

THE CHILDREN'S MERCY HOSPITAL  
PEDIATRIC POST-GRADUATE TRAINING POLICIES

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## Definitions:

"Appointment" is the Resident's appointment to the Program, in accordance with the terms of the Post-Graduate Training Agreement;

"ACGME" means the Accreditation Council for Graduate Medical Education;

"Agreement" means the Post-Graduate Training Agreement between a Resident and the Hospital outlining the terms and conditions of the Resident's Appointment to the Program;

"Board" means the examining or certifying board that is approved by the Council of Medical Education of the American Medical Association and the American Board of Medical Specialties;

"Drug" means:

- a. any drug which is illegal under federal, state or local laws, including but not limited to marijuana, heroin, hashish, cocaine, hallucinogens, and depressants and stimulants not prescribed for current personal treatment by an accredited physician;
- b. alcohol; or
- c. any other substance causing altered behavior;

"Graduate Medical Education Council" (GMEC): a committee of our sponsoring institution (The University of Missouri at Kansas City) that has the responsibility for monitoring and advising on all aspects of residency education. Voting membership on this committee includes residents nominated by their peers as well as program directors, administrators, faculty and the accountable Designated Institutional Official. The GMEC of UMKC includes the pediatric residency program directors and the Chairman of the Department of Pediatrics.

"Hospital" means The Children's Mercy Hospitals and Clinics, a not-for-profit corporation, including its Medical Staff, administration and committees of each;

"Impaired Resident" means a Resident who:

- a. engages in the illegal use of "drugs";
- b. is under the influence of "drugs" while providing services at the Hospital or while participating in any aspect of the Program; or
- c. is unable to perform the essential functions of his position, with or without an accommodation, without posing a direct threat to the health or safety of the Resident or others.

“Intervention” means a confrontation of a Resident by a representative from the Missouri Physicians Health Program, two members of the Resident Medical Education Committee, and other persons beneficial to the process;

“Medical Staff Education Committee” means the committee at the Hospital that has institutional oversight for all post-graduate medical education at the Hospital;

“Monitoring” means, with regard to an impaired Resident, the longitudinal follow-up of the Impaired Resident to ascertain compliance with recommendations of the evaluation and treatment programs;

“Program” means the specialty training, comprising a series of learning experiences in post-graduate medical education at the Hospital;

“Program Director” means the administrative director of the Program as designated by the Hospital;

“Resident” means an individual at any level of post-graduate medical education participating in a Program conducted by the Hospital. Trainees in subspecialty Programs are specifically included.

“Sponsoring Institution” means the institution that assumes the ultimate responsibility for a program of Graduate Medical Education.

Words used in these Policies shall be read as the masculine or feminine gender, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provisions of these Policies.

## SECTION I - EDUCATIONAL POLICIES

### 1.1 Selection Criteria and Appointments to the Program

All applicants will complete an application form and submit it through ERAS (Electronic Residency Application System). This data will be compiled and reviewed by the Program Director (PD) and the Associate Program Directors (APD). They will select applicants for interview based on academic achievement, professional qualifications, written letters of recommendation, Dean's letter, community activities, Step I & II scores, and any other contributing information included in the application.

The applicants invited for interview will arrange an interview date. The applicant will arrange for transportation. If the applicant is traveling from out of town, one night of housing will be arranged and paid for by the program.

The interview will include meeting with the Medical Director of Graduate Medical Education (DME) or Chairman of Pediatrics and/or their representatives and the Program Director (PD) and Associate Program Directors (APD), an interview with a faculty member, and interview with the residents. During or prior to the interview day, the applicant will be advised about salary, vacation, professional leave, sick leave, professional liability insurance, health insurance benefits, call rooms, meals on call, and parking ([www.childresmercy.org](http://www.childresmercy.org)).

At the end of the interview period, a Resident Selection Committee consisting of the PD, APD, Chief Residents and representative faculty will review each candidate. The candidates to be ranked will be placed in order based on clinical ability, academic performance, interpersonal skills, integrity, judgment, motivation, honors, accomplishments, research, maturity, confidence, ability to communicate and other contributing information. The rank order list will be forwarded to the National Resident Matching Program (NRMP) prior to the published deadline. Occasionally, candidates will be selected outside the NRMP in compliance with NRMP rules. It is the policy of the Hospital not to discriminate on the basis of race, color, national origin, gender, sexual orientation, age, religion, disability, or other basis prohibited by law in admissions or access to, or treatment or employment in its programs and activities, or in the provision of physician/staff privileges.

#### a. Term of Residency

The duration of the Program is determined by the accreditation requirements and the eligibility requirements for Board certification. For residencies in which there is no external accreditation or Board certification, the duration is determined by the Program Director with the approval of the Medical Staff Education Committee. Acceptance into the Program is considered a commitment by the Resident and the Hospital to completion of the Program, subject to the terms of the Agreement. Agreements are offered on a yearly basis if performance is satisfactory to warrant advancement.

## b. Post-Graduate Training Agreement

Appointment to the Program is documented by a completed and signed copy of the Hospital Post-Graduate Training Agreement. The Agreement and these Policies specify the Resident's responsibilities, financial support and benefits to be provided, duration of Appointment and conditions for reappointment, and policies regarding professional activities. Residents are additionally subject to policies and procedures addressing employees and clinical practice.

### 1.2 Performance Evaluation

Performance evaluation is an essential component of each Program. The Program Director, with participation of members of the teaching staff, shall:

- a. At least semi-annually, evaluate the knowledge, skills and professional growth of the Resident, using appropriate criteria and procedures.
- b. Communicate each evaluation to the Resident in a timely manner.
- c. Advance Residents to positions of higher responsibility only on the basis of their
- d. Satisfactory progressive scholarship and professional growth.
- e. Maintain a permanent record of evaluation for each Resident and have it accessible to the Resident and other authorized personnel.

A written final evaluation will be provided for each Resident who completes the Program. The evaluation will include a review of the Resident's performance during the final period of training and verify that the Resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation will be part of the Resident's permanent record maintained by the Hospital.

Guidelines for performance evaluation are provided by the ACGME and the American Board of Pediatrics. These guidelines highlight areas most important to adequate performance as a physician. Additional areas may be evaluated including, but not limited to, observance of Hospital and medical staff policies and procedures, and satisfactory and timely completion of medical records.

Successful performance and evaluation on a single or series of rotations does not necessarily constitute overall satisfactory performance.

Attendance at the Program's educational conferences will be monitored and determined by the Program Director.

Residents will participate in in-training examinations annually if such are available from the applicable Board.

Resident evaluation files are confidential and available only to the Resident, the Program Director, the Executive Medical Director (or his designee), a committee of teaching staff appointed by the Program Director to assist in the evaluation of the performance of the Resident, members of the Medical Staff Education Committee in the case of a review of suspension or termination of the Resident, accrediting agencies when necessary, and government entities when required by law. The Hospital considers evaluation files to be issues of peer review and education. The

files will be protected from disclosure to individuals and entities other than those set forth above to the maximum extent permitted by applicable law.

The training programs of the Children's Mercy Hospital embrace the goal of competency based evaluation. Each clinical section of the Hospital is currently defining the specific knowledge, skills and attitudes required for residents to demonstrate competency on each rotation. Each section will be developing tools to measure core competency. The program director will review data from all rotations and assure that each resident attains competency in the six core areas. The ACGME core competencies are as follows:

**a. Patient Care**

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

- i. communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- ii. gather essential and accurate information about their patients
- iii. make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- iv. develop and carry out patient management plans
- v. counsel and educate patients and their families
- vi. use information technology to support patient care decisions and patient education
- vii. perform competently all medical and invasive procedures considered essential for the area of practice
- viii. provide health care services aimed at preventing health problems or maintaining health
- ix. work with health care professionals, including those from other disciplines, to provide patient-focused care

**b. Medical Knowledge**

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavior) sciences and the application of this knowledge to patient care. Residents are expected to:

- i. demonstrate an investigatory and analytical thinking approach to clinical situations
- ii. know and apply the basic and clinically supportive sciences which are appropriate to their discipline

**c. Practiced-Based Learning and Improvement**

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

- i. analyze practice experience and perform practice-based improvement activities using a systematic methodology

- ii. locate, appraise and assimilate evidence from scientific studies related to their patients' health problems
- iii. obtain and use information about their own population of patients and the larger population from which their patients are drawn
- iv. apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- v. use information technology to manage information, access on-line medical information, and support their own education
- vi. facilitate the learning of students and other health care professionals

#### d. Interpersonal and Communication Skills

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates. Residents are expected to:

- i. create and sustain a therapeutic and ethically sound relationship with patients
- ii. use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- iii. work effectively with others as a member or leader of a health care team or other professional group

#### e. Professionalism

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

- i. demonstrate respect, compassion and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- ii. demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- iii. demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

#### f. Systems-Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- i. understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- ii. know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources

- iii. practice cost-effective health care and resource allocation that does not compromise quality of care
- iv. advocate for quality patient care and assist patients in dealing with system complexities
- v. know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

### 1.3 Advancement

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

### 1.4 Unsatisfactory Performance

Unsatisfactory performance by a Resident, as judged by the teaching staff and/or Program Director, will result in corrective action as necessary to maintain the quality of patient care, the quality of the Program, the smooth operation of the Hospital, and the well-being of the Resident. Corrective action usually begins with the teaching staff physician, chief resident, or the Program Director discussing a deficiency with the Resident involved. However, the Program Director has the authority to administer any appropriate disciplinary action including, but not limited to:

- a. Placement of a Resident on probation with specific requirements that must be met in order for the Resident to continue in the Program.
- b. Alteration of the usual Resident responsibilities for a period of time.
- c. Require that a Resident repeat a portion of the Program.
- d. Temporarily suspend the Resident from the Program without pay until there is an indication that a severely deficient performance is likely to improve.
- e. Terminate a Resident from the Program.

### 1.5 Initiation, Continuation and Termination of the Appointment

Initial Appointment to the Program occurs when a prospective Resident and the Program Director complete and sign the Agreement. Initial Appointment is for one year.

The Resident must obtain a regular state medical license in Missouri or a Temporary Certification of Registration to practice medicine in the State of Missouri before beginning the program. The Resident must maintain all required state licenses or Temporary Certification of Registration at all times to continue in the Program.

Continuation of the Appointment normally occurs at the expiration of each year's Agreement. Continuation and a new Agreement are contingent on the mutual agreement of both the Resident and the Hospital, as well as satisfactory completion of the Program to that point in accordance with all policies and procedures established by the Hospital.

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

Termination of the Appointment normally occurs at the end of the last year of training, but may occur at any other time at the option of the Resident or the Hospital with a written notice of the proposed termination date sixty (60) days in advance. The Hospital will provide a written reason for any termination it initiates, and the Program Director will provide an opportunity for the Resident involved to discuss the rationale for a termination that the Hospital initiates. Any termination or non-renewal of an Appointment by the Hospital is subject to the procedures under Section 1.6 of these Policies.

When a Resident completes or terminates an Appointment, all of the Hospital's property must be returned to the appropriate department head or the Program Director. Furthermore, all medical records must be completed and all unpaid Hospital bills must be settled. Unsatisfied claims will be deducted from the final paycheck.

## 1.6 Disciplinary Action Policy and Procedures

### Purpose:

The purpose of this policy is to address the steps involved in resident/fellow disciplinary and grievance actions.

### Procedure:

#### a. Actions by the Program Director

- i. The Program Director ("PD") can take disciplinary action against a resident/fellow ("resident") based on the resident evaluation, poor academic performance, inappropriate or unprofessional behavior, or other deviations from acceptable performance.
- ii. The disciplinary action may be in the form of a written warning, probation (short term or long term), mandatory counseling, suspension, non-renewal or termination of the resident's contract, or other discipline as determined by the PD.
- iii. Except in instances where patient care is threatened or there has been other serious professional misconduct, the PD will inform the Department Chair and Medical Director and Administrative Director of GME of the anticipated disciplinary action.
- iv. In the event that patient welfare is jeopardized by the resident, the PD or an Associate Program Director, in the absence of PD, is empowered to suspend a resident from clinical activity, pending a hearing. The Medical Director, Administrative Director of GME and applicable Department Chair will be notified immediately of a suspension from clinical activity.

#### b. Medical Staff Education Committee

The P.D. within five weekdays shall notify the Chair of the Medical Staff Education Committee (membership as defined in the Medical Staff Bylaws) who along with a peer resident representative shall meet within five weekdays from notification of action. The Medical Staff Education Committee ("MSEC") by majority vote may decide:

- i. To take no further action but approve the action taken by the PD; or
- ii. To change the disciplinary action which may include a written warning, placing the resident on probation, suspending the resident, determining

that unsatisfactory rotations must be satisfactorily repeated, non-renewing a contract, terminating a resident/fellow, or other actions as agreed upon by the MSEC.

- iii. The MSEC will send a letter to the resident/fellow within five weekdays regarding the actions of the committee.

**c. Appeal Process**

In the event the resident disagrees with the decision of the MSEC, the resident has the option to appeal the decision in writing within five week days, and appear in person before the Pediatric Residency Program Committee ("PRPC").

- i. PRPC Membership (Voting Members), consist of
  - a. Two members of the clinical faculty selected by the Executive Medical Director
  - b. A Program Director selected by the Executive Medical Director
  - c. A resident/fellow selected by the resident
  - d. A clinical faculty member selected by the resident
  - e. The Pediatrics Department Chair (or appropriate Voting Member Department Chair)
  - f. In the absence of the Executive Medical Director or his designee the Medical Director of GME will perform his duties
- ii. The PRPC Chair is to be elected or appointed by the committee from among the medical staff members on the committee.
- iii. The Medical Director of GME or his/her designee will attend the hearing as an impartial observer.
- iv. The Executive Medical Director reserves the right to modify the membership to assure the integrity and impartiality of the hearing committee.
- v. No member of the committee shall have been personally been involved in the events that led to the proposed disciplinary action or have any other interest that would affect the objectivity and fairness of the hearing.
- vi. A quorum must be present. A quorum consists of the majority of the members present with at least one resident and two faculty representatives.
- vii. Alleged complaints by the resident of illegal discrimination or harassment are processed through the Hospital's Human Resources Department.

**b Hearing Process**

The hearing before the PRPC shall take place within 20 week days of the notification to the resident. Written notice of the time and location of the hearing will be sent to the resident at least ten week days prior to the hearing. The resident is required to attend the hearing and present his/her views on the matter that resulted in disciplinary action. The resident will be allowed to present evidence to the PRPC. The resident may bring witnesses to the hearing and may be represented by legal counsel or another representative. The resident must inform the PRPC in writing of the names of any witnesses and representative/counsel. If the resident chooses to be represented by legal counsel the person

presenting information to the PRPC on behalf of the MSEC also has the right to be represented by legal counsel at the hearing, and will notify the resident of counsel's attendance at least five (5) weekdays prior to the hearing date.

If the PRPC determines that no disciplinary action is warranted following the hearing, the resident will be notified of such decision by the chair of the PRPC within five weekdays, and the resident will be allowed to continue the training. If disciplinary action is affirmed, a letter confirming the final decision will be forwarded to the resident within six weekdays following the conclusion of the hearing. This final letter will clearly state the decision of the committee which could include any of the following: effective date of termination, non-renewal of contract, identify the problem, delineate the requirements to correct the deficiency, assign an advisor, delineate the duration of remediation, state the effects of remediation on length of training, propose the method of any additional clinical supervision, and detail the actions required by the resident to bring about a conclusion of the remediation program.

All communication to the resident is copied to the Program Director and the Medical Director of GME.

The decision of the PRPC is final.

## 1.7 Grievance/Complaint Procedure

Residents who feel they have been treated unfairly or have complaints (except regarding discipline, non-renewal or termination covered by the procedures under Section 6, above) are encouraged to use the following procedure:

1. Discuss the problem with the appropriate attending physician, Chief Resident or the Hospital department head as soon as possible, usually not later than thirty (30) days after the Resident becomes aware of the complaint.
2. If the problem is not resolved under step 1, the Resident should contact the Program Director within fifteen (15) days after the decision by the individual contacted under step 1. Except in unusual circumstances, the Resident shall put the complaint in writing, and the matter shall be promptly investigated. Confidentiality, to the extent feasible, will be maintained. The Resident shall be informed of the result of the investigation.
3. If the matter is still unresolved after steps 1) and 2), the Resident may request that the Medical Staff Education Committee consider the matter. The request should be submitted to the Chair of the Medical Staff Education Committee in writing within fifteen (15) days after the determination under step 2.
4. If the matter is still unresolved after step 3, the Resident may submit the complaint in writing within thirty (30) days to the Executive Medical Director, who will meet with the Resident and make a final decision.

Any Resident who feels he cannot use the above procedure should contact the Hospital Human Resources Department for confidential assistance. A Resident will not suffer adverse consequences for making a complaint or taking part in the investigation of a complaint. Residents who knowingly allege a false claim shall be subject to disciplinary action, including dismissal or termination.

The Hospital will make appropriate arrangements to assure that disabled persons can make use of this grievance process on the same basis as the non-disabled. Such arrangements may include, but are not limited to, the provision of interpreters for the deaf, providing taped cassettes of material for the blind or assuring a barrier-free location for the proceedings.

### 1.8 Completion of Individual Rotations

Categorical pediatric residents must complete 36 months of residency to receive certification. Individual rotations vary from 28 to 32 days, depending on the yearly schedule. Each rotation is supervised by an attending physician who must complete a written evaluation documenting satisfactory completion. Residents must also complete a minimum of fifteen days and receive a satisfactory evaluation to receive credit for the month. Residents who fail to complete fifteen days, regardless of the reason, will be required to receive approval for credit from the faculty overseeing the rotation and from the Program Director. No credit will be given for days already completed. Unsatisfactory performance on a given rotation will necessitate repeating the rotation. Ability to use elective month for remediation will be at the discretion of the Program Director.

### 1.9 Completion of Residency and Certification

Upon completion of 36 months of residency, pediatric residents in good standing will receive a certificate in Pediatrics. Residents have a maximum of 48 months available to complete this training. During the final week of residency, residents are required to complete a check-out process. This includes completion of medical records and return of parking pass and pager. Upon return of the check-out sheet on the final day of residency, certificates will be issued. Residents are expected to work until this final day unless vacation has been previously approved. Failure to report for work will result in withholding of certificate.

## SECTION II - RESIDENT SUPERVISION POLICY

Every patient seen by a resident in Children's Mercy Hospital is seen under the supervision of a staff physician who assumes complete responsibility for those patients for whom he/she is the attending physician. The staff physician is also responsible for the education of the residents. Attending supervision may be direct or indirect. Indirect supervision occurs when the responsible staff is aware of the patient and is available to assist or provide direct supervision if needed but is not physically present. In these instances, a senior resident may provide direct supervision over a more junior resident. Supervision is always available from senior residents, fellows and attending physicians. Residents are required to obtain help in any clinical situation in which they are inexperienced or in which they are unsure of the appropriate clinical

management. A list of procedures performed on pediatric patients by residents and what level of trainee may perform them is also listed in this document.

## 2.1 Pediatric Resident Level 1 Job Description

Pediatric Level 1 (PL-1) residents will provide patient care under the supervision of senior residents and attending physicians. PL-1 residents will be given graduated responsibility for patient care based on training received during the course of the residency as well as the experience and knowledge gained by each resident.

Pediatric Level 1 residents will:

1. Obtain and record detailed historical information from patients and families.
2. Perform and record detailed physical examinations on their patients.
3. Discuss with the supervising resident and/or attending physician the history and/or physical findings and present a diagnostic and therapeutic plan.
4. Write orders for patient care including diagnostic studies and therapies based on the plan.
5. Record daily progress notes in the patient record. Modifications of the diagnostic and therapeutic plan, based on further examination of the patient and discussion with the supervising resident and/or attending physician will be recorded in the progress notes and patient orders.
6. Discuss as appropriate the diagnoses and diagnostic and therapeutic plan with other professionals (such as nursing, social work, nutrition) involved in the patient's care.
7. Discuss appropriate diagnoses and plans with patients and families.
8. Develop discharge planning, including prescriptions and home health care, along with the supervising resident and/or attending physician.
9. Complete medical records in a timely manner according to hospital guidelines
10. Be actively involved in teaching, directing and supervising medical students and participate in the evaluation of students.
11. Fully participate in the teaching program including teaching conferences, morning report, Grand Rounds, attending rounds, care conferences and other educational experiences. It is expected that PL-1 residents will be self-directed learners, including continuing education outside the structured residency educational program.
12. Receive timely evaluations of performance on a monthly basis from attending physicians. Residents will be afforded the opportunity to

evaluate the faculty and educational experience of each rotation including communication and professionalism of the faculty.

## 2.2 Pediatric Level 2, 3, and 4 Residents

Pediatric Level 2, 3 and 4 residents (senior residents) will supervise PL-1 residents, students and other trainees in inpatient and outpatient settings. Senior Residents will be given increased responsibility based on training and demonstrated ability.

Senior residents will:

1. Obtain and record concise historical information from patients and families and verify information gathered by students and residents who are under their supervision.
2. Perform and record concise physical examinations on patients and verify the findings of the students and residents who are under their supervision.
3. Discuss with the PL-1 resident and/or attending physician the history and physical examination, and assist the PL-1 resident in developing a diagnostic and therapeutic plan.
4. Verify orders written by the PL-1 resident. \*
5. Write concise admission notes detailing history, physical examination and plans.
6. Develop discharge planning, including prescriptions and home health care, with the attending physician.
7. Complete medical records in a timely manner according to hospital guidelines.
8. Be actively involved in teaching, directing and supervising PL-1 residents and medical students and participate in the evaluation of the PL-1 residents and students.
9. Fully participate in the teaching program including teaching conferences, morning report, Grand Rounds, attending rounds, care conferences and other educational experiences. It is expected that Senior Residents will be self-directed learners, including continuing education outside the structured residency educational program.
10. Senior Residents will receive timely evaluations of performance on a monthly basis from attending physicians. Residents will be afforded the opportunity to evaluate the faculty and educational experience of each rotation.

\* Only residents in their second year or higher will be permitted to write orders for restraints in accordance with General Rules and Regulations, Article V, Section 1 i. Resident physicians may be designated by the staff physician to write orders to limit withhold or withdraw life-sustaining treatment from a

patient with a terminal condition. In accordance with General Rules and Regulations Article VIII 2 d, the responsible staff physician must co-sign the resident's initial order. All levels of residents under the supervision of their attending Medical Staff Member will be allowed to determine appropriate candidates for sedation/anesthesia. Ordering and administering sedation is governed by the Moderate and Deep Sedation Guidelines of the hospital.

## PROCEDURES

### *Tissue Specimen Collection*

Resident Level Authorized	Skill
1	Arterial puncture
1	Bladder catheterization
1	Bladder tap
2	Bone marrow aspiration
1	Capillary blood sample
1	Clean catch urine technique
1	Lumbar puncture
2	Paracentesis
2	Thoracentesis
1	Venipuncture

### *Laboratory Procedures*

Resident Level Authorized	Skill
1	Blood smear analysis
1	EKG analysis
1	Interpretation of a chest X-ray
1	KOH preparation/analysis
1	Stool occult blood analysis
1	Urine dipstick analysis
1	Urine microscopic analysis
1	Wet preparation/analysis
1	Wood light examination

### *Therapeutic Procedures*

Resident Level Authorized	Skill
1	Aspiration of soft tissue abscess
1	Cerumen removal
2	Chest tube placement
1	Corneal abrasion management
2	Exchange transfusion in a neonate
1	Eye drop administration
1	Fluorescein dye administration
1	Gastric intubation
1	Intramuscular injection
1	Intravenous medications
1	Laceration repair
1	Reduction of nursemaid's elbow
1	Subcutaneous injections
1	Placement of UV and US lines
1	Placement of UV and UA lines

### *Diagnostic Procedures*

Resident Level Authorized	Skill
1	Blood pressure measurement
1	Developmental screening
1	Hearing Screening
1	Pelvic examination
1	Transillumination of the scrotum
1	Vision screening

### *Emergency Care*

Resident Level Authorized	Skill
1	Basic Life Support certification
1	Pediatric Advanced Life Support certification
1	Neonatal advanced life support certification

### *Miscellaneous*

Resident Level Authorized	Skill
1	Circumcision
2	Ordering patient restraints

All procedures listed under "1" may be performed by a first year resident under the direct supervision of a senior resident until that resident competent to perform the procedures independently or indirectly under the attending pediatrician. All procedures listed under "2" may be performed by all residents under the direct supervision of the attending pediatrician or by senior residents who have demonstrated proficiency in performing the procedures as witnessed and documented by an attending physician.

## **2.3 Responsibilities of Residents and Clinical Fellows**

In participating in educational activities and providing services in the residency/clinical fellowship program, the resident/clinical fellow agrees to do the following:

1. Obey and adhere to the applicable policies, procedures, rules, bylaws, and regulations of the hospitals to which he or she rotates.
2. Obey and adhere to all applicable state, federal, and local laws, as well as the standards required to maintain accreditation by the ACGME, RRC, JCAHO, HIPAA and any other relevant accrediting, certifying, or licensing organizations.
3. Participate fully in the educational and scholarly activities of the Program, including the performance of scholarly and research activities as assigned by the Program Director, attend all required educational conferences, assume responsibility for teaching and supervising other residents and students, and participate in assigned Hospital and University committee activities.
4. Fulfill the educational requirements of the program.
5. Use his or her best efforts to provide safe, effective, and compassionate patient care and present at all times a courteous and respectful attitude

toward all patients, colleagues, employees and visitors at the Hospitals and other facilities and rotation sites to which the resident is assigned.

6. Provide clinical services:
  - a. Commensurate with his/her level of advancement and responsibilities
  - b. Under appropriate supervision
  - c. At sites specifically approved by the Program
  - d. Under circumstances and at locations covered by the professional liability insurance maintained for the resident by the Hospital
  - e. Develop and follow a personal program of self-study and professional growth under guidance of the Program's teaching faculty
  - f. Fully cooperate with the Program, School of Medicine and Hospital in coordinating and completing documentation required by the RRC, ACGME, Hospital, School of Medicine, Department and/or Program, including but not limited to the legible and timely completion of patient medical records, charts, reports, duty hour logs, operative and procedure logs, and faculty and Program evaluations.

Failure of the Resident or Clinical Fellow to comply with any of the Responsibilities set forth above shall constitute grounds for disciplinary action, up to and including suspension or termination from the Program.

### 2.3 Supervision of Residents and Fellows

The GME requires that programs provide a written plan for adequate supervision that is distributed to faculty and housestaff for review. The plan should include the following elements:

- a. Residents and clinical fellows must be provided with prompt reliable systems for communication and interaction with supervisory physicians.
- b. Clear indication of supervisory lines of responsibility.

#### 2.3.1 Evaluation of the Program

Residents and clinical fellows will be provided with the opportunity to submit confidential written evaluations of the Program and the Program faculty to the Program Director on at least an annual basis or more frequently as required by an individual RRC. The files from these evaluations may be reviewed during the internal review process.

## SECTION III - Medical Records

Residents and Clinical Fellows shall be responsible for the preparation of a complete, legible medical record for each patient seen in an inpatient or outpatient setting. The record shall contain patient specific information as appropriate to the care, treatment, and services provided.

This record shall include patient identification data, and a history and physical. The components of a history and physical, as appropriate, include: chief complaint,

developmental, and behavioral history and current status, social history, family history, review of body systems, physical examination, assessment, and treatment plan. Special reports such as consultations, clinical laboratory, X-ray and others, provisional diagnosis, medical or surgical treatment, pathological findings, progress notes, final diagnosis, condition on discharge, follow-up and autopsy report shall be included in the electronic record when indicated. Medical records shall be completed within the time designated by the Hospital's policy on medical records as follows:

### 3.1 Inpatient and Observation Records

- a. All inpatient and observation records shall be completed electronically and electronically signed except for orders recorded in the intensive care units and the immediate post operative procedure note.
- b. Record Completion - Residents and Clinical Fellows record completion is to be accomplished within 30 days of the patient's dismissal. Any records not completed in 30 days will be considered to be delinquent. A weekly list of incomplete and delinquent records will be sent to the staff Members, the President of the Medical Staff, and the department chairpersons for appropriate action.
- c. History & Physical - A history and physical examination shall be completed within (30) days prior to the time of procedure. The history and physical examination shall be completed electronically except in cases where the provider has no reasonable access to the hospital's electronic information system.

On the day of the procedure and prior to the procedure, the history and physical examination shall be reviewed, the patient shall be reassessed, and the patient's condition shall be documented. This shall also include sedations.

If a complete history and physical examination are not recorded in the medical record before the time stated for an operation, the operation will be postponed unless the staff physician/dentist states in the medical record that such a delay would be detrimental to the patient's well being.

All other inpatient histories and physical examinations shall be performed within 24 hours of admission to the hospital.

The admitting attending physician must electronically sign.

- d. Discharge Summary -A discharge summary must be dictated or electronically submitted for all patients who have been admitted for more than 48 hours or patients who expire. In all cases, the discharge summary or note must be completed in a timely manner, consistent with good patient care and effective communication with the referring physician.

The discharging attending physician must electronically sign the discharge summary.

- e. Progress Notes - Progress notes shall be entered in the electronic medical record daily, during the time of the patient's admission, and electronically signed by the person entering the note.

Appropriate entries will be made in the electronic medical record by the Medical Staff to document their participation in the patient's care and their supervision of the House Staff. Thereafter, the medical staff member shall be required to either complete his/her own note, or electronically sign the resident's daily note.

Healthcare providers who are credentialed, employed, or contracted to provide healthcare services for hospital patients, may document in the electronic medical record.

- f. Authentication of Medical Records - All electronic medical records will be authenticated by the use of an electronic computer signature code. Any outpatient clinic records not completed electronically will be signed and dated by the provider.
- g. Operative Reports - All operative reports are to be dictated at the time of operation but no later than 24 hours after the procedure, and electronically signed by the physician prior to the patient's discharge. Any patient anesthetized in the Operating Room or OR Procedure Room for any procedure requires a dictated operative report. The immediate Post-Procedure Note Form must be completed at the termination of the procedure, or the same components as found in the form must be documented immediately in a post-procedure progress note.

The Medical Staff Member must electronically sign the operative report.

- h. Consultation Reports - The physician/dentist responsible for a patient's care (or his/her designee) will write an order for a consultant when consultation is requested. When consultation is needed in an urgent or complicated case, physician-to-physician communication is recommended. The date and time the consultation was requested will be documented. Consultants will see the patient in a timely fashion and will complete the consultation report, including the date and time the patient was seen, in the electronic medical record.

The Medical Staff Member must electronically sign the consultation report.

- i. Orders and Verbal Orders - All orders shall be documented in the patient's medical record either in writing or electronically and signed and dated by the authorized person who gave the order or the responsible Member of the Medical Staff.

All verbal orders in the patient's medical record must be authenticated by the practitioner within 48 hours after the order is written.

A verbal order shall be considered to be in writing if dictated, recorded, and read back to the practitioner giving the order. The order must be given to licensed and credentialed nursing staff or other personnel specifically authorized by the Medical Staff to accept verbal orders, as follows:

Laboratory (Laboratory Unit Secretary, Phlebotomist, Laboratory Technician I & II, Clinical Laboratory Scientists I, II & III, Clinical Laboratory Scientist Supervisor, Histotechnologist, Histology Supervisor, Client Services Representative, Clinical Lab Coordinator)

Pharmacy (Registered Pharmacist)

Radiology (Registered Technologist, Records Specialist)

Respiratory Therapy (Certified Respiratory Therapy Technicians, Registered Respiratory Therapists)

Nutrition Services (Diet Technician, Registered Dieticians, Nutrition Assistants)

Verbal orders shall be identified as such, signed by the person to whom given with the name of the authorized person who gave the order. Persons authorized to write orders shall include those with independent statutory authority (physicians/dentists of the Medical Staff and House Staff) and those who are legally given authority to order patient care within the scope of the practitioner's practice (including registered nurses with collaborative practice agreements, protocols or standing orders).

Medical students may write orders, however, the physician/dentist involved with the patient must sign the order before it is carried out.

- j. Restraint Orders - Any verbal order for restraints must be authenticated within 24 hours. A physician's order is required for all restraints. The order must be reviewed and renewed in accordance with the hospital Restraint/Seclusion Policy. In an emergency, a registered nurse may initiate the use of restraints but must obtain a physician order within one hour of restraint application.

Any verbal order for restraints must be dated and authenticated within 24 hours of the order being given. The physician's order must specify the type of restraint to be used, clinical justification/the reason for restraint, less restrictive interventions attempted before restraining, and criteria for the patient's early release from restraints.

Restraint orders must be dated, time limited and specify a start and end time for the restraint application. If the patient needs to be restrained and greater than 60 minutes have elapsed since the last release time specified or the patient's escalating behavior is not

related to the behavior giving rise to the initial order, a new order is required.

### 3.2 Outpatient Records

- k. Record Completion - Total completion of the record for outpatient visits is to be accomplished within 30 days of the patient's visit.
2. All records are the property of the Hospital and original records shall not be removed from the Hospital facilities except as set out in department protocol or as required by court order, subpoena or statute. In case of readmission of a patient, all previous records shall be available for the use of the staff physician/dentist whether the patient is attended by the same physician/dentist or another.
3. Medical record review for completeness and appropriateness of care of patients will be monitored by the Medical Staff at least quarterly by retrospective chart review and reported to the Medical Staff Performance Review Committee.

### SECTION IV - MOONLIGHTING

The University of Missouri-Kansas City School of Medicine and the Children's Mercy Hospital training programs recognize that residency education is a full-time endeavor. For this reason, moonlighting, defined as professional and patient care activities outside of the educational program, must not interfere with the ability of the resident to achieve the goals and objectives of his/her respective educational program. For any moonlighting that takes place by residents sponsored by the University of Missouri-Kansas City, the following stipulations apply:

1. The resident must have a permanent license before applying for moonlighting activity. The resident must notify the program director in advance of any planned moonlighting activity and receive written approval of the activity from the program director. For internal moonlighting the resident must follow the medical staff office procedures.
2. The program director must acknowledge in writing that the moonlighting activity will not interfere with the ability of the resident to achieve the goals and objectives of the educational program. This acknowledgement must be kept in the resident's file.
3. The hours spent in moonlighting to the institution, must be counted toward the 80 hour weekly limit on duty hours and must meet all duty hours regulations.
4. The resident must show proof to the program director and the Office of Graduate Medical Education of individually obtained professional liability coverage (outside of that provided by the institution) for all moonlighting activities external to the institution and its major affiliates. Proof of this coverage will be maintained in the resident's file.

5. The program director must forward copies of any planned moonlighting activity approved by him/her to the Office of Graduate Medical Education.
6. Residents must not be required to engage in moonlighting activities by their respective program or institution.
7. Program directors must monitor residents for fatigue associated with moonlighting, and other effects of moonlighting on performance of the resident, and must restrict the resident from moonlighting if they determine that the resident does not have sufficient time for rest and restoration or that the moonlighting activity is adversely affecting resident performance.

### *Internal Moonlighting Policy*

#### 4.1.1. Intensive Care Nursery (CMH and TMC)

- a. Moonlighting opportunities are available in the CMH and TMC intensive care nurseries to categorical pediatric Year 2 and 3 residents and med/peds Year 2, 3 and 4 residents. To be eligible, the following criteria must be met:
  1. The resident must hold a permanent medical license in the State of Missouri as required by law.
  2. The resident must have approval from the Program Director of Graduate Medical Education.
  3. The resident must have successfully completed a one-month rotation in both the CMH and TMC intensive care nurseries.
  4. Residents who transfer into the program will be granted moonlighting privileges on a case by case basis upon the review of their nursery experience and at the discretion of the Director of Medical Education.
  5. Med/Peds residents need to complete additional paperwork to become employees of CMH. In addition, they must receive clearance from their contractual employer and documentation that their malpractice insurance coverage will cover the moonlighting.
  6. Must complete all application paperwork required by the Medical Staff Office.
- b. Scheduling of the moonlighting shifts will be the responsibility of the Pediatric Chief Residents. Residents who meet the above criteria will only be allowed to moonlight during elective rotations or when on an Intensive Care Nursery rotation.

Weekend shifts begin at 11 AM and end at 7 AM the following morning.  
Weekday shifts begin at 4 PM and end at 7 AM the following morning.

The number and dates of moonlighting positions available each month are variable. The number is determined after assigned residents and NNP call slots are filled. Available dates are sent to moonlighting groups via email. The resident for a particular shift will be selected from a drawing of those who respond. Equal opportunity is given to all eligible.

If a resident accepts a moonlighting shift and is unable to perform or complete it, it is his/her responsibility to find an eligible replacement. The replacement will not come from the Jeopardy Call schedule.

- c. Moonlighting residents are responsible for providing care to all current ICN patients as well as new admissions. When at TMC ICN, this also includes caring for all patients in or admitted to the well baby nursery, completing perinatal consults and attending all required deliveries. A neonatologist or neonatology fellow will serve as the supervisor.

#### 4.1.2 Other Moonlighting

- a. Moonlighting outside of the Children's Mercy system is discouraged. Residents who are considering these opportunities must be at the level of PL-2 or PL-3 and currently in good standing. Approval from the Program Director is required.
- b. The resident must obtain appropriate state licensure. If outside of the State of Missouri, the resident is responsible for paying for the cost of the medical license.
- c. Malpractice insurance from Children's Mercy will NOT cover the moonlighting. It is the responsibility of the resident to obtain malpractice coverage.

### SECTION V - WORK HOURS POLICY

#### 5.1 Resident Duty Hours Policy

The resident duty hour policy of the University of Missouri-Kansas City School of Medicine and Children's Mercy Hospital was adopted verbatim from the following Common Program Requirements for All Core and Subspecialty Programs, effective July 1, 2003:

#### 5.2 Resident Duty Hours and the Working Environment

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

##### 4.2.1 Supervision of Residents

- a. All patient care must be supervised by qualified faculty. The program director must ensure, direct and document adequate supervision of residents at all times. Residents must be provided with rapid reliable systems for communicating with supervising faculty.
- b. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
- c. Faculty and residents must be educated to recognize the signs of fatigue and adopt policies to prevent and counteract the potential negative effects.

#### 5.2.2 Duty Hours

- a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.
- d. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

#### 5.2.3 On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

- a. In-house call must occur no more frequently than every third night, averaged over a four-week period.
- b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.

- c. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.
- d. At-home call (pager call) is defined as call taken from outside the assigned institution.
  - i. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
  - ii. When resident are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
  - iii. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

#### 5.2.4 Oversight

- a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.
- b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

#### 5.2.5 Duty Hours Exception

An RRC may grant exceptions for up to 10% of the 80-hour limit, to individual programs based on a sound educational rationale. However, prior permission of the institution's GMEC is required.

## SECTION VI - TIME OFF FROM WORK

### 6.1 Paid Time Off for Illness/Family Leave

1. The Resident will accrue 1 day (8 hours) of paid time off for the Resident's illness after each full month of service.

In addition, during the first three (3) years of training, the Resident will be given, due to the Resident's illness, up to two (2) weeks (10 days) exclusive of Saturdays, Sundays and holidays) to be used for any absence(s) due to the Resident's illness or maternity leave during the term of appointment, without being required to use accrued paid time off for illness.

2. The Resident may use up to five (5) days of accrued paid time off for illness of a family member or for paternity leave. (For the purposes of this provision, "family member" is defined as the Resident's spouse, child, parent or sibling.)

If the Resident has no accrued paid time off for illness, time off for illness will be without pay, unless the resident uses available vacation days or the Resident qualifies for worker's compensation or long-term disability insurance.

3. Accrued paid time off for illness may be used concurrently with an approved leave of absence due to the Resident's or a family member's illness. Accrued paid time off for illness may be carried over from one year to the next. No payment will be made for unused accrued paid time off for illness at termination of the Appointment.

## 6.2 Vacation

The Resident is eligible for up to twenty (20) days of paid vacation during the PL-1 and PL-2 years. During the PL-3 year, the resident will have five (5) days of paid time to attend a CME conference and fifteen (15) days of paid vacation, exclusive of Saturdays, Sundays and holidays. Vacation may be taken during vacation-approved months, and must be approved in advance by the Program Director or his/her designee. Vacation also may be used concurrently with an approved leave of absence.

The educational meeting must be approved in advance by the Program Director or his/ her designee.

Vacation may not be carried over from one year to the next and no payment will be made for unused vacation at the termination of the Appointment.

## 6.3 Bereavement Policy

Residents are allowed 2 days per year to attend funeral services of a family member. These days do not count as vacation or sick days. The resident should notify the Chief Resident as soon as possible so service coverage can be addressed. If the resident is required to miss a call, the back-up call person will be activated.

If the death involves an immediate family member (spouse, child, parent or sibling) and the resident will require more time off, the resident should contact the Program Director or the Chief Resident as soon as feasible. Extended time off may be taken as a leave of absence (unpaid).

## 6.4 Interview Days Policy

Residents are allowed up to 5 days total to interview for a job or fellowship position. Although it is preferred that these days are taken while the resident is on outpatient rotations, it is realized that this is not always possible. All interview day requests must be submitted on the official Time Off Request

Sheet and approved by the Chief Residents. Interview days will be granted in accordance with the following:

1. No more than 2 days are granted during an inpatient rotation\* and no more than 5 days during an outpatient rotation. Requests that exceed 5 total days off from an elective rotation (including interview days, vacation, meeting time, boards or camp) will require prior approval by the Program Director and the rotation's attending physician.
2. The resident is solely responsible for notifying the attending physician at the start of the rotation of his/her approved interview days.
3. If the interview day falls on the day of the resident's Continuity Clinic, it is the responsibility of the resident to point this out to the Chief Residents. The Chief Resident will then notify the Continuity Clinic of the approved cancellation. The Continuity clinic must be given 2 weeks notification for the cancellation. If the interview is arranged less than 2 weeks in advance, the resident must arrange for one of his/her peers to see his/her already scheduled clinic patients.
4. Interview days taken during inpatient rotations\* must take into consideration the call schedule and clinic schedule for all residents on the team.
5. Interviews days taken during Emergency Medicine rotations must be scheduled on days off and may not exceed 4 days.
6. Once a job is secured, no additional interview days may be taken. Abuse of this will result in the use of vacation days.

\*Inpatient rotations include NICU, PICU, TMC NICU, MCU, H/O, Blue, Gold and General Pediatrics inpatient rotations

## 6.5 Maternity Leave Policy

Residents becoming pregnant during residency should meet with the Program Director early in the pregnancy. The Program Director will in turn notify the Chief Residents. Residents may take up to 12 weeks per year for the birth or adoption of a child in accordance with the Family Medical Leave Act if eligible. Time beyond this must be approved by the Program Director. Residents will be paid for all accrued sick days. In addition, during the first 3 years of training, the resident will be given up to two weeks (10 days) exclusive of Saturday, Sundays and holidays, to be used for any absence(s) due to the resident's illness or maternity leave during the term of appointment, without being required to use accrued paid time off for illness. Time taken beyond this may be taken as vacation days, time without pay or a combination of the two. Residents who deliver midway through a rotation must have completed 15 working days or 90% of the rotation in order to receive credit for the month. If fifteen days have not been completed, the entire month will need to be completed at a later date. All rotations not completed while on leave need to be completed prior to the end of residency.

## 6.6 Paternity Leave Policy

A resident who is adopting a baby or whose significant other is pregnant should notify the Director of Pediatric Residency Program and Chief Resident as soon as possible. If at all possible, the resident should be placed on an elective or outpatient month around the time the baby is due to arrive. Residents on inpatient months will only be allowed four days off within that month.

Pediatric residents may use 5 days of accrued time off when on outpatient months. This time may be taken immediately after the birth/adoption or anytime within a 12 week period after the birth/adoption. The 5 days do not have to be used consecutively and may be divided within the 12 week period.

All residents may take up to 12 weeks off in accordance with the Family Medical Leave Act. Pediatric residents may use 5 days of accrued time off. Time taken beyond this may be taken as vacation time, time without pay or a combination of the two.

Regardless of how the time off is scheduled, the resident must complete a minimum of 15 working days of the rotation to receive credit.

## 6.7 Meeting Days Policy

All categorical pediatric year 3 residents are given 5 weekdays per year to attend a medical meeting. One or two of these days may be used as travel days. This time must be taken during a vacation eligible month. These days are non-transferable (i.e. cannot be changed to vacation days and must be used during the third year of residency training). A resident at any level of training may use vacation days to attend a meeting. If available, the resident may use the educational stipend to help cover the cost of the meeting. (See the Stipend Policy for further details.)

All meetings must be approved by the Director of Medical Education and the Chief Residents. Audio or videotape meetings are not acceptable, regardless of the meeting's eligibility to provide CME hours.

Residents will be required to sign up for CME hours while at the meeting. Following the meeting, the resident must provide a copy of his/her granted CME hours as proof of attendance.

A minimum of 2 weeks notice must be given prior to the meeting in order for clinic cancellations to be approved. If less than 2 weeks notification is given, the resident will be required to make arrangements for one of his/her peers to see already scheduled clinic patients.

## 6.8 Leave of Absence Policy

Leaves of absence are granted on a case-by-case basis by the Program Director, in accordance with applicable law. Leaves of absence are normally unpaid. The ability to use vacation and/or sick time will be decided by the Program Director. The decision will be based on the underlying need for the leave of absence. Reasons for which a leave of absence may be granted include: the birth of a child or placement of a child by adoption or foster care; the serious health condition of a resident; the serious health condition of a resident's

family member; and other circumstances. The resident may be terminated from the program if the length of the leave of absence extends beyond six (6) months. The resident may be required to make up all rotations missed.

## 6.9 Other

1. If the leave of absence occurs over the holidays (December & January off) , you will be assigned two holidays to work instead of one during that year (as you will not be working a major holiday).
2. The December month will include the Christmas holiday block and the January month will include the New Year's holiday block. Therefore, if your leave begins in December, you will be assigned to work Christmas. If you leave ends in January, you will be assigned to work New Year's.
3. You will not be allowed to work more than three inpatient months in a row during your pregnancy.
4. You may not be on inpatient during the month of your due date.
5. Requests regarding leave of absence and surround months (i.e. not coming back to inpatient) count as official master schedule requests and supersedes other master schedule requests.

## SECTION VII - BENEFITS

### 7.1. Educational Stipend Policy

All pediatric and medicine/pediatric residents will receive an educational stipend:

Postgraduate Year I	(PL-1)	\$ 500.
Postgraduate Year II	(PL-2)	\$1000.
Postgraduate Year III	(PL-3)	\$1500.

These annual stipends for categorical pediatric residents are non-transferable, so that any money left in an individual's account will not be carried over to the following academic year. All medicine/pediatric residents are given a one-time stipend of \$1000, which may be used at any time throughout their 4-year residency period.

Educational stipends may be used toward the purchase of educational materials such as books, audio or videotapes, computer programs, PDAs, medical equipment or computers. The Residency Coordinator can order books and supplies from UMKC with sales tax exemption. If books or supplies are purchased elsewhere, all receipts should be given to the Residency Coordinator and the resident will be reimbursed. The resident will not be reimbursed for the sales tax if purchases are made elsewhere.

A resident may also use his/her educational stipend to cover the cost of attending a medical meeting. The meeting must meet the requirements as outlined in the Meeting Days Policy. This money may be used for registration fees, airfare or mileage reimbursement per Hospital Policy, hotel accommodations and food allowance. These funds cannot be used for a rental

car unless the need for the car is justified and approved by the accounting department prior to leaving for the meeting. All airfare reservations must be arranged through the travel agency used by Children's Mercy Hospital in order to receive reimbursement. If a resident finds a lower airfare, this must be communicated prior to the purchase of the ticket. Upon return from the meeting, the resident must provide the Residency Coordinator with all itemized receipts and a copy of the CME certificate so that arrangements for reimbursement can be made.

## 7.2. Health Insurance

The Resident is eligible for group health, vision, and dental insurance for the Resident and the Resident's dependents, at the Hospital's expense. Health and dental insurance coverage is fully explained in and governed by the health insurance plan and summary plan description.

## 7.3. Other Insurance

**Long-term Disability Insurance:** The Resident is eligible for a benefit equal to sixty per cent (60%) of the Resident's base salary if the Resident is disabled for a period of at least ninety (90) days, in accordance with the terms of the life insurance policy.

**Professional Liability Insurance:** Professional liability insurance is provided through the Hospital's self-insured trust in the amount of two million dollars (\$2,000,000.00) at the Hospital's expense, in accordance with the terms of the self-insured trust.

All insurance coverage is explained in and governed by the terms of the applicable plan or policy and may change from time to time.

## 7.4. Memberships

Candidate membership in the American Academy of Pediatrics will be provided to the Resident at the Hospital's expense.

## 7.5. Flexible Spending Account

The Resident is eligible to participate in this optional account, which may be used to pay for child care, uncovered medical expenses, and health and dental insurance deductibles with pre-tax income.

## 7.6. Meals

The Resident will be provided meals through the Hospital cafeteria at the Hospital's expense when the Resident is on-call at night. The Program Director determines the amount of money available for the purchase of food.

## 7.7. Parking

The Resident will be provided free parking at the Hospital during the term of the Appointment.

## 7.8. Library

The Resident will be eligible to use the medical library located on the ground floor of the Hospital during the term of the Appointment; this library is available at all hours and on all days. The Resident also is eligible to use the library at the University of Missouri-Kansas City at the times and on the days established by the University through on-line access.

## 7.9. Housestaff Quarters

The Resident will be provided a lounge, locker, on-call sleeping rooms and showers at the Hospital for the exclusive use of residents in the Program, at the Hospital's expense. No living quarters will be provided to the Resident by the Hospital.

## 7.10. Notary Public

The Resident will be provided Notary Public service at the Hospital's expense.

## 7.11. Moving Allowance

A moving allowance of \$300 is provided for any Resident moving from outside the metropolitan Kansas City area.

# SECTION VIII - RESIDENT WELL-BEING POLICIES

## 8.1. Prohibited Harassment

The Hospital does not tolerate harassment of any kind. Harassment is verbal or physical conduct that denigrates or shows hostility or aversion toward a Resident and/or his relatives or associates because of his/her race, color, national origin, gender, sexual orientation, age, religion, disability, or other basis prohibited by law, and that :

1. has the purpose or effect of creating an intimidating, hostile, abusive or offensive environment; or
2. has the purpose or effect of unreasonably interfering with an individual's work or educational performance; or
3. otherwise adversely affects an individual's employment or educational opportunities.

Any Resident who believes he/she is a victim of harassment must bring the matter to the immediate attention of the Program Director. The Resident also may use the grievance/complaint procedure set forth under Section I.7 above. Except in extraordinary circumstances, the Resident shall put the complaint in writing, and the matter shall be promptly investigated. Confidentiality, to the extent feasible, will be maintained. The Resident shall be informed of the result of the investigation. If the Resident is dissatisfied with the outcome of an investigation, he/she may submit the

complaint to the Executive Medical Director who will make the final decision.

Residents who believe they cannot utilize the above procedure should contact the Hospital's Human Resources Department for confidential assistance.

A Resident will not suffer adverse consequences for making a complaint or taking part in the investigation of a complaint. Residents who knowingly allege a false claim, and any Resident who violates this policy, shall be the subject of disciplinary action, including dismissal or termination.

## 8.2. Substance Abuse

The Hospital has the legal right to implement rules on substance abuse governing Residents' activities and conduct on or off Hospital property. Compliance with the requirement that Residents be drug-free while on the job should be considered an essential qualification of employment.

Residents should be aware of the following substance abuse policy guidelines:

1. The illegal use, sale or possession of narcotics, drugs or controlled substances while participating in the Program or on Hospital property is an offense that may result in dismissal or termination. Any illegal substances will be turned over to the appropriate law enforcement agency and may result in criminal prosecution.
2. Residents who are under the influence of alcohol, or who possess or consume alcohol while participating in the Program or while on Hospital property, have the potential for interfering with their own as well as others' safety. Such conditions will be proper cause for disciplinary action, including dismissal or termination.
3. Off-the-job illegal drug use which could adversely affect a Resident's job performance or which could jeopardize the safety of others or Hospital property is proper cause for disciplinary action, including dismissal or termination.
4. Residents who are arrested for off-the-job activity may be considered to be in violation of this policy. In deciding what action to take, the Hospital will take into consideration the nature of the charges, the Resident's status, the Resident's record, and other factors relative to the impact of the Resident's arrest upon the conduct of Hospital business.
5. Residents undergoing prescribed medical treatment with a controlled substance should report this treatment to the Program Director, when the controlled substance may affect the Resident's ability to perform his job without adversely affecting the health or safety of the Resident or others. The use of controlled substances as part of a prescribed medical treatment program is not grounds for disciplinary action, although it is

important for the Hospital to know when such use is occurring so that the safety and health of the Resident and others may be protected.

The Hospital may allow the consumption of alcoholic beverages, in moderation, at some Hospital-sponsored events or meetings. The abuse of alcoholic beverages is prohibited by the Hospital in these situations, and may result in disciplinary action, including dismissal or termination.

The Hospital will provide assistance in certain circumstances for persons seeking to correct a substance abuse problem, and this will be encouraged in appropriate cases as explained in the Impaired Resident Policy, section 13, below.

### 8.3. Policy for Impaired Residents

The purpose of the Impaired Resident Policy at the Hospital is to promote the physical and emotional health and well-being of Residents while providing safe patient care. This policy is designed to educate, detect, intervene upon, rehabilitate and monitor residents as impaired.

#### *Philosophy*

It is the policy that Impaired Residents be treated in the same manner as those subject to other treatable diseases with respect to confidentiality, retention in the program, performance, sick leave and other benefits.

#### *Procedure*

1. Any person with reasonable suspicion that a Resident may be impaired will report this to the chair of the Resident Education Committee or another member of the Committee if the chair is unavailable. A Resident who recognizes possible impairment in himself may also approach the Committee to seek assistance.
2. An investigation will be conducted by the Resident Education Committee in conjunction with the Missouri Physicians Health Program to determine the validity of the report. If the investigation reveals that the Resident poses a direct threat to the health or safety of himself or others, appropriate steps will be taken to remove the threat.
3. If the investigation reveals probable impairment, intervention will occur. The Resident will be requested to submit voluntarily to an evaluation by an appropriate professional outside the Hospital and follow any recommendations made by the evaluator, Resident Education Committee, and Missouri Physicians Health Program staff. The Resident will be given a choice of treatment locations. If the Resident volunteers to submit to the evaluation and follow any recommendations made, the cost of treatment not covered by health insurance as well as fees for monitoring and follow-up shall be the responsibility of the Resident unless otherwise required by law.

If the initial evaluation reveals that the Resident is not impaired, the Hospital will pay the entire cost of the evaluation. Ongoing monitoring may be required if the evaluation reveals that the Resident is not impaired.

If the Resident refuses evaluation and/or treatment, the Program Director will be notified, and will decide on appropriate action. No report will be made to the Program Director if the Resident agrees to evaluation and complies with all terms of the treatment program.

4. Long-term follow-up of the Resident will be the responsibility of the Missouri Physicians Health Program which will report periodically to the Resident Education Committee. Upon termination of the Resident from the Program, monitoring will be the sole responsibility of the Missouri Physicians Health Program.
5. If, during monitoring, the Missouri Physicians Health Program finds that the Resident is not complying with treatment recommendations, the Committee for Resident Wellness will report such to the Program Director, who will take appropriate action.
6. The Impaired Resident must receive a release to return to work from the treating professional and the Missouri Physicians Health Program before returning, absent extraordinary circumstances.

### *Confidentiality*

Information regarding the Impaired Resident and treatment will be maintained by a member of the Committee for Resident Wellness, in secure files separate from the Impaired Resident's evaluation file, and released on a need-to-know basis only, in accordance with applicable law.

### *Education*

It is the goal of the Program that Resident impairment is prevented by education and early detection of potential impairments. To this end, a representative from the Missouri Physicians Health Program and/or the Committee for Resident Wellness will be invited yearly to give a presentation open to all Residents, Hospital physician staff, community physicians and Hospital employees. Other education programs may occur when possible.

## **8.4. Counseling**

The Children's Mercy Hospital offers an Employee Assistance Program. The EAP offers professional consultation and short term assistance and referral for additional assistance if necessary. The program is called 'New Directions.' Brochures are available through the Chief Residents' office, the Program Director, or Human Resources.

## SECTION IX - MISCELLANEOUS

### 9.1. ER Missed Shift Policy

It is required that any missed shifts will be made up. Every attempt will be made for the Resident to pay back to the resident who worked for him/her.

### 9.2. Off-Site Rotations

#### a. Office Month

All residents are required to complete a one-month rotation in an outpatient pediatric office. Residents may choose to do this in the Greater Kansas City area or in another location. The resident must have a supervising pediatrician who is responsible for overseeing the rotation and completing a written evaluation.

Residents who choose to do this rotation outside the state of Missouri must at their own expense obtain a permanent medical license or training permit in the appropriate state. Malpractice insurance from CMH will be in effect.

#### b. Other Off-Site Rotations

Off-site rotations require approval of the Program Director. Unless the resident is using a call-free month, scheduling of a specific month requires the approval of the Chief Resident.

The resident must initially provide a written description of the rotation, including its location, objectives, name of supervising physician, schedule of clinical and didactic experiences and clinical responsibilities. After approval, the resident will be responsible for making all necessary arrangements, including obtaining a permanent medical license or training permit at his/her own expense in the appropriate state. Malpractice insurance from CMH will be in effect. The resident must receive a written evaluation from the supervising physician after completion of the rotation. Upon completion of an international rotation, the residents must meet with the Director of Medical Education. Residents are also encouraged to give a formal presentation to the housestaff about their international experience.

Residents participating in off-site rotations outside the Greater Kansas City area must either use their call-free month or arrange with the Chief Resident to have their calls covered. Chief Residents should be informed a minimum of 4 months in advance if the call-free month is NOT being used. They will have the discretion to approve or deny the month based on the number of residents available to take call. Residents will be required to make up missed calls as directed by the Chief Residents.

Resident using his/her call-free month must still notify the Chief Resident in writing as minimum of 2 months prior to the rotation.

### c. International Rotations

Residents at PGY II and III level may consider one month international elective rotation with the prior approval of the Program Director and the Executive Medical Director. Detailed information, application process, minimum requirements are outlined in detail at CMH website. All residents approved for such international rotation will be provided their regular salary and benefits and a travel stipend of \$1,000 to cover travel related costs.

### 9.3. Jeopardy Call Policy

The purpose of the Jeopardy Call Policy is to ensure adequate coverage to the Hospital in the event that a resident is unable to take call. Residents placed on Jeopardy Call may be from any given year, depending on the number available to take call any given month. The Jeopardy Call resident must be available via beeper during the 24 hours he/she is on Jeopardy Call and must be able to come to the Hospital within one hour when called. Jeopardy Call residents will cover any spot on the call schedule with the exception of moonlighting shifts (including any ER shift).

If a PL-1 or PL-2 home call resident is available, he/she will be called in, prior to the PL-3 home call resident, to cover any call positions that they have previously done. Therefore, if a resident has not had the PICU rotation, he/she cannot cover the PICU call position.

The PL-3 home call resident can be called in to fill any position previously stated.

If a resident misses a call, he/she is required to make it up to the resident who was called in to cover. Paybacks will be arranged by the Chief Residents. No more than 10 calls can be given to a particular resident in one month; any additional missed called will be replaced the next month.

In the event that two residents are unable to take call on a given night and there is only one resident scheduled for Jeopardy Call, the Chief Resident will decide where to place the Jeopardy Call resident. The Chief may also need to find a second resident, who is not scheduled for call, to fill a slot.

Jeopardy Call positions are CALL positions. There is no compensation in the way of less call the following month, for being called in to work. Should a resident be unable to take call when scheduled for Jeopardy Call, he/she needs to notify immediately the Chief Resident. If the resident fails to do so and is subsequently needed for call, this will count as a missed call.

Residents unable to take call should notify the Chief Resident as soon as possible. If it appears that the resident will need to miss multiple calls or ER night shifts, the Chiefs may attempt to trade calls/shifts with the input of the involved resident.

#### 9.4. Continuity Care Clinic Cancellation and Post-Call Policy

Each resident will have Continuity Clinic (CCC) one half day per week. Occasional clinic day changes are unavoidable, but every effort will be made to keep a resident's clinic on the same day of the week for the duration of his/her residency. All clinic blocks and cancellations must go through the Chief Residents. Residents are not to call CCC or Adolescent Clinic scheduling to make these changes.

##### *Post-Call Clinic Blocking*

At least four weeks prior to the start of a rotation, the Chief Residents will notify the appropriate clinics of each resident's post-call clinic dates. Calls to be included will consist of the following: Blue, Gold, General Inpatient, TMC NICU, CMH NICU, PICU and Hem/Onc. Jeopardy calls and moonlighting shifts will not be included. Clinic will be cancelled on these post-call days. Attempts are made to limit cancellation to one per month.

##### *Clinic Cancellations*

CCC/ACC clinics will ONLY be cancelled for approved vacation, meeting or interview days, board exams or extraordinary circumstances as defined by the Chief Residents. These cancellations will only be granted when a minimum of 4 weeks notification is given. If 4 weeks notification is not given, the resident will be required to arrange for one of his/her peers to see his/her already scheduled clinic patients.

##### *Away Rotations*

When a resident plans an away rotation other than an office month, he/she must notify the Chief Residents in writing 4 months in advance. Arrangements will then be made to schedule two all-day clinics for the resident during that month.

During office rotations in the KC area, the resident will continue to fulfill his/her regular CCC/ACC requirements. When a resident arranges an office month outside the KC area, written notification must be given to the Chief Residents 4 months in advance. The resident's CCC/ACC will then be cancelled for that month.

#### SECTION X - REVISIONS TO POLICIES

The Hospital reserves the right to amend or interpret any or all of these Policies at any time. Generally, these Policies are reviewed annually by the Pediatric Department Education Committee and the Medical Staff Education Committee. Revisions are forwarded to the Medical Staff Executive Committee and the Central Governing Board of the Hospital for approval.

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