



# **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) sex, race, color, creed, rural background, socioeconomic status, national origin, ancestry, citizenship, gender, gender identification, transgender, sexual orientation, religion, age, disability, genetic information and veteran status. In addition, we value persons with broad life experiences, with records of service to disadvantaged populations, and with other attributes that may enhance the learning 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.

**AIMS:** The University Of South Dakota School Of Medicine will be a leader in educating students who with knowledge, skill, and compassion dedicate their lives to the well-being of their patients, their community, and their profession. 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 empathetic pediatricians committed to providing care and advocating for the well-being of children in their communities.

**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 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, the USD SSOM GME office, and/or or the Sanford GME office.

A complete list of the USD SSOM GME policies and benefits is found on the “New Innovations” website:

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

Residents receive a username and password for New Innovations 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, a Program Evaluation Committee, a Wellness Committee, and a Recruitment 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 Faculty, and the Chair of the Pediatric Department advise the Program Director.

#### **Residency Clinical Competency Committee**

The Residency Clinical Competency Committee's primary purpose is to perform at minimum semiannual reviews of each resident's educational progress, assign "Milestones", and to make recommendations to the Program Director. The Clinical Competency Committee's review utilizes objective rotation performance evaluations based on the Competencies and the specialty-specific Milestones. An Associate Program Director serves as the Chair of this Committee. The Clinical Competency Committee (CCC) meets at minimum semi-annually to assess individual resident performance.

#### **CCC Membership**

All members of the CCC are 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 and residency 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 evaluates the residency program at least annually and forms recommendations for program improvements to the Program Director. The Program Evaluation Committee

(PEC) actively participates 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 appointed by the Program Director. Members must include a minimum of two program faculty members and at least one resident 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) 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. Action 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 residency curriculum retreat, held in early spring and open to all members of the Pediatrics Residency faculty, generally serves as the annual PEC meeting. All faculty and residents are invited to attend. Smaller PEC meetings occur at least twice yearly and when necessary.

### **Residency Meetings**

Open to all members of the Pediatrics faculty, this group meets as a "Town Hall" and provides an opportunity for communication between faculty members, provision of residency updates, and faculty development.

Residency updates are also provided at the following meetings: USD Department of Pediatrics faculty meetings, Sanford Children's Specialty Clinic (SCSC) All Provider Meetings, Pediatric outpatient faculty meetings, and Pediatric division meetings as needed.

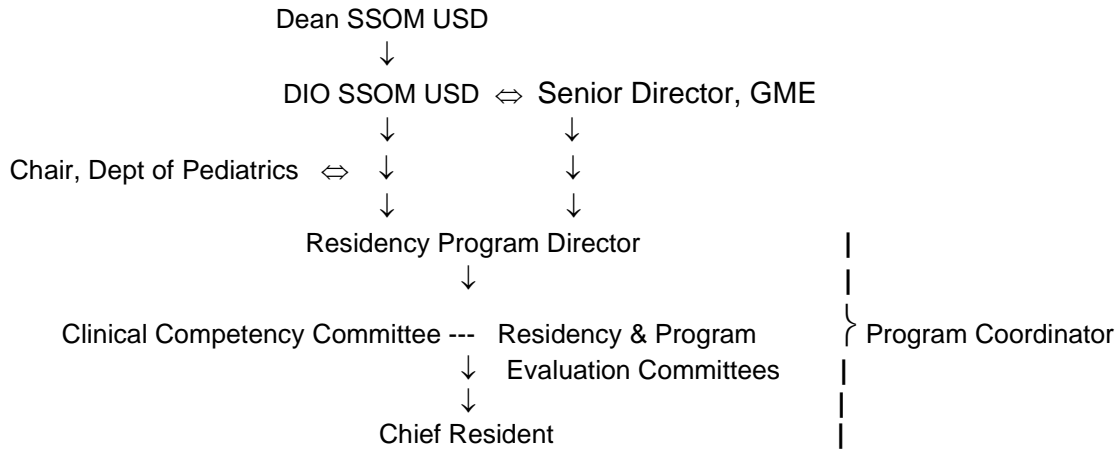
### **Recruitment Committee**

The faculty Recruitment Committee will consist of the Program Director, Associate Program Director(s), and key faculty appointed by the Program Director. A subgroup of the Recruitment Committee reviews the applications, interview summaries, and references of applicants applying to the Pediatric Residency Program and advises the Program Director concerning interview offers.

The entire faculty Recruitment Committee will organize recruitment activities, interview applicants, and 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 Recruitment Committee, the matter will be referred to the DIO of the USD SSOM for review and decision concerning the proposed resident applicant(s). An additional recruitment committee consisting of resident members will operate in parallel to the faculty committee, with intermittent joint events, to organize virtual and in-person recruitment activities and provide input regarding applicant encounters.

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

USD Pediatric Department Chair: Michelle Baack, MD

Program Director: Jessica White, MD

Associate Program Directors: Jennifer Haggar, MD, Ashley Sandeen, DO, KayeLyn Wagner, MD MME

Chief Residents: Ashlesha Bagwe, MD, Ana Nevarez Gilbert, MD,

USD GME Coordinator: Cherise Dunn, C-TAGME

Director, Sanford Medical Education: Shane Samuels, MSA

Pediatric Residency Coordinator: NEW



## (B) PROGRAM OVERVIEW

The Pediatric Residency Program of the Sanford Children’s Hospital, USD SSOM prepares graduates to practice Pediatrics in a variety of settings: consultation, in-patient, including NICU and PICU, and outpatient. The program places education first and clinical service second, resulting in a manageable caseload and call schedule. In keeping with the missions of our partner institutions, and in recognition of the rural nature of South Dakota, we place a strong emphasis on obtaining the intellectual and procedural skills necessary for a holistic approach to preventive and primary pediatric care. We additionally emphasize advocating and caring for all children with behavioral, developmental and or complex multi-system disease in all settings.

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 diagram 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. There are 13 Blocks (units) per academic year in addition to a minimum of thirty-six half-day continuity clinics as a longitudinal unit.

### PGY1:

1st Year Block Diagram

4 Week Blocks	1	2	3	4	5	6	7	8	9	10	11	12	13
Experience or Rotations	GP (IP) Site 1	GP (IP) Site 1	GP (IP) Site 1	GP (IP) Site 1	GP (OP) Site 1	*PULM 2 wks Site 1 *NEUR O 2 wks (IP/OP) Site 1	AI (OP) Site1	NICU (IP) Site1	TN (IP) Site1	*ENDO Vacation Eligible (IP/OP) Site 1	CM Vacation Eligible Site 1	SP (IP/OP) Vacation Eligible	ELEC (IC) Vacation Eligible

### PGY2:

2nd Year Block Diagram

4 Week Blocks	1	2	3	4	5	6	7	8	9	10	11	12	13
Experience or Rotations	GP (IP) Site 1	GP (IP) Site 1	NICU (IP) Site 1	PICU (IP) Site 1	DB (OP) Site 1	RS CARDS (IP/OP) Site 1	RS HEME/ ONC (IP/OP) Site 1	RS GI (IP/OP) Site 1	RS ID (IP/OP) Vacation Eligible Site 1	EM (OP) Site 1	ELEC (IC) Vacation Eligible	ELEC (IC) Vacation Eligible	ELEC (IC) Vacation Eligible

### PGY3:

3rd Year Block Diagram

4 Week	1	2	3	4	5	6	7	8	9	10	11	12	13
Experience or Rotations	GP (IP) Site 1	GP (IP) Site 1	GP (OP) Site 1	EM (OP) Site 1	NICU (IP) Site 1	PICU (IP) Site 1	ADOL (OP/IP) Site 1	CM (OP) Site 1	SP (IP/OP) Site 1	SP (IP/OP) Vacation Eligible Site 1	*Mental Health (IP/OP) Vacation Eligible Site 1	ELEC (IC) Vacation Eligible	ELEC (IC) Vacation Eligible

## (C) SUBSPECIALTY ROTATIONS

The ACGME requires residents to take a minimum of nine subspecialty rotations including adolescent medicine and developmental-behavioral pediatrics.

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

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

\*For Sanford Pediatrics Residency Program, the faculty has determined these **required subspecialties** to be Hematology/Oncology, Cardiology, Gastroenterology, and Mental Health.

# 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 “SELECTIVE” ROTATIONS

In addition to the four required subspecialties (RS), adolescent medicine, and developmental-behavioral pediatrics, residents are required to select three additional rotations consisting of a single subspecialty or combination of two subspecialties from the previous list 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 an additional four (Cardiology, Gastroenterology, Hematology/Oncology, Mental Health) of the nine minimum subspecialty rotations that the ACGME requires.** Residents must choose an additional three subspecialty rotations from the lists above.

Residents are also encouraged to take a wide variety of electives with the approval of the Program Director.

## **(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. Evaluations completion through an electronic evaluation system (New Innovations) is required within 10 days following the 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 are summarized and released semi-annually to the attending/senior resident 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. The resident must review the completed evaluation on the electronic evaluation system and acknowledge receipt of the evaluation. Evaluations serve as a basis for the Clinical Competency Committee to assign semi-annual milestone evaluations and the final summary evaluation. Evaluations additionally serve as the basis for recommendations regarding progression of level and/or readiness for independent practice. The final summary evaluation serves as part of the permanent record of each resident for inquiries concerning future employment, licensure, staff privileges, etc. 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**

Attending physicians in certain rotations (PICU, Inpatient, NICU & Continuity Clinic) 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 is administered annually in mid-July. If a resident is for some reason unable to take this examination, an equivalent assessment of medical knowledge will be assigned and administered by the Program Director. Residents receiving a result indicative of a less than 90% likelihood of passing the certification examination will be required to submit a written study plan to be reviewed by the program director and the faculty mentor.

### **Portfolios**

Each resident is required to maintain an Individual Learning Plan (ILP) portfolio in Pedialink (AAP Website). ILPs will be reviewed at mentor meetings and with the Program Director.

### **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 to add or transition faculty mentors made upon request.

### **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.

### **(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 five 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 policies 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 leave days are noncumulative and do not carry over into the next contract year. Upon termination from the Residency Corporation or at the time of program completion, any unused vacation leave will not be paid. 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.

Vacation must be taken from 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, consideration must be given to the resident’s ability to fulfill rotation requirements and the rotation director and the program director must approve such requests. ***Vacation requests not consisting of five consecutive working days require program director permission prior to approval. Vacation requests submitted less than 90 days prior to the requested time off require documentation of approval from the rotation director, continuity clinic director (if time requested affects continuity clinic), and program director permission prior to program approval.***

### **Submitting a Vacation Request**

Residents submit vacation requests via the online scheduling software (Qgenda). Requests will be reviewed twice monthly by the chief residents and Program Coordinator.

After the Chief Resident and Program Coordinator review the Qgenda request, they will ensure that the vacation request complies with all program regulations, maintains adequate patient coverage, and was submitted prior to submission deadlines. They will also review email or paper documentation for requests requiring additional approvals (see above). This policy is necessary to accommodate administration, faculty, nursing and patient scheduling.

If each of those stipulations is met, the Program Coordinator will document the vacation leave. 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 (DocuSign).

### **Vacation Request Deadlines**

Standard requests consist of five consecutive workdays within one vacation-eligible block and should be submitted at least 90 days prior to the requested time off. Requests submitted 60-90 days prior to the requested time off, require signatures/email verification from the directors of all rotations affected by the vacation (including the continuity clinic director) and the Program Director. This documentation must be submitted to the Chief Resident and Program Coordinator in addition to submitting a Qgenda request for review.

Any vacation requests submitted with less than 60 days before the requested time off **will not be granted**, except for emergent or extenuating circumstances.

### **Interview Days:**

The USD SSOM administration allows current PGY-2 and PGY-3 residents a total of five excused days during their residency for job or fellowship interviews. Additional days require use of vacation or paid days off. While the rules for requesting vacation leave, detailed above, apply, the residency program understands there may be extenuating circumstances since timing of interview invitations is unpredictable.

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

Residents are responsible to ensure rotation obligations are covered and rotation directors have approved time off for interviews. This includes arranging coverage for scheduled service time, cross cover shifts, or back-up shifts and completing shift trades (swaps) on Qgenda. The Program Coordinator and Chief Resident may assist the resident in fulfilling this obligation and should verify arrangements involved in coverage do not violate clinical and educational work hour (duty hour) regulations.

It is the resident's responsibility to submit documentation of permission from the directors of rotations affected by the interview, including continuity clinic director if a clinic day is affected, and the Program Director to the Chief Resident and Program Coordinator. The resident should also place a request for "Interview Day" into Qgenda prior to the interview day.

### **Paid Days Off**

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>

Residents receive 10 paid days off each academic year. These days may be taken to care for oneself, a partner, dependent, or parent. These days are often unplanned, and it is the resident's/fellow's professional duty to notify their rotation contact and their program coordinator at or before the beginning of resident's shift. If it is possible to plan ahead, please do so and notify the program administration and attending physician as soon as possible.

These days are encouraged to be taken as individual units, but may be combined with approval from the Program Director. Any absence for illness in excess of three scheduled days requires a written statement from a physician documenting the need for absence.

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 individuals responsible to ensure coverage of patient care as well as individuals responsible for monitoring rotation requirements.

If the resident is on an inpatient rotation (General Pediatrics Inpatient, NICU, PICU), he or she must notify the clinical service (the on-call attending physician, senior resident, NICU nurse practitioner team, and/or designated personnel responsible for patient assignments) by phone as soon as the resident is aware of the need for leave. The resident should also notify the chief resident and report coverage arrangements.

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, all sick/personal day notifications should occur prior to the start of the shift.

For all rotations, the resident must notify the attending physician for the rotation, continuity clinic (if applicable), residency coordinator, and the chief resident. These notifications may be made by email. 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 educational requirements.

### **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 working hours. For routine appointments, residents should schedule appointments that can be accommodated by their rotation. (For example, routine appointments should be avoided during continuity clinic, NICU, PICU, or general pediatrics inpatient rotations.) Residents must notify the attending physician of the affected rotation of the scheduled appointment. Residents must also notify the Chief Resident and Program Coordinator through a Qgenda request if time off qualifies for PDO.

Additional leave (including prolonged or recurrent illness, pregnancy, etc.) may be approved depending on appropriate documentation. Vacation time may be applied to these absences in order to receive additional paid leave. The Family Medical Leave Act (FMLA) for qualifying events protects residents. The USD GME policy also provides two additional weeks of paid leave for a qualifying event one time in residency. Time away from training that meets requirements for FMLA may be eligible for waivers of training from the American Board of Pediatrics. Final decisions regarding waiver eligibility will be determined by the Clinical Competency Committee and Program Director at the spring CCC meeting during the final year of training. <https://www.abp.org/content/absences-general-pediatrics-training>.

### **Educational Leave/CME Policy**

Each resident is entitled to five personal education days (PED) per academic year. PED may be taken for structured educational activities intended to strengthen the resident's training. Examples of eligible activities included conference attendance, participation in healthcare-related meetings, and local, regional, or national pediatrics courses. Interns may use up to two education days for study time for Step 3. Study time for the Pediatrics in-training exam



or Pediatrics Board Exam is not eligible for PED at this time.

Residents are highly encouraged to plan yearly rotation block schedules to accommodate education day opportunities in rotations outside of Inpatient, PICU, NICU, Term Newborn or third year outpatient blocks. For all rotations, residents may be required to make up some of the missed days dependent on ability to fulfill educational requirements.

Prior to scheduling educational days, the resident must check with the Chief Resident to verify education days do not interfere with patient care and scheduled call. The resident must also submit a leave request through Qgenda as well as submit email documentation of approval to Chief Residents and Program Coordinator from directors of the affected rotations. Similar to scheduling interview days (above), it is the resident's responsibility to arrange a coverage plan for any service shifts affected.

In general, residents may be required to make up missed days on a later date if not otherwise able to fulfill minimum rotation requirements (such as thirty-two half-days of clinic or 200 hours of inpatient service or if the resident requires more time to demonstrate completion of rotation goals/objectives).

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 should provide 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 requesting the back-up resident cover.*** If a resident needs Backup coverage, he/she must contact the scheduled Backup resident as well as the Chief 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 only covers the General Pediatrics Inpatient rotation.

There will be one Senior resident (PGY2, PGY3) scheduled for Backup each 24-hour period. Back-up coverage will be evenly distributed amongst eligible residents to the greatest extent possible with average of 28 back-up shifts per resident (not including holiday scheduling). The resident may NOT sign up for coverage while on Outpatient, Inpatient, PICU, NICU and ED rotations. 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 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 will be covered. On the days with no intern backup, the backup senior will be called in if necessary for coverage.

If a resident is scheduled for Backup call, the resident is expected to promptly answer their phone or pager; arrive at the hospital within 30 minutes; 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.

Any resident scheduled for Backup who is unavailable for any reason upon activation of the Backup system will be required to use a paid day off. The resident will also be required to take a backup shift from the resident who provides patient coverage in this scenario. If a resident becomes aware they are ineligible for their Backup shift (for example, illness), they should attempt to trade backup shifts and notify the Chief Resident as soon as possible.

### **(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).

**PGY-1:** Interns will be assigned cross-cover shifts during non-inpatient rotations in the second half of the academic year.

**PGY-2 and PGY-3:** Numbers of cross-cover shifts will be dependent on the total senior residents in the program. The Chief Resident will calculate a targeted goal for cross-cover hours per resident at each level of training on a yearly basis.

Residents unavailable for a scheduled cross-coverage shift will be expected to use a paid day off. If the resident is unavailable due to illness or emergency, he/she will activate the Backup system. If the resident is unavailable for other reasons, he/she will be expected to work a cross-coverage shift for the resident who covers for them.

### **(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 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 plus 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, administrative, and clinical responsibilities, averaged over a four-week period, inclusive of call. **One day is defined as one continuous 24-hour period.**

Adequate time for rest and personal activities must be provided after each shift. This should consist of an 8-hour time period 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. <https://www.acgme.org/>

### **Summary of Clinical and Education Work Hour (Duty Hour)**

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

**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 (12 hours): 6 consecutive nights**

**4) Maximum In-House On-Call Frequency (24hrs + 4 hrs): 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) Time spent in the hospital while on at-home call counts toward 80-hour limit.  
b) At home-call must be considered when assessing one-day-in seven free of duty when averaged over 4 weeks  
c) Frequency is not subject to every-3<sup>rd</sup>-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 inpatient hours, outpatient hours, vacation, paid-days off). ***It is the resident's responsibility to monitor his/her duty hours to ensure there are no violations.***
2. If the resident is notified of a violation in the New Innovations system, they must provide an explanation. The resident should also notify their attending physician of a violation to allow systems-based adjustments as needed.
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 withholding of the resident's paycheck until all records are complete. Failure to comply with this expectation will also be considered in the residents' milestones evaluation. Any resident 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, 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 during the day, it is mandatory that he/she make arrangements with another individual (resident, nurse practitioner, or attending physician dependent on rotation) to provide patient care and communicate those arrangements with the attending physician

The Chief Resident and/or Program Director must approve any extended absence.

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" is 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 (if on hospitalist inpatient or NICU), the attending on service, the Chief Resident, and Program Director (in that order). He/she must provide handoff using I-PASS to the backup resident or attending prior to leaving. If the resident is too tired to drive, the resident should arrange a ride, or sleep in the call room until no longer impaired. The residency program will cover the cost of a taxi or ride share.

It is the expectation of attending physicians to cover the work of the resident until proper resident coverage can be put in place, if necessary. The Inpatient team will initiate the Backup system. NICU and PICU attending physicians and neonatal nurse practitioners will cover the work of the resident on those services. 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**. Residents not meeting this requirement will be expected to outline a written plan for improvement for discussion with mentors. The Clinical Competency Committee will also consider conference attendance in evaluation of formative milestone progression.

## **(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. The meal allowance for the academic year per resident will be announced at the beginning of each year.

## **(N) RETREATS**

Each year, all pediatric residents have a combined weekend retreat for the purposes of team-building and professional development. All pediatric residents are excused from their rotations 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 provide inpatient coverage during 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. PGY-2 residents will develop the retreat itinerary. The Residency Program Leadership team must approve the retreat itinerary and budget prior to the retreat. The Chief Resident and/or Program Coordinator will notify each class prior to the weekend retreat which activities are exclusive to residents.

### **(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 coordinate meetings with the faculty mentor/advisor 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 as well as the affected faculty members. PGY1 residents will be assigned a faculty mentor/advisor within three 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. **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 per hospital policy. Hospital-issued scrubs will be worn on designated rotations and may not be worn outside of the hospital or taken home

#### **(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 South Dakota Resident Medical License before performing any official duties as a physician.

#### **(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. This is a SSOM USD GME policy.

### **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 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/or 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 in a timely manner.
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/or the patient's Attending Physician on a regular daily basis on all assigned patients and confer more frequently when caring for patients that are more complex.
5. All major, emergent, or important diagnostic or therapeutic questions must be discussed with the Supervising Resident and/or the patient's Attending Physician following admission.
6. The resident is responsible for initiating a consult by placing an order and calling or speaking to the consultant to coordinate care. While a text or page can notify a consultant of a consult, the text or page **must be HIPAA compliant** and followed by a conversation.
7. Residents must ensure excellent continuity of patient care following discharge by completing the discharge summary within 48 hours (preferably on the day of discharge). Discharge planning and education for patients and families should begin at the time of admission. To assist with discharge planning, a summary of the hospital course should be kept for all patients and must be up-to-date whenever a change in resident coverage is anticipated.
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).
  - a. I-PASS: **I**llness Severity – **P**atient summary – **A**ction list – **S**ituation awareness and contingency planning – **S**ynthesis by the receiver
9. At the end of the block or when transferring care to another service, residents should provide verbal AND written handoff to the oncoming team. (i.e., transfer summaries or an off-service note for more complex or chronic patients and updated hospital course summary).
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 Resident.
2. See and evaluate all patients as soon as possible after admission.
3. Perform at least one daily Work Round with each Primary Resident and more frequently for critical patients.
  - a. Special attention should be given to overseeing the primary patient care resident in situations involving care of complex patients, patient transfers, and patients with DNR status or other end-of-life concerns.

4. Make Chart Rounds frequently to ensure appropriate care is being given to each patient. The Supervising Resident immediately prior to discharge of a patient to insure all the patient's problems have been addressed prior to discharge should review the entire patient chart.
5. Be available to the Primary Resident to help with patients.
6. Supervise sub-interns (4<sup>th</sup> 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/evaluate notes.
7. Serve as an educational resource to all members of the care team while providing support, encouragement, and leadership by example to the Primary Patient Care Team.
8. Work closely with the patient's Attending Physician to ensure that the patient receives proper care and that the Primary Resident has the opportunity to achieve educational goals.
9. 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).
10. 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 physician or consultant as determined by the Faculty Supervisor. When the Resident acts as the primary physician, 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 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**

Each PGY-1 Resident should be responsible for the pre-rounding, rounding, and ongoing care of an average of eight patients with a maximum of 10 patients per day. A lower number of patients may be appropriate for Critical and Intensive Care situations. This number may be adjusted in unusual circumstances with approval from the Program Director or the Chairman of the Department of Pediatrics. The 10 patient limit does not include admissions.

Each PGY-1 Resident may be assigned a maximum of five new patients per 24-hour period. A lower number of assigned admissions may be appropriate for patients that are more complex. Subsequent patient admissions will be assigned to the Supervising senior resident. 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 two interns and a maximum of 30 patients with three 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. 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 reach out to their supervising resident or attending physicians for any concerns, including but not limited to the following:

1. Multiple simultaneous 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**

Each PGY-2 & PGY-3 resident will be responsible for rounding with the Attending Physician and the ongoing care of a maximum of eight patients (including those under the care of a sub-intern). They will also be responsible for all new admissions at the discretion of the Attending Physician.

## **NICU**

PGY-1 and PGY-2 residents will be responsible for the ongoing care of an average of five to a maximum of eight patients. 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 decrease to a maximum of two 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 three per half-day session. The number of patients seen by a PGY-2 Resident, when averaged over the year, must not be less than four per half-day session. The number of patients seen by a PGY-3 Resident, when averaged over the year, must not be less than five per half-day session. The maximum number of outpatients per half-day in any outpatient clinic for any resident level is 12.

## (C) FACULTY SUPERVISION

Residents must be supervised at all training sites and at all levels of training by a faculty member. 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.

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 provided 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 highly 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 must 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 residents in good standing during the second half of their PGY-2 year or PGY-3 year.

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. Residents must also be on-track to pass the ABP board certification based on predicted pass rate on the in-training exam. 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. Moonlighting hours count toward the 80-hour workweek maximum and must be documented as duty hours through New Innovations. If the 80-hour workweek limit is exceeded through moonlighting, permission for moonlighting will be revoked.

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 to obtain licensure and receive professional liability insurance personally or through his/her moonlighting 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.

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

Employee Assistance Programs

Through USD: <http://www.workhealthlife.com/Standard3>

Through Sanford: <https://www.vitalworklife.com/>

Faculty Advisor

Program Director

Associate Program Director(s)

Program Coordinator

Pediatrics Department Chair

Fellow residents

Faculty members  
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) PROFESSIONAL CONDUCT AND MISCONDUCT**

See the New Innovations website for GME Policies on professional conduct and misconduct.  
<https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals>

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, or the Associate Director acting in the interest of the Program Director, will specifically discuss with the resident regarding the breach of professionalism as soon as possible.

Behaviors or incidents occurring at a hospital site will be addressed by the Program Director in conjunction with the hospital personnel as appropriate, according to the code of conduct policy of the appropriate hospital. Incidents involving inappropriate sexual comments or behaviors will be addressed by the Program Director in conjunction with hospital personnel and/or USD SSOM staff as appropriate, according to the Discrimination/Harassment Policy. Behaviors that indicate the presence of impairment in the resident/fellow will be addressed according to the Physician Impairment Policy. These may proceed simultaneously.

The results of discussion remains 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 Associate Program Directors and/or resident's faculty mentor/advisor will assist in addressing the professionalism concern. At the semi-annual (or quarterly) ILP meeting, the Program Director will review any past professional breaches and will discuss with the resident the results of self-reflection and the achievement of behavioral change.

Should there be disagreement between the Program Director and the resident over professional behavior, the SSOM GME due process procedure will be activated (Notification of DIO, and if necessary, the Dean, see below). Should there be difficulty in forming a remediation plan, the USD SSOM GME office will assist.

## **(H) ACADEMIC IMPROVEMENT PLANS**

See the New Innovations website for GME Policies on academic improvement (GME policies 2022-2023). <https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals>

**Academic Improvement:** The Program Director is responsible for assessing and monitoring a resident's academic and professional progress in the six ACGME areas of competency:

Failure to perform adequately in any of these areas may result in corrective action, up to and including termination. If a resident is not progressing appropriately, the program will inform the resident of the deficiency (initially through structured feedback/evaluations with the next step being a letter of deficiency) and provide him/her with an opportunity to correct the

deficiency. At times, it is possible and appropriate for the program to provide extra assistance or educational experiences for the resident to aid in this process. **Ultimately, the resident/fellow is responsible for taking the necessary steps to meet expectations.**

If the resident fails to correct the deficiency, additional action may be taken including repetition of a rotation(s), an additional letter of deficiency, non-promotion to the next training level and/or extension of the current training level, non-renewal of contract, and termination from the program.

## **(I) CONCERN REPORTING, DISCIPLINARY ACTION, AND ASSURANCE OF DUE PROCESS**

See the New Innovations website for GME Policies on concern reporting and due process (GME policies 2022-2023). <https://www.new-innov.com/Login/Host.aspx?Control=DepartmentManuals>

**Concern Reporting:** This refers to the review of resident concerns or issues related to the work environment, the program, or the faculty. Concerns must be dealt with in as confidential a manner as possible, and without fear of retaliation.

- **Informal Concern Process:** It is encouraged that any resident with a concern will bring that concern to whom they feel is most appropriate to handle the concern. It is recognized that there are times when it is preferred to have concerns reported anonymously. To help facilitate the latter, a Praise/Concern form is available through New Innovations and is easily accessible in the resident lounge via a QR code.
- **Formal Concern Process:** Residents should report a concern or incident to the 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 an Associate Program Director or Program Director for resolution. If satisfactory resolution is still not achieved after the Program Director has become involved, the resident should provide a written complaint report to the DIO/Chair of GMEC. Additional information is available online in the GME Concern Reporting Policy.

**Due Process:** due process applies to actions taken because of academic deficiencies and/or misconduct, and that may affect the intended career development of the resident.

**Academic Matters:** A resident may request a review of the program's decision to take an action for academic matters. The resident must submit a written request for review 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. See below for additional applicable policies.

**Misconduct Matters:** A resident may request a review of the decision to take an action for resident misconduct matters. 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.

## **(J) 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 concerns is delineated in these policies.

In addition, USD follows the policies set forth by the South Dakota Board of Regents, found below. If a concern is not handled to the satisfaction of a resident/fellow by the parent training program, the concern 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)**

[https://www.acgme.org/globalassets/pfassets/programrequirements/320\\_pediatrics\\_2022\\_tc\\_c.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/320_pediatrics_2022_tc_c.pdf)

Residents must 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 must demonstrate the ability to:

- Gather essential and accurate information about their patients

- Organize and prioritize responsibilities to provide patient care that is safe, effective, and efficient
- Provide transfer of care that ensures seamless transitions
- Interview patients and families about the particulars of their medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease
- Perform complete and accurate physical exams
- Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment
- Develop and carry out patient management plans
- Counsel patients and families
- Provide effective health maintenance and anticipatory guidance
- Provide appropriate role modeling
- Provide appropriate supervision
- Provide behavioral and mental health care across all clinical settings that is sensitive to the developmental stage of the patient and the cultural context of the patient and family and
- Identify, manage, co-manage, and appropriately refer patients with common behavioral and mental health issues to specialists and resources when indicated
- Perform procedures (as listed on page 13) used by a general pediatrician in practice (including description of procedural steps, description of indications/contraindications, complications, pain management, post-procedural care, interpretation of applicable results).

Learning Opportunities:

- Inpatient and outpatient rotations
- Simulations

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 must:

- Demonstrate sufficient knowledge of the basic and clinically supportive sciences appropriate to pediatrics
- Demonstrate competency in the understanding the indications, contraindications, and complications for arterial line placement, arterial puncture, chest tube placement, circumcision, endotracheal intubation of non-neonates, thoracentesis.

Learning opportunities:

- Conferences
- Outpatient and hospital rotations
- Small group discussions

Evaluation Methods:

- 360° Global Review
- Board review sessions and performance on rotation quizzes

- Completion of individual study plans
- 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 must demonstrate the ability to:

- Analyze and evaluate their practice experiences and implement strategies to continually improve their quality of patient practice
- Identify strengths, deficiencies, and limits in one's knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' healthcare problems
- Use information technology to optimize learning
- Become an effective teacher
- Participate in the education of students, residents, and other health professionals
- Take primary responsibility for lifelong learning to improve knowledge, skills, and practice through familiarity with general and experience-specific goals and objectives and attendance at conferences

Learning opportunities:

- Conferences
- Committee assignments
- Outpatient and hospital rotations
- Meetings with program director, associate program directors, and mentors

Evaluation Methods

- 360° Global Review
- Exam MCQ
- Patient Survey

### **(D) INTERPERSONAL & COMMUNICATION SKILLS**

Goal: Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Objectives: Residents must demonstrate competence in:

- Communicating effectively with patients, families, and the public as appropriate, across a broad range of socioeconomic and cultural backgrounds
- Communicating effectively with physicians, other health professionals, and health-related agencies
- Working effectively as a member or leader of a healthcare team or other professional group
- Educating patients, families, students, residents, and other health professionals
- Acting in a consulting role to other physicians and health professionals

- Maintaining comprehensive, timely, and legible medical records
- Demonstrating the insight and understanding into emotion and human response that allows one to appropriately develop and manage human interactions
- Communication with patients and families to partner in assessment of care goals, including, when appropriate, end-of-life goals.

Learning opportunities:

- Hospital and outpatient patient care experiences
- Small group discussions
- Simulations
- Meetings with program director, associate program director, and mentors
- Resident recruitment and selection
- Medical student teaching through appointment as Clinical Instructor for USD

Evaluation Methods:

- 360° Global Review
- Patient Survey

### **(E) PROFESSIONALISM**

Goal: Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.

Objectives: Residents must demonstrate competence in:

- 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 respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation
- Respect for patient privacy and autonomy
- Ability to recognize and develop a plan for one's own personal and professional well-being
- Appropriately disclosing and addressing conflict or duality of interest

Learning opportunities:

- Inpatient and outpatient rotations
- Conferences
- Small group interactions
- Simulations
- Committee membership as appropriate
- Physician well-being programs

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, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.

Objectives: Residents must demonstrate competence in:

- Working effectively in various healthcare delivery settings and systems relevant to their clinical specialty
- Coordination of patient care across the healthcare continuum and beyond as relevant to their clinical specialty
- Advocating for quality care and optimal patient care services
- Working in interprofessional teams to enhance patient safety and improve patient care quality
- Participation in identifying system errors and implementing potential systems solutions
- Incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate
- Understanding health care finances and its' impact on individual patients' health care decisions
- Advocate for the promotion of health and the prevention of disease and injury in populations

Learning opportunities:

- Outpatient and hospital rotations
- Conferences
- Committee assignments
- SAFE Training and QI bootcamp

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  
Concern Reporting Policy  
Counseling Services Policy  
Disability Services and Accommodations  
Disaster  
Discrimination and Harassment  
Due Process  
Evaluations  
Humanitarian Rotation  
Humanitarian Rotation Application

Immigration Law  
Immunization Policy  
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 and Medical Leave Request Form  
Family Medical Leave  
Fringe Summary FY22  
FY21 Flex System Plan Document  
GME Leave Overview  
Health Insurance  
Lab Coats  
Leaves of Absence  
Military Leave  
Part-Time Benefits

Professional Liability Insurance  
SBC \$1000 Deductible  
SBC \$500 Deductible  
Stipends  
Tax-free Spending Accounts  
Term Life Insurance  
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](http://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 based on 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 based on 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.

### **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 the pediatrics specialty board 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](http://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.