INTERNAL MEDICINE/PEDIATRICS
RESIDENCY PROGRAM

The University of Kansas School of Medicine - Wichita
550 N. Hillside
Wichita, Kansas 67214

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Policy and Procedure Manual

Revised: June 2013
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Revised: June 2013
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<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Robert Wittler, M.D.</td>
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</tr>
<tr>
<td></td>
<td>Garold Minns, M.D.</td>
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<tr>
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<td>Website:</td>
<td></td>
<td></td>
<td><a href="http://wichita.kumc.edu/medpeds/">http://wichita.kumc.edu/medpeds/</a></td>
</tr>
<tr>
<td>Chief Resident:</td>
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<td></td>
<td><a href="mailto:sstevens2@kumc.edu">sstevens2@kumc.edu</a></td>
</tr>
</tbody>
</table>
PEOPLE

PEDIATRICS RESIDENCY PROGRAM
ADMINISTRATIVE STAFF / FACULTY

UKSM-W Pediatrics

Robert Wittler, M.D.
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| Jennifer Brannon, M.D. | Katherine Melhorn, M.D. |
| Mark Harrison, M.D. - Student Clerkship Director | Kerri Meyer, M.D. - Child Abuse Pediatrics |
| Gretchen Homan, M.D. | Natalie Sollo, M.D. |
| | Julie Wellner - Teaching Assoc. |
| | Cari Schmidt, Ph.D., - Research Assistant Professor |

Wesley Peds Specialty Clinic – 3243 E. Murdock, Suite 500, 67208, Phone: 962-2080

| Cynthia Battiste, MD.- Peds Cardiology | Shobana Kubendran, MBBS, MG, CGC, Genetics Counselor |
| Valarie Kerschen, M.D. - Neurodevelopmental Disabilities | Iram Sirajjudin, MD - Peds Allergy/Immunology |
| Maria Riva, MD - Peds Pulmonology | Shelby Evans Ph.D. - Psychologist |

| Robert Wittler, MD - Peds Infectious Disease | |
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INTERNAL MEDICINE PROGRAM
ADMINISTRATIVE STAFF / FACULTY

UKSM-W Internal Medicine

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Faculty

Jon P. Schrage, M.D., Professor and Chairman
Tom Schulz, M.D., Assistant Professor - Associate Program Director
William Salyers, M.D., Assistant Professor - Associate Program Director
K. James Kallail, Ph.D., Professor, Associate Chair of Research

Faculty Directors (DIME's)

<table>
<thead>
<tr>
<th>KUSM-W PATIENT CARE CLINIC</th>
<th>293-1818</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennifer Jackson, M.D., Assistant Professor</td>
<td>Director - KU Wichita Center for Medicine Clinic</td>
</tr>
<tr>
<td>Shannon Leach, RN</td>
<td>Senior RN, KUSM-W Clinic</td>
</tr>
<tr>
<td><strong>Address:</strong> 1125 N. Topeka</td>
<td>Fax: 264-3646 or 293-1866</td>
</tr>
<tr>
<td><strong>WESLEY MEDICAL CENTER</strong></td>
<td>962-2212</td>
</tr>
<tr>
<td>Melissa Gaines, M.D., Assistant Professor</td>
<td>Director, IM Education (DIME)</td>
</tr>
<tr>
<td>Janell Vulgamore</td>
<td>Coordinator, IM Education</td>
</tr>
<tr>
<td><strong>VIA-CHRISTI-ST. FRANCIS</strong></td>
<td>268-5894</td>
</tr>
<tr>
<td>Donna Sweet, M.D., Professor</td>
<td>Director, IM Education (DIME)</td>
</tr>
<tr>
<td>Sherri Skupa</td>
<td>Secretary, IM Education</td>
</tr>
<tr>
<td><strong>VA MEDICAL CENTER</strong></td>
<td>688-6799 (Ext 3440)</td>
</tr>
<tr>
<td>Mona Brake, M.D., Clinical Assistant Professor</td>
<td>Director, IM Education (DIME)</td>
</tr>
<tr>
<td>Lisa Blackburn</td>
<td>Secretary &amp; Affiliations Coordinator</td>
</tr>
</tbody>
</table>

Internal Medicine Department Staff – UKSM-W phone: 293-2650 fax: 293-1878

| Andrea Flessner | Senior Residency Coordinator | aflessner@kumc.edu |
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MED/PEDS RESIDENT ROSTER
2013-2014

PGY I

Hannah Fisher, M.D.
Gilbert Kisang, M.D.
Sabina Safder, M.D.

PGY II
Simran Brar, D.O.
Brian Guhl, M.D.
Mohinder Vindhyal, M.D.

PGY III
Subash Ala, M.D.
Ragneel Bijjula, M.D.
Anjalee Carlson, D.O.
Brent Duran, M.D.
PGY IV
Nicholas Knighton, D.O.
Shana Stevens, M.D. Chief
Program Educational Goals

The Med/Peds program is sponsored jointly by the Department of Internal Medicine and the Department of Pediatrics. The program prepares residents for board certification in both Internal Medicine and Pediatrics. Med/Peds is a four-year curriculum with 24 months required in each specialty. Throughout their training, residents alternate between the two specialties in 4-month blocks.

Curriculum

During the initial one-year equivalent of internal medicine and pediatrics, Med/Peds residents enhance their interview skills, history taking skills, physical examination skills, problem list creation, differential diagnostic abilities, diagnostic plan formulation, and therapeutic skills. They also develop discharge-planning skills and participate in weekly general internal medicine and pediatric clinic activities. They participate in procedures expected of general internists and pediatricians. During the first nine months of medicine and pediatric rotations, they take call approximately every 5th night, functioning at a level of non-supervisory resident. They are responsible for evaluation of acutely ill patients, obtaining histories and performing physicals on patients admitted during the night and participating in the resuscitation of patients who require such.

During the third and fourth year of this curriculum, Med/Peds residents take the equivalent of one-year of internal medicine again, which will be spent on subspecialty electives and a required six months of supervisory experience on the ward team and/or ICU rotation. During this time, they gain experience in consultation, both as a general internist and on the subspecialty services. Residents are responsible for coordinating and supervising cardiopulmonary resuscitation for the patients needing such and are responsible for supervising first-year medicine residents on call. In the third and fourth years of pediatrics, the Med/Peds residents also participate as supervisory residents on the inpatient and newborn services. For two months the residents alternate between night float in the inpatient setting and acute care for the pediatric outpatient. They also rotate through pediatric subspecialty experiences and with a pediatric emergency medicine specialist.
Pending changes:

PGY-1 & PGY-2 Rotations in *Internal Medicine*

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient General Medicine</td>
<td>4 months (may vary)</td>
</tr>
<tr>
<td>General Supervisory/Night Float</td>
<td>1 month</td>
</tr>
<tr>
<td>Night Float/Geriatrics</td>
<td>1 month</td>
</tr>
<tr>
<td>City Wide Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td>Acute Care Resident</td>
<td>1 month</td>
</tr>
<tr>
<td>Medicine Subspecialty Elective</td>
<td>2 months</td>
</tr>
<tr>
<td>Critical Care Medicine (ICU)</td>
<td>1 month</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1 month</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1 month</td>
</tr>
</tbody>
</table>

PGY-1 & PGY-2 Rotations in *Pediatrics*

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Pediatrics</td>
<td>4 months</td>
</tr>
<tr>
<td>NICU</td>
<td>2 months</td>
</tr>
<tr>
<td>Peds Subspecialty Rotations</td>
<td>2 months</td>
</tr>
<tr>
<td>Acute Care/Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td>Normal Newborn</td>
<td>1 month</td>
</tr>
<tr>
<td>Pediatric Emergency Medicine</td>
<td>1 month</td>
</tr>
<tr>
<td>PICU</td>
<td>1 month</td>
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<tr>
<td>Behavior/Development</td>
<td>1 month</td>
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</tbody>
</table>

PGY-3 & PGY-4 Rotations in *Internal Medicine*

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient General Medicine: Supervisory**</td>
<td>4 months</td>
</tr>
<tr>
<td>Medicine Subspecialty Rotations</td>
<td>6 months</td>
</tr>
<tr>
<td>Internal Medicine Electives**</td>
<td>2 months</td>
</tr>
<tr>
<td>Critical Care Medicine (ICU); Supervisory</td>
<td>1 month</td>
</tr>
</tbody>
</table>

PGY-3 & PGY-4 Rotations in *Pediatrics*

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Pediatrics</td>
<td>2 months</td>
</tr>
<tr>
<td>Behavior/Development</td>
<td></td>
</tr>
<tr>
<td>Adolescent Medicine</td>
<td></td>
</tr>
<tr>
<td>Pediatric Subspecialty Rotations **</td>
<td>4 months</td>
</tr>
<tr>
<td>Acute Care Clinic &amp; Night Float/Supervisor</td>
<td>2 months</td>
</tr>
<tr>
<td>Pediatric Emergency Medicine Supervisor</td>
<td>1 month</td>
</tr>
<tr>
<td>NICU</td>
<td>1 month</td>
</tr>
<tr>
<td>Inpatient Supervisor</td>
<td>1 month</td>
</tr>
<tr>
<td>Newborn Supervisor</td>
<td>1 month</td>
</tr>
<tr>
<td>Pediatric Elective **</td>
<td>1 month</td>
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</table>

*Two subspecialty rotations are required to be Med/Peds combined rotations in the 3rd and 4th year.

When Med/Peds Residents are assigned to NICU rotations (Peds), ICU rotation (Med), or Med I Services (Med), their outpatient clinic assignments may be reduced or modified.
### General Competencies

#### PGY-1

<table>
<thead>
<tr>
<th>ACGME Category</th>
<th>Activities</th>
<th>Assessment Tools</th>
</tr>
</thead>
</table>
| **Patient Care** | 1) Gathers essential and accurate information  
2) Performs thorough and accurate exam  
3) Synthesizes data into a problem list and differential diagnosis  
4) Formulates diagnostic and therapeutic plan with supervision  
5) Provides informed consent for basic procedures  
6) Performs basic clinical procedures in preparation for supervisory role  
7) Demonstrates caring and respectful behavior | *Rotation Evaluations  
*Continuing clinic evaluations  
*Mini CEX’s  
*Patient Survey  
*Chart Reviews  
*Procedure Log  
*Inpatient Chart Audits |
| **Medical Knowledge** | 1) Demonstrates basic knowledge of pathophysiology and disease processes  
2) Develops basic knowledge base for inpatient and outpatient clinical care  
3) Initiates discussion with faculty and supervisors to secure information  
4) Demonstrates the ability to seek and locate relevant clinical information  
5) Able to apply medical knowledge to basic patient care | *Rotation Evaluations  
*ACP  
*In-Training Exam  
*Web-based assessment tools |
| **Practice-Based Learning and Improvement** | 1) Develops the ability to self-evaluate educational needs and performance; recognizing limitations in knowledge and skills; vigilant for areas of improvement  
2) Incorporates relevant feedback and instruction into clinical activities  
3) Facilitates the learning of others on the care team  
4) Uses technology to enhance patient care and medical education  
5) Progress on scholarly activity projects | *Rotation Evaluations  
*Journal Club Test  
*Problem Based Learning & Improvement clinic project  
*Inpatient guideline chart review |
| **Interpersonal and Communication Skills** | 1) Develops effective and respectful communication skills, including appropriate language and grammar and appropriate use of interpreters.  
2) Develops accurate, timely, legible and comprehensive documentation skills  
3) Learns to present a case accurately and succinctly  
4) Establishes an effective therapeutic relationship with patients and families  
5) Identifies appropriate providers and settings in which to obtain information  
6) Demonstrates effective listening skills | *Peer Surveys  
*Nurses Surveys  
*Patient Surveys  
*Mini CEX  
*Rotation Evaluations  
*Web-based Communication Module  
*Inpatient Chart Audit |
| **Professionalism** | 1) Demonstrates respect and compassion  
2) Displays a professional appearance  
3) Demonstrates a commitment to ethical issues  
4) Considers the needs of patients and families  
5) Considers the needs of colleagues  
6) Demonstrates constructive and respectful working relationships with other health care professionals  
7) Shows reliability, responsibility and accountability to others; completes assigned duties  
8) Acknowledges errors and accepts criticism positively by improving behavior and skills | *Patient Surveys  
*Rotation Evaluations  
*Nurses Surveys  
*Peer Surveys |
| **Systems-Based Practice** | 1) Develops knowledge of medical practice and the clinical delivery system  
2) Identifies the need for appropriate hospital and community resources  
3) Identifies error-prone system issues and needed improvements  
4) Identifies efficiency problems and needed improvements  
5) Advocates for quality patient care; enabling families to participate responsibly in the care of the patient | *SBL Project  
*Management Conference assessment |
Minimum requirements for advancement of residents to PGY-2 level of training:
1. Attendance at required conferences unless on approved leave or excused. While on Pediatrics, residents must maintain a 60% attendance rate for noon conferences and a 50% attendance rate for morning conferences. Internal Medicine requires a 90% attendance for Morning Case Conference (extra call can/will be given when the 90% attendance is not maintained. Internal Medicine requires a 60% attendance rate for noon conferences.
2. Satisfactory overall evaluation in all categories.
3. Achievement of general competencies.
4. No breach in contractual obligations.
5. No instances of unethical or unprofessional behavior that have not been remediated.
6. Capable of assuming supervisory responsibilities for PGY-2 level of training as determined by the Competency and Selection Committee.

PGY 2
The competencies below are expected when those listed for PGY1 above are achieved

<table>
<thead>
<tr>
<th>ACGME Category</th>
<th>Activities</th>
<th>Assessment Tools</th>
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</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>1) Coordinates patient care among all members of the health care team</td>
<td>*Rotation Evaluations</td>
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<tr>
<td></td>
<td>2) Manages patients appropriately based on available evidence, sound judgment, and patient preferences</td>
<td>*Continuing clinic evaluations</td>
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<td>3) Formulates diagnostic and therapeutic plans independently</td>
<td>*Mini CEX’s</td>
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<td>4) Demonstrates knowledge of indications/risks for most required procedures for which appropriate informed consent is obtained</td>
<td>*Patient Survey</td>
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<td>*Chart Reviews</td>
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<td></td>
<td></td>
<td>*Procedure Log</td>
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<td></td>
<td>*Inpatient Chart Audit</td>
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<tr>
<td>Medical Knowledge</td>
<td>1) Develops an advanced understanding of disease states</td>
<td>*Rotation Evaluations</td>
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<tr>
<td></td>
<td>2) Demonstrates the skill of reading and interpreting the medical literature</td>
<td>*ACP</td>
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<td>3) Actively participates in conferences and didactic sessions</td>
<td>*In-Training Exam</td>
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<td></td>
<td>*Web-based assessment tools</td>
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<tr>
<td>Practice-Based Learning and Improvement</td>
<td>1) Gain competence in bedside teaching</td>
<td>*Rotation Evaluations</td>
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<td></td>
<td>2) Use information technology to support patient care decisions</td>
<td>*Journal Club Test</td>
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<td></td>
<td>3) Implements strategies to improve knowledge based on feedback, performance on written exams and self-assessment</td>
<td>*Chart Review</td>
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<td>*PBL&amp;I Clinic Project</td>
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<td></td>
<td></td>
<td>*Inpatient guideline chart review</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>1) Communicates effectively to maximize understanding of patient/caregiver/family with ability to appropriately elicit, facilitate, clarify, confront and interpret information</td>
<td>*Peer Surveys</td>
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<tr>
<td></td>
<td>2) Presents topics informally and formally to groups of learners</td>
<td>*Nurses Surveys</td>
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<td></td>
<td>3) Develops skills to negotiate</td>
<td>*Patient Surveys</td>
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<td></td>
<td>4) Uses effective and appropriate verbal and non-verbal communication with patients and colleagues</td>
<td>*Mini CEX</td>
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<td>*Rotation Evaluations</td>
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<td>*Grand Rounds</td>
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<td></td>
<td></td>
<td>*Web-based Communication Module</td>
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<td></td>
<td>*ACP Presentation</td>
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<tr>
<td>Professionalism</td>
<td>1) Establishes a sense of accountability to patient care</td>
<td>*Patient Surveys</td>
</tr>
<tr>
<td></td>
<td>2) Manages and directs a health care team</td>
<td>*Rotation Evaluations</td>
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<tr>
<td></td>
<td>3) Develops conflict management skills</td>
<td>*Nurses Surveys</td>
</tr>
<tr>
<td></td>
<td>4) Works with consultants and other health care teams</td>
<td>*Peer Surveys</td>
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<tr>
<td></td>
<td>5) Demonstrates sensitivity and responsiveness to a diverse patient population including age, race, culture</td>
<td></td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>1) Works with ancillary team members to provide high quality, cost effective health care</td>
<td>*SBL Project</td>
</tr>
<tr>
<td></td>
<td>2) Participates in developing means to improve systems of practice and health management</td>
<td>*Management Conference assessment</td>
</tr>
<tr>
<td></td>
<td>3) Demonstrates familiarity with documentation criteria for Evaluation and Management coding of different levels of care</td>
<td></td>
</tr>
</tbody>
</table>
Minimum requirements for advancement of residents to PGY-3 and PGY-4 level of training:
1. Attendance at required conferences unless on approved leave or excused. While on Pediatrics, residents must maintain a 60% attendance rate for noon conferences and a 50% attendance rate for morning conferences. Internal Medicine requires a 90% attendance for Morning Case Conference (extra call can/will be given when the 90% attendance is not maintained. Internal Medicine requires a 60% attendance rate for noon conferences.
2. Mastery of basic procedural skills as required by ABIM.
3. Completion of 3 mini CEX's successfully.
4. Satisfactory overall evaluation in all categories.
5. Satisfactory achievement of general competencies.
6. No breach in contractual obligations.
7. No instances of unethical or unprofessional behavior that have not been remediated.
8. Completion of scholarly activity requirements: 1 KUSM-W Grand Rounds, 1 ACP abstract presentation or comparable regional presentation which is required to progress to PGY-4.
9. Capable of assuming supervisory responsibilities of PGY-3 level of training as determined by the Competency and Selection Committee.

**PGY-3 and PGY-4**
The competencies below are expected when those listed for PGY2 above are achieved.

<table>
<thead>
<tr>
<th>ACGME Competencies</th>
<th>Activities</th>
<th>Assessment Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>1) Counsels and educates patients and families</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Provides appropriate informed consent and competently performs required diagnostic and therapeutic procedures</td>
<td>*Continuing clinic evaluations</td>
</tr>
<tr>
<td></td>
<td>3) Functions as an internal medicine and pediatric consultant</td>
<td>*Mini CEX’s</td>
</tr>
<tr>
<td></td>
<td>4) Integrates knowledge with clinical judgment</td>
<td>*Patient Survey</td>
</tr>
<tr>
<td></td>
<td>5) Reasons well in ambiguous situations, spending time appropriate to the problem complexity and directing proper care including patient preferences</td>
<td>*Chart Reviews</td>
</tr>
<tr>
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<td></td>
<td>*Procedure Log</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Inpatient Chart Audit</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>1) Accesses all available information to support clinical decision making</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Demonstrates investigatory and analytical approach to the acquisition and application of knowledge using evidence-based skills</td>
<td>*ACP</td>
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<td></td>
<td></td>
<td>*In-Training Exam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Web-based assessment tools</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>1) Analyzes own practice for needed improvement</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Finds and uses evidence from scientific studies and clinical guidelines effectively</td>
<td>*Journal Club Test</td>
</tr>
<tr>
<td></td>
<td>3) Develops life-long learning skills to maintain fund of knowledge</td>
<td>*Chart Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*PBL&amp;I Clinic Project</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Inpatient chart review</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>1) Demonstrates the ability to maintain a therapeutic relationship with patients and families and provide effective education in verbal and written form</td>
<td>*Peer, patient, nurse surveys</td>
</tr>
<tr>
<td></td>
<td>2) Able to effectively discuss emotionally charged issues such as end-of-life care and family violence</td>
<td>*Mini CEX</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Grand Rounds/ACP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Web-based Modules</td>
</tr>
<tr>
<td>Professionalism</td>
<td>1) Demonstrates initiative and provides leadership</td>
<td>*Patient Surveys</td>
</tr>
<tr>
<td></td>
<td>2) Practices altruism and advocacy</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>3) Is sensitive to ethical dilemmas and analyzes relevant ethical values and potential outcomes+</td>
<td>*Nurses Surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Peer Surveys</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>1) Understand the interaction of practice within the larger health care system</td>
<td>*SBL Project</td>
</tr>
<tr>
<td></td>
<td>2) Advocate for patients within the health care system</td>
<td>*Management Conference assessment</td>
</tr>
<tr>
<td></td>
<td>3) Use systematic approaches to improve patient care and reduce errors</td>
<td></td>
</tr>
</tbody>
</table>
Throughout residency training, residents accrue technical procedural expertise necessary for practice. Resident procedural qualifications are monitored and certified by appropriate faculty and a database of their procedural skills is maintained. Residents must perform all procedures under the supervision of faculty, other qualified health care providers, or another resident who has demonstrated competency previously in performing the procedure.

After the resident has demonstrated proficiency at the procedure, completed the minimum number of qualifying procedures, and demonstrated knowledge of the indications, contraindications and complications of the procedure, he/she may perform subsequent ones without direct supervision and may supervise other residents or students in these procedures. Residents may sign documentation for procedures performed but a faculty signature is required for competency. The Program Director’s approval is required for hospital credentialing.

Residents will be expected to provide complete and proper documentation in the medical record for each procedure performed. This includes dictating the following procedural skills: Central venous access, arterial line placement, paracentesis, thoracentesis, bone marrow biopsy, lumbar puncture, and arthrocentesis; in addition to other elective procedures as indicated.

New Innovations
Med/Peds Residents are required to log their procedures into New Innovations. Once logged New Innovations will send an electronic message to the supervising attending requesting a confirmation of the witnessed procedure. The email also requests information as to whether the resident passed or did not pass the procedure. Once the attending has completed the confirmation, New Innovations generates a message to the residency coordinator confirming the procedure. When the resident has logged and been passed for a targeted number of procedures (Internal Medicine only), that resident will be credentialed in that procedure. A report is generated and sent to the Program Director for signature. A report of credentialed procedures for each resident is given to the core programs, Wesley Medical Center, and a copy placed in the resident’s permanent file. Residents are to review their procedure log frequently for confirmation and for accuracy. Faculty Advisors and the Program Director may view these logs at any time.

In order to be signed off a particular procedure, the resident will have met the minimum number required by the Internal Medicine Program and provide the coordinator with a signed procedure card indicating the resident has acquired the technical skills to adequately perform the procedure unsupervised. The Pediatric Residency Program does not require a certain number of procedures performed before a resident may be signed off but the resident must demonstrate technical skills adequately to the Attending. The resident should also log all procedures in New Innovations. (See below). A report of procedures will be provided to the Faculty during the 6 month and year-end reviews and to the residents upon request and upon graduation.

To document your completed procedure go the New Innovations website. https://rms1.new-innov.com/Login
Institution Login: WCGME

1. Enter your name and password
2. Go the “My Procedure Log”
3. Enter a procedure log

If you are unable to find the supervising Attending’s or Upper Level Resident’s name please enter as other and add name to comment section below. Then notify Residency Coordinator. If you have completed a paper card, obtain the Attending’s signature as confirmation. The Coordinator may confirm the procedure for the Attending with the signed paper documentation card only.

The Attending/Supervisor will receive an automatic email requesting a confirmation of the procedure.

Confirmation by Supervising Attending or Upper Level Resident:
Scroll to the section labeled Notifications on the Home Page
1. Click the link under Logger to get to the procedures to confirm
2. When the screen refreshes, the list of procedures to confirm is displayed.

3. Select the appropriate radio button for each procedure
   a. Pass – indicates you supervised the resident
   b. Not Pass – confirm you were the supervisor but the resident did not pass
   c. Refuse – select if you were not the supervisor or do not wish to confirm the procedure.
   d. Leave Unconfirmed
4. Click the +Add Comment link to enter your comments
5. Click View Entire Log to expand and view all fields in the log
6. When finished click Save Confirmations
During residency, Med/Peds residents are expected to be familiar with the following procedures. Each resident has the responsibility to request instruction from the faculty or senior residents as necessary. Many procedures completed while on Pediatric rotations may be counted toward procedural requirements for internal medicine.

**Required by Internal Medicine**
- Pap smear/endocervical culture (5)
- Drawing venous blood (5)
- Drawing arterial blood/arterial puncture (5)
- Placing a peripheral venous line (5)
- Paracentesis (abdominal) (5)
- Thoracentesis (5)
- Lumbar puncture (5)

Central venous access - (combo of 5 for graduation—but 5 of one to be able to perform unsupervised)
- Femoral
- Subclavian
- Internal jugular

**Required by PEDIATRICS  No specific number required**
- Lumbar puncture (signed off by peds person)
- Bag & mask ventilation
- Administer immunizations
- Neonatal endotracheal intubation
- Neonatal delivery room resuscitation
- Peripheral intravenous catheter placement
- Umbilical catheter placement
- Simple laceration repair (simple suturing)
- Bladder catheterization
- Incision & drainage of an abscess
- Reductions of simple joint dislocations
- Simple removal of foreign body
- Temporary splinting of a fracture

**Must be familiar with the following procedures:**
- Arterial line placement
- Endotracheal intubation of non-neonates
- Arterial puncture
- Thoracentesis
- Circumcision *(required by IM)*
PATIENT DOCUMENTATION - Peds

To be able to document patient numbers and resident involvement to the Residency Review Committee, we ask residents assigned to subspecialty rotations outside of the medical center to document the patients they have seen, the level of involvement the resident has had with the patient, and what the diagnosis was for that patient.

Patient documentation slips or data entry into the ACGME website are to be used for this and may be obtained from the residency coordinator.

The subspecialty rotations that require patient documentation are as follows:

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Medicine</td>
<td>Allergy</td>
</tr>
<tr>
<td>Behavioral/Developmental Pediatrics</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Child Psychiatry</td>
<td>Community Medicine</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Emergency Medicine (pediatric patients only)</td>
<td>Endocrinology/Metabolism</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Hematology/Oncology</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Neurology</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Pediatric Preceptorship</td>
</tr>
<tr>
<td>Nephrology</td>
<td></td>
</tr>
</tbody>
</table>

It is expected that documentation of patient contacts for the entire month should be turned in. However, if the attending’s practice is very busy (exceeds 20 patients per day), the resident may record fifteen (15) days worth of patient information. Anything less than this will be unacceptable.

This monthly documentation must be turned in to the pediatric residency coordinator by the end of the resident’s subspecialty rotation.
CHART AUDIT PROCESS

**Pediatrics**

1. Chart Audit forms are available in New Innovations to the residents assigned to the Inpatient service (Ward and PICU) for the month.

2. It is the resident’s responsibility to choose two patient charts during the month, for which they have taken responsibility from admission to dismissal. The chart number and initials must be written on the form.

3. The resident then makes an appointment with the attending of the record to review his/her documentation of the chart. The attending may electronically sign the form.

**Internal Medicine**

1. Chart Audits are completed while on the IM Acute Care rotation. The chart audit process is under revision at the current time (May 2012)

2. Resident chart audits are reviewed in 3 areas

3. General Ward, formative evaluation is reviewed by the resident’s advisor during their 6-month and end of year evaluation.

4. The PBL Quality of Care evaluation is reviewed by the general ward attending the first and last week of the rotation.

5. The City Wide Ambulatory block continuity clinic patient care audit is reviewed by the Ambulatory Director at the end of the rotation.
SCHOLARLY PRESENTATIONS

Med/Peds Scholarly Activity Track

Med/Peds residents are expected to gain broad experience across the fields of Internal Medicine and Pediatrics during their training. To ensure that breadth within the scholarly activity of Med/Peds residents, a timeline of the required scholarly presentations for residents in the program has been outlined below.

PGY-1  
Residents will present a 2 journal articles for review that will include one pediatric and one internal medicine journal. Please follow internal medicine guidelines.

PGY-2  
Residents will prepare and present an hour long grand rounds presentation to be delivered during the monthly Med/Peds Grand Rounds Conference. The presentation topic is expected to be applicable to the broad audience that includes internal medicine and pediatric residents and attending physicians. It should ideally involve a topic that reflects the interconnectedness of the two specialties. Topics for the presentation must be reviewed and approved by the Associate Program Director for Med/Peds before preparation of the lecture begins. Residents are encouraged to utilize their faculty mentors and the Associate Program Director for Med/Peds in preparation of the talk.

PGY-3  
Residents will prepare and present a clinical case or research abstract at the regional ACP meeting held in the fall of each year. In order to properly prepare for this requirement, residents will need to gather ideas for cases during their first 2 years of training. The case should be selected in consultation with a faculty advisor in Internal Medicine, or one of its subspecialties. Preparation for this project will follow the timeline set forth by the ACP and will take place during the fall of the PGY-3 year, necessitating preparation begin during the end of the PGY-2 year.

PGY-4  
Residents will prepare and present an hour long grand rounds presentation to be delivered during the monthly Med/Peds Grand Rounds Conference. The presentation topic is expected to be applicable to the broad audience that includes internal medicine and pediatric residents and attending physicians. It should ideally involve a topic that reflects the interconnectedness of the two specialties. Topics for the presentation must be reviewed and approved by the Associate Program Director for Med/Peds before preparation of the lecture begins. Residents are encouraged to utilize their faculty mentors and the Associate Program Director for Med/Peds in preparation of the talk.

Other Learning Activities
Internal Medicine requirements:

SBL – System’s based learning project – Med/Peds residents participate in structured programs to develop skills in SBL and PBL. Each resident must demonstrate basic competency in these areas. These programs run concurrently in their rotation assignments but often involve patient experience on their assigned rotations. Med/Peds residents are required to complete one SBL a year. (See Appendix H & I (pgs 90-97) in the Policy/Procedure Manual – Internal Medicine website: http://wichita.kumc.edu/im/resident/2011_2012/policy.pdf)
EBM - Evidence Based Medicine - An EBM exam is part of the Journal Club and competency requirements for the IM program; we encourage you to complete this during your Intern year. You will complete this exam via the Angel system (Authenticated Networked Guided Environment for Learning). If you have any questions about the EBM content, please contact Dr. Kallail at kkallail@kumc.edu or 293-2650.

Mini- CEX’s Evaluation of Resident Skills (see pgs 57-58 in the Policy and Procedure Manual - Internal Medicine website) Total of 10 required over 3 years: 4 during PGY1, 3 during PGY2, and 3 during PGY3. Not required during PGY4 year.

Journal Club: Complete 9 evaluations over 4 years – not required to present IM Journal Club(see pgs 64-67 in the Policy/Procedure Manual – Internal Medicine website)

Pre-clinic Conferences – Ambulatory medicine didactic curriculum (Preclinic-Yale Curriculum) will be completed prior to your Internal Medicine Clinic start time each week. You will be given access to this curriculum via ANGEL soon after beginning your residency.

In Training Exams – Yearly for both programs. Vacation/leave will not be granted during this time.

Web-based Communications Curriculum: http://webcampus.drexelmed.edu/doccom/

The BASIC MODULES provide a good overview of doctor-patient communication skills. You should review these modules first, before beginning the required curriculum.

- **Review the Basic Modules 1 – 4:**
  - 01 Overview
  - 02 Mindfulness and Reflection in Clinical Training and Practice
  - 03 Therapeutic Aspects of Medical Encounters
  - 04 Balance, Self-Care

**STEP 1: ESSENTIAL ELEMENTS MODULES**

The ESSENTIAL ELEMENTS MODULES are required by the end of your 1st year of residency.

- Complete the Essential Elements Modules 5 -12:
  - 05 Integrated Patient-centered and Doctor-centered Interviewing
  - 06 Build a Relationship
  - 07 Open the Discussion
  - 08 Gather Information
  - 09 Understand the Patient’s Perspective
  - 10 Share Information
  - 11 Reach Agreement
  - 12 Provide Closure

- Complete the Module tests on FIVE of the eight modules.

The ADVANCED ELEMENTS MODULES are required by the end of your 2nd year of residency, but can be completed any time before then. Five completed modules are required.

- **Review the Advanced Elements Modules 13 -19:**
  - 13 Responding to Strong Emotions
  - 14 It Goes Without Saying: Nonverbal Communication in Clinician-Patient Relationships
  - 15 Understanding Difference and Diversity in the Medical Encounter: Communication Across Cultures
  - 16 Promoting Adherence and Health Behavior Change
  - 17 Shared Decision-Making
  - 18 Exploring Sexual Issues
  - 19 Exploring Spirituality & Religious Beliefs

- Complete the Module tests for FIVE of the seven modules.
The COMMUNICATING IN SPECIFIC SITUATIONS MODULES are required by the end of your 3rd year of residency, but can be completed any time before then. Five completed modules are required. However, it is recommended that you complete as many modules as possible to enhance your communication skills with patients. You may also complete the COMMUNICATING WITH COLLEAGUES modules (37-42).

- Review Modules 20 – 42 according to your needs and interests. Five must be completed.
  - 20 Family Interview
  - 21 Communication and Relationships with Children and Parents
  - 22 The Adolescent Interview
  - 23 The Geriatric Interview
  - 24 Tobacco Intervention
  - 25 Motivating Healthy Diet and Physical Activity
  - 26 Anxiety and Panic Disorder
  - 27 Communicating with Depressed Patients
  - 28 Domestic Violence
  - 29 Alcohol: Interviewing and Advising
  - 30 Drug Abuse Diagnosis and Counseling
  - 31 Medically Unexplained Symptoms and Somatization
  - 32 Advanced Directives
  - 33 Giving Bad News
  - 34 Communication Near the End of Life
  - 35 Dialog about Unwanted Outcomes
  - 36 Ending Doctor-Patient Relationships
  - 37 The Oral Presentation
  - 38 Communication on Healthcare Teams
  - 39 Talking with Impaired Physicians
  - 40 Giving Effective Feedback: Enhancing the Ratio of Signal to Noise
  - 41 Professionalism: Boundary Issues
  - 42 Effective Clinical Teaching

- Complete the Module tests for FIVE of the modules.

**IMPORTANT INFORMATION**
- The Communications Curriculum is part of the core residency curriculum and REQUIRED.
- Performance on the Communication Curriculum will be included as part of your annual evaluation.
- Unsatisfactory or incomplete work on this curriculum may delay promotion and/or graduation.
- If you have problems with the curriculum, the faculty contact is Dr. Kallail at 293-2650.

**Pediatrics:**
QI projects – 2 total, should be done during the years resident is on Peds rotations for 8 months
Pedialink – Goals and Objectives for each academic year

**Required Conferences and Meetings**

Med/Peds residents must maintain over 4 years an attendance average of greater than 60% to graduate from the program. Residents are expected to attend Pediatric conferences while on Pediatric rotations and Internal Medicine conferences while on Internal Medicine rotations, however residents will receive credit for attendance wherever they attend. Attendance is required at All Resident Meetings for both programs. While residents are on their Peds block rotations, absences follow the Pediatric guidelines which state residents will not be excused from conferences for any reason. Residents must maintain a 60% average for noon conferences and a 50% average for morning teaching conferences. (See following page for Peds lectures) While on their Internal Medicine block rotations, absences will follow the Internal Medicine guidelines which are detailed below.

The attendance will be logged into New Innovations where residents and faculty may monitor resident attendance. The Residency Coordinator will track and collect attendance records from Wesley Medical Center, Via Christi St. Francis, Dole VA, and UKSM-W. Residents must sign-in to each conference to register their attendance.

IM Conferences are recorded electronically (audio and PowerPoint) and may be accessed through the Internal Medicine website. Residents are expected to review those conferences they are unable to attend. Website pathway to access
Internal Medicine

Residents are required to attend an ongoing series of didactic conferences. A calendar of departmental conferences is distributed monthly. Residents are expected to attend all conferences unless they have approved leave or are excused. Attendance will be reviewed regularly for compliance and will be part of the decisions leading to advancement. If attendance falls below 60% for any conference type*, action may be taken by the program director to remediate the deficiency. *90% attendance is required at MTC; if your attendance falls below this percent, residents will be given extra call assignments.

**Morning Teaching Conference** is held Tuesday, Wednesday, and Thursday from 8:00-8:45 am. MTC Boot Camp will be held July-August, Monday-Friday, 8:00-8:30 am. Residents should attend Morning Teaching Conference at their assigned hospital. Residents are assigned to hospitals monthly by the Chief Residents. This is to insure there are a sufficient number of residents for conference attendance. Please check the monthly attendance sheet given by the Chief Resident in charge of MTC.

**Hospital Grand Rounds** is held weekly at noon. Grand Rounds is held on Monday at Wesley Medical Center, Tuesday at Via Christi-St. Francis, and Thursday at the VA Medical Center. Residents should attend Grand Rounds at their assigned hospital. **KUSM-W Grand Rounds** is held weekly on Friday at noon usually beginning in September.

Residents are strongly encouraged to attend Grand Round sessions at other hospitals for their own educational benefit. Additional conference attendance will count toward the attendance requirement (i.e., if you are assigned to VC-SF and attend 3 of 4 Grand Rounds held at VC-SF for 75% attendance and also attend two WMC Grand Rounds, your Grand Rounds attendance for the month would = 125%).

**Pre-Clinic Conference** is held weekly at the KUSM-W Patient Care Clinic – KU Wichita Center for Medicine - before the scheduled ambulatory patient sessions. The Medical Director of the Clinic will forward attendance information to the IM Coordinator so residents MTC attendance will not be affected when in clinic.

**Board Study** is held weekly on Wednesday usually at Via Christi-St. Francis. Residents are expected to attend Board Study regardless of their In-Training Exam scores.

**Management Conference** is held monthly at KUSM-W. This series of monthly one-hour seminars enables the residents to gain skills in practice management, quality assessment, risk assessment, risk improvement, medicolegal issues and cost-effective medicine. Residents are required to participate in a WCGME sponsored practice management seminar series that repeats annually. **All Resident Meeting** (ARM) is held monthly at KUSM-W in conjunction with the Management Conference. **ARM is a required meeting** regardless of what block rotation the resident is on.

**Journal Club** is held monthly at noon at KUSM-W.

**M&M** is held monthly at VC-SF.

**Typically the IM conference locations are as follows:** Monday – Wesley(WMC), Tuesday – VCSF, Wednesday – VCSF, Thursday – VA, Friday – UKSM-W.

**Pediatric Conferences:** All conferences are from Noon (12:00 p.m. to 1:00 p.m.) unless otherwise noted. (*) Indicates RRC Core Curriculum Activities

<table>
<thead>
<tr>
<th>Conference</th>
<th>Frequency</th>
<th>Occurrence</th>
<th>Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning Teaching Conference</td>
<td>Daily (M-Th)</td>
<td>8:00 – 8:45 am</td>
<td>July–June</td>
</tr>
<tr>
<td>Grand Rounds</td>
<td>Weekly</td>
<td>Friday</td>
<td>Sept.–June</td>
</tr>
<tr>
<td>Adolescent Conference</td>
<td>Monthly</td>
<td>1st Monday</td>
<td>Sept.–June</td>
</tr>
<tr>
<td>Ambulatory Care* (Clinic)</td>
<td>Monthly</td>
<td>1st Tuesday</td>
<td>Sept.–June</td>
</tr>
<tr>
<td>Neonatology *</td>
<td>Monthly</td>
<td>1st Wednesday</td>
<td>Sept.–June</td>
</tr>
<tr>
<td>Mortality Review (11:30 a – 1:00 p)</td>
<td>Monthly</td>
<td>1st Thursday</td>
<td>July–June</td>
</tr>
<tr>
<td>Event ---------------------------------</td>
<td>Frequency</td>
<td>Date</td>
<td>Location</td>
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<tr>
<td>Internal Medicine / Pediatric Combined Conference</td>
<td>Monthly</td>
<td>2nd Monday</td>
<td>Sept. – June</td>
</tr>
<tr>
<td>Ethics Conference</td>
<td>Every other Month</td>
<td>2nd Tuesday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Research Conference</td>
<td>Every other Month</td>
<td>2nd Tuesday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Allergy/Immunology</td>
<td>Every other Month</td>
<td>2nd Wednesday</td>
<td>Sept – June</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Every other Month</td>
<td>2nd Wednesday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>All Residents Meeting</td>
<td>Monthly</td>
<td>2nd Thursday</td>
<td>Sept – June</td>
</tr>
<tr>
<td>Faculty Meeting</td>
<td>Monthly</td>
<td>2nd Thursday</td>
<td>July – June</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>Every other Month</td>
<td>3rd Monday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Every other Month</td>
<td>3rd Monday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Neurology</td>
<td>Every other Month</td>
<td>3rd Tuesday</td>
<td>Sept – June</td>
</tr>
<tr>
<td>Evidence Based Medicine</td>
<td>Every other Month</td>
<td>3rd Tuesday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Behavioral Medicine</td>
<td>Every other Month</td>
<td>3rd Wednesday</td>
<td>Sept – June</td>
</tr>
<tr>
<td>Evidence Based Medicine</td>
<td>Monthly</td>
<td>3rd Tuesday or Wednesday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Residency Committee</td>
<td>Monthly</td>
<td>3rd Wednesday</td>
<td>July – June</td>
</tr>
<tr>
<td>Nephrology Conference</td>
<td>Every other Month</td>
<td>3rd Thursday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Child Development</td>
<td>Every other Month</td>
<td>3rd Thursday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Faculty and Residents</td>
<td>Monthly</td>
<td>4th Monday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Every other Month</td>
<td>4th Tuesday</td>
<td>Sept – June</td>
</tr>
<tr>
<td>Genetics</td>
<td>Every other Month</td>
<td>4th Tuesday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Every other Month</td>
<td>4th Wednesday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Every other Month</td>
<td>4th Wednesday</td>
<td>Sept - June</td>
</tr>
<tr>
<td>Peds in Review</td>
<td>Monthly</td>
<td>4th Thursday</td>
<td>Sept. – June</td>
</tr>
<tr>
<td>PREP Review</td>
<td>Monthly</td>
<td>5th week or 1st Friday Morning Conference</td>
<td>Sept – June</td>
</tr>
<tr>
<td>Sub-Specialty Conference</td>
<td>By Arrangement</td>
<td>5th Week of Month</td>
<td>Sept - June</td>
</tr>
</tbody>
</table>

All residents in pediatrics are expected to attend each morning report when rotating on inpatient service (and other rotations as schedule permits), noon conference (at the assigned hospital), grand rounds, all resident meetings and other department sponsored meetings, unless prohibited by call responsibilities, urgent patient care issues, or vacation. Sign-in lists will be available to obtain credit for attendance. You will not be credited with attendance at a conference if you arrive after 12:15. Residents are required to attend at least 60% of conferences. Failure to do so may impede your progress in the program or result in withholding of certificate of completion until the requirement is met.
Resident Duty Hours

Duty 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.

- Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
- Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
- PGY-2, 3, & 4 residents who have completed a 24-hour duty period may spend up to an additional 4 hours to ensure an appropriate, effective, and safe transition of care. Residents must not be assigned to outpatient clinics, including continuity clinics, during this 4-hour period.
- PGY-2, 3, & 4 residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- Residents should use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m. is strongly suggested.

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks).

At-home call cannot be assigned on these free days. A 10-hour break for rest and personal activities must be provided between all daily duty periods and in-house call. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80 hour weekly limit on duty hours.

Residents must notify the supervising faculty ASAP if they might exceed their maximum duty hours. The attending supervising faculty will make every effort to dismiss the resident from duties as soon as the maximum duty hours are completed. Residents must not be scheduled for in-house call more than once every three nights, averaged over four weeks.
Resident Recruitment, Selection, Appointment

Recruitment of residents for KUSM-W sponsored programs is a responsibility of each separately accredited residency program. The Wichita Center for Graduate Medical Education (WCGME) employs the residents in Wichita and Salina Health Education Foundation (SHEF) employs the residents in Salina. Pursuant to requirements of the contract annually executed between KUSM-W and WCGME, (as the coordinating entity) WCGME will assist each program with the resident recruitment process. Selection of residents to participate and be enrolled in KUSM-W residency programs is the responsibility of the KUSM-W acting through its program directors. The KUSM-W participates in the National Resident Matching Program (NRMP) and all programs are required to abide by NRMP policies. The graduate medical education office of the KUSM-W serves as the liaison between all residency programs and NRMP.

The minimum criteria for medical and osteopathic graduates to be considered for KUSM-W residencies are:

- Academic and clinical qualifications to be appointed as a resident physician in the University of Kansas School of Medicine-Wichita sponsored residency programs;
- Eligible for employment by WCGME or SHEF;
- A student in good standing or a graduate of a medical or osteopathic school approved by the Kansas State Board of Healing Arts;
- Anticipated eligibility for licensure by Kansas State Board of Healing Arts and for registration by the U.S. Drug Enforcement Agency
- International Medical Graduates (IMG’s) must have current or anticipated certification by the Educational Commission for Foreign Medical Graduates (ECFMG); or who have completed a Fifth Pathway program provided by an LCME-accredited medical school.
- For non-citizens, permanent residency status in the United States, Work Authorization, a J-1 visa, or H-1B. No other visas are accepted.

This does not preclude residency programs from developing additional criteria.

Programs will not discriminate with regard to gender, race, age, religion, national origin, sexual preference, disability, or veteran status.

Once an individual has been "matched", or has been offered and has accepted a residency position outside the NRMP process, the program director will notify the WCGME or SHEF office so that a resident Letter of Appointment and Resident Agreement can be prepared for signatures. In order to issue a Letter of Appointment and an Agreement, the WCGME or SHEF office must be provided with the following:

- Application for Residency
- ECFMG Certificate and Visa (if applicable)
- Starting and Estimated Completion Dates
- Year-in-Program

When the signed agreement is received from the resident, the respective office will forward a copy to the program director. A copy of the application for residency is sent to the Kansas City campus to enroll the resident in the University of Kansas. The WCGME and SHEF offices will assist the new residents in applying for state licensure, DEA registration and to meet all other requirements for employment. All contracted residents must submit two certified copies of their medical school diploma prior to beginning residency.

Individuals with prior residency training must have a letter/certificate from their previous program director(s). This letter must document residency credit and dates of training.
Evaluation, Promotion & Dismissal

The resident is evaluated on multiple occasions during their training program based on his/her performance on the wards, in the clinic, at conferences, at morning teaching conference, and other educational functions. These reports may be reviewed online in New Innovations at https://www.new-innov.com.

- An evaluation is completed at the conclusion of each rotation by the attending (general and subspecialty).
- Residents are requested to complete an evaluation on the rotation/attending as well.
- Evaluation of performance in the ambulatory continuity clinic is completed every six months.
- Chart audits for residents in Internal Medicine are reviewed in three areas:
  - the General Ward for both specialties formative evaluation is reviewed by the resident’s Advisor during their 6 month and End of Year evaluation period;
  - the PBL Quality of Care evaluation is reviewed by the General Ward Attending the first and last week of the rotation;
  - the City Wide Ambulatory block continuity clinic patient care audit is reviewed by the Ambulatory director at the end of the rotation.
- Chart audits for residents in Pediatrics are reviewed by the resident’s Advisor during the 6 month and End of Year evaluation period.
- Each resident on Internal Medicine rotations will perform patient interviews and exams under faculty observation and receives an evaluation of his/her clinical performance (i.e., clinical exam or Mini CEX). Interns will perform and be evaluated on 4 mini clinical exams in the patient care facility of KUSM-W.
- Patient Satisfaction surveys are conducted twice during the year in Internal Medicine
- Nursing surveys are conducted twice during the year in both programs
- Peer surveys are conducted during general medicine ward rotations in both programs
- A self-evaluation of Internal Medicine clinic charts will be conducted during PGY-2 as part of the Ambulatory Care Rotation.
- A Individual Learning Plan is completed by the residents and reviewed by their pediatric advisors to help with planning goals and objectives. This form is found on Pedialink
- Attendance levels at a variety of teaching conferences are used as an evaluative tool on a monthly basis.
- The Pediatric In-Training Exam is required of all residents each year [usually given in July]. The score is used not as a threshold for advancement, but to identify residents who may need additional study in specific areas of pediatrics or assistance with a general study program in preparation for the board certification exam. However, if there is consistent poor performance on the ITE along with concerns about the resident’s clinical skills or professionalism, it may be considered as a part of the justification for probation or prolongation of the training program. The Internal Medicine program takes their In-Training exam in October.
- PBL & SBL evaluations
- Journal Club evaluations
- Web-based assessments
- Communication Modules

The Med/Peds Competency and Selection Committee meets quarterly to review all resident progress and well as other matters concerning the residency. The committee makes suggestions regarding any necessary corrective actions, advancement of responsibilities, and suitability to sit for boards. The following people attend the Med/Peds Competency and Selection Committee: The Program Directors, The Associate Program Directors, and the Internal Medicine, Pediatrics, and Med/Peds Residency Coordinators of the program.

The residency office compiles a portfolio which includes the faculty evaluations from all assigned rotations, the In-Training Examination Scores, procedure log, record of scholarly activity, conference attendance record, patient, nursing and peer evaluations, and the continuity clinic evaluation, mini CEX’s; SBL and PBL projects. Based on these discussions, decisions will be developed concerning progress in the program, need for and type of remediation, and suitability for promotion or recommendation for dismissal.
All decisions that adversely affect the resident’s timely progress in the program or continuation in the program will be communicated in writing to the resident during a face-to-face meeting. The written notification to the resident will include information regarding how to file a grievance. Residents may meet with their advisor or Associate Program Director to appeal adverse decisions. Also, the WCGME grievance procedure applies to residents who wish to appeal decisions of the program.

The Pediatric Residency committee members, along with the resident’s advisor, complete a Semi-Annual Evaluation Summary form as scheduled by the Residency Committee in November/December of each year and May/June of each year to determine promotion of each resident to the next year. The residents’ advisor meets with the resident at least quarterly to review the residents’ progress and evaluations, and recommendations of the Pediatric Residency Committee. Finally, the Pediatric Program Director completes the ABP Annual Evaluation of the Resident for promotion to the next year and credits for meeting requirement of training.

Progress through the residency program occurs as the result of increasing competency and skill, not necessarily time spent in each training year. Advancement is dependent on the following factors:

- Satisfactory evaluations of performance on inpatient and subspecialty rotations completed by appropriate faculty, private physicians, teaching attendings, nursing staff, and patient feedback. This includes inpatient chart audits and documentation of patient interactions in private offices, and evaluation forms.
- Satisfactory evaluation by outpatient attendings, nursing staff, and patient surveys during clinic days, including observation of interactions with patients and of clinical skills. Evaluation of performance in the Ambulatory Care Clinic is made every six months.
- Progress made in successful performance of required Procedures.
- Progress made and completion of scholarly activity projects.

Progress toward competency in all areas of the six general competencies is expected each review. By the mid PGY 2 year, the resident is expected to reach competency in at least 33% of the attributes listed in the evaluation. By the end of the PGY 3 year the resident is expected to attain competency in 67% of the attributes in each of the six general competencies. By the end of the last year of training, the resident should be competent in all areas. Any concerns or remedial work requirements are addressed with the resident by the resident’s advisor and the program director after the review. More frequent reviews may be scheduled if necessary to update the resident’s progress if corrective actions have been identified.

MONTHLY SERVICE EVALUATION

Before the end of each rotation the Resident Evaluations are sent to respective faculty, private and teaching attending physicians, nursing staff and resident peers who have had contact with a given resident by New Innovations. The attending physician should discuss evaluations with the resident. The Inpatient Supervising Resident will also be consulted on evaluations for the residents completing the inpatient service. These evaluations are returned at the end of the rotation to the Residency Coordinator, and entered into the respective resident’s file.

SIX-MONTH EVALUATION OF OUTPATIENT CLINIC PERFORMANCE

The Six-Month Evaluation of Resident Out Patient Clinic Performance Form is distributed by the Residency Coordinator every six months, once in December for the time period from July through December and once in June for January through June, to evaluate each residents' performance in the Ambulatory (Continuity) Care Clinic. Clinic faculty will evaluate each resident with whom they have worked with those six months. Nursing staff and patients/parents selected by faculty attendings will evaluate each resident in regards to patient care, interpersonal and communication skills, and professionalism.
RESIDENT EVALUATION OF ROTATION AND FACULTY

Feedback from residents about the organization and conduct of each service, as well as the teaching and supervision provided by the faculty, is vital. Constructive criticism is welcome at anytime, but the program expects written comments from each resident at the completion of each rotation. This information is used to improve rotations and to provide suggestions to faculty for enhancing the educational experience. There should be no concerns about retribution as a result of such feedback, because the feedback given to teaching faculty is a summary of evaluations.

The Resident Evaluation of Rotation and Faculty should be completed by each resident at the completion of each service rotation. This evaluation is completed through New Innovations. All evaluations of staff and service are kept confidential.

PROMOTION

After satisfactory completion of each year of GME experience, as attested to by the program director and the program promotion committee, a resident in good standing may be promoted to the next year of their program subject to the terms, limitations and conditions described in this document and the Resident Agreement. The decision to promote is expressly contingent upon several factors, including but not limited to:

- Satisfactory completion of residency requirements
- Full compliance with the terms of the Resident Agreement
- The continuation of the Program's accreditation by the ACGME
- The availability of a position
Resident Remediation Policy

If the need for resident remediation is identified, the following protocol is implemented:

- The program director will be notified of the concern as soon as possible.
- In coordination with the attending assigned to the service, plans will be made to alter the patient load for the remainder of the rotation. Patient care quality will be preserved.
- A meeting will be arranged with the resident in need of remediation and a formal written remediation plan will be developed. This meeting will involve the program director, resident, and their faculty advisor.
- It is desirable for the resident to remain on the service unless concerns about the safety of patients or other substantial mitigating factors exist that suggest a change of rotation is the optimal course of action.
- The resident will be re-assessed at the conclusion of the rotation to determine if further remediation is necessary or to develop an extended remediation plan.

Probation, non-renewal of agreement or dismissal from the program may occur for reasons as delineated in the WCGME Due Process Guidelines written in the WCGME Resident Policy and Procedure Manual. The residency follows these guidelines when remediation of a resident’s deficiencies has been unsuccessful by the program director and advisor.

GUIDELINES FOR ADDRESSING CONCERNS ABOUT RESIDENT PERFORMANCE

Although each situation is handled as is appropriate for that circumstance, there are general guidelines that are followed:

- Concerns that are brought to the attention of faculty or program director are addressed as quickly as possible with the resident. Minor errors of omission are noted by the program director in personal files, but not in the resident’s permanent file unless repeat errors are noted.

- “Early Warning” notices are available to faculty to complete and send to the program director when a concern arises about a resident’s performance. The notice allows the attending to elect having the program director deal with the concern if the attending is not comfortable discussing it with the resident. This documentation is added to the resident’s file.

- Errors of omission, consistent complaints about interpersonal relationships, violations of hospital or training program rules are discussed with the resident by the program director, the advisor is notified, and documentation of the warning and expected outcome is placed in the permanent file. An appropriate system of monitoring remediation is instituted.

- The file for each resident is reviewed at each semi-annual evaluation and specific remediation outlined for any concerns. If the resident does not make corrective actions, an adverse action may occur as outlined in the WCGME Policy and Procedure manual.
**Supervision Policies**

**Supervising Physician** – in the clinical learning environment, each patient must have an appropriately credentialed and privileged attending physician who is ultimately responsible for that patient’s care. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident.

**Direct Supervision** – the supervising physician is physically present with the resident and patient.

**Indirect Supervision**
- **With direct supervision immediately available** – the supervising physician is physically present within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- **With direct supervision available** – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

The program director and faculty members will assign the privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident.

Senior residents should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident.

PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available.

**Attending and Resident General Expectations Regarding Supervision**

**Expectations**\(^1\) for Attendings regarding supervision are the following:

1. Set expectations for when to be notified at the start of the rotation
   a. Admissions
   b. Discharges
   c. Patient death
   d. Clinical deterioration
   e. Unexpected need for change in clinical support or treatment
   f. Transitions of care
   g. Family/legal issues
   h. End-of-life care

2. Reassuring residents that it is always appropriate to call, including affirming that there will not be negative repercussions for seeking the attending physician’s input

3. Ready availability of the supervising attending physician
   a. Providing contact numbers to residents
   b. Responding promptly to resident requests for assistance

4. Recognition of resident uncertainty

5. Balancing providing supervision while allowing for resident decision-making autonomy

6. Planning communication, such as specifying a regular time for contact during each on-call night

Expectations for residents:

1. Seek attending input early
2. Contact attending for set expectations as defined above
3. Contact attending when the senior resident is unavailable or unable to provide supervision to the PGY-1 resident
4. Contact attending when uncertain about clinical decisions
5. Contact attending when needing help with the system/hierarchy
6. Current and complete patient summary checkout document will be provided by the on service resident to the on call resident at times of patient care handoff
7. Initiate planned communication with the attending (#6 in attending expectations)
8. A care plan should be formulated and proposed when contacting the attending to maximize education
9. Senior residents will monitor and supervise the junior resident in real time

For any of the situations noted in #2, 3, 4, or 5 communications with the attending should be in person or by phone (not texting).

Reporting Lines

Inpatient Services
The supervising faculty is responsible for all patient care activities. The senior resident is responsible for communicating directly with the supervising faculty on a daily basis and more frequently, if necessary. Any major change in patient status or any major new findings (e.g., clinical deterioration, death, transitions of care, end-of-life care) will be reported to the attending faculty by the senior resident. The senior resident will ensure that the faculty is informed of each patient's status during rounds, or immediately if the situation indicates. When the senior resident is on vacation, the first-year residents will report directly to the attending faculty. The attending faculty is always available by pager/phone for acute emergent problems.

First-year residents are to report directly to the senior resident. They will keep the senior resident informed of all major changes in patient care status, new important laboratory information, or other important patient care data. In those cases in which the senior resident is not available, interns are to report directly to the attending physician. In any situation in which the first-year residents are not able to reach the senior resident or feel there are major patient concerns incompletely addressed, they will contact the attending faculty directly for consultation. When the 1st year resident is taking sick leave, on vacation, post call or is otherwise unavailable, the supervising senior resident will assume care of her/his patients or assign them to another resident. The senior resident and 1st year resident should not be off duty simultaneously.

Sub-Specialty Services
On services in which the resident, regardless of level, works directly with faculty, the resident is to report directly to the attending faculty on a daily or, if necessary, more frequent basis. All information of importance about the patient will be reported daily on rounds. Any changes in patient status that require immediate action will be reviewed with the attending faculty who will always be available by phone or pager.

Hospital Call
Each hospital has On-Call / Night Float responsibilities and duties that vary depending on the level of training and training site. For internal medicine, the DIME at each hospital will inform residents of the duties for internal medicine services. For pediatrics, the pediatric program coordinator and chief resident will inform residents of the their duties.

Residents on-call are to notify the responsible resident during the hand off process for any patient care issues that occur on hospitalized patients. They are also to clarify with the responsible resident who will notify the attending for any important or major changes in patient status. In all cases in which important patient issues arise at night or on weekends while the on-call team is covering the hospitalized patients, the responsible faculty must be informed. In most cases, it is the responsibility of the senior resident on-call to ensure that the responsible faculty is notified. The on call resident must communicate directly to the responsible physicians and must never communicate solely through an intermediary.
Junior residents always will keep the senior resident who is on-call informed of any important changes in patient care status. Patients requiring admission from the emergency room will be seen by the senior resident who will notify the junior resident of the patient’s admission. All patients seen in the emergency room by senior residents will be discussed with the responsible faculty member who is always available by phone or pager. The On-Call / Night Float team will manage new admissions until care is transferred to the responsible team via direct communication.

Requests for relief from call responsibilities should be made before the call schedule is completed. Please see Leave Request Section.

**Special Cases**

Every patient encounter involving residents in this program will have a supervising faculty responsible for the patient's welfare. Therefore, residents must use good judgment (see Supervision section) in deciding when supervising faculty should be notified of changes in patient status. In any case in which the internal medicine attending faculty is unavailable, the resident should notify the responsible Director of Internal Medicine Education at the teaching site and, if necessary, they should contact the internal medicine program director for any unresolved patient care issues. If the pediatric attending is unavailable, the resident should notify the pediatric program director.

In cases in which residents evaluate patients for acute emergent problems in the hospital who are not on the teaching service, the physician of record must be contacted to discuss the care of the patient and to make arrangements for transfer of ongoing care to the attending of record. In cases in which the resident is unable to contact the physician of record or finds the disposition unacceptable, the resident should contact the Director of Internal Medicine Education at that hospital for further deliberation about the appropriate physician(s) to provide on-going care of the patient.

**PICU Supervision Policy**

Expectations for PICU attendings regarding supervision are the following:

1. Set expectations for when to be to be notified at the start of the rotation
   a. Admissions
      i. The PICU attending will notify the on-call resident when it is determined that a patient will be admitted to the Pediatric Critical Care service along with the admission status (inpatient/outpatient-observation) determination.
      ii. The on-call resident will then notify the on-call PICU attending with their initial interview and exam findings along with their assessment and care plan recommendations.
   b. Discharges
      i. All PICU patient discharges or transfers (unplanned, or against medical advice) require notification and acknowledgement by the attending or their designate before the discharge order is documented. Any planned discharges or transfers that fail to take place also require notification and acknowledgement by the attending or their designate.
   c. Patient death
      i. All patient deaths (expected or unexpected) occurring in the PICU, require notification and acknowledgement by the attending or their designate.
   d. Clinical deterioration
      i. Any PICU/sedation patient experiencing significant clinical deterioration requires notification and acknowledgement by the attending or their designate along with the on-call resident’s initial evaluation and exam findings, assessment and care plan recommendations. Determination of the need for the attending’s physical presence should be established during this communication.
   e. Unexpected need for change in clinical support or treatment
      i. Any PICU/sedation patient experiencing significant clinical deterioration requires notification and acknowledgement by the attending or their designate along with the on-call resident’s initial evaluation and exam findings, assessment and care plan recommendations. Determination of the need for the attending’s physical presence should be established during this communication.
   f. Transitions of care
      i. The occurrence of any unplanned transition of care for PICU/sedation patients requires notification and acknowledgement by the attending or their designate.
   g. Family/legal issues
      i. Any PICU patients with significant/urgent family status change, especially those involving agencies of law enforcement requires notification and acknowledgement by the attending or their designate following the on-call resident’s initial evaluation and assessment of the situation.
   h. End-of-life care
Any significant change in the expected end-of-life-care care or outcome for PICU patient designated as in need of end-of-life-care requires notification and acknowledgement by the attending or their designate along with the on-call resident’s initial evaluation and exam findings, assessment and care plan recommendations.

2. Reassuring residents that it is always appropriate to call, including affirming that there will not be negative repercussions for seeking the attending physician’s input
   i. Any perceived variation from this expectation should be promptly reported to the medical director of the PICU, or to the Chief Medical Officer of WMC.

3. Ready availability of the supervising attending physician
   a. Providing contact numbers to residents
      i. PICU on-call attendings contact information will be displayed on the updated patient check-out summary form
   b. Responding promptly to resident requests for assistance
      i. Pages or voice messages to PICU attending will be responded to within 15 minutes of their receipt.
      ii. “STAT” pages will be responded to immediately upon receiving them. “STAT” pages require the on-call resident to specify with the page-operator to label the page as “STAT”. Unless otherwise arranged for and agreed to, “STAT” notifications will be by pager rather than by contact by cell phone (paging establishes an institutional record of attempted contact).

4. Recognition of resident uncertainty

5. Balancing providing supervision while allowing for resident decision-making autonomy

6. Planning communication, such as specifying a regular time for contact during each on-call night
   i. Unless otherwise arranged for and agreed to, on-call PICU attendings will review PICU patients’ status, issues and expected clinical course with the night-call residents at the beginning of the resident’s on-call period.
   ii. Unless otherwise arranged for and agreed to, night-call residents will update on-call PICU attendings of PICU patients’ status, issues and recent clinical course between 21:30 and 22:00 each night.
   iii. Unless otherwise arranged for and agreed to, night-call residents will update on-call PICU attendings of PICU patient’s status, issues and recent clinical course between 06:15 and 06:45 each morning.

Expectations for PICU on-call residents:

1. Seek attending input early (see # 8)

2. Contact attending for set expectations as defined above

3. Contact attending when the senior resident is unavailable or unable to provide supervision to the PGY-1 resident

4. Contact attending when uncertain about clinical decisions (see # 8)

5. Contact attending when needing help with the system/hierarchy (see # 8)

6. Current and complete patient summary checkout document will be provided by the on-service resident to the on-call resident at times of patient care handoff

7. Initiate planned communication with the attending (# 6 in attending expectations)

8. A care plan should be formulated and proposed when contacting the attending to maximize education

For any of the situations noted in #2, 3, 4, or 5 communications with the attending should be in person or by phone (not texting).
Handoffs/Handovers

Optimizing the handoff procedure and preventing miscommunications is essential for patient safety. A formal handoff exercise will be completed during the new resident orientation. Handoffs are to be accomplished with both a printed standardized, handoff document and a face-to-face verbal process. The verbal process will be consistent and incorporate the elements of a patient summary, illness severity, an action list for oncoming resident, and situation awareness for problems that may occur and appropriate intervention. The receiver of the verbal handoff will summarize what was heard, ask questions, and restate action/to do items. Attendings are physically present during the handoff session on selected services. Chief residents are expected to monitor the handoff process on a continuing basis and report to the respective program director or associate program director resident compliance with the handoff process.

Leave Requests

You must complete a leave request form to begin the approval process for all leave. Go to the Med/Peds Website under residents, the leave requests. Complete the form – and do not leave blanks. After submission, the request will be routed to the program coordinator. If you do not receive a copy of the leave request within 1 week, please call the coordinator to verify receipt. Remember that you have 2 clinics so coverage must include IM and Peds.

**Pediatrics:** you will be informed by the Pediatric Education Office of the call schedule each month. Requests for leave from call responsibilities on a particular day should be made at or before the first working day of the prior month. A tentative call schedule will then be distributed for review with an accompanying deadline for changes. If changes are needed after that deadline, it will be the resident’s responsibility to find coverage for call.

**Internal Medicine:** uses the table below as a leave request timeline. Requests must be submitted according to the following schedule:

<table>
<thead>
<tr>
<th>For Block:</th>
<th>Requests Due By:</th>
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<tbody>
<tr>
<td>1 July 1 - 28</td>
<td>May 16</td>
</tr>
<tr>
<td>2 July 29 – Aug 25</td>
<td>June 14</td>
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<tr>
<td>3 Aug 26 – Sept 22</td>
<td>July 12</td>
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<tr>
<td>4 Sept 23 – Oct 20</td>
<td>August 9</td>
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<tr>
<td>5 Oct 21 – Nov 17</td>
<td>September 6</td>
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<tr>
<td>6 Nov 18 – Dec 15</td>
<td>October 4</td>
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<tr>
<td>7 Dec 17 – Jan 13</td>
<td>November 1</td>
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<td>8 Jan 13 – Feb 9</td>
<td>November 29</td>
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<td>9 Feb 10 – Mar 9</td>
<td>December 19</td>
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<td>10 Mar 10 – April 6</td>
<td>January 24</td>
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<td>11 April 7 – May 4</td>
<td>February 21</td>
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<tr>
<td>12 May 5 – June 1</td>
<td>March 21</td>
</tr>
<tr>
<td>13 June 2 - 30</td>
<td>April 18</td>
</tr>
</tbody>
</table>

PGY-1 residents may request 1 weekend free from call (Friday evening through Sunday night). PGY-2, PGY-3, and PGY-4 residents may request 2 weekends free from call (Friday evening through Sunday night). Additional requests beyond the weekends listed above will be honored only when doing so will not place undue burdens on other residents. As per the duty hour regulations all residents should average over the month one day free of duty for every seven days. Once the call schedule is issued, it is the responsibility of individual residents to work with his/her colleagues to switch call dates if necessary.

The IM call schedule will be prepared by the chief residents and distributed 15 days before the first day of the call month. Any changes in the call system will be communicated promptly and clearly to the departmental residency office as well as to the DIME at the hospital in which the call is to be taken for internal medicine. If illness or other personal situations develop that precludes someone from completing their call assignment, the resident is responsible for notifying the chief resident who will arrange a substitution. The chief resident will notify another resident who will assume the call responsibilities for the resident who is indisposed.
Moonlighting & Locum Tenens Policy

Residents may not be required to engage in moonlighting or locum tenens activities; however, if a resident desires to engage in moonlighting or locum tenens activities the following guidelines must be followed. Moonlighting and locum tenens must never interfere with regular resident responsibilities. Moonlighting residents are expected to be present (and appropriately rested) in their educational setting during all prescribed hours. Moonlighting and locum tenens must never occur without advance written permission of a resident's Program Director. The resident's performance will be monitored by the Program Director for the effect of these activities upon residency performance.

Moonlighting:
Moonlighting is defined as any remunerative activity, outside the requirements of the residency program, in which an individual performs duties related to health care. This includes, but is not limited to: providing direct patient care, conducting “wellness” physical examinations, reviewing medical charts, EKGs, or other information for a company or an agency, clinical teaching in a medical school, providing medical opinions or testimony in court or to other agencies, and serving as a sports team physician or medical official for an event.

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External remunerative Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

Any moonlighting by a resident at any of the following organizations is considered “internal” moonlighting, and hours spent moonlighting at these organizations must be counted against the resident’s 80 hour workweek total: Wesley Medical Center, Via Christi Hospitals Wichita, Inc., and Salina Regional Health Center. Reporting of the hours is the resident’s responsibility. Residents may be granted permission to moonlight only if they have obtained full licensure from the Kansas State Board of Healing Arts and have their own individual DEA registration number. Residents working under J-1 sponsorship are prohibited from engaging in outside remunerative activities of any kind. This is a condition of the J-1 visa under ECFMG and INS regulations. PGY-1 residents are not permitted to moonlight.

Program Directors, acting as agents of the Dean and the University, will establish policies governing moonlighting activities for their residents that are in compliance with university and Residency Review Committee guidelines. These policies establish the maximum number of hours that a resident will be permitted to moonlight per week, month and year. Policies and procedures for requesting and granting permission for moonlighting are the responsibility of each Residency Program and its Program Director and/or Departmental Chair. Residents on formal probation may not participate in moonlighting activities until they have been restored to good standing in their programs. A copy of the letter approval form for moonlighting and locum tenens must be kept in the resident’s program file.

KUSM-W residents are provided professional liability insurance via a State of Kansas self-insurance program. This insurance (occurrence type with tail and with the following limits: basic coverage $200,000/600,000; excess coverage $800,000/2,400,000) covers residency-related acts performed under the supervision of a member of the residency teaching staff and approved locum tenens, but DOES NOT cover moonlighting activities. Additional occurrence type insurance, with limits of coverage not less than those provided via the state plan, must be arranged to cover moonlighting activities. Such insurance may be purchased by the resident or may be arranged by another individual/agency (i.e., the moonlighting employer). If the resident is not personally responsible for purchasing the additional coverage, he/she must request a certificate of insurance to document the existence of the appropriate coverage.

Salary advances (zero percent interest loans) to cover the cost of premiums for such insurance are available via the WCGME office. Residents moonlighting at a VA Medical Center do not need to purchase additional insurance to cover their VA moonlighting activities if they have signed “fee basis agreements” which result in their appointment to the VA Medical Staff. As such, the residents are covered by the Federal Tort Claims Act and do not require individual Professional Liability Insurance coverage.
Approved Moonlighting Sites – Peds and Internal Medicine
The following sites have been approved. Any resident moonlighting at an unapproved site is in violation of the guidelines and will be subject to revocation of moonlighting privileges.

- Via Christi Regional Medical Center-St. Francis/E.R. and MECS
- Wesley Medical Center/E.R. and MECS
- Via Christi Regional Medical Center-St. Joseph/E.R. and MECS
- Wichita Clinic Ambulatory Care Clinic and Maple Ridge
- McConnell Air Force Base
- Emergency Services of Kansas - Newton site only
- Hospice Services of Wichita - Attending: Gerard Brungardt, MD
- Wesley Medical Center Neonatal Intensive Care Unit

Locum Tenens:
Locum tenens activities approved, in advance, by a resident’s Program Director, Chief Operating Officer and Executive Vice Chancellor, will be covered by the resident’s state-provided insurance and do not require the purchase of additional coverage. Locum tenens activities are considered to be controlled situations in which a KUSM-W Residency Program responds to a request from a Kansas physician for a qualified resident to provide “coverage” for him or her while away from the usual site of practice for a limited time due to illness, vacation or attendance at a continuing medical education activity.

Locum tenens activities will typically occur only in “rural” communities. A request for a locum tenens activity in a more urban setting will not be approved unless there are unusual extenuating circumstances. Resident coverage for a practicing physician should not be requested unless coverage via other physicians in the community is impossible or inappropriate. Forms to be used in requesting approval for coverage of locum tenens activities to ensure state-provided insurance must be submitted at least two weeks in advance of the activity to the WCGME office. These forms are available at the program and WCGME offices.

The resident’s performance will be monitored for the effect of these activities upon performance. Any adverse effects may lead to withdraw of permission for moonlighting and/or locum tenens.
Med/Peds Chief Resident

The Med/Peds Chief Resident is a PL-4 resident selected by Med/Peds residents, with approval of the program directors and department chairs, to function as a liaison between faculty, staff, hospital personnel and the residents.

1. Serve as a role model among peers, supporting the goals and objectives of the residency program.

2. Review call and rotation schedules monthly to ensure smooth transitions between the Pediatric and Internal Medicine rotations, and to avoid conflicts between call and clinic schedules and rotation duties. Assist in coordinating changes in schedules if needed.

3. Coordinate, plan and schedule speakers to present educational lectures at the Joint Med/Peds conference which meets once per month.

4. Assist with recruitment of medical students for the Med/Peds Residency, which may include interviews, tours, dinners and area recruitment fairs and social events. Serve on the Match selection committee as a representative of the residents.

5. Assist the Program Director and Program Coordinator to establish the yearly schedule of rotations and assist with changes as necessary.

6. Assist with planning the agenda for the quarterly Med/Peds All-Resident Meeting.

7. Act as a liaison between residents, faculty and categorical Pediatric and Internal Medicine chief residents concerning issues related to resident and student education.

8. The Chief Resident may be requested to attend educational/development opportunities regarding chief resident duties. Feedback reports to the residents and faculty would be expected.

Med/Peds Chief Resident Selection Process

1. All residents successfully completing their PGY-3 year and holding an unrestricted Kansas license to practice medicine are considered for selection.

2. Interested residents may apply for the position by memo to the current chief resident, program coordinator or program director by February 1.

3. In early February, the current chief resident and program coordinator will prepare a ballot containing the names of those residents interested in the position and hold an election.

4. The results of the election will be collected by the program coordinator and will not be released to any of the residents until final approval by the program director.

5. The program director and full-time faculty will review the results of the ballot and may seek input from the pediatric department staff and pediatric hospital staff regarding issues, such as conference attendance and chart completion, prior to final approval of the selection.

6. The program director will notify the selected candidate as soon as the selection is approved, no later than 1 week following the election.
Internal Medicine Clinic

The outpatient setting provides a type of patient exposure different from the acute hospital care setting and allows the resident to develop a style of evaluation and treatment unique to the ambulatory care setting. Indeed, many internists spend the majority of their professional career in the ambulatory care clinic and have affirmed the importance of ambulatory care experience during residency training. As a result, outpatient training is as important as inpatient training.

The resident will be assigned to one of the weekly half-day continuity outpatient clinics. Additional outpatient assignments are possible if the patient load warrants. Generally, residents assigned to morning clinic should be in the clinic by 8:45 am for Pre-Clinic Conference and should expect to be present until at least 12:00 p.m. The resident assigned to afternoon clinic should be in the clinic by 1:15 p.m. for Pre-Clinic Conference and should expect to be present until at least 5:00 p.m. Requesting an alteration in clinic hours for all but unique situations should be avoided. The Internal Medicine Clinic Director must approve any changes. Clinic assignments are created to facilitate adequate coverage on all hospital rotations.

All patients seen in the ambulatory care clinic are to be reviewed by the supervising faculty. The clinic is not concluded and residents should not depart until all patients are seen and dismissed, and folders/boxes checked and emptied. Other documentation, including completing charts and reviewing labs, can be completed outside the clinic using the VPN as long as charts are submitted to faculty within 48 hours of the scheduled clinic time. Any outpatient issues that arise after clinic hours will be handled by the responsible resident who will notify the supervising faculty for their outpatient clinic depending on the clinical severity of the patient's problem.

Residents have 24-hour access to their outpatient records. All residents are required to access their records at least once during the week outside of their normal clinic time. This can be done personally by going to the clinic or through a personal computer or the computer in the Internal Medicine Library at WMC. Residents will be required to obtain VPN access on personal computers and this can be done by contacting the IT department at KUSM-W.

Emergent Patient Problems
Assigned patients may need evaluation at times other than one’s clinic session. Residents must be available to their clinic patient's at all times unless checked out to another resident. If a patient has an emergent condition, the resident should either direct the patient to call and request an appointment or go to the emergency room closest to their location depending on the severity of the complaint. The patient will be seen the same day or following day by an appropriate resident to prove acute care. If there is doubt about what to do, residents need to contact their clinic supervisor or send the patient to the ER.

Vacation or Leaving Town
Patient’s need to have a resident available at all times. This helps facilitate physician patient relationships and improve patient care. If a resident is taking department leave, they need to find another resident to take their clinic calls and turn in that resident’s name on their leave request. The resident then needs to check out to the Via Christi and Wesley operators prior to turning off his/her pager. If a resident is going out of town without leave, i.e., leaving for the weekend, he/she needs to either find another resident to cover patient calls and check out to that resident as if on leave or check out through WMC and Via Christi to a cell phone. Resident pagers do not get reception outside the Wichita Metropolitan Area.

Post-call/Night Float
When a resident is post call or on night float, they are still responsible for their clinic patients. For residents who are post call, clinic calls will be sent normally. Residents can turn their pagers on silent and return calls when they wake up, or if they choose to turn their pagers off, they must call the clinic at 4pm to see if they have any issues to address. Residents on night float can work out how they would like to be contacted with the clinic prior to the start of their rotation. Residents cannot neglect their continuity patients while on night float and doing so will be reflected in clinic evaluations.

Faculty Supervision
Each outpatient clinic session has faculty supervisors who provide guidance, instruction, and supervision about the patient’s evaluation and management. Any problems with clinic organization, personnel, or policy should be
reviewed with the faculty supervisor. Requests for absence, late arrival, or early departure should be authorized by the faculty before discussion with the scheduling personnel. Appropriate paper work must be completed with the internal medicine residency office. Since, the faculty is responsible for all patient encounters and procedures, they should have the opportunity to see each patient before dismissal and must supervise procedures. All clinic notes must be submitted to faculty. For the first six months, all intern patients must be seen by a faculty member. After the first six months, all Medicare patients with a level four visit or higher must also be seen by a faculty member. Any time a resident has questions regarding patient care, they should consult with their clinic attending and have them see the patient if appropriate.

**Medical Records**
The problem-oriented medical record is required in the outpatient setting. Each chart should have an updated problem list. Residents also are encouraged to maintain an active medication list and preventive health maintenance form on each chart. Out of clinic coverage of phone calls and/or patient care issues require documentation. Notes can either be written in the chart or dictated. Review of systems and physical exam must be done using the EMR.

**Controlled Substances Policy**
Residents shall not call in prescriptions for controlled substances on weekends or after normal clinic hours. Patients on chronic narcotics should be seen every three months for reevaluation of the need for the medication. Residents must document the reason for the medication.

**Departure Tips For PGY-4 Seniors**
- On the last dictated note, include a paragraph that highlights the major problems you have addressed in the patient's care, including any issues that need to be addressed in future visits.
- Update the problem list in the EMR. Update the preventive health information under the “Health Maintenance” section. Assure patients that the clinic will continue to provide health care and meet their needs even though you will be leaving.
The primary outpatient department of the pediatric program is located at Carriage Park and is under the direction of Natalie Sollo, M.D., Medical Director of Ambulatory Pediatrics. In addition to Dr. Sollo, there are several full-time faculty members who participate in at least one clinic/week providing supervision and teaching for the residents’ continuity clinic. Our philosophy is that the resident’s educational experience should include comprehensive and longitudinal care for their patients and families. To attain that goal the continuity and acute care clinic is set up to mimic a group pediatric practice. Each resident acts as an independent pediatrician working along with his/her colleagues in the group.

Residents assigned to afternoon clinic are expected to be in the clinic from 1 p.m. to 5 p.m. Morning clinic is from 8:45 am to noon (when on a IM block) and 8:00am to 11:00am (when on a Peds block). If a resident has seen all scheduled patients and completed charts and callbacks before 5 p.m., it is expected that he/she would help see patients that are still waiting. No one is to leave before 4:30 p.m. without checking out with the nurses and attending physician. It is imperative to have answered all messages and phone calls before leaving the area.

Residents rotating on the ward are responsible for finding coverage for the inpatients during their designated days in the clinic.

WESLEY CLINIC MANAGERS

J.R. Teer Director, Wesley Clinics, Level G, Medical Arts Tower Bldg.
Phone 962-7086 Pager 123-2007

Cheryl Bolton Patient Accounts Manager, Health Strategies, Suite 232
Phone 962-3205 Pager 123-1433

A MESSAGE FROM THE CLINIC STAFF:

Our staff at Wesley Pediatric Clinic welcomes you. We are excited and pleased to share in your learning experience. It is our goal to create an environment that will be similar to what you will have when you enter private practice.

In this portion of the handbook you will find information about our employees and a brief description about each of the staff and what their responsibilities are. Also included are brief summaries of how our office works, office policies and copies of our most commonly used forms.

Please check in with the nurses when you arrive to see patients. If you are delayed in arriving in the office, please let us know. The patients are assigned to you either because of the recommendations of graduating residents, or because they are new and will become your patients.

Again, welcome!! This is your office, your staff, and your practice. We are pleased that you have chosen to spend this time with us and hope you will be pleased with our office and our staff.

WHO ARE OUR PATIENTS?

Our patients are the most important people, even when they owe us money, are later for appointments or are difficult to engage.

******************
Our patients are not an interruption of our work; they are the purpose of it. We are not doing them a favor by helping them; they do us a favor by giving us the opportunity to help them.

******************
Our patients belong to all of us. Words not allowed in our vocabulary are “This is not my patient.”

******************
Our patients are not just statistics, names on file or account numbers. They are human beings with feelings and emotions like our own.
NURSING PURPOSE AND PHILOSOPHY

The purpose of the Wesley Pediatric Clinic nursing staff is:

1. To provide the best quality nursing care for all patients using our services.

2. To participate in and support the process of resident and student education.

SCHEDULING - Med/Peds Specific
Your scheduled time in the office will be 8:00 a.m. to 11:00am for morning clinic and 1:00 – 5:00 p.m. for afternoon clinic if you are on a Pediatric Block. If you are on an Internal Medicine block your a.m. clinic will begin at 9:00am and end at noon. We try to encourage our patients to arrive 15 minutes before their appointment time so we can have them in the exam room at the proper time. If you are running late, please call us so we can let the staff and patients know.

All changes in your office schedule must be pre-arranged by way of a leave request. The Residency Coordinator will send leave requests to the clinic but you should confirm that the changes have been made with the receptionist. We like to have as much advance notice as possible because it can be difficult to reach patients to reschedule.

NURSING ASSISTANCE
The nurses are here to assist you in any way possible. You will have a nurse assigned to work with you each day. Check the chalkboard each day to see who is assigned to you. Anytime you are with a patient and need help, ask your assigned nurse. You can help them do their job more efficiently if you leave their desk area and counter top free of your belongings and your body. Please use the resident charting area for phone calls, chart work, and conversation.

TELEPHONE MESSAGES
Telephone messages and prescription refill requests on days that you are scheduled in the office will be placed in your message slot in the nursing area. Please check for these as soon as you come in and throughout the day. If you do not take care of them while you are here, you will be paged. If you are not scheduled in the office your nurse will page you.

PATIENT PHONE CALLS
Clinic
1. 1st year residents will each take unassigned patient calls one day per week.

2. Clinic calls will be triaged. Nurses will screen calls and inform residents of calls in batches at assigned times of the day. (11-12 and after 3). Emergent calls will be scheduled directly to an appointment without needing to speak to a resident.

After hours non-English speaking patient calls
The protocol for non-English speaking patients is:
1. When the operator gets the phone call, she will put the patient on hold and call the language line.

2. On a three-way call the operator will figure out what the patient needs. If it is something that will require her to page the doctor on call, she will place the patient and the language line on hold and page you.

3. When you call back she will place you on a three-way call with the patient and the language line and then hang up.
QUICK PEARLS OF CLINIC

- Patients who need to be seen must call for an appointment. The number to call is 962-3110. Patients can also call this number for test results, refills, questions, etc.

- To reach one of the nurses, call 962-3263. The lead nurse, Mary Brown, RN, can be reached at 962-2571. These numbers are NOT to be given to patients.

- New baby appointments are scheduled with Dixie at 962-3144. This is Dixie’s private number and is NOT to be given to patients. She does have voicemail if you need to call after hours.

- Clinic hours are 8:00 a.m. to 4:30 p.m. Monday through Friday. Patients are scheduled M-F from 8:45 a.m. until 4:00 p.m.

- When you arrive each day at the clinic, please check in with the phone nurse and check your box for messages.

- At the end of each clinic day, all charge tickets, patient forms, etc. should be returned to your box. These items are not to be left in the resident conference room.

- Clinic patient charts are NOT to be taken out of the clinic.

- Sample drugs must be signed out when given to patients (JCAHO rule).

- HIPAA – Do not leave charts lying out on counters unattended, hang tickets backwards on door when shots are needed, etc.

- Any charts and/or tickets not completed within 7 days will be reported to the hospital as delinquent.

- For coding questions, call Erika Bloomquist at 962-3206.