>
</tr>
<tr>
<td>NICU</td>
<td>1 EU</td>
</tr>
<tr>
<td>Term Nursery</td>
<td>1 EU</td>
</tr>
<tr>
<td>Behavioral-Developmental Pediatrics</td>
<td>1 EU</td>
</tr>
<tr>
<td>Same Day Sick (acute illness)</td>
<td>1 EU</td>
</tr>
<tr>
<td>KU Emergency Medicine</td>
<td>1 EU</td>
</tr>
<tr>
<td>Junior Ambulatory</td>
<td>1 EU</td>
</tr>
<tr>
<td>Inpatient Neuro/Pulm (CMH)</td>
<td>1 EU</td>
</tr>
<tr>
<td>Inpatient Endo/Renal (CMH)</td>
<td>1 EU</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PGY 2</th>
<th>1-2 Educational Units (days), 1 ½ EU (nights)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient General Pediatrics/Heme-Onc</td>
<td>1 EU</td>
</tr>
<tr>
<td>NICU</td>
<td>1 EU</td>
</tr>
<tr>
<td>Term Nursery</td>
<td>1 EU</td>
</tr>
<tr>
<td>KU PICU</td>
<td>1 EU</td>
</tr>
<tr>
<td>Acute Care</td>
<td>1 EU</td>
</tr>
<tr>
<td>Community Pediatrics</td>
<td>1 EU</td>
</tr>
<tr>
<td>Research Planning/Radiology</td>
<td>½ EU</td>
</tr>
<tr>
<td>Outpatient Neuro/Pulm (CMH)</td>
<td>1 EU</td>
</tr>
<tr>
<td>Outpatient Endo/Renal (KU)</td>
<td>1 EU</td>
</tr>
<tr>
<td>Other requirements including individualized curriculum</td>
<td>1-2 EU</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PGY 3</th>
<th>1-2 Educational Units (days), 1 ½ EU (nights)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient General Pediatrics/Heme-Onc</td>
<td>1 EU</td>
</tr>
<tr>
<td>CMH PICU</td>
<td>1 EU</td>
</tr>
<tr>
<td>Adolescent Medicine</td>
<td>1 EU</td>
</tr>
<tr>
<td>Other requirements including individualized curriculum</td>
<td>4 ½ -5 ½ EU</td>
</tr>
</tbody>
</table>

### Required Subspecialties

- **KU rotations as a single EU**
- **KU rotations as combo EU**
- **CMH rotations**
  - Allergy/Immunology
  - Nephrology
  - Child Abuse
  - Cardiology
  - * can do longitudinal for full EU
  - Medical Genetics
  - Endocrinology
  - Dermatology
  - Gastroenterology
  - ID
  - Hematology-Oncology
  - Pediatrics
  - Sports Medicine
  - Rheumatology
  - Sleep Medicine

### Elective Subspecialties (includes any of the required subspecialties above as well)

- **KU rotations as a single EU**
- **KU rotations as combo EU**
- **CMH rotations**
  - Child and Adolescent Psychiatry
  - Anesthesia
  - Pediatric Anesthesia
  - Hospice and Palliative Care
  - Dentistry
  - Ophthalmology
  - Neurodevelopmental Disabilities
  - Radiology
  - Orthopedic Surgery
  - Pediatric Surgery
  - Sports Medicine
  - Rehab Medicine
  - Sleep Medicine
Appendix K: Pediatric Residency Program Leadership

Residency Leadership
Program Director: Lisa Gilmer, MD
Associate Program Directors: Osama Almadhoun, MD and Heather Von Bevern, MD
Pediatric Chief: Laura Blasi, MD  Vice Chair of Education: Pam Shaw, MD
Residency Coordinator: Jennifer Lynn  Residency Administrative Assistant: Lilian Valdez
Director of Resident Research: Apurva Panchal, MD  Resident Simulation Liaison: Grace Brouillette, DO
Directors of Continuity Clinic: Katie Petelin, DO and Whitney Pressler MD

Pediatric Program Evaluation Committee
The Program Evaluation Committee will be composed of educational leadership and educational liaisons and include representation from the residents. The PEC should 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 evaluations of faculty, resident, and others, as specified below and
- assuring that areas of non-compliance with ACGME standards are corrected

Subcommittees
Curriculum Committee- reviews program and individual rotation curriculum including goals and objectives and assessment tools; meets throughout the year
  Membership: PD, APDs, Rotation Directors, Pediatric chief, Residents

Recruitment Committee- reviews structure of resident recruitment and makes recommendations to PD regarding candidates for Match ranking; meets once a month in Nov, Dec, Jan and in Feb for final rank meeting
  Membership: PD, APDs, Chair, Faculty interviewers, Pediatric chief, Residents, Coordinator

Resident Liaison Committee- meets to settle individual resident or resident group issues; meets as needed
  Membership: Pediatric chief, six class representatives (2 from each PGY level)

Pediatric Clinical Competency Committee
The Clinical Competency Committee must be composed of three members of the residency faculty. The Clinical Competency Committee should participate actively in:

- reviewing all resident evaluations by all evaluators semi-annually
- preparing and assuring the reporting of Milestones evaluations of each resident semi-annually to ACGME
- making recommendations to the program director for resident progress, including promotion, remediation, and dismissal

Subcommittees
Academic and Professionalism Committee- hears academic and professional matters requiring additional intervention beyond meeting with PD are brought; meets on an as needed basis
  Membership: Vice Chair of Education or Vice Chair of Patient Care will chair this subcommittee depending on circumstances of resident concern
Academic Matters: Resident Mentor, SIPR Mentor, APD, Resident Advocate
Professional Matters: Resident Advisor, Behavioral Pediatrician, APD, Resident Advocate

Full descriptions of the Pediatric Program Evaluation Committee and the Pediatric Residency Clinical Competency Committee are available in the Pediatric Policies and Procedures Manual
Appendix L: Pediatric Medical Education- Culture of Learning

Promote a learner focused environment
- Program accountability for learning opportunities
- Learner accountability for own learning
- Transformational learning (creates change)
- Collaborative learning environment
- Create passion for learning

Data-informed curriculum, instruction, & assessment
- Incorporate best practices
- Strategic plans focus on learning
- Monitor learning progress
- Use technology as a resource to enhance learning opportunities

Academic excellence
- Transparent accountability
- Build fund of knowledge
- Information sharing
- Creation of quality instructional programs
- Create a passion for a shared vision

Negotiating within the culture
- Clearly communicated organizational goals
- Build relationships with key stakeholders
- Anticipate/Address barriers to change
- Exceed accreditation standards
Appendix M: Residents as Teachers

Residents are expected to participate in the education of patients, families, students, residents and other professionals. Throughout residency, you will learn many skills and techniques to help you become a better teacher.

There are many, many resources available when you search Residents as Teachers on the internet. The following are some good references for you to use to improve these skills on your own.

American Academy of Pediatrics Residents as Teachers Guide
http://www2.aap.org/sections/ypn/r/resident/resident_teachers.html

Residents as Teachers Curriculum Modules (Alliance for Academic Internal Medicine)
http://www.im.org/p/cm/ld/fid=401

KU SOM-Wichita Strategies in Clinical Teaching
http://wichita.kumc.edu/preceptor/introduction.html

University of Southern California Residents Teaching Skills Website
http://residentteachers.usc.edu/

Practical Professor, Practical Doc (lots of different teaching nuts and bolts)
http://www.practicaldoc.ca/teaching/practical-prof/teaching-nuts-bolts/one-minute-preceptor/

University of Pittsburg Residents As Teachers
http://www.ame.pitt.edu/Residents-as-Teachers.php#gme

Vanderbilt Residents as Teachers
http://pediatrics.mc.vanderbilt.edu/interior.php?mid=9238

Teaching Expectations for Residents

Senior Residents: informal teaching sessions; student presentations; discussing assessments and plans; giving feedback on these activities and other areas of performance
  Goal: Teach the students how to be pediatricians

Junior Residents: teaching by example such as physical examination skills, communication with patients/parents/nursing/other health professionals; note writing and order writing; time management; feedback on any of these areas
  Goal: Teach the students how to be physicians
Appendix N: Handoff

A handoff, also known as a handover or sign out, is a real time, active process of passing patient specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient’s care.

Handoff Examples: Day shift to Night shift, ED or Clinic to Floor, Floor to ICU, ICU to Floor

According to studies by the Joint Commission, when patients are harmed, the majority of the time poor or ineffective communication is identified as a contributing factor. An estimated 80 percent of serious medical errors involve miscommunication between caregivers when patients are transferred or handed off.

The handoff should be a standardized process within your area/department, so that it does not vary from person to person. When regarding a patient, the handoff should include a combination of a verbal report as well as a review of documented information (i.e. in the patient’s medical record). Handoff communication should always include an opportunity to ask questions.

Our inpatient handoff tools for the Floor and PICU are housed within the O2 EMR system so that they can be easily accessed by each member of the healthcare team. Although a good amount of the information on the written handoff is automatically populated by O2, residents are expected to keep the list up dated. Numerous dot phrases have been created to make this process easier.

These following mnemonics were used to create our verbal and written check out. SIGNOUT is used for handoff of the service between day and night teams. IPASS is a new Handoff Curriculum coming out of the pediatric community and may be incorporated into our current handoff practices.

SIGNOUT (Program preferred handoff tool)
S – Status (Stable, Sick, DNR/DNI)
I – Identifying Data Survey
G – General Hospital Course
N – New Events of the Day
O – Overall health or current status/clinical conditions/comorbidities
U – Upcoming Possibilities/possible problems- Contingency plans/rationale
T – Tasks/To Do List/Pending, anticipate results – Contingency plans/rationale
? – Any questions

IPASS
I- Illness severity (stable, “watcher”, unstable)
P- Patient summary (summary statement, events leading up to admission, hospital course, ongoing A/P)
A- Action list (to do list, time line and ownership)
S- Situation awareness and contingency planning (know what’s going on, plan for what might happen)
S- Synthesis by receiver (receiver summarizes what was heard, asks questions, restates key action/to dos)

Elements of a good handoff:
- Problem list and O2 handoff tool are updated prior to conducting the handoff
- Professionalization is maintained when entering handoff notes into O2 (assume they are discoverable)
- Report is given in a quiet area that is conducive to transferring information with limited interruptions
- Immediate access to O2 is ensured during the verbal handoff
- Communication is concise and conducted in a manner consistent with protecting patient confidentiality
- Clarification is offered/solicited, questions are answered, and information is read or repeated back as needed
- Patient is informed of any transfer of responsibility if appropriate
- If change of service, O2 treatment team is updated

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A special note about Nursing-Physician Handoff

Thanks to the efforts of the 2013-2014 Resident Council, there has been a significant push to change the culture of nurse to resident communication. Implementing this culture change begins with the adaptation of the iSBARR for all pages.

iSBARR (nursing phone handoffs)
i- Identify self
S- Situation
B- Background
A- Assessment
R- Recommendations
R- Read back

It is expected that when a nurse pages you, he or she present the patient, the concern and the recommendations in iSBARR format. If this doesn't happen, please ask the nurse to tell you about the patient using iSBARR. All nursing staff has been training in this communication model. Ongoing refresher training is provided for residents and nursing alike.
Appendix O: Pediatric Residency Forms and Other Documents on Blackboard

Forms are available on Blackboard.  http://www.kumc.edu/students.html

Advising

Initial Advisor-Advisee Meeting Form  Spring Advisor-Advisee Meeting Form
Semi-Annual Meeting with Program Director Form

Evaluations

Faculty Evaluation of Residents  Resident Evaluation of Faculty
Mid-Rotation Evaluation of Resident  360 Nurse, Allied Health Evaluation of Resident
360 Patient Evaluation of Resident  360 Peer Evaluation of Resident
360 Medical Student Evaluation of Resident  Resident Evaluation of Rotation
Resident Evaluation of Program  Critical Incident Form
Evaluation of a Teaching Conference  Continuity Clinic Evaluation
Medical Student Evaluation of Resident
Resident Performance Review/Final Summative Evaluation Form

Clinical Documentation Forms

Outpatient H&P Checklist  Chart Stimulated Recall Form
ED Admission Review  Inpatient Admission Review
Delivery Checklist  Circumcision Checklist
Individualized Curriculum Checklist  International Rotation Checklist

Vacation/Leave

Vacation/Leave Request Form  Deadlines for Vacation Requests
FMLA Checklist

Schedules

Master Schedule  Monthly Call Schedule
Continuity Clinic Schedule  MTC Schedule
Conference Schedule

Other Forms

Educational Fund Reimbursement Form  International Travel Grant Application Form
Home Call Documentation Form

ACGME Requirements

Common Program Requirements  Requirement document FAQs
Requirements for Training in Pediatrics, effective July 1, 2013

NAS and Milestones

Milestones  21 Milestones to be surveyed annually in 2013-2014

ACGME Resident Survey