PEDIATRICS RESIDENCY MANUAL

SANFORD CHILDREN'S HOSPITAL

SANFORD SCHOOL OF MEDICINE OF THE UNIVERSITY OF SOUTH DAKOTA

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Abbreviations

ABP - American Board of Pediatrics

ACGME - Accreditation Council for Graduate Medical Education

APD – Associate Program Director

DIO - Designated Institutional Officer

EM - Emergency Medicine

EMR - Electronic Medical Record

GME - Graduate Medical Education

ILP - Individualized Learning Plan

NICU - Neonatal Intensive Care Unit

NRMP - National Residency Match Program

PC – Program Coordinator

PD – Program Director

PICU - Pediatric Intensive Care Unit

SSOM - Sanford School of Medicine

SSOM USD - Sanford School of Medicine of The University of South Dakota

I. FORWARD

(A) WELCOME TO RESIDENTS

Welcome to the Sanford Pediatrics Residency Program, the Department of Pediatrics at Sanford Children's Hospital and the University Of South Dakota Sanford School Of Medicine (USD SSOM).

The University of South Dakota (USD) employs a broad definition of diversity that includes (but is not limited to) disability, gender identity and expression, sexual orientation, age, religion, race/ethnicity, nationality, veteran status and other important social dimensions that are part of the campus community. Inclusive excellence is a strategy for transforming USD into an institution that conceptualizes inclusiveness and excellence together, makes inclusiveness ubiquitous, assigns responsibility for inclusiveness to everyone on campus and utilizes a broad definition of inclusiveness.

https://www.usd.edu/diversity-and-inclusiveness/diversity-and-inclusiveness-statement

AIMS: The Sanford School of Medicine is dedicated to preparing generalist physicians to practice medicine in the upper Midwest. In 2010, the Sanford Health System and the SSOM USD established a Pediatrics Residency Training Program to expand the University's mission. We look forward to working with you, making sure your time here is both educational and enjoyable.

The information contained in this Policy Manual pertains to all residents in the Pediatrics Department's programs. Policies in these manuals have been developed in accordance with standards set by the American Board of Pediatrics (ABP) and the Accreditation Council for Graduate Medical Education (ACGME) and are subject to periodic review and change by the faculty, Program Director (PD), the Senior Director, Graduate Medical Education of Sanford Health, and the SSOM USD Designated Institutional Officer (DIO).

Residents are responsible for acknowledging and understanding the policies and guidelines contained in this manual.

(B) MISSION/VISION STATEMENTS

Mission: Training pediatricians to be successful.

Vision: Personalized education in Pediatrics.

We, the faculty of the Sanford Pediatric Residency Program, incorporate this mission and vision as we prepare our residents to be proficient in all six ACGME competencies: patient care, medical knowledge, practice-based learning and improvement; interpersonal and communication skills; professionalism; and system-based practice.

(C) INTRODUCTION

The following pages outline general policies, guidelines and curricula. It is impossible to anticipate every nuance or circumstance to which they may apply. Discretion must be left to the Program Director, the Associate Program Director(s), the Pediatric Residency Committee, the Clinical Competency Committee, the Program Evaluation Committee, the Chief Resident(s) and the individuals responsible for the conduct and administration of the residency program when issues are not specifically addressed in these pages. **Each resident is responsible for becoming thoroughly familiar with the material contained in this Handbook.**

As a physician in residency training, each resident must participate in the educational aspects of the training program while providing direct care of patients under the supervision of the Program Director and faculty. The USD SSOM Graduate Medical Education (GME) Office provides a general orientation for new residents in late June. The Program Director will also provide an orientation regarding: the organization and structure of the residency program, which includes educational goals and objectives; duties and responsibilities; rotation, call, and vacation schedules; issuing of equipment (pagers, etc.); and a variety of other matters that are important to each resident during their training.

As stipulated in the residency agreement (contract), each resident is obligated to abide by the policies, procedures and regulations in the *Resident Handbook and all pertinent GME and University policies*.

These policies and guidelines are subject to periodic review and approval by the medical school administration, the faculty, and/or the Program Director or Chair of the Department of Pediatrics. Questions or concerns regarding the content of this handbook should be addressed to the Residency Program Director, Chair of the Department of Pediatrics, or the USD SSOM GME office.

A complete list of the USD SSOM GME policies and benefits are tabled below and can be downloaded from the “New Innovations” website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals
(The policies are in the “GME Policies” folder located in the “Department Manuals” tab.)

Username and password for New Innovations will be assigned during resident orientation.

II. ADMINISTRATION

(A) ADMINISTRATIVE STRUCTURE OF THE RESIDENCY PROGRAM

The Pediatric Residency Program has a Program Director, Associate Program Director(s), a Residency Coordinator, Chief Resident(s), a Residency Committee, a Clinical Competency Committee, and a Program Evaluation Committee that are ultimately or directly responsible to the DIO and Dean of USD SSOM and to the Senior Director, GME of Sanford Health. The Pediatric Residency Program Director is appointed by the DIO, the Dean of USD SSOM, and the Senior Director, GME of Sanford Health and reports directly to the DIO and the Senior Director, GME of Sanford Health.

The Residency Clinical Competency Committee, the Program Evaluation Committee, the Residency Committee, and the Chair of the Pediatric Department advise the Program Director.

The Residency Clinical Competency Committee and the Program Evaluation Committee are made up of key faculty members of the Residency Program and, when necessary, representative residents. The Residency Committee is made up of faculty members of the Residency Program and all residents.

Residency Clinical Competency Committee
The Residency Clinical Competency Committee's primary purpose is to perform semiannual reviews of each resident's educational progress, assign "Milestones" and possibly "Entrustable Professional Acts (EPAs)," and to make recommendations to the Program Director. The Clinical Competency Committee's review utilizes objective rotation performance evaluations that are based on the Competencies and the specialty-specific Milestones. The Associate Program Director serves as the Chair of this Committee. The Clinical Competency Committee (CCC) meets semi-annually to assess individual resident/fellow performance, though an extra meeting may occur to discuss resident evaluations.

CCC Membership
All members of the CCC are to be appointed by the Program Director. Members must include a minimum of three program faculty members. Other CCC members may be faculty from other programs and non-physician members of the healthcare team. Residents/fellows may not be members of the CCC.

The members of the CCC may be the same or different members appointed to the Program Evaluation Committee.

CCC Responsibilities
The CCC is responsible for

1) Reviewing all resident evaluations,
2) Preparing and assuring the reporting of Milestones evaluations,
3) Advising the program director regarding resident progress, including promotion, remediation, and dismissal.

Although the CCC is tasked with advising the program director, the program director makes the final determination of each resident's ability to practice independently.

CCC Process
Members are assigned resident(s) to pre-review before the CCC meets. Members are responsible for presenting to the CCC their assigned resident(s)' performance. The committee discusses each resident and makes its advisement to the program director.

CCC Meeting Frequency
Semi-annual (minimum).

Program Evaluation Committee
The Program Evaluation Committee is charged with evaluating the residency program at least annually and makes recommendations for program improvements to the Program Director. Overall, the Program Evaluation Committee (PEC) meets annually at minimum to actively participate in planning, developing, implementing, and evaluating the educational activities of the program with the goal of improving the educational environment for residents.

PEC Membership
All members of the PEC are to be appointed by the program director. Members must include a minimum of two program faculty members and at least one resident/fellow from the program. The members of the PEC may be the same or different members appointed to the Clinical Competency Committee.

PEC Responsibilities
Using evaluations of faculty, residents, and the GMEC report card, the PEC should review and make recommendations for revision of competency-based curriculum goals and objectives, addressing areas of non-compliance with ACGME standards.

The PEC is responsible for monitoring

1) Resident performance,
2) Faculty development,
3) Graduate performance (including board certification results),
4) Program quality,
5) And the previous year's action plan(s).

Monitoring intent is program improvement, not individual remediation.

The PEC must document formal, systematic evaluation of the curriculum in meeting minutes and is responsible for producing an Annual Program Evaluation (APE) on a yearly basis. The APE should include written action plan(s) to document initiatives to improve performance in the areas above (as needed), including language as to how these plans will be measured and monitored. Actions plans should be reviewed and approved by the teaching faculty and documented in meeting minutes.

PEC Process
Programs should use the APE template in New Innovations as released by the USD SSOM GME office. The template offers structure to guide the PEC through the APE process.

PEC Meeting Frequency
Annual (minimum).
Of note, the annual residency curriculum retreat, held in early spring, generally serves as the annual PEC meeting. All faculty and residents are invited to attend. A smaller PEC meeting occurs when necessary.

Residency Committee
Though labeled a “Committee,” this “committee” meets basically as a “Town Hall,” which meets about once a month, is open to all members of the Department, and serves as a “large” program evaluation committee at times. The Residency Committee is charged with: reviewing and developing proposals regarding resident educational and service guidelines; complying with the ACGME Pediatrics Review Committee’s specific requirements; determining strategic educational plans; and improving resident education. The Program Director serves as the Chair of the Residency Committee.

The Residency Committee also reviews the applications, interview summaries, and references of applicants applying to the Pediatric Residency Program. The Committee will advise the Program Director concerning the acceptance of individual applicants and the determination of the National Residency Match Program (NRMP) ranking order. Should there be disagreement between the Program Director and the Residency Committee, the matter will be referred to the DIO of the USD SSOM for review and decision concerning the proposed resident applicant(s).

A schematic of the Sanford Children’s Hospital, SSOM USD Pediatrics Residency Program responsibility tree is shown below:

Dean: Timothy Ridgway MD

Designated Institutional Officer (DIO): Nedd Brown, EdD

Medical Director, Graduate Medical Education of Sanford Health: David Theige, MD

Interim Chair: Joseph A. Zenel, MD

Program Director: Jessica White, MD

Associate Program Director: KayeLyn Wagner, MD

Chief Residents: Jade Arrobas, DO; Annie Martino, MD; Emelia Stille, DO

Residency Coordinator: Kelley Yseth

(B) PROGRAM OVERVIEW

The Pediatric Residency Program of the Sanford Children's Hospital, USD SSOM was developed to prepare graduates to practice Pediatrics in a variety of settings: consultation, in-patient, including NICU and PICU; and out-patient. The program places education first and clinical service second, resulting in a manageable caseload and call schedule. Because of the rural nature of South Dakota, a strong emphasis is placed on residents obtaining the intellectual and procedural skills necessary for preventive and primary pediatric care and for advocating and caring for all children with behavioral, developmental and or complex multi-system disease, in the inpatient, outpatient, community, and rural setting.

The program consists of 36 months of training in Pediatrics leading to eligibility to sit for the initial certifying examination administered by the American Board of Pediatrics (ABP). The program has integrated rotations at Sanford Children's Hospital, Sanford USD Medical Center, and other facilities throughout the region.

Ambulatory care training accounts for approximately 40% of overall residency training and includes emergency medicine, subspecialty pediatrics medicine, primary care medicine, and approximately one half-day per week in a continuity ambulatory pediatrics clinic.

The following list indicates the sequence of clinical rotations. Variations may occur according to changes in accreditation guidelines, previous individual residency training, and personal resident preferences. Each rotation, "Block," or "unit" represents 4 weeks.

PGY-1: 1 Block (unit) = 4 weeks; 13 Blocks (units) per academic year
4 Blocks – General Pediatrics Inpatient Service (Day Shifts for majority of academic year)
- 1 additional unit of weekend cross-cover shifts starting in late winter
- +/- Overnight shifts in spring

1 Block – Neonatal Intensive Care Unit
1 Block – Term Newborn
1 Block – Acute Illness (26th Syc/MB2/32nd Ellis)
1 Block – General Pediatrics Outpatient Service (26th Syc/MB2/32nd Ellis)
1 Block – Subspecialty selective (Vacation eligible)
1 Block – Endocrinology (Vacation eligible)
1 Block – Community Experience (Vacation eligible)
1 Block – Pulmonology/Neurology (2 weeks each)
1 Block – Individualized Curriculum (IC) Elective (Vacation eligible)
Weekly – Continuity Clinic (36 sessions of 1/2 day, 26 weeks minimum)

PGY-2: 1 Block (unit) = 4 weeks; 13 Blocks (units) per academic year
2 Blocks – General Pediatric Inpatient Service (Day/Night Shifts)
- 4 additional units of weekend cross-cover shifts

1 Block – Neonatal Intensive Care Unit
1 Block – Pediatric Intensive Care Unit
1 Block – Developmental/Behavioral pediatrics
1 Block – Infectious Disease (Vacation eligible)
1 Block – Emergency Medicine (Vacation eligible)
1 Block – Elective (or Surgery/Anesthesia/Procedures) (Vacation eligible)

3 Blocks – Mandatory Subspecialties (Cardiology, GI, Heme/Onc)
3 Blocks – Individualized Curriculum (IC) Elective (Vacation eligible)
Weekly – Continuity Clinic (36 sessions of 1/2 day, 26 weeks minimum)

PGY-3: 1 Block (unit) = 4 weeks; 13 Blocks (units) per academic year
2 Blocks – General Pediatric Inpatient Service (Day/Night Shifts)
- 2 additional units of weekend cross-cover shifts
1 Block – Neonatal Intensive Care Unit (as Supervising Resident)
1 Block – Pediatric Intensive Care Unit
1 Block – Emergency Medicine
1 Block – General Pediatrics Outpatient Service (26th Syc/MB2/69th Louise)
1 Block – Adolescent Medicine (CO, Yankton, Fargo, Sioux Falls)
1 Block – Community Medicine
2 Block – Subspecialty selective
1 Block – Mental Health (Vacation eligible)
2 Blocks – Individualized Curriculum (IC) Elective (Vacation eligible)
Weekly – Continuity Clinic (36 sessions of 1/2 day, 26 weeks minimum)

(C) SUBSPECIALTY ROTATIONS

The ACGME requires residents to take a minimum of nine subspecialty rotations including adolescent medicine and developmental-behavioral pediatrics. Residents are also encouraged to take a wide variety of electives with the approval of the Program Director.

The ACGME requires that in a pediatrics residency program, residents are required to take four out of the thirteen subspecialties listed below:

Allergy/immunology#
Cardiology*
Child Abuse
Dermatology#
Endocrinology
Genetics
Gastroenterology*
Hematology/Oncology*
Infectious Disease*
Nephrology
Neurology
Pulmonary*
Rheumatology#

*For Sanford Pediatrics Residency Program, the faculty has determined that Hematology/Oncology, Cardiology, Gastroenterology, and Infectious Disease (vacation eligible for this rotation) will be mandatory.
For these 4-week subspecialty rotations the resident will have to go off campus; however, a 2-week rotation in dermatology is available on campus.

RESIDENT SUBSPECIALTY ELECTIVE ROTATIONS

As mentioned above, in total, the residents are required to take a minimum of nine subspecialty rotations, three of which consist of a single subspecialty or combinations of subspecialties from the previously listed subspecialties or the subspecialties listed below:

Anesthesiology
Hospice and Palliative Medicine
Neurodevelopmental disabilities
Pediatric Dentistry#
Child and Adolescent Psychiatry
Ophthalmology
Orthopedics
Sports medicine
ENT
Radiology#
Sleep medicine#
Surgery
Physical medicine/rehabilitation

For these 4-week subspecialty rotations the resident will have to go off campus; however, a 2-week rotation in radiology is available on campus.

In summary, all residents will take adolescent medicine and developmental-behavioral rotations as per ACGME guidelines. In addition, Sanford Pediatrics Residency Program has already "chosen" three (Cardiology, GI, Hematology/Oncology) of the nine minimum subspecialty rotations that the ACGME requires (four if no vacation during Infectious Disease).

(D) EVALUATIONS

Rotation Evaluations
Each resident is required to evaluate his or her educational experience and rate to what degree each of the ACGME competencies was taught upon completion of each rotation. An evaluation form is provided through an electronic evaluation system (New Innovations) and should be completed within 10 days following a rotation.

Attending Evaluations
Each resident must perform an evaluation through the electronic evaluation system for each of his or her attending physicians (and the senior resident supervisor, if applicable) following each rotation. The evaluation rates how the attending and senior resident taught and modeled the six ACGME competencies. Those evaluations will not be released directly to the attending/senior resident, but rather will be summarized and released semi-annually in order to protect anonymity of the evaluating residents.

Resident Evaluations

Attending physicians and fellow residents, if applicable, evaluate each resident upon completion of a rotation. These are objective performance evaluations based on the Competencies and the specialty-specific Milestones. Review criteria may include an evaluation of some or all of the six ACGME competencies depending on the rotation (e.g. General Peds Inpatient, Continuity Clinic) (See section IV for details). The resident must review the completed evaluation on the electronic evaluation system and acknowledge receipt of the attending physician's evaluation. Evaluations serve as a basis for the Clinical Competency Committee to assign semi-annual milestone evaluations and the final summary evaluation. The final summary evaluation serves as part of the permanent record of each resident for inquiries concerning future employment, licensure, staff privileges, etc. The resident evaluations are reviewed on a monthly basis by the Program Director and are reviewed at least twice a year by the Residency Clinical Competency Committee.

Ancillary Staff/Nurse Evaluations

Attendings in certain rotations (PICU, Inpatient, NICU & Continuity Clinic) will distribute resident evaluation worksheets (360 evaluations) to ancillary staff and nurses with whom residents have worked. At least one such evaluation should be returned to the Program Coordinator by the end of each academic year.

Patient Surveys

Attendings in certain rotations (PICU, Inpatient, NICU and Continuity Clinic) will distribute resident evaluation worksheets (360 evaluations) to patients and/or their families in order to evaluate their interactions with the resident. At least one patient evaluation should be returned to the Program Coordinator by the end of each academic year.

All evaluations are the basis for annual program review by the Program Evaluation Committee.

Pediatrics In-training Exams

All Pediatric residents will take the ABP In-Training Exam (ABP ITE) to determine areas of strength and areas requiring additional education. This is an evaluation of the "Medical Knowledge" competency. The ABP ITE will be administered annually in mid-July.

Portfolios

Each resident is required to maintain an Individual Learning Plan portfolio in Pedialink (AAP Website), which will be reviewed periodically at resident meetings and/or with the Program Director. The portfolio will be reviewed by the Program Director at the meeting scheduled with the resident at least 2 times a year (Goal is 3-4 times per year). The following are suggested inclusions in the portfolio that should be posted by the end of the resident's training:

1) Practice-Based Learning and Improvement
    a) Residents should identify problems they believe they do not have sufficient knowledge to solve and write answers to questions on how they found required information.
    b) Documentation of PREP-SA participation

2) Professionalism
    a) Residents should describe an example of professionalism

Meetings with Program Director
The Program Director meets with each resident at least two times per year to review the resident's evaluations and individual learning plan, discuss the resident's progress, and advise as necessary. At these meetings, the resident has the opportunity to provide verbal feedback regarding rotations, faculty teaching, and other issues of importance to her/his training. Of note, the ACGME requires the Program Director to meet with all the residents at least twice a year.

Meetings with Faculty Mentor
Faculty mentors meet with each resident at least two times per year to review the resident's evaluations and individual learning plan, discuss the resident's progress, and advise as necessary. Faculty mentors are assigned at the beginning of the intern year with adjustments made based on individual resident or faculty requests.

Summative Evaluation
The Program Director must provide a summative evaluation for each resident upon completion of each academic year and upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. The final summative evaluation must:

1) Document the resident's performance during the final period of education, and
2) Verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

ACGME and National Academy of Science, Engineering and Medicine (NASEM) (formerly Institute of Medicine (IOM)) Recommendations
Because of the unique opportunities afforded by being a small program (6 residents per year), we hope to integrate innovation in resident education and will incorporate new ACGME recommendations and requirements as they appear.

(E) PATIENT LOG

Residents are not required to document individual daily experiences in performing patient care in the electronic evaluation system unless patient encounter numbers are questioned to be insufficient by the ACGME.

(F) PROCEDURAL COMPETENCE

The resident will document his or her experiences in performing various procedures in the electronic evaluation system (New Innovations).

Certification of procedural competence is based on documentation in the electronic evaluation system of procedures with attending physician confirmation. Certification in required procedures is necessary for completion of the Pediatric Residency.

Residents must be able to competently perform procedures used by a pediatrician in general practice. This includes 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 procedures:

(a) Basic and advanced life support;
(b) Bag-mask ventilation;
(c) Bladder catheterization;
(d) Giving immunizations;
(e) Incision and drainage of abscess;
(e) Lumbar puncture;
(f) Neonatal endotracheal intubation
(g) Peripheral intravenous catheter placement;
(h) Reduction of simple dislocation;
(i) Simple laceration repair;
(j) Simple removal of foreign body
(k) Temporary splinting of fracture;
(l) Umbilical catheter placement; and
(m) Venipuncture.

In addition, residents must be competent in the understanding of the indications, contraindications, and complications for the following procedures:

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

When these procedures are important for a resident's post-residency position, residents should receive real and/or simulated training.

All residents are expected to maintain PALS and NRP certification and keep a copy of their current certification on file in the Program Coordinator's office.

As per USD SSOM GME policy, once a resident has performed a number of certain procedures and is found to be competent in initiating these procedures without supervision, those procedures will be listed on the resident's badge. In general, performing 5 successful events for a procedure will qualify for competency. Those procedures are:

Bag-mask ventilation
Bladder catheterization
Giving immunizations
Incision and drainage of abscess
Lumbar puncture
Peripheral intravenous catheter placement
Reduction of simple dislocation
Simple laceration repair
Simple removal of foreign body
Temporary splinting of fracture

Venipuncture
Circumcision

(G) LEAVE REQUESTS (Specific to Pediatrics)

For GME leave policies please see GME Policies at the “New Innovations” website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

1. Vacations:

For GME vacation policy please see GME Benefits at the “New Innovations” website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

Vacation Days

Residents may take a total of 15 weekdays of vacation during each academic year. Vacation time does not accrue from year to year and must be taken in the same academic year the vacation is earned. Residents are not paid unused vacation leave at the time of the completion of their program. Residents must return to work after their approved vacation leave. Failure to return from vacation at the scheduled return time will be considered a “performance issue” (professionalism) and may be grounds to dismiss or not to issue a subsequent year’s contract.

Each resident is allowed to take vacation from only vacation-eligible blocks each year. (See the “Program Overview” section regarding which blocks are vacation-eligible.)

It is preferred that only 5 working days be taken in any single vacation-eligible block. Those requested vacations should consist of 5 consecutive working days, Monday through Friday, in order to allow for the best possible educational experience during the affected rotation. It is possible to request: (1) more than 5 days in a block, (2) less than 5 days in a block, or (3) non-consecutive workdays within the block rotation. However, the rotation director and the program director must approve such requests. The resident is responsible for obtaining the necessary signatures & submitting the request form for approval prior to vacation request deadlines.

Submitting a Vacation Request

For a vacation request to be approved, the request must be submitted via the official leave request form. The leave request form is available in the resources section of New Innovations. Residents must fill out a leave request form, which includes the intended start and end dates and, if necessary (see below), appropriate signatures from the affected rotation directors. Residents must then submit the form to the Chief Resident with enough time to allow for the Chief Resident and the Program Director to review and approve the request before the approval deadline described below.

After the Chief Resident receives the form, she/he will ensure that the vacation request complies with all program regulations, has all the required signatures, and was submitted prior to vacation submission deadlines. If each of those stipulations is met, the Chief

Resident will document the vacation leave, and notify the continuity clinic scheduler & continuity clinic rotation director of the vacation approval so that any "missed" continuity clinic sessions during the proposed vacation will be blocked. The Chief Resident will then sign the form, indicating that all the above steps have been completed and pass the form to the Residency Coordinator for further processing, which includes obtaining the Program Director's signature. Further processing includes electronically forwarding the completed form to the USD Residency Corporation Office for Human Resources (HR) to process and keep in the resident's file.

Vacation Request Deadlines & Required Signatures

Standard requests that consist of 5 consecutive workdays within one vacation-eligible block should be submitted at least 60 days prior to the requested time off. Such a request requires only the resident to sign the form prior to delivering it to the Chief Resident for review. This policy is necessary to accommodate administration, faculty, nursing and patient scheduling.

If a request is submitted 30-60 days prior to the requested time off, the resident is responsible for obtaining the signatures from the directors of all rotations affected by the vacation including the continuity clinic director, prior to submitting the form to the Chief Resident for review. The rotation director and continuity director signatures indicate their approval of the leave request.

All vacation requests that involve either (1) more than 5 days in a block, (2) less than 5 days in a block, or (3) non-consecutive workdays within the block rotation must be submitted to the Chief Resident for review at least 60 days prior to the requested time off. In general, if these 3 types of requests are submitted less than 60 days prior to the requested time off, these will not be approved, except for emergent or extenuating circumstances. Regardless of how far in advance this type of request is submitted, the resident is responsible for obtaining the signatures from the directors of all rotations affected by the vacation including the continuity clinic director if more than one clinic session is affected, prior to submitting the form to the Chief Resident for review. The rotation director and continuity director signatures indicate their approval of the leave request.

Any vacation requests submitted with less than 30 days before the requested time off will not be granted, except for emergent or extenuating circumstances. In order for these less than 30-day requests to be considered, the submitted vacation request form must include signatures from the director of the rotation affected by the vacation and the continuity clinic rotation director, indicating director(s) approval of the request, prior to submitting the form to the Chief Resident for review.

Summary of Vacation Requests Submitted to Chief Resident

The Request	***Time before actual vacation*** *(# of days prior to requested time off)*	***Required Signatures*** *(other than from the resident)*
5 consecutive workdays	≥ 60 days	No additional signatures required
5 consecutive workdays	30-60 days	Director of affected rotation & Continuity clinic rotation director
5 non-consecutive workdays	≥ 60 days	Director of affected rotation
Less than 5 workdays	≥ 60 days	Director of affected rotation

More than 5 workdays	≥ 60 days	Director of affected rotation
More than 1 continuity clinic day affected	≥ 60 days	Continuity clinic rotation director

Interview Days:

The USD SSOM administration allows current PGY-2 and PGY-3 residents a total of 5 excused days during their residency for job interviews ("real life job" interviews) or for fellowship interviews. After the allowed 5 days are used, the resident must use vacation days for any remaining interview time. While the rules for requesting vacation leave, detailed above, apply, the residency program understands there may be extenuating circumstances since timing of interview invitations cannot be predicted.

Residents are urged to schedule interviews during elective months. If it is unavoidable to interview during other rotations, the resident may be required to make up some of the missed rotation days and/or continuity clinic sessions, depending on the total number of clinical days missed during that rotation.

The resident must verbally notify (text message, email, in person) the Chief Resident as soon as an interview is scheduled so that the Chief Resident can work with the resident to ensure the rotation obligations are covered and rotation directors have approved time off for interviews.

It is the resident's responsibility to fill out a leave request form, obtain signatures from the director of the rotations affected by the interview, including continuity clinic if a clinic day is affected, and submit the form to the Chief Resident for approval by the Chief Resident and Program Director prior to leaving for interview(s).

The resident is also responsible for arranging coverage for any scheduled call the resident would miss and must notify the Chief Resident of that arrangement. Recognizing that interviews are often scheduled with little notice; the Chief Resident may suggest a different arrangement to ensure that all residents involved in coverage do not violate clinical and educational work hour (duty hour) regulations.

Paid Days Off

A resident has 10 paid days off to account for sick leave and personal leave per year. When a resident is unable to report for duty due to illness or injury or requires leave for personal reason(s), he or she must notify the people most affected by the sick leave/personal day, in particular the attending physician of the day for the rotation, Continuity Clinic (if applicable), Residency Coordinator, and the Chief Resident. Notifications can be made by email.

If the resident is on an inpatient rotation (General Pediatrics Inpatient, NICU, PICU), he or she must additionally notify the clinical service (the on-call attending physician, senior resident, and/or designated personnel responsible for patient assignments) by phone as soon as the resident is aware of the need for leave. If the resident is unable to contact the clinical service, he/she should contact the hospital operator OR notify the chief resident.

For General Pediatrics Inpatient, the senior resident (PGY-2, PGY-3) must also verbally sign out all the patients on the service to the activated Back-up senior. If possible, sick/personal day notifications should occur prior to the start of the shift.

The Residency Program Coordinator should be notified within 24 hours of the paid day off by either email, phone, or text. In general, the Chief Resident notifies the Program Director, who gives final approval of the paid day off. Of note, a sick day/personal day may have to be made up if the time off affects the resident being able to complete the rotation's or continuity clinic's educational requirements.

Failure to notify the appropriate people reflects a deficiency in professionalism and will be noted in the resident's portfolio.

As per USD SSOM GME policy, "Residents/fellows will receive 10 scheduled workdays, regardless of length, of paid days off at the beginning of their employment and each contract year thereafter. Paid Days Off (PDO) do not accrue from year to year and must be taken in the same academic year the PDO is earned. Residents are not paid unused PDO at the time of the completion of their program. Residents must return to work after their approved PDO leave. Failure to return from PDO at the scheduled return time will be considered a "performance issue" (professionalism) and may be grounds to dismiss or not to issue a subsequent year's contract.

Paid Days Off should be used singularly, except in extenuating circumstances. PDO may be used for bereavement, unexpected family events, illness, or injury.

Any absence for illness in excess of three scheduled days requires a written statement from a physician documenting the need for absence. Sick leave can be used for an illness or injury of the resident, spouse, dependent children, or parent.

Additional leave (including prolonged or recurrent illness, pregnancy, etc.) may be approved depending on appropriate documentation; however, this leave will be without pay. Vacation time may be applied to these absences in order to receive additional paid leave. Residents are protected by the Family Medical Leave Act (FMLA) for qualifying events. The USD GME policy also provides 2 additional weeks of paid leave for a qualifying event one time in residency.

For full Paid Days Off details refer to GME Benefits section at the "New Innovations" website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

Personal time to attend medical, mental health, and dental care appointments

For all rotations, when necessary, residents may attend medical, mental health, and dental care appointments during their working hours. For routine appointments, residents should try to schedule appointments that can be accommodated by their rotation. (For example, no routine appointments should be scheduled when in continuity clinic, NICU, PICU, or general pediatrics inpatient rotations.) Residents must notify the Chief Resident and the supervising resident or attending physician of the affected rotation of the scheduled appointment.

Educational Leave/CME Policy

Each resident is entitled to 5 educational days per academic year. Prior to scheduling educational days, the resident must check with the Chief Resident to make sure education days do not interfere with patient care and scheduled call. The resident must also submit a

leave request form to the Chief Resident with signatures from the directors of the affected rotations, indicating approval. Similar to scheduling interview days (above), it is the resident's responsibility to arrange a coverage plan for any call shifts that would be missed.

Residents are encouraged to plan ahead and arrange for educational leave/CME during an elective block. Understanding that this isn't always possible, residents must be aware that they may not use more than 2 workdays for education leave during certain service rotations (Inpatient, PICU, NICU, Term Newborn) due to the educational objectives of those rotations. For those rotations, a request for educational leave will only be granted if the resident is presenting at a conference. If the leave would occur during one of the other rotations that are not vacation-eligible and the resident misses more than 2 workdays, then the resident may be required to make up some of the missed days on a later date. There will be exceptions to this policy to accommodate accepted presentations at national meetings and other associated scholarly or advocacy events.

The resident must make up for any call duties that are unfulfilled during educational leave in arrangement with the rotation director of the affected rotation.

Upon return from educational leave, the resident may be asked to give a report to the residents and faculty at morning report, noon conference, or other determined venue.

(H) BACKUP POLICY (aka "Jeopardy Call" or "Filling in for Someone Else")

The Backup system covers unplanned resident absences for both day and night shifts on the general pediatrics inpatient service. This "Backup" system allows for resident coverage when a resident needs to call in sick or has taken a personal day. ***For any absences that are planned in advance, the resident taking leave is expected to find a colleague to cover for himself/herself rather than relying on the back-up resident to cover.*** If a resident needs Backup coverage, he/she must contact the Chief Resident or the scheduled Backup resident. The resident requiring Backup coverage also needs to contact and inform the current general pediatrics inpatient attending physician (hospitalist) of his/her absence.

Backup Coverage

The Back-up system currently only covers the General Pediatrics Inpatient rotation.

There will be one Senior resident (PGY2, PGY3) scheduled on Backup each 24-hour period. The residents covering Backup for a rotation block will work together to ensure that each day of the general pediatrics inpatient rotation block is covered.

Each PGY-2 and PGY-3 resident will be scheduled for Backup call during four blocks each academic year. The resident may NOT sign up for coverage while on Outpatient, Inpatient, PICU, NICU and ED rotations. Although not always possible, residents are encouraged not to sign up for Backup coverage when they are in a Cross-Coverage rotation (See "Cross-Coverage" below). To avoid late cancellations of continuity clinic necessitated by work hour regulations (duty hours), senior residents (PGY2, PGY3) may not cover backup on the day prior to their own continuity clinic.

PGY-1 residents will be scheduled for Backup call during 3 blocks in the second half of the academic year. Backup will be for day shift (6am - 6pm) only. Given the small number of interns, not all days can be backed up. On the days with no intern backup, the backup senior will be notified if he/she needs to help cover the service.

If a resident is scheduled for Backup call, the resident is expected to promptly answer their phone or pager; to be able to arrive at the hospital within 30 minutes (must be in town with transportation, and have child care available); and be in a condition to work (i.e. while on backup call, the resident should not partake in any recreational activities that would impair readiness for clinical work).

If a resident requests Backup, he/she will NOT be expected to provide a return "backup" to the covering resident. If a backup resident is called in for overnight call, he/she will be excused the next day (post-call) to meet clinical and education work hours hour regulations (duty hours). If a resident is called in for more than two backup shifts that pull him/her out of clinical duties from another rotation within the same block unit (not counting weekends), then he/she will be taken off Backup the rest of that block rotation.

If a resident forgets he/she is on Backup and is unavailable or out of town when called in for backup, that resident will be expected to take a personal day for that unfilled backup day and will be expected to provide a return "backup" to the resident that does cover.

(I) CROSS-COVERAGE (aka "Scheduled Weekend Shifts")

Residents from other rotations cover general pediatrics inpatient service on Friday nights (12 hours), Saturdays (24 hours) & Sundays (12 hours) Three senior resident (PGY2, PGY3 or combination) will be assigned per cross-cover block.

PGY-1: Currently, each PGY-1 resident will be assigned to have 2 cross-cover blocks during Blocks 6-11 during non-inpatient rotations.

PGY-2: Each PGY-2 resident will have a total of 4 cross-cover blocks divided between their non-inpatient rotations.

PGY-3: Each PGY-3 resident will have 2 cross-cover blocks divided between their non-inpatient rotations.

If a resident forgets he/she is on cross-coverage and is unavailable or out of town when called in, that resident will be expected to take a personal day for that unfilled cross-coverage day and will be expected to provide a return "cross-cover" to the resident that does cover.

(J) CLINICAL AND EDUCATIONAL WORK HOURS (DUTY HOURS)

Clinical and education work hours (duty hours) encompass the clinical and academic activities related to the training program, including patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Clinical and education work hours do *not* include reading and preparation time spent away from the clinical and education work (duty) site. While not included in work hours, reading and preparation time spent away from the duty site are considered necessary for the resident's education.

Shift Lengths

Clinical and education work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain beyond their scheduled period of duty up to 4 additional hours to continue to provide emergent care, to participate in didactic activities, transfer care of patients, and maintain continuity of medical and surgical care. No new patients may be accepted after 24 hours of continuous duty.

In-House & At-Home Call

In-house call is defined as those clinical and education work hours beyond the normal workday, when residents are required to be immediately available in the assigned institution. The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call, for PGY-1 and above, must occur no more frequently than every third night, averaged over a four-week period.

At-home call (or pager call) is defined as call taken from outside the assigned institution. At-home call is not allowed for PGY-1 residents. The frequency of at-home call for all other residents is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit. The Program Director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

Required Time Off Between Shifts

Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. ***One day is defined as one continuous 24-hour period*** free from all clinical, educational, and administrative duties. Adequate time for rest and personal activities must be provided after each shift. This should consist of an 8-hour time period provided between all daily clinical experience and education periods and after 12-hour in-house call shifts. The resident **must** have 14 hours free of duty following each 24-hour in-house clinical experience and education shift.

Per 2020 ACGME guidelines, there may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than 8 hours free of clinical experience and education. Those specific circumstances must be monitored by the program director. Note that these residents are still included in the 80-hour, maximum duty period length and one-day-off-in-seven standards.

For more on Duty Hours, visit the ACGME website.

Clinical and Education Work Hour (Duty Hour) Summary

To ensure adequate rest between daily duty hours and after in-house call, daily routine and call schedules for each rotation will be designed to accommodate the following duty hour limits for each year of residency training:

1) **Maximum Hours/Week** (averaged over 4 weeks): **80 hours**
   a) Includes moonlighting (Moonlighting not allowed for PGY-1)

2) **Maximum Duty Period Length**
   a) PGY-1 and above: **24 hours** (***28 hours max***, incl. 4 hours for effective transitions of care)

3) **Maximum Consecutive In-House Night shifts** (12hrs): ***6 consecutive nights***

4) **Maximum In-House On-Call Frequency** (24hrs, PGY-1 and above): **Every 3rd night**

5) **Minimum duty-free days/week** (averaged over 4 weeks): ***1 day***
   a) This minimum does not include at-home calls
   b) "*One day" is defined as one continuous 24-hour period.*

6) **Minimum Time off between Scheduled Duty Periods**
   a) Recommended: ***10 hours*** (PGY-1-3)
   b) Mandatory: ***8 hours*** (PGY-1-3)
   c) Post call (s/p 24-hr shift): ***Mandatory 14 hours off***

7) **At Home Call:**
   a) Counts toward 80-hour limit & requirement for one-day-in seven free of duty when averaged over 4 weeks, however the frequency is not subject to every-3rd-night limitation

Clinical and Education Work Hour (Duty Hour) Recording Procedure

All residents must fully and accurately complete their time record on a daily basis using the electronic reporting system (New Innovations). Clinical and education work hours (duty hours) are to be recorded for all rotations.

1. Residents must complete time records on a daily basis (including in-patient hours, out-patient hours, vacation/sick, teaching time and so on for that month). ***It is the resident's responsibility to monitor his/her duty hours to ensure there are no violations.***

2. If the residents is notified of a violation in the New Innovations system, they must provide an explanation.

3. The program and the GME office will review time records for accuracy.

4. The GME office will compile the information from all residency programs and will provide this information to Sanford USD Medical Center and Hospital Finance Departments.

If a resident misses the due date for this process or does not accurately complete the tracking as required, Medicare funding may be in jeopardy. Failure to comply with this expectation may result in the resident's/fellow's paycheck being withheld until all records are complete. Any resident/fellow who violates this policy is subject to the procedures outlined in the Professional Conduct and Misconduct Policy at the "New Innovations" website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

Clinical and education work hours (duty hours) for resident physicians are variable and depend to some extent upon the particular rotation and call responsibilities. It is critical that

each resident remains in contact with the attending physicians and nursing personnel while on service and are aware of their patient's conditions at all times while on duty, in or out of the hospital. If a resident must leave the hospital for a brief period of time during the day, it is mandatory that she/he make arrangements with another resident to cover patient care and communicate those arrangements with the attending physician. Any extended absence must be cleared by the Chief Resident and/or Program Director.

For more information regarding clinical and education work hours (duty hours), visit the ACGME website and see "Clinical Experience and Education" in "GME Policies" at the "New Innovations" website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

Clinical and Education Work Hour (Duty Hour) Monitoring and Communication Protocol by the GME Office

1. The GME Specialist monitors clinical and education work hour (duty hour) recordings on a weekly basis to ensure compliance with USD SSOM Duty Hour/Duty Hour Tracking Policy.

2. New Innovations notifies resident, program administration, and GME administration when a violation occurs.

3. The GME Specialist reviews violation.

4. The GME Specialist communicates with resident through New Innovations, asking for particulars involving the violation and encouraging the resident to speak with program administration about the violation. That communication within New Innovations to the resident is visible to program administration. Follow-up communication may occur via email.

5. The resident reviews the violation, ensuring work dates and times are accurate. If dates and times are accurate, the resident should indicate a "cause" for the violation in New Innovations. If none of the provided "causes" are appropriate, the resident may write in their reason or elaborate further regarding the indicated cause via New Innovations or email.

6. Based on resident response, the violation is either justified in New Innovations or logged as a duty hour violation to be reported to the Graduate Medical Education Committee (GMEC).

7. Duty hour violation trends are tracked by program and training location by the GME Office to ensure ongoing compliancy with ACGME rules.

(K) FATIGUE POLICY

Should a resident be unable to perform clinical duties while on service due to fatigue the resident should inform the senior resident, the Chief Resident, and PD in that order; sign out patient-care to the backup resident and either go home or sleep in the call room. If the resident is too tired to drive, the resident should arrange a ride. The residency program will cover the cost of a taxi or ride share.

It is the expectation of attendings to cover the work of the resident until proper back up can be put in place, if necessary. The Inpatient team will initiate the back up policy. NICU and PICU services will have attendings cover the work of the resident. Continuity Clinic providers will take appointments of residents or move/cancel patients scheduled.

(L) CONFERENCES AND ATTENDANCE

Residents are expected to attend a variety of conferences and rounds specifically designed to provide educational opportunities. Attendance is required at protected didactic activities including core noon conferences, Quality Improvement Bootcamp, and the Pediatric Boot Camp. Additional educational opportunities include Pediatric Grand Rounds, Morning Report, Journal Club, Schwartz Rounds, Safety Rounds, teaching rounds at participating hospitals, and specialty-specific conferences. Remote access to educational opportunities will be available for designated circumstances with preference given to in-person attendance. Some recorded lectures may be available for later review and credit through notification of the Program Coordinator. Residents must notify the Chief Resident of education-related conflicts for attendance in order to be excused.

Residents are expected to maintain an 80% overall attendance rate.

(M) MEALS

Breakfast and lunch are provided during weekdays at the Sanford Physician Center. Residents on duty are provided access to food services at all institutions in the pediatric residency program when on-call on evenings and weekends. Residents are granted a yearly budget for meals on campus when on-call on evenings and weekends. The meal allowance for the academic year per resident will be announced at the beginning of each year.

(N) RETREAT POLICY

Each year, all pediatric residents have a combined retreat for the purposes of team-building and professional development. This retreat is scheduled to occur on a Friday, Saturday and Sunday morning. All pediatric residents are excused from their rotations (as arranged by the Chief Resident) for the scheduled dates of the retreat and are expected to attend the entire retreat. While immediate families (significant others, children) are invited to attend, there will be retreat activities designated for residents only. Except for emergencies, if any resident does not attend the retreat, that resident will be scheduled to take call during the retreat due to issues of inadequate inpatient resident coverage during the time of the retreat. The residents may invite the Chief Resident(s), the Program Coordinator, the Associate Program Director(s) and/or the Program Director at their discretion.

The residency program covers the cost of lodging for the residents as well as most meals and activities. However, the Program Director and Program Coordinator must approve the budget prior to the retreat. In general, the retreat itinerary will be developed by the PGY-2 residents and must be approved by the Program Director and Program Coordinator. The Chief Resident and/or Program Coordinator will notify each class prior to the weekend retreat which activities are exclusive.

(O) Faculty Mentor/Advisor

All residents are assigned a faculty mentor, separate from the Program Director as an academic mentor/advisor. It is the responsibility of the faculty mentor/advisor to be available

to the resident. While the faculty mentor/advisor may initially contact the resident mentee/advisee, it is the responsibility of the resident to frequently meet with the faculty mentor/advisor and at minimum twice per year. A resident may choose to change mentor/advisors at any time but must notify the Program Director or Program Coordinator if such a change is made. PGY1 residents will be assigned a faculty mentor/advisor within 1-3 months after the start of their academic year. Residents are encouraged to choose a separate career mentor.

(P) MEDICAL LIBRARY

The Wegner Health Science Information Center is the central medical library for Sioux Falls and South Dakota. It serves as medical library for the Sanford School of Medicine, Sanford USD Medical Center, Sanford Children's Hospital, and the VA Medical Center. The Wegner Center strives to provide high-quality services to meet the educational, research, and informational needs of students, residents, practicing physicians, and hospital staffs.

Most Wegner library resources are available through the Internet. In addition to the Wegner Center's extensive collection of books, journals, and audiovisual materials, computerized literature searching gives access to more than 800 bibliographic databases. Interlibrary loans can provide books, journals or audiovisuals from other state, local or national libraries. Please follow library regulations regarding the return of checked-out items.

"Up to Date" is available through the Sanford "One Chart" EMR system (EPIC).

(Q) NOTICES FOR RESIDENTS

Residents are responsible for monitoring their email accounts (Sanford & USD), mailboxes (at the continuity clinic & in the resident lounge), and New Innovations for all notices regarding clinical and education work (duty) hours, meetings, conferences, evaluations and other special interest items. ***Residents are urged to develop the habit of checking and answering emails daily for important communications.***

(R) PHOTOCOPYING

Residents are responsible for their own photocopying. At Sanford, photocopiers are available in the Wegner Center, the Program Coordinator's office, and the resident lounge. Residents should call the maintenance number on the photocopier in the lounge if the photocopier is not functioning appropriately. The resident(s) may notify the residency program office for assistance.

(S) UNIFORMS

Residents will be provided long, white laboratory coats. Identification (ID) badges with resident name, picture, and residency program are also provided and must be worn at all times. Hospital-issued scrubs will be worn on designated rotations and may not be worn outside of the hospital.

(T) CALL ROOMS/LOCKERS/LOUNGE

Residents have call rooms, lockers, and a lounge available for their sole use located in the basement of the Sanford Children's Hospital, close to the resident classroom. The resident ID badge grants access to the lounge.

(U) RESIDENT MEDICAL LICENSE *Very Important*

All resident physicians new to the Sanford Pediatric Residency Program and the Department of Pediatrics at Sanford Children's Hospital, SSOM USD must contact the Residency Office shortly after acceptance into the residency program to begin the application process for their resident license. They must have their official S.D. Resident Medical License before reporting to a hospital or performing any official duties.

Resident physicians cannot participate in patient care experiences until their professional liability insurance is in effect and the South Dakota State Board of Medical and Osteopathic Examiners has issued a resident license.

(V) RESIDENT YEAR ADVANCEMENT *Very Important*

All PGY-1 resident physicians in the Sanford Pediatric Residency Program must take the Step 3 Medical Licensing Examination (USMLE or COMLEX equivalent) in order to advance to PGY-2. All PGY-2 resident physicians in the Sanford Pediatric Residency Program must pass the Step 3 Licensing Examination (USMLE or COMLEX equivalent) in order to advance to PGY-3. <u>This is a SSOM USD GME policy.</u>

III. GENERAL RESIDENT STAFF POLICIES
[Sanford Pediatric Residency Program, Sanford Children's Hospital and SSOM USD]

(A) PATIENT CARE RESPONSIBILITIES

i. Inpatient Rotations Patient Care Responsibility

The Attending Physician, the patient's "Physician of Record," has ultimate responsibility for patient care, but residents have responsibility for all patients assigned to them. The "chain of responsibility" for patient care is the Primary Patient Care Resident, Supervising Resident, and the Attending Physician (the Physician of Record). In the event of a problem or question when the patient's Attending Physician cannot be reached, the "chain of responsibility" extends to the hospital Rotation Director; and the Program Director or his/her designee. Other physicians to contact, should "chain of responsibility" be uncertain, are the Chief Medical Officer or the Chair of the Department.

Responsibilities of the Primary Patient Care Resident (may be at any level of training):

1. See and evaluate all assigned patients as soon as possible after admission. That includes performing a comprehensive evaluation of the patient, writing admission orders and an admission H&P Note, and discussing the patient assessment and management plans with the Supervising Resident and Attending Physician in a timely manner. H&Ps must be completed by the end of the shift.

2. See, evaluate, and care for assigned patients daily, writing orders as indicated by the complexity and severity of patient illness.

3. Write a daily Progress Note on all assigned patients, which should be in the chart in a timely manner (by end of shift).

4. Confer with the Supervisory Resident and the patient's Attending Physician on a regular daily basis on all assigned patients and confer more frequently when caring for more complex patients.

5. All major, emergent, or important diagnostic or therapeutic problems must be discussed with the Supervising Resident and/or the patient's Attending Physician following admission.

6. When a resident is responsible for initiating a consult that resident is responsible for calling the consultant personally on all consults ordered to help coordinate care. A "text" is **not** considered a "call to the consultant." While a "text" can notify a consultant of a consult request, that "text" must be immediately followed by a personal call or face-to-face request.

7. Residents must ensure excellent patient care following discharge by completing the discharge summary within 48 hours, but preferably on the day of discharge. Discharge planning and education for patients and families should begin at the time of admission.

8. Residents are responsible for signing out their patients to the covering physician, whether resident or attending physician, prior to going off duty. Procedure for sign out must follow patient transfer policy established by the rotation director (IPASS).

9. At the end of the block, residents should provide verbal AND written communication about patients with oncoming residents. An off-service note is encouraged, particularly for more complex or chronic patients.

10. Residents must abide by all the Medical Staff bylaws of the hospital or patient care setting where they work.

Responsibilities of the Supervising Resident (PGY-2 or PGY-3 Resident):

1. Assign patients to the Primary Patient Care Resident.

2. See and evaluate all patients as soon as possible after admission.

3. Perform at least one daily Work Round with each Primary Patient Care Resident and more frequently with the Primary Patient Care Resident on critically-ill patients, dependent upon the complexity and severity of the patient's illness.
   a. Special attention should be given to overseeing the Primary Patient Care Resident in situations involving care of complex patients, patient transfers from PICU, and patients with DNR status or other end-of-life status.

4. Make Chart Rounds frequently to insure appropriate care is being given to each patient. The entire patient chart should be reviewed by the Supervising Resident immediately prior to discharge of a patient to insure all the patient's problems have been addressed prior to discharge.

5. Supervising Residents should not write orders except in an emergency or when asked to do so by the Primary Patient Care Resident.

6. Be available to the Primary Patient Care Resident to help with patients.

7. Supervise sub-interns (4th year med students or “third-pillar” med students from USD SSOM) and write H&P notes, progress notes, discharge summaries, & orders regarding all patients being covered by the sub-interns. Supervise “second-pillar” students and cosign/grade notes.

8. Serve as an educational resource to all members of the Primary Care Team while providing emotional support, encouragement, and leadership by example to the Primary Patient Care Team.

9. Work closely with the patient’s Attending Physician to ensure that the patient receives proper care and that the Primary Patient Care Resident has the opportunity to achieve educational goals.

10. Supervise resident sign out of his/her patients to covering physician, whether resident or attending physician, prior to going off duty. Procedure for sign out must follow patient transfer policy established by the rotation director (IPASS).

11. Residents must abide by all the Medical Staff bylaws of the hospital or patient care setting where they work.

ii. Elective, Consultation, & Emergency Medicine (EM) Patient Care Responsibility

For Elective, Consultation (Subspecialty) or EM Rotations, Residents are assigned to a Faculty Supervisor who may be the patient’s Attending Physician or the patient’s Consulting Physician dependent upon the rotation and the role of the Faculty Supervisor.

The Resident responsibilities for patient care are dependent upon the resident’s role as the Primary Patient Care provider or Consultant as determined by the Faculty Supervisor. When the Resident acts as the Primary Patient Care provider, the Resident’s responsibilities are the same as for Inpatient Ward Services. In the event that a question or problem arises where the resident cannot contact the Faculty Supervisor or his/her designee, the Resident should contact the hospital Rotation Director followed by the Program Director or his/her designee. When in a Consulting role, the “chain of responsibility” for patient care is the Resident, Faculty Supervisor, and patient’s Attending Physician. Other physicians to contact, should “chain of responsibility” be uncertain, are the Chief Medical Officer or the Chair of the Department.

When the Resident is acting in a Consultative role, orders can be written by the consulting Resident only in an emergency situation or at the patient’s Attending Physician’s specific request as that is the responsibility of the Primary Patient Care Resident. Residents must abide by all the Medical Staff bylaws of the hospital or patient care setting where they work.

iii. Outpatient Rotation Patient Care Responsibility

In the Ambulatory Care setting, the patient care “chain of responsibility” is determined by the role of the Resident and the Resident’s Faculty Supervisor as outlined previously. However, the “chain of responsibility” for Resident supervision is the Faculty Supervisor, Rotation Director, and then the Program Director or designee. Other physicians to contact, should “chain of responsibility” be uncertain, are the Chief Medical Officer or the Chair of the Department.

The Resident responsibility for patient care is the same as outlined previously in this section describing the Resident role as Consultant or Primary Patient Care Provider.

iv. "Non-teaching" Service Patient Care Responsibility

In Ambulatory Care settings, the Resident may participate in urgent/emergent care of "Non-teaching" patients (patients not covered by the resident's service) at the discretion of the Faculty Supervisor, until the arrival of the patient's Attending Physician or appropriate designee. Under no other circumstances may the Resident be involved in the care of "non-teaching" patients without the expressed prior approval in writing from the Program Director or his/her designee. Other physicians to contact, should "chain of responsibility" be uncertain, are the Chief Medical Officer or the Chair of the Department.

In the Inpatient setting, a Resident may participate to the level to which they are competent in the urgent/emergent care of "non-teaching" patients under the moral and ethical expectations of a Physician until the arrival of the patient's Attending Physician or appropriate designee. Under no other circumstances may the Resident be involved in the care of "non-teaching" patients without the expressed prior approval in writing from the Program Director or his/her designee. Other physicians to contact, should "chain of responsibility" be uncertain, are the Chief Medical Officer or the Chair of the Department.

(B) THE NUMBER OF ADMISSIONS & PATIENTS PER RESIDENT

1. Inpatient Setting

In the inpatient setting, the number of patients assigned to each Resident must be such as to permit detailed study and effective management of each patient while ensuring that the Resident is challenged with diverse and complex medical problems. The conditions outlined below may change depending on ACGME requirement(s).

Hospitalist Service: PGY-1 Residents

On average, each PGY-1 Resident should be responsible for the ongoing care of five to eight patients, depending on the nature and severity of the individual patient illnesses. A lower number of patients may be appropriate for Critical and Intensive Care situations. Each PGY-1 Resident is responsible for pre-rounding, rounding, and the ongoing care of a maximum of 10 patients per day, except under unusual circumstances with approval by the Program Director or the Chairman of the Department of Pediatrics. This limit of 10 does not include new admissions throughout the day.

Each PGY-1 Resident may be assigned a maximum of five new patients per day (24-hour period) and no more than eight new patients in a 48-hour period. When the maximum number of new patients that can be assigned has been reached or when the patients admitted to the PGY-1 Resident are extremely complex but of a lesser number, the Supervising Resident (PGY-2 or PGY-3) must admit and assume primary patient care responsibility for subsequent admissions. Those patients admitted by the Supervising Resident may be reassigned to other inpatient team members on the following day.

Hospitalist Service: PGY-2 & PGY-3 Residents

Each PGY-2 & PGY-3 resident may be responsible for the ongoing care of a maximum of 20 patients when accompanied by no other residents or only 1 intern, 24 patients with 2 interns and a maximum of 30 patients with 3 interns. If the hospital census exceeds 30 patients the PGY-2 or PGY-3 senior should coordinate with the on-call hospitalist for coverage of additional patients. All of these patient maximums include the patients covered by the senior resident and the other residents on the inpatient team. These maximums will not be increased based on medical students or other non-physician learners on the team.

Each PGY-2 & PGY-3 resident may admit a maximum of 10 new patients in a 24-hour period.

All residents should recognize their limitations and are advised to reach out to their supervising senior residents or attending physicians, including in but not limited to the following circumstances:

1. Multiple simultaneous admissions (> 3 admissions)
2. Challenging social situations (example: non-accidental trauma)
3. Medically complex patients with any dilemma in management
4. Any other issue that may compromise patient care

PICU

On the Pediatric Intensive Care Rotation, a PGY-2 or PGY-3 Resident may be responsible for the ongoing care of a maximum of 8 patients, including those under the care of a first year Resident or sub-intern being supervised (should there be a first year Resident in the PICU). These conditions may change depending on new proposed ACGME requirements.

NICU

PGY-1 and PGY-2 residents will be responsible for the ongoing care of four to a maximum of eight patients, which are assigned at the discretion of the attending physician. The PGY-3 resident will be the primary resident physician for a maximum of eight patients during the day when unaccompanied by another resident. When accompanied by a junior resident, this number will be decreased to a maximum of 2 primary patients to allow the PGY-3 to assume a supervisory role. During night shifts, the PGY-3 will be responsible for covering up to a maximum of 30 patients.

2. **Outpatient Setting** (including Continuity Clinic)

In the Ambulatory Care (and Continuity Clinic) setting, the patient volume for Residents must be large enough to provide adequate numbers of return patients but not so large a number as to interfere with teaching. The number of patients seen by a PGY-1 Resident per clinic (half-day session), when averaged over the year, must not be less than 3 per half-day session. The number of patients seen by a PGY-2 Resident, when averaged over the year, must not be less than 4 per half-day session. The number of patients seen by a PGY-3

Resident, when averaged over the year, must not be less than 5 per half-day session. The maximum number of outpatients per half-day in any outpatient clinic is 12 for all three residency years. These conditions may change depending on ACGME requirement(s).

(C) FACULTY SUPERVISION

Residents must be supervised at all training sites and at all levels of training. Residents are assigned a faculty supervisor during each rotation. The faculty supervisor may be the patient's attending physician, the consulting physician, or the teaching-attending physician depending upon the role of the faculty supervisor for a given patient. The responsibility for resident supervision extends to all resident activity in the Residency Program during the rotation of the faculty supervisor.

The responsibilities of the faculty supervisor are as follows:

1. Provide supervision, guidance, and education to the residents assigned to them.
    a. Special attention should be given to overseeing residents in situations involving care of complex patients, patients transferred from the PICU, and patients with DNR status or other end-of-life status.
2. Faculty supervisor must document supervision of the resident in each patient's medical record.
3. Faculty supervisor must see the patient and write a note in the chart within 24-hours of admission or consultation.
4. Faculty supervisor must counter-sign notes and orders and write progress notes when appropriate.
5. Although the faculty supervisor is not enjoined from writing orders, residents should write all orders on a patient assigned to them.
6. Faculty supervisor must provide the resident and Program Director with a resident performance evaluation in a timely manner using Residency Program evaluation guidelines at the completion of each resident's rotation. Faculty are encouraged to give mid-rotation feedback to the resident.

Residents are encouraged to communicate with supervising Faculty Attendings any time that resident feel the need to discuss any matter relating to patient-care. The following are circumstances and events where residents must communicate with supervising Faculty Attendings:
● circumstances mentioned in the USD policy ● if requested to do so by other Faculty Attendings in any primary or specialty program, staff member, and/or patients or family ● If any error or unexpected serious adverse event is encountered at any time ● If the Resident is uncomfortable with carrying out any aspect of patient care for any reason

Residents/fellows must convey directly to the attending physician any substantial change in the condition or status of a patient under the care of that attending physician, including admission, transfer to a hospital area providing a higher level of care, discharge (including those from the ER), and the development of any complications.

Of note, first-year Residents must be under Direct Supervision, that is, the supervising physician must be physically present with the first-year resident and patient. The supervising physician can be a second-year or third-year resident or attending physician.

(D) MEDICAL CHARTING WORKFLOW BY RESIDENTS

Sanford Children's Hospital and Specialty Clinics use the EPIC EMR system. As such, the residents will be expected to type and/or dictate, through DRAGON Software, the orders, notes, and history and physical examinations. Sanford Children's Specialty Clinic is responsible for providing resident information to the EMR department prior to the residents' start in the program and for training residents how to use the EPIC EMR system for both hospital and clinic charting.

(E) MOONLIGHTING

"Moonlighting" is limited to PGY-2 and PGY-3 residents and may take place outside of the residency as well as within the residency.

Outside moonlighting is work outside the Residency Program and its affiliated hospitals by a resident that is reimbursed in any way. Residents in good standing in the Program may moonlight, if appropriately licensed and with the prior approval of the Program Director. Moonlighting is allowed during a resident's free time as long as it does not interfere with his/her education and overall health. Moonlighting is not allowed during Inpatient rotations at any hospital. Residents may not moonlight more than 48 hours per month. Hours spent moonlighting will be counted toward the 80-hour workweek maximum.

The Residency Program will not provide professional liability insurance or any licensure or permits, such as DEA number, for work performed by a resident outside the Residency Program and its institution (Sanford Health). It is each resident's responsibility to be certain that professional liability insurance and licenses be provided in each instance of moonlighting by the resident or his/her moonlight employer. All moonlighting arrangements are between the resident and the physician or institution for which he/she works the moonlighting assignment.

Residents must notify the Program Director through the Program Coordinator of all moonlighting activities concerning duration and frequency prior to the moonlighting activity. The Program Director or his/her designee will monitor moonlighting activities of all residents. Residents will be counseled for excessive moonlighting activity and a resident may be restricted from moonlighting if moonlighting interferes with his/her education and overall health. Moonlighting that occurs within the Residency Program and/or the sponsoring institution or the sponsoring institution's non-hospital sites will be counted toward the 80-hour workweek limit or duty hours. If the 80-hour workweek limit is exceeded through moonlighting, permission for moonlighting will be denied.

See the New Innovations website for GME Policy on moonlighting:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

(F) COUNSELING

Resources are available to residents to deal with stress, fatigue, anxiety, depression, or burnout, and to provide counseling and other support services. Resources to residents include the following:

Chief Resident

Faculty advisor
Program Director
Associate Program Director(s)
Program Coordinator
Pediatrics department chair
Fellow residents
Faculty
Faculty mentor/advisor
Nursing supervisors
Sanford Health System Ombudsman (Executive Director, Medical Education)
USD SSOM DIO
USD SSOM Human Resources
Community physician, psychologist, psychiatrist through the resident's health insurance.

(G) GRIEVANCE PROCEDURE

Breaches of professionalism are addressed on a case-by-case basis. The immediacy for addressing the breach depends on the critical nature of the unprofessional behavior; faculty may immediately address the resident for witnessed severe unprofessional behavior. Otherwise, faculty will bring the matter to the Program Director's attention. The Program Director will specifically discuss with the resident regarding the breach of professionalism as soon as possible. The results of discussion will be kept confidential but critical incidents will be included in the resident's portfolio. The remediation plan is dependent upon the type of breach. When appropriate, in addition to the Program Director directly investigating resident behavior, the resident's faculty mentor/advisor may be notified so that the mentor/advisor can also counsel the resident and assist in improving the resident's professionalism. Should there be disagreement between the Program Director and the resident over professional behavior, the SSOM GME grievance procedure will be activated (Notification of DIO, and if necessary, the Dean). Should there be difficulty in forming a remediation plan, the USD SSOM GME office will be contacted for assistance. At the semi-annual (or quarterly) ILP meeting, the PD will review any past professional breaches and will discuss with the resident the results of self-reflection and the achievement of behavioral change.

(H) DISCIPLINARY ACTION AND ASSURANCE OF DUE PROCESS

Due Process: as described within, due process applies to actions that are taken as a result of academic deficiencies and/or misconduct, and that may impact the intended career development of the resident. (See Academic Improvement Policy and Professional Conduct and Misconduct Policy at the "New Innovations" website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

Complaint: refers to the review of resident complaints or issues related to the work environment, the program, or faculty.

Academic Matters: A decision not to promote a resident to the next PGY level, to extend a resident's contract, to extend a resident's defined period of training, to not renew a resident's contract, and/or to terminate the resident's participation in a residency program would all be considered actions with potential impact on the trainee's career development. A review of the program's decision to take an action for academic matters may be requested by the resident. A written request for review must be submitted to the DIO/Chair of GMEC within 14 days of learning of the action. Upon a request for review, the DIO/Chair of GMEC

will first determine whether the matter is reviewable under this policy and if so, the DIO/Chair of the GMEC will then forward the resident file to the VP/Dean of USD SSOM.

At this time, the VP/Dean of USD SSOM may wish to ask questions of the resident and Program Director. The VP/Dean of USD SSOM may also convene a panel of faculty to review the resident's appeal. The VP/Dean of USD SSOM will then render a decision. This decision will be immediately effective, binding and final, and not subject to further appeal.

Misconduct Matters: A review of the decision to take an action for resident misconduct matters may be requested by the resident. The review process will be the same as that for academic matters (outlined above), with the following exception: The VP/Dean of SSOM will determine whether the resident received appropriate notice and an opportunity to be heard regarding the matter at hand, and whether the decision to take the action was reasonably made.

The procedures as outlined above shall not preempt the Medical Staff By-laws or personnel codes of the hospitals and shall not preempt or limit any right of the hospitals under the Agreement with Physician (resident contract) to immediately suspend a resident.

Complaint Matters: This refers to some cause of distress (such as an unsatisfactory working condition) that is felt by the resident to present a reason for complaint, but does not impact intended career development. Complaints must be dealt with in as confidential a manner as possible, and without fear of retaliation. A complaint or incident should be reported to the resident's Chief Resident or attending physician. If the Chief Resident or attending is unable to help the trainee effectively resolve the issue, the resident should take the problem to the Program Director for resolution. If satisfactory resolution is still not achieved after the Program Director has become involved, the resident may provide a written complaint report to the DIO/Chair of GMEC.

The DIO/Chair of GMEC will review the written complaint report and meet with the resident to ensure that steps as outlined above for Complaint Matters were followed. The DIO/Chair of GMEC may then convene other individuals deemed necessary to perform a reasonable inquiry and problem-solving process, including but not limited to the complainant's Program Director, hospital administrators, other residents or faculty, and/or human resources personnel. The DIO/Chair of GMEC and/or other appropriate participants will investigate all the issues associated with the complaint and will provide a final and binding decision to the resident, unless precluded by confidentiality (i.e. if a complaint culminates in a personnel action against a resident, faculty, or staff member).

See Policy on disciplinary action and assurance of due process at GME Policies at the "New Innovations" website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

(I) DISCRIMINATION/HARASSMENT POLICY

Both Sanford Children's Hospital and the USD SSOM GME office have written policies in place for dealing with complaints relative to discrimination or harassment of various types (i.e. race, sex, age, etc.). The procedure for reporting grievances is delineated in these policies.

In addition, USD follows the policies set forth by the South Dakota Board of Regents, found below. If a grievance is not handled to the satisfaction of a resident/fellow by the parent training program, a complaint can be directed to the Director, Equal Opportunity and Chief Title IX Coordinator at 205 Slagle Hall (605-677-5651) or the Vice President, Student Services/Dean of Students at 218 Muenster University Center (605-677-5331).

SOUTH DAKOTA BOARD OF REGENTS

- Sexual Harassment
- Equal Opportunity, Non-Discrimination, Affirmative Action
- Human Rights Complaint Procedures

See Policy on discrimination/harassment at GME Policies at the "New Innovations" website:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

For SD Board of Regents policy on Harassment:

https://www.sdbor.edu/policy/Documents/1-17.pdf#search=harassment

For SD Board of Regents policy on Employee-Employee and Faculty-Student Consensual Relationships:

https://www.sdbor.edu/policy/Documents/1-23.pdf#search=harassment

IV. CURRICULUM (ACGME COMPETENCIES)

Residency programs must require that residents obtain competence in the six areas listed below to the level expected of a new practitioner (unsupervised practice). Assessment of resident performance is based on Milestones assigned per competency. The following are the knowledge, skills, and attitudes required by our program to fulfill these requirements:

(A) PATIENT CARE

Goal: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Objectives: Residents are expected to…

- Gather essential and accurate information about their patients
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- Develop and carry out patient management plans
- Counsel and educate patients and their families
- Provide health care services aimed at preventing health problems or maintaining health
- Work with health care professionals, including those from other disciplines, to provide patient-focused care

Learning Opportunities:

- Hospital and outpatient rotations

Evaluation Methods:

- 360° Global Review
- Patient Survey

(B) MEDICAL KNOWLEDGE

Goal: 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.

Objectives: Residents are expected to…
- Develop clinically applicable knowledge of the basic and clinical sciences that underlie the practice of medicine
- Demonstrate the ability to apply scientific principles in clinical problem solving and decision-making
- Demonstrate the ability to find practice-relevant information and critically evaluate current medical information and scientific evidence

Learning opportunities:
- Conferences
- Outpatient and hospital rotations
- Small group discussions

Evaluation Methods:
- 360° Global Review
- Exam MCQ
- ABP In-training Examination

(C) PRACTICE-BASED LEARNING & IMPROVEMENT

Goal: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Objectives: Residents are expected to…
- Analyze and evaluate their practice experiences and implement strategies to continually improve their quality of patient practice
- Use information technology or other available methodologies to access and manage information and support patient care decisions and their own education
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Facilitate the learning of students and other health care professionals

Learning opportunities:
- Conferences
- Committee assignments
- Outpatient and hospital rotations
- Scheduled conferences with program director

Evaluation Methods
- 360° Global Review
- Exam MCQ
- Patient Survey

(D) INTERPERSONAL & COMMUNICATION SKILLS

Goal: Residents must be able to develop a professional relationship with patients and their families using verbal and non-verbal skills to communicate effectively and work effectively as a team member or leader.

Objectives: Residents are expected to…
- Create and sustain a therapeutic and ethically sound relationship with patients
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Work effectively with others as a member or leader of a health care team or other professional group

Learning opportunities:
- Hospital and outpatient patient care experiences
- Small group discussions
- Scheduled conferences with program director
- Resident recruitment and selection
- Medical student teaching

Evaluation Methods:
- 360° Global Review
- Patient Survey

(E) PROFESSIONALISM

Goal: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Objectives: Residents are expected to…
- Demonstrate respect, compassion, and integrity; a responsiveness to needs of patients and society that supersedes self-interest; and accountability to patients, society, and the profession
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities
- Respect for patient privacy and autonomy

Learning opportunities:
- Conferences
- Small group interactions during outpatient and hospital rotations

Evaluation Methods:
- 360° Global Review

(F) SYSTEMS-BASED PRACTICE

Goal: 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.

Objectives:
- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for quality patient care and assist patients in dealing with system complexities
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

Learning opportunities:
- Outpatient and hospital rotations
- Conferences
- Committee assignments

Evaluation Methods
- 360° Global Review
- Case review

IV. GME POLICIES

See "New Innovations" website for full, detailed list of policies & benefits:

https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals

(A) RESIDENCY POLICIES

Academic Improvement
Away Rotation
Away Rotation Application
Clinical Experience and Education
Counseling Services Policy
Disability Services and Accommodations
Disaster
Discrimination and Harassment
Due Process and Resident Complaint
Evaluations
HIPPA, Privacy, and Virtual Conferences
Humanitarian Rotation
Humanitarian Rotation Application
Immigration Law
Immunizations
Jury Duty and Civic Responsibility

Liability Management
Moonlighting
Non-Competition
PGY3 Progression
Physician Impairment
Policy Review
Professional Conduct and Misconduct
Promotion
Recruitment, Eligibility, and Selection
Resident Closure/Reduction
Social Media
Supervision
Transfers
Transitions of Care
Vendor Interaction
Visa
Well-Being Policy

(B) RESIDENT BENEFITS & LEAVE POLICIES

$1000 Deductible Coverage Manual
$500 Deductible Coverage Manual
2020 Coverage Manual Temporary Benefits Addendum
5500 Annual Report Summary
Benefit Disclaimer
COBRA
Dental Insurance
Disability Insurance
Education Allowance
Educational Leave
Emergent Leave
Families First Coronavirus Response Act
Family Medical Leave
Fringe Summary FY21
FY21 Flex System Plan Document
Health Insurance
Lab Coats
Leave of Absence
Military Leave
Part-Time Benefits
Professional Liability Insurance
SBC $1000 Deductible
SBC $500 Deductible
Sick Leave
Sick Leave
Stipends

Tax-free Spending Accounts
Term Life Insurance
Time Off Request Form
Time Off Request Form
Time Off Request Form
Vacation Leave
Vision Insurance
Workers' Compensation

V. RESIDENT ELIGIBILITY CRITERIA

(A) FIRST POSTGRADUATE YEAR (PGY-1) APPLICATIONS

Eligibility
Applicants for the GME program at the Department of Pediatrics at Sanford Children's Hospital and the USD SSOM are eligible for appointment if they meet *one* of the following qualifications:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education who have passed *both* Step 1 and Step 2 CK of the United States Medical Licensing Examination (USMLE). (No more than three attempts per USMLE step are allowed by the state licensing board.)
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association who have passed *both* Step 1 and Step 2 CE of the COMLEX USA. (No more than three attempts per COMLEX step are allowed by the state licensing board.)
3. Graduates of medical schools outside the United States and Canada who meet *each* of the following qualifications:
    a. Hold a currently valid Standard Certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), the requirements for which include passing *both* Step 1 and Step 2 CK of the USMLE.
    b. Are citizens of the United States OR hold either a J-1 visa or a permanent immigrant visa ("green card"). An H1-B visa will be considered only in unusual circumstances approved in advance in writing by the Designated Institutional Official. All residents regardless of medical school or country of origin must hold a currently valid Social Security Number as evidenced by an official Social Security Card.

Note: Foreign nationals who are graduates of medical schools in the United States and Canada are not considered international medical graduates and do not require ECFMG sponsorship.

Additionally, applicants to residency programs will only be considered at the time of application if they are eligible for ALL of the following:

1. Appropriate licensure in the State of South Dakota.
2. Participation in Federally qualified health programs such as Medicare and Medicaid. A list of individuals with sanctions that would disqualify their participation can be found on the Health and Human Services Office of Inspector General website at: www.oig.hhs.gov.

3. Professional liability insurance through the carrier designated by USD SSOM at the usual and customary rates offered all other residents in the same discipline at the same PGY level.

Issues that may preclude eligibility for the above include, but are not limited to, prior felony convictions, substance abuse, malpractice judgments or settlements, or disciplinary actions by a state medical board.

Resident Selection Criteria – Resident Recruitment
Residents are selected from among eligible, qualified applicants on the basis of their academic credentials, abilities, aptitude, preparedness, communication skills, and personal qualities including motivation and integrity. This university, in compliance with all applicable Federal and State laws and regulations, does not discriminate on the basis of race, color, national origin, sex, age, religion, disability, political beliefs, or status as a veteran in any of its policies, practices, or procedures. This includes but is not limited to admissions, employment, financial aid, and educational services.

Please note that the program, in partnership with its sponsoring institution USD SSOM engages in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty members, senior administrative staff members, and other relevant members of its academic community. See:

https://www.usd.edu/diversity-and-inclusiveness/diversity-and-inclusiveness-statement

NRMP & ERAS
First-year residency positions will be offered to U.S. graduating seniors selected through an organized matching program, such as the National Resident Matching Program (NRMP). Most residency programs, as does ours, require applicants to apply through the Electronic Residency Application Service (ERAS). First-year residency positions offered to candidates other than U.S. graduating seniors will also be selected through an organized matching program, such as the National Resident Matching Program (NRMP). Applicants for these positions should consult the publications of the NRMP or alternative matching program for specific requirements and date deadlines.

(B) SECOND POSTGRADUATE YEAR (PGY-2) AND ABOVE

Appointments for second year and above levels are made in accordance with policies established by each specialty program in compliance with the standards of the Accreditation Council for Graduate Medical Education, its Residency Review Committees, and the requirements of the respective American specialty certification boards.

The PGY level of the initial appointment is determined by the amount of previously completed graduate medical education that is acceptable for credit by the specialty board of the training program to which the resident is appointed and the functional level at which training will be pursued. All previous GME training must be assessed and verified by the Program Director prior to appointment and assigning level of training. Whenever there is uncertainty in this regard, the applicant shall obtain from the specialty board a written appraisal of previous training and a statement of additional training requirements that must be met to qualify the resident for certification by that board.

Initial appointment and all reappointment of residents currently in GME programs to levels of training beyond the PGY-1 must meet the following:

1. Allopathic (MD) applicants or reappointments for the PGY-2 year must have passed *both* Step 1 and Step 2 CK of the USMLE and, at a minimum, possess a valid resident license in the State of South Dakota. PGY-1 residents must have registered to take Step 3 USMLE before starting their PGY-2 residency.
2. Allopathic (MD) applicants and reappointments at the PGY-3 and above levels must have passed Steps 1-3 of the USMLE and possess a resident license in the State of South Dakota. Failure of a current resident to obtain resident licensure by the expected time of promotion to the PGY-3 year may result in immediate suspension or termination from the residency appointment. The only exception will be if the allopathic physician is a graduate of a foreign medical school. Foreign medical graduates may be appointed to a PGY-3 position contingent upon obtaining resident licensure within 90 days of appointment to allow for processing of licensure materials after completing 24 months of GME training in the United States. Failure to obtain resident licensure within 90 days of appointment may result in immediate suspension or termination from the residency appointment.
3. Osteopathic (DO) applicants or reappointments for the PGY-2 year must have passed *both* Step 1 and Step 2 CK of the COMLEX (or USMLE) and, at a minimum, possess a valid resident license in the State of South Dakota. PGY-1 residents must have registered to take COMLEX 3 before starting their PGY-2 residency.
4. Osteopathic (DO) applicants or reappointments for the PGY-3 year must have passed COMLEX USA Steps 1, 2, and 3 (or USMLE) and possess a valid resident license in the State of South Dakota.

(C) GRADUATES OF FOREIGN MEDICAL SCHOOLS

Residency appointments for graduates of medical schools outside the United States and Canada may be offered only to those individuals who meet all requirements of Federal and State laws applicable to such appointments, including visa requirements. Such applicants must hold a currently valid Standard ECFMG Certificate prior to appointment, or have a full, unrestricted license to practice medicine in a U.S. licensing jurisdiction in which they are training or practicing.

Foreign national physicians admitted to the United States for graduate medical education training under the authority of the Sanford School of Medicine at The University of South Dakota must hold either a J-1 visa under the sponsorship of the ECFMG or a permanent immigrant visa ("green card"). An H1-B visa will be considered only in unusual circumstances and must be approved in writing in advance by the Designated Institutional Official at USD SSOM.

Eligibility requirements can be found at www.ECFMG.org. It is the responsibility of the applicant to complete all ECFMG requirements, visa requirements, and licensure requirements before accepting appointment to a residency position and before beginning residency training. Failure to do so may result in immediate termination of the residency appointment.