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Mission for the Child Abuse Pediatrics Fellowship

The mission of the UTHSCSA Division of Child Abuse Pediatrics (CAP) is to restore, promote and enhance the medical and mental health of children at risk for abuse and neglect. The purpose of the fellowship training program is to train pediatricians to become proficient in child abuse pediatrics in order to pursue a career as a clinician, educator, researcher, and community leader in the prevention, detection and treatment of child abuse and neglect. Training will be accomplished within a framework which emphasizes proficiency in the six competencies articulated by the Accreditation Council of Graduate Medical Education:

Proficiency includes competency in:

1. Medical Knowledge
2. Patient Care
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems Based Practice

As reflected across:

1. Development of clinical expertise for:
 - a. All acute and chronic medical presentations of child abuse including physical abuse, sexual abuse, neglect, (supervisional, medical, nutritional, physical, psychosocial), drug endangerment or exposure, perinatal drug exposure, psychological maltreatment, pediatric condition falsification (medical child abuse), and conditions which may be mistaken for child abuse.
 - b. General health-related needs of children at risk of abuse and neglect including medical and dental needs and systems of service for children in foster care.
2. Development of teaching skills
3. Pursuit of scholarly activity
4. Development of administrative skills
5. Development of community liaison skills including:
 - a. Competence in communicating medical findings to partners in the multidisciplinary model approach to child abuse and neglect
 - b. Understanding the roles, systems and capabilities of other agencies and disciplines that evaluate, investigate and manage abused and neglected children.
 - c. Understanding of the various civil and criminal legal settings within which medical expertise is needed
 - d. Knowledge and critical review of legislative and public policy issues related to child abuse.

Requirements for Admission to the Fellowship Program(also outlined in the ERAS application) :

1. Completed application form and curriculum vitae
2. Successful completion of a General Pediatrics Residency approved by the American Board of Pediatrics and the ACGME.
3. Board certification or eligibility to take the specialty examination offered by the American Board of Pediatrics.
4. Original university, professional school, and FLEX/National Board/USMLE transcripts (mailed directly to me from the institution at your request) as well as FMG registration certificate if relevant, with notary-certified English translations of all international university degrees and graduate training certificates.
5. A minimum of 3 letters of reference from recent supervising faculty (it is suggested that one letter be from the Chairman of Pediatrics or the Residency Program Director and when possible, from a Child Abuse Pediatrician).
6. A personal statement that details reasons for pursuing a career in Child Abuse Pediatrics and future professional goals.
7. Fulfillment of criteria to obtain a permanent Texas Medical License.
8. United States Citizenship or permanent visa. (See the Policy, “Resident Selection” in section “Specific Policies.”)

Additional documents may be requested subsequently in accordance with university policies and procedures. Competitive applicants will be invited to schedule interviews by directly contacting Ms. Sandra Quiroz (210-704-3939), Division Administrator, to arrange a visit to San Antonio for meetings with program faculty and staff. Employment is contingent upon successful clearance of the applicable sanctions and security checks according to current university policy and regulations

Recruitment Timeline for Prospective Fellows/Selection Process:

- a. One position is offered for each academic year.
- b. Competitive applicants will be invited for an interview, which will consist of a meeting with the program director, a tour of the facility, lunch with 1-2 current fellows, and interviews by selected faculty and staff. Each interviewer completes an evaluation and rates the individual relative to previous applicants. Upon completion of the interview process for all viable candidates, a rank list is generated by the faculty members of the Division of Child Abuse Pediatrics. The order of the rank list is based upon those candidates who are considered to have the strongest potential with regard to a) clinical skills, b) ability to develop into a competitive, independent investigator or clinical educator, c) personal attributes that promote leadership, teamwork, responsibility, sensitivity and compassion for others. Once the results of the match are known, the selected fellows are contacted and offered a contract for the corresponding academic year. Orientation materials are supplied in the spring prior to the beginning of the first year of appointment.
- c. The Joint Commission has clarified HR Standard 1.20 to provide that hospitals are now required to screen trainees in the same manner as staff employed by the hospital if the trainees work in the same capacity as staff who provides care, treatment and services. In order to meet this standard and continue to provide safe, quality patient care and excellent educational opportunities, the GME has implemented additional screening requirements for trainees. These additional requirements are consistent with the requirements imposed on other employed staff. House staff paid by University Hospital or the University of Texas Health Science Center, are required to successfully pass all screening requirements including a criminal background check **prior to beginning their training at this institution.**

Overall Goals for Competency by Year of Training

Year 1: During this year the fellow develops basic understanding of the evaluation and management of infants, children and adolescents who are suspected victims of abuse and/or neglect by working closely with the faculty and various members of the multidisciplinary team in both the inpatient and outpatient setting. The supervision by the faculty is mostly on site, in person, and readily available day and night. The fellow is expected to have already developed strong skills in the ACGME core competencies, including general care of sick patients. The fellow is expected to have already developed excellent clinical judgment in general pediatrics but now needs to take those skills and add the knowledge base and experience necessary to understand the assessment of children who are suspected victims of abuse at an expert level. The fellow will function at a level between that of a general resident and the faculty. The fellow will review assessment and management plans with the faculty physician.

During this year, the fellow also learns through didactics and is also strongly encouraged to read extensively. They may wish to refer to the Division Article File and Classic Article File for recommended reading and to the American Board of Pediatrics Content Specific Specifications for topics of which they may research articles. In addition, fellows are expected to review chapters from Child Abuse: Medical Diagnosis & Management, 3rd Edition (Reece and Christian), Diagnostic Imaging of Child Abuse 2nd Edition (Kleinman) and Child Abuse and Neglect: Diagnosis, Treatment, and Evidence (Jenny) as well as the CD-ROM: "Medical Evaluation of Suspected Child and Adolescent Sexual Abuse"(Kellogg and Adams). By the end of this year, the fellow should comprehend the level of material presented in the basic textbooks of child abuse pediatrics, and develop a

much deeper and broader understanding of several areas of clinical care by reading the medical literature and original studies. Much of this deeper learning should be guided by the patients seen. We expect the fellows to regularly search the medical literature for guidance on the care of their patients and to make the use of evidence-based medicine a life-long practice.

During this year the fellows are closely supervised in the performance of the consults and clinic visits. They must review with the supervising faculty or senior fellow the symptoms, diagnosis, therapy and potential complications of their patients. They are asked to remain closely supervised until they have demonstrated competence as judged by evaluations and the program director. By the end of the year they should have attained competence in most of child abuse pediatrics areas.

During this year the fellow should investigate possibilities for their area of research. Approximately two months of accumulative time will be dedicated to research

Year 2: This year is intermediate. The level of responsibility is similar to Year 1, except that the closeness with which the faculty will supervise is individualized to the fellow and to the clinical circumstances. The fellow and faculty physician still discuss the assessment and management of each patient, but the faculty should encourage more decision making and critical thinking by the fellow. Efforts to see and participate in the care of patients with less common presentations of abuse or neglect will be encouraged throughout the year, even during months dedicated to research. In addition, fellows will be expected to take more of a leadership role in the multidisciplinary case reviews and child fatality reviews.

The fellow is expected to have attained by this time the level of knowledge available in basic child abuse pediatrics textbook(see Year 1 for list of textbooks). The fellow will continue to learn through didactics but is expected to exhaustively review the relevant scientific and clinical literature on their patients and on specific difficult clinical situations. Emphasis on the reading for this year is original literature and evaluation of the medical literature by critical reading.

The fellow is progressing with the research component at this time, as reviewed under the research timetable. Approximately four months will be dedicated to research and fellows will continue to present their progress to the Scholarly Oversight Subcommittee.

Year 3: By this year, the fellow should have attained clinical competence in the evaluation and management of infants, children and adolescents who are suspected victims of all types of child maltreatment, at all levels of severity and acuity. He/she has not yet totally mastered clinical care, but has developed the level of competence to proceed to more independent care of the patients with consultation with the faculty physician. The faculty physician is always immediately available to consult and to see the patients and will review the clinical care at least once daily with the fellow for the purposes of encouraging the fellow to think critically and maturely about the problems presented. The primary goal of this year is for the fellow to gain the experience and maturity needed to assume a leadership role in the assessment, management, advocacy, and prevention of child maltreatment.

The research work should be completed this year. Please see the Scholarly Activity section for requirements for graduation.

Assessment and Evaluation - all years

The attending physicians will communicate daily with the fellow about the appropriateness of decisions and care rendered by the fellow and will see and examine all patients. The attending will have the responsibility to address deficiencies as they arise. At the end of every month, the attending will complete a written evaluation of the fellows performance and will discuss with the fellow any areas of significant concern or areas in which the fellow is particularly skilled. Also note the relevant policy on “Resident Supervision” and “Resident Evaluation.”

Research

Learning the methods and science behind meaningful scientific inquiry is an integral part of fellowship training. One goal of the fellowship is to train physicians who understand the depth and breadth of the field of child abuse pediatrics. It is imperative that pediatric sub-specialists have a firm understanding of research methods and that they have had firsthand experience designing, conducting, and reporting scientific inquiry in their chosen field. The ICI seminar (along with corresponding research) provides the core component of education in research.

Oversight for the fellow’s research will be provided by the PSOS to which the fellow is assigned at the beginning of the fellowship, and by the Division-appointed faculty mentor. It is hoped that each fellow will have at least one first authored article submitted to a quality peer-reviewed scientific journal prior to completion of the fellowship.

With each formal evaluation session, research goals will be included in those discussed by the fellow and the Program Director. These same goals should be reviewed with the research mentor. All research mentors are aware of the American Board of Pediatrics requirements and will tailor projects to fit these needs specifically. In other words, fellows will assume projects which have a known working model and a realistic time frame for completion during fellowship.

The Division will fund travel for fellows to attend one child abuse conference per year. Fellows are nominated as Scholar members of the Helfer Honorary Society and are encouraged to attend and present at an annual Helfer meeting at least once during their fellowship.

The Introduction to Clinical Investigation (ICI) seminar provides didactic instruction on the basics of clinical and basic science research. This is a required two-week, full-time course offered in February of the first year of fellowship. Statistical consultation is available for specific research projects.

Research Timetable

The American Board of Pediatrics, Subboard for Child Abuse Pediatrics takes the research/scholarly requirement very seriously. In view of that, the fellows are strongly urged to set specific goals to be accomplished by certain dates. The following is a suggested timetable.

Year 1, months 1 - 6: Gain experience in child abuse pediatrics evaluation and management in clinical settings. Identify potential areas of interest for research and quality improvement activities and discuss interests with faculty research mentor.

Year 1, months 7 - 12: Broaden knowledge of the medical literature of child abuse pediatrics, and select articles that provide background information for areas of research interest. The fellow will

complete the ICI seminar during this timeframe (offered annually in February). The fellow should have sufficiently explored the medical literature on the area of interest to have a good grasp of what research questions exist. The fellow should present his/her interests, plans and identify mentor(s) within the division and at the January meeting of the Scholarly Oversight Subcommittee in the fellow's first year of fellowship.

Year 2, months 1 - 6: Formalize hypotheses and write research protocol. Undergo required CITI and HIPAA training in preparation of applying for IRB approval. Obtain IRB/COGS approval (this one step will take several months, and prior to applying for IRB approval, the research protocol must be fully developed). By the end of this period the fellow should have either already started the actual protocol(s) or be completely ready to start. All logistic issues should be resolved.

Year 2, month 7 - first half year 3: Complete project, begin analysis of data, and explore further issues which may need to be tested. By the end of the first half of 3rd year, the fellow should have enough accomplished that he/she can confidently expect to be able to prepare a manuscript the last half of the third year.

This timetable is only a guideline. Obviously the latter stages are hard to predict, particularly since one cannot be certain of what the results will be until the research is performed. This makes the initial stage even more important to accomplish on time. The timetable for the first year and a half should be regarded as the latest one can take to accomplish these goals, and it would be ideal to have this all accomplished by the end of year one.

Evaluation

The CAP fellows are formally evaluated on a monthly basis by faculty, staff, other subspecialists, and multidisciplinary team members. This evaluation is in writing, and records of these evaluations are confidentially maintained by the Program Director. The fellows have the opportunity to read and sign their evaluations. Copies will be provided if so desired.

Every six months, as part of a mandatory meeting, the fellow will meet privately with the Program Director to discuss recent evaluations, progress, deficiencies, accomplishments, and problems. The fellow's Individual Learning Plan and in-progress personal statement(see Addendum for template) will be reviewed and revised as needed. Both immediate and longer term professional goals for the fellow will be reviewed and discussed. More frequent meetings may be requested by the fellow. While the value of these evaluations is stressed, the process should be completed in a non-threatening manner.

If the fellow has any significant disagreement with any specific evaluation, it is the privilege of the fellow to place a written response in his/her evaluation folder. The fellow is encouraged to discuss any such disagreement with the evaluator informally. If agreement can not be reached, the Program Director and/or Dr. Nolan, Assistant Dean of GME, will meet with both parties to mediate. Under such circumstances where the matter still does not achieve resolution, the Chairman of the Department of Pediatrics will review the matter.

Fellows also participate in the evaluation process by completion of a periodic evaluation of the program and faculty. Also, fellows are encouraged to informally discuss strengths and weaknesses in the program with faculty, especially the Program Director.

Child Abuse Pediatrics In-Training Examination

When made available, an in-training examination is required for all fellows during the fellowship. The American Board of Pediatrics will be developing a child abuse pediatrics in-training exam. This exam will be taken by each fellow at least twice during the training program. Results of this exam will be used to aid the fellow in determining personal deficiencies and by the Program Director to determine weaknesses in the training program.

DEVELOPMENT OF CLINICAL EXPERTISE

Rotation Schedule	1st Year	2nd Year	3rd Year
Center for Miracles (CFM)	8 months	7 months	5 months
Research	2 months	3 months	5 months
Forensic Pathology			1 month
ER Trauma	1 month	1 month	
ICU Trauma	1 month		
Child Psychiatry		1 month	
Behavior/Development			1 month

- Inpatient call will not exceed 14 days per month with 2 weekends.

Clinical responsibilities of fellow to CAP Team

■ CFM clinic rotations:

- 16 clinical shifts per month in the PGY4 & 5 years of fellowship—comprising of at least 2 half day sexual abuse clinics per week and 2 half day physical abuse clinics per week
- Inpatient Call – up to 14 days per month
- Up to 2 weekends per month – consisting of urgent shifts (when on ER/FNE rotation) and call

Clinical supervision is provided by division faculty to promote gradual acquisition of clinical independence. All clinic patients of the first-year fellow are presented to a faculty member who will be in direct attendance for pivotal parts of patient evaluation. All documentation for clinic patients seen by fellow in first year will be reviewed in detail by faculty member. Timely guidance in clinical assessment, skills in decision-making, documentation and liaison with community services will be provided to fellow to assist and guide patient management.

All clinic patients seen by the second-year fellow will be at least briefly reviewed with a faculty member.

The independent third-year fellow will seek faculty support in clinic patient management and documentation on an as-needed, case-by-case basis.

All inpatient consults will be presented to faculty, personally seen by faculty, and documented by faculty.

Division faculty and staff will be continuously available to each fellow to guide and supervise patient care throughout fellowship. Division faculty bear responsibility to maintain direct involvement with fellows who see patients throughout fellowship to monitor quality of fellows' work, provide clinical teaching for fellows, provide feedback, and assure excellence in patient care.

Work hours will be tracked to assure compliance with ACGME guidelines. At-home hours of availability for call are not counted as work hours. Call duties requiring in-house activity are counted.

DEVELOPMENT OF TEACHING SKILLS

A. Clinical: supervision and teaching of residents and medical students at Center for Miracles, Children's Hospital of San Antonio, and University Hospital. When possible, attend inpatient rounds to discuss consultative patients with primary service.

B. Didactic:

- a. Participation in the PGMEC Teaching Skills Seminars during 1st year
- b. Formal presentation at local, regional and/or national conferences during 2nd and/or 3rd years
- c. Formal presentations for Child Protective Services
- d. Formal and informal presentations as requested for medical and community trainings
- e. According to fellow interest and CAP team need, enhance structure for resident and medical student teaching.

PURSUIT OF SCHOLARLY ACTIVITY

The American Board of Pediatrics requires completion of 4 components of Scholarly Activity to be eligible to sit for the Child Abuse Pediatrics board exam following the completion of the 3-year fellowship:

1. Participation in a structured core curriculum in scholarly activities
2. Supervision by a Scholarly Oversight Subcommittee who reports to the Departmental Scholarly Oversight Committee
3. A specific work product approved by the Scholarly Oversight Committee which is one of the following:
 - a. A peer-reviewed publication in which the fellow played a substantial role
 - b. An in-depth manuscript describing a completed project (generally, a manuscript that has been, or is about to be, submitted for review for journal publication)

- c. A thesis or dissertation written in connection with the pursuit of an advanced degree
4. A comprehensive document (the personal statement) describing the scholarly activity that includes a description of his/her role in each aspect of the activity and how the scholarly activity relates to his/her own career development plan. (samples of past personal statements are available for review)

Fellows are expected to attend the PGMEC Core Curriculum Seminars (CC) presented in the fall of first and second years of fellowship and the 2-week Introduction to Clinical Investigation course (ICI) presented in February of the first year of fellowship. Each fellow also presents 3 times per year to the Department Pediatric Scholarly Oversight Subcommittee (PSOS; see below).

A. Research Curriculum: All fellows must complete a research project and a Quality Improvement (QI) project during their fellowship. In addition, there are 2 choices for completing the scholarly activity/research requirements of the CAP fellowship: completing the CC seminars and the ICI which is organized by the Department of Internal Medicine and approved by the PGMEC for Pediatric fellows.

B. Research Expectations: The fellow is expected to attend the CC/ICI courses and present to the PSOS during the first year. By the end of the first year, the fellow should propose a research project that is subjected to approval by the Division of Child Abuse Pediatrics faculty. A significant study of publishable quality should be completed during the second year and be submitted for publication by the third year. A major goal is publication as a first author in a peer-reviewed journal by completion of the fellowship. The fellow will be encouraged to collaborate on additional projects and to present research results at a national meeting and at the annual Pediatric Research Day held in May. Third-year fellows are encouraged to present at Pediatric Research Day.

C. Research Mentorship: One CAP faculty will be appointed as mentor in addition to the PSOS members.

D. Scholarly Activity:

1. All fellows are expected to engage in scholarly activity projects in which they develop hypotheses or in projects of substantive scholarly exploration and analysis that require critical thinking. Areas in which scholarly activity may be pursued include, but are not limited to: basic, clinical, or translational biomedicine; health services; bioethics; education; and public policy. Fellows must gather and analyze data, derive and defend conclusions, place conclusions in the context of what is known or not known about a specific area of inquiry, and present their work in oral and written form.
2. A Scholarly Oversight Committee in conjunction with the trainee, mentor and program director will determine whether a specific activity is appropriate to meet the ABP guidelines for scholarly activities.
3. Each fellow will be assigned to a Pediatric Scholarly Oversight Subcommittee prior to the start of their fellowship. Fellows will meet and present their scholarly activity to their respective Scholarly Oversight Subcommittee three times a year. The subcommittee will review research progress and report to the overall Scholarly Oversight Committee. Members of the overall Scholarly Oversight Committee are:
 - i. Steven Seidner M.D., Professor, Neonatology, and Chair of SOC

- ii. Minnette Son M.D., Professor, Pediatric Critical Care
- iii. Brad Pollock, PhD, MPH, Professor and Chair of Department of Epidemiology and Biostatistics

4. The Scholarly Oversight Committee will
 - i. Determine whether a specific activity is appropriate to meet the ABP guidelines for scholarly activity
 - ii. Determine a course of preparation beyond the core fellowship curriculum to ensure successful completion of the project
 - iii. Evaluate fellow's progress as related to scholarly activity, including review of the fellow's personal statement at the conclusion of their fellowship
 - iv. Advise the program director on the fellow's progress and assess whether the fellow has satisfactorily met the guidelines associated with the requirement for active participation in scholarly activities
5. The interim reports to the Scholarly Oversight Subcommittees are generally 10-15 minutes in duration. Fellows fill out a form describing their progress and timeline prior to the meeting. In addition, fellows are expected to give a powerpoint presentation that briefly summarizes scholarly activities since the previous meeting (to include presentations, article reviews for the Quarterly, journal clubs, testimony) and focuses on research progress as well as QI projects, then anticipated next steps for the following 4 months. Please check with CAP faculty if further guidance is needed.

DEVELOPMENT OF ADMINISTRATIVE SKILLS

A. Quality Assurance:

1. Fellows will be familiar with the principle of continuous quality improvement(CQI) and may attend the PGMEC didactic on CQI offered in fall of second-year.
2. In addition to scholarly work, fellows must complete at least one QI activity.

B. Committees: The fellow may be assigned to serve on division or hospital committees or task forces at the discretion of the Division Chief/Program Director.

C. Didactic: Career development, professionalism, medical ethics, practice management and health care economics topics are included in the PGMEC Core Curriculum and fellows will attend division meetings.

DEVELOPMENT OF COMMUNITY LIAISON SKILLS

A. Resources: The fellow will gain extensive experience with identifying, accessing, and referring to a variety of community resources including mental health providers, child advocacy centers, child protection agencies, family and child service providers, law enforcement, child prevention programs, and court systems through provision of patient care Center for Miracles, and by attending community meetings that promote collaborative approaches to the detection, prevention and treatment of child abuse and neglect.

B. Community multidisciplinary case review: The fellow will participate in collaborative case reviews held at ChildSafe (a children's advocacy center), Child Protective Services,

and San Antonio Police Department; fellows will also participate in Child Fatality Review meetings.

- C. Legal:** The fellow will present medical information in a professional, objective, and clear manner, with honesty in regards to the level of medical certainty in his or her opinion in any case discussions or testimony. The fellow will learn how to assume the roles of fact and expert witness properly.
- D. Child abuse prevention:** Fellow will become knowledgeable about various approaches to child abuse prevention, and will contribute prevention material to the Center for Miracles and UTHSCSA Child Abuse Division websites.
- E. Policy:** The fellow will learn about and keep current on legislative and public policy changes affecting the field of child abuse. They will also become familiar with state legislative initiatives that provide funding and support for child abuse assessment centers.

Documentation of Proficiency in Patient Care:

Fellow Log:

All CAP Fellows are required to maintain a personal log of all consults and patients evaluated, as well as procedures such as colposcopy during their training. In addition, outpatient evaluations, inpatient evaluations, paper consults and case staffings will be tracked by the FACN project manager on a monthly basis. This data will serve the following purposes:

1. Demonstrate proficiency to the sub-specialty board.
2. Demonstrate proficiency when applying for clinical privileges.
3. Maintain data for fellowship accreditation purposes.
4. Document an appropriate experience with diagnosis and management of children and adolescents as it relates to the sub-specialty field of Child Abuse Pediatrics.

Each entry should include the following data:

1. Diagnosis
2. Date
3. Multidisciplines involved (CPS, SAPD, LCSW, case manager, etc)
5. Patient name
6. Hospital and medical record number
7. supervising attending physician

In addition, fellows will track their publications, scholarly activities, and presentations in their portfolio. When a fellow completes their training, he/she will provide the Program Director with periodic updates of publications and presentations post-fellowship. When possible, fellows should keep a continuous record of these activities in their personal statement sections.

The fellow should be observed and have the supervising physician document proficiency to the fellowship director to determine they have met the requirements for clinical care. They should, however, continue to keep a log of all patients seen throughout the fellowship.

Evaluations will be collected after month-long blocks of time and include 360 degree evaluations by nurses, social workers, case managers, CPS workers, attorneys and other MDT members.

Advanced Life Support Certification

All fellows are encouraged to maintain certification in the American Heart Association Pediatric Advanced Life Support Course and CPR during their fellowship. Course tuition may be waived for all University physicians to the above courses when offered at the University Hospital.

CONFERENCES/MEETINGS

A. Required participation:

1. Division of Child Abuse didactic series. Monthly to quarterly.
2. Journal club – 2-3 times monthly
3. PGMEC CC Seminars (Year 1 and 2), including online trainings
4. Forensic pathology lectures (5 per year)
5. Child Psychiatry lectures (5 every other year)
6. Helfer Society Child Abuse Conference (at least once during their fellowship)

B. As often as possible, other obligations permitting:

1. Child Development didactic series: 4 per year
2. Child Fatality Review panel – monthly

C. Department of Pediatrics

1. Child Abuse Division meetings – monthly
2. Grand Rounds—at least twice monthly

D. National Meetings

The fellow will be expected to attend at least one major child abuse conference per year. Options include San Diego Conference on Child Maltreatment, APSAC Colloquium, Shaken Baby Conference, Helfer Society Meeting, etc.

E. Procedure & Payment/Reimbursement for Attendance at Conferences/National Meetings

Refer to Fellowship Expense Account Appendix to this handbook for attendance and reimbursement procedures for conferences and meetings. Further guidance on UTHSCSA reimbursement policy for attendance of meetings/conferences can be found at the following link: <http://www.uthscsa.edu/hop2000/6.2.14.pdf>. For any other questions regarding permitted expenditures from the Fellow Expense Account, contact the Project Coordinator (Ms. Quiroz)

Fellow call schedules

- The call schedule will be developed by the senior CAP fellow, after each fellow and faculty has been given the opportunity to express his or her preferences.
- The call schedule will be drafted at least 1 month in advance. Anyone anticipating a prolonged, planned absence should document their leave schedule on the UT and Christus calendar as soon as the Division Chief has approved leave. The senior CAP should consult these calendars when drafting the call schedule
- Changes can be made for issues of personal preference after the schedule comes out in the rare instance that an individual fellow has unexpected personal commitments. These changes must be reported to the Program Director as soon as possible. We ask that changes made after the schedule comes out be kept to a minimum. When call days are changed, it is the responsibility of the particular fellow to make sure the change is acceptable to all other members of the program who are affected by the change. Also, the proportion of weekdays and weekend days should remain the same.
- When not on call, fellows are not expected to come in on weekends.
- Holidays will be treated the same as weekend days in terms of fellow responsibilities. The Holidays recognized by the UTHSCSA will be those recognized by the Division.
- Night call is taken from home and will be scheduled in one week blocks.

Please see the policy, “Resident Work Hours,” in the section on specific policies.

Faculty Advisors

During the first year of fellowship, a Division faculty member will serve as a personal faculty advisor to the fellow. Fellows will receive informal feedback throughout the year from their advisor in addition to the formal evaluations completed monthly by the supervising faculty. \

After the start of the second year of the fellowship, the fellow may elect to name another faculty member as his/her faculty advisor, perhaps a research mentor.

As stated above, it is the function of the Program Director to mediate any disagreements regarding formal evaluations or any other problems.

Senior Resident Status (PGY-6)

Purpose: The ACGME requirements for sub-specialty training in Child Abuse Pediatrics state the program must provide training for the resident not only to be competent child abuse sub-specialists, but also to be supervisors and teachers.

It is the belief of the program that in order to assist the residents in learning to be the leader of an academic care team, the resident (also referred to as fellow, although the ACGME uses the term resident) must have some experience in the role of functioning as a faculty, staff physician. For this to be an optimal experience, the program faculty must provide some oversight and direction. It is critical, however, that the fellow have some experience functioning more autonomously than in the earlier stages of the fellowship experience and supervise the general pediatric house staff and medical students without the program faculty being immediately present and dominating the team.

It is anticipated that the Child Abuse Pediatrics resident will typically take the first two years of the fellowship to learn the evaluation and management of children who are suspected victims of abuse or neglect, and will be clinically competent by the beginning of the third year of fellowship. During the last year of fellowship, the fellow should have the opportunity to grow into the role of functioning as an academic faculty, with mentorship by the program faculty.

Role of the Program Faculty: The faculty will not be as involved with the hands on management of patients or cases evaluated by the senior fellow, but will continue to see the patients as needed. The faculty will remain ultimately responsible for the quality of care given to the patients, the quality of education supplied to the general pediatric residents and medical students, and the education of the fellow. A specific faculty member will always be available to:

1. Review the plans and care of the patients
2. Provide phone consultation or, when necessary, to assist the senior resident.
3. Review the senior resident's teaching of the general pediatric house staff, and to seek the general residents' and medical students' feedback on the efficacy of the senior resident's teaching.
4. Provide formal evaluation of the resident's performance, progress, and leadership at the end of the rotation.
5. Countersign the notes of the independent senior resident.

The goal is for the senior resident to learn to function independently and hone his/her leadership skills, while still having the supervision of the faculty to guide him/her. However, it is expected that the senior resident has acquired competence earlier in the fellowship, and the supervision at this point is focused on the development into a fully responsible academic physician.

Advancement to Senior Resident Status: It is anticipated that most fellows should advance to this stage at the beginning of their third year. However, this is not to be viewed as automatic. Some residents will not be ready at this point. The resident will advance to the Senior Resident Status when the program director and the program faculty have determined that the resident has attained clinical competence to function as a Child Abuse Pediatrician. Specific criteria will be:

1. Satisfactory evaluations by the supervising faculty on recent rotations.
2. A consensus among the entire program faculty that the individual resident is competent to use good judgment and in possession of adequate knowledge to function independently and provide competent care.
3. Documentation of competency in most areas of the specialty.
4. Self-assessment by the resident that they are ready to progress to this stage.

Other GME Policies:

It is beyond the scope of this document to exhaustively include all GME resident and fellow policies. Other policies not included in this document can be found on the GME website: <http://www.uthscsa.edu/gme/gmepolicies.asp>

Resources Available to Fellows

1. Computer access with Internet capabilities as well as the ability to do Medline searches
2. Slide-making capabilities
3. Photocopying
4. University of Texas Health Science Center at San Antonio/Briscoe Library
5. Santa Rosa Children's Hospital Medical Library
6. Free hospital parking
7. UTHSCSA Office of Graduate Medical Education has links to resources for fellows on going into practice, debt management, personal safety and other topics posted at: <http://www.uthscsa.edu/gme/residentsfellows.asp>

Specific Policies: Child Abuse Pediatrics Fellowship

1) Child Abuse Resident Moonlighting Policy

The resident is highly encouraged to review the UTHSCSA GME moonlighting policy. <http://www.uthscsa.edu/gme/Policies/6.5%20Moonlighting%20by%20Fellows%20-%202012-02.pdf>

At all times, and especially if there is any inconsistency between this policy and the UTHSCSA GME policy on moonlighting, the UTHSCSA GME policy shall take precedence.

Guidelines for Moonlighting

Moonlighting is defined as compensated clinical work performed by a resident during the time that he/she is a member of a residency program. *Moonlighting is a privilege, not a right.*

As UTHSCSA-sponsored graduate medical education (GME) programs are responsible for ensuring a high quality learning environment for the residents, moonlighting is discouraged but allowed as long as it does not interfere with the fellows' educational goals and does not interfere with the fellows' responsibilities.

In assessing whether special circumstances warrant permitted moonlighting, the Program Director shall consider the following factors prior to granting moonlighting permission:

- a) The responsibilities in the moonlighting circumstance are delineated clearly in writing (using the Moonlighting Documentation form that can be accessed at: <http://www.uthscsa.edu/gme/documents/6.4.1MoonlightingDocumentationForm-2012-10.pdf>.) and are **prospectively** approved in writing by the resident's program director;
- b) The resident is not on probation or administrative status;
- c) The written documentation of the moonlighting activity is filed with resident records and is available for GME Committee monitoring;
- d) The moonlighting workload is such that it does not interfere with the ability of the resident to achieve the goals and objectives of the GME Program;
- e) The moonlighting does not place the resident in jeopardy of violating any of the current ACGME and specialty-specific Duty Hours Standards;
- f) The moonlighting opportunity does not replace any part of the clinical experience that is integral to the resident's training program;
- g) The resident is licensed for unsupervised, independent medical practice in the state where the moonlighting will occur;
- h) The resident's performance in the training program will be monitored for the effect of moonlighting on the resident's ability to participate in program activities and on the resident's level of fatigue. Adverse effects will lead to withdrawal of permission to engage in moonlighting;
- i) Moonlighting hours **must** be counted towards the 80-hour maximum weekly limit in contemporaneous New Innovations tracking; and,
- j) The resident considering moonlighting has procured professional liability (including "tail" insurance), and workers' compensation coverage. Professional liability insurance is provided by the U.T. System Medical Liability Self-Insurance Plan only for those activities that are an approved component of the training program. There is NO coverage for professional activities outside of the scope of the residency program

Accepting outside responsibilities when on call or on service, leaving early to moonlight, coming back late, etc., are not acceptable.

If the program director and division head determine that a particular fellow's moonlighting is detrimental to the fellow's progress or the function of the division, they reserve the right to curtail the fellows outside work. The fellowship program itself is an intense and encompassing experience and must be recognized as the fellow's paramount occupational and educational activity during the time of his/her training.

It is strongly recommended that, if a fellow wishes to moonlight, she or he confine the moonlighting to activities within the Department of Pediatrics at UTHSCSA.

2) Sickness or Family Emergencies Policy

Any absences must be approved by either the Program Director or the Division Chief through direct contact unless extraordinary events have taken place. If circumstances dictate that a fellow miss an on-call evening or weekend, it is not necessary that the fellow do extra call at another time or find others to cover. The Faculty scheduled for those dates will cover. If a substantial number of calls are missed, the Program Director may, at his/her discretion, ask that the fellow make these up to ensure an adequate educational experience and continuing clinical contact.

3) Dress Code Policy

The Department of Pediatrics mandates appropriate attire at all times during duty hours. In addition, proper professional attire is expected at all times, as summons for court testimony may occur at any time.

4) Malpractice Coverage Policy

The Department of Pediatrics provides malpractice coverage for all fellows in the training program. This coverage is extended to all activities that are related directly to one's position as a Child Abuse Pediatrics Fellow for the Department of Pediatrics. Coverage is not provided for care rendered that is independent of one's responsibilities as a fellow.

5) Resident Eligibility, Selection and Appointment Policy

Eligibility Requirements:

In order to be considered for fellowship selection, each applicant must have:

1. Completed an application form and provided a recent curriculum vitae;
2. Graduate of medical school in the U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA). Graduate of an international medical school, meeting one of the following qualifications:
 - a. Have a currently valid ECFMG certificate or
 - b. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction; or,
 - c. Be a graduate of international medical school who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
3. Successfully completed a General Pediatrics Residency approved by the American Board of Pediatrics and the ACGME;
4. Board certification or eligibility to take the specialty examination offered by the American Board of Pediatrics;
5. Provided original university, professional school, and FLEX/National Board/USMLE transcripts (mailed directly to me from the institution at your request) as well as FMG registration certificate if relevant, with notary-certified English translations of all international university degrees and graduate training certificates;
6. Provided a minimum of 3 letters of reference from recent supervising faculty (it is suggested that one letter be from the Chairman of Pediatrics or the Residency Program Director and when possible, from a Child Abuse Pediatrician);
7. Provided a personal statement that details reasons for pursuing a career in Child Abuse Pediatrics and future professional goals;
8. At the time of commencement of the fellowship, fulfilled all criteria to obtain a permanent Texas Medical License; and,
9. United States Citizenship or permanent visa.

All resident applicants must be screened against Office of the Inspector General (OIG) and General Services Administration (GSA) lists; individuals listed by a federal agency as excluded, suspended, or otherwise ineligible for participation in federal programs (Institutional Compliance Agreement p.6 of 18) are ineligible for residency or fellowship at UTHSCSA.

Non-citizens must have permanent resident status or a J-1 visa for medical residency positions at the UTHSCSA.

Selection:

It is the policy of the UTHSCSA and its affiliated hospitals to sustain resident selection processes that are free from impermissible discrimination. In compliance with all federal and state laws and regulations, the University of Texas System Policy, and Institutional Policy, no person shall be subject to discrimination in the process of resident selection on the basis of gender, race, age, religion, color, national origin, disability, sexual orientation, or veteran status.

The Program Director and Faculty will choose the best candidate from a pool of applicants. The best candidate is the one most able to meet the goals and objectives of the fellowship and the demands of the specialty. These judgments are based on the applicant's academic performance, the assessment of their faculty as reflected in letters of recommendation, and personal qualities evaluated during the interview process conducted by faculty and resident representatives, including motivation, integrity, and communication skills.

In addition to the guidelines above, the TSBME mandates a postgraduate resident permit for all residents entering Texas programs. These rules essentially make it necessary for the resident to demonstrate that he/she will be eligible for permanent licensure in Texas. Residents are expected to be familiar with the regulations at <http://www.tsbme.state.tx.us/rules/171.htm>.

5) Transfer Policy

The Child Abuse Pediatrics Fellowship program at UTHSCSA does not accept child abuse fellows transferring from other programs. Any candidate interested in applying for the Child Abuse Fellowship must apply as a PGY-4 and meet the qualifications as outlined above.

6) Resident Evaluation Policy

Resident evaluation policies are consistent with the UTHSCSA GME "Policy on Resident Evaluation." Residents will be evaluated in writing at the end of each clinical rotation. Standard resident evaluation forms will be distributed to the faculty attending supervising the rotation via the New Innovations electronic evaluation system.

Each resident is to keep a log of medical and other procedures.

The Program Director will elicit periodic feedback from the research mentor for each fellow. This will occur at least twice a year.

The Program Director will meet with each resident twice yearly to review

1. Evaluations from rotations
2. Progress in research
3. Progress in acquisition of procedural skills
4. Progress in acquisition of teaching and leadership skills
5. Results of the ABP Sub-specialty In-Training examination.

These evaluations will be performed at least twice a year, consistent with the applicable specialty-specific program requirements of the ACGME. A written report of each such evaluation will be placed in the resident's departmental file. Residents will be notified promptly in writing if an evaluation may result in an adverse action such as probation, non-advancement, or termination. Residents should be given the opportunity to indicate in writing when they have disagreements with the written evaluation.

These standards of evaluation will be applied equitably to all residents, be consistent with all relevant institutional policies, assure due process, and wherever possible, be published and available to members of the resident staff.

Evaluations of residents are to be used in making decisions about promotion, program completion, remediation, and any disciplinary action. The procedures for each of these actions are specified elsewhere.

As per ACGME requirements, a final exit evaluation will be kept on file.

Evaluations of Faculty, Educational Experience and Overall Program

On a yearly basis, the entire Division will meet to review the Program and evaluate progress in meeting the goals and objectives as specified in the Office of GME Policy Manual and in the Program Requirements of the ACGME. The evaluations elicited above will be reviewed and the residents' participation in this meeting will be encouraged. A report will be generated evaluating the Program's effectiveness with an action plan to address all deficiencies identified by consensus of the group. On a yearly basis, the program will distribute evaluation forms for the residents to provide written evaluations of each core faculty member, the quality of the various rotations, the didactic conferences, and the overall program. For faculty evaluations, to ensure confidentiality, the evaluation forms will be confidentially delivered to the Assistant Dean of GME (Dr. Nolan). The Assistant Dean of GME will review the evaluations, summarize the feedback in writing, and provide that written feedback to the faculty. At the Annual Review of Program Effectiveness (ARPE), which shall be conducted annually, all faculty and residents will be provided evaluation forms to provide feedback on the performance of the program. At the ARPE, the entire Division will meet to review the Program and evaluate progress in meeting the goals and objectives as specified in the Office of GME Policy Manual and in the Program Requirements of the ACGME. The evaluations elicited above will be reviewed and the residents' participation in this meeting will be encouraged. A report will be generated evaluating the Program's effectiveness with an action plan to address all deficiencies identified by consensus of the group.

7) Resident Promotion and Discipline Policy

The Program accepts the responsibility to train physicians who will be

- Clinically competent with adequate mastery of the medical literature of child abuse pediatrics
- Competent leaders of the child abuse evaluation and multidisciplinary teams
- Competent in the academic aspects of medicine, including basic research skills and basic teaching skills.
- Good citizens and who will practice medicine with appropriate professionalism and high ethical conduct.

Every sixth months the resident will meet with the Program Director to assess progress. If the resident's progress is deficient, the Program Director may require remediation, additional experience in difficult areas, or further academic training in order to maximize the likelihood of completion of the above goals.

The program will not graduate residents or recommend they be allowed to sit for the Certifying Examination of the American Board of Pediatrics, Sub Board for Child Abuse Pediatrics, unless they have attained the basic skills listed above. The program should allow reasonable opportunities to remediate and obtain further training before a final determination is made not to graduate the resident. Exceptions to this are discussed in the policy, "Resident Grievance and Appeal Procedure Pertaining to Dismissal or Nonrenewable."

8) Resident Grievance and Appeal Procedure Pertaining to Dismissal or Nonrenewal Policy

The Graduate Medical Education Committee, excluding the University Health System representative, serves as the appeals body for all residents in programs sponsored by UTHSCSA, independent of their funding source, for dismissal or nonrenewal. Such dismissal or nonrenewal could occur because of failure of the resident to comply with his/her responsibilities or failure to demonstrate appropriate medical knowledge or skill as determined by the program's supervising faculty. This appeals mechanism is open to a resident dismissed during the academic year or a resident whose contract for the following academic year is not renewed in a categorical program in which there has been no explicit information provided to the resident that advancement was on a pyramidal system.

It is the responsibility of the Child Abuse Pediatrics faculty to document a warning period prior to dismissal or failure to reappoint a fellow and to demonstrate efforts for the provision of opportunities for remediation. As a rule, a resident is not dismissed without a probationary period except in instances of flagrant misconduct (see next paragraph). Opportunities must be provided and documented for the resident to discuss with the department's or division's program director or chair the basis for probation, the expectations of the probationary period, and the evaluation of the resident's performance during the probation. Discussions with the resident will be documented, copies provided to the resident, and the original documents placed in the resident's training file.

According to the *UTHSCSA Handbook of Operating Procedures 5.13.3 B 2*, several specific examples of misconduct for which an individual may be subject to dismissal include (but are not limited to) the following: being under the influence of intoxicants or drugs; disorderly conduct, harassment of other employees (including sexual harassment), or the use of abusive language on the premises; or fighting, encouraging a fight, or threatening, attempting, or causing injury to another person on the premises. The full text is available at www.uthscsa.edu/hop/hop5%2D13.pdf.

In the event that a resident is to be dismissed or his/her contract not renewed, he/she may initiate a formal grievance procedure. The resident shall present the grievance in writing to the Associate Dean for Graduate Medical Education within 30 working days after the date of notification of termination or nonrenewal. The grievance shall state the facts upon which the grievance is based and the requested remedy sought. The Associate Dean for Graduate Medical Education shall respond to the grievance with a written answer no later than ten calendar days after he/she receives it.

If the resident is not satisfied with the response, he/she may then submit, within 10 days of receipt of the Associate Dean for Graduate Medical Education's response, a written request for a hearing. The hearing procedure will be coordinated by the Associate Dean for Graduate Medical Education, who will not be a voting participant. The hearing will be scheduled within thirty (30) days of the resident's request for a hearing. The hearing should be held before at least three members of the Graduate Medical Education Committee. The Associate Dean will determine the time and site of the hearing in consultation with the resident and the program leadership. The resident shall have a right to self-obtained legal counsel at his/her own expense; however, retained counsel may not actively participate, speak before the hearing participants, or perform cross-examination. The Associate Dean will preside at the hearing. The format of the hearing will include a presentation by a departmental representative; an opportunity for a presentation of equal length by the house officer; and an opportunity for a response by the representative, followed by a response of equal length by the house officer. This will be followed by a period of questioning by the Graduate Medical Education Committee members present. The Associate Dean in consultation with the departmental representatives and the resident will determine the duration of the presentations and the potential attendees at the hearing.

The resident will have a right to request documents for presentation at the hearing and the participation of witnesses. The Associate Dean at his/her discretion following consultation with the hearing panel will invite the latter.

The final decision will be made by a majority vote of the Graduate Medical Education Committee participants and will represent the final appeal within the Health Science Center and its affiliated hospitals.

9) Duty Hours and Work Environment Policy

The Child Abuse Fellowship Training Program recognizes that a sound academic and clinical education should be carefully planned and balanced with concerns for patient safety and resident well-being. Learning objectives of the program will not be compromised by excessive reliance on residents to fulfill service obligations.

Professionalism, Personal Responsibility, and Patient Safety

The Child Abuse Fellowship Training Program educates residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients (CPR VI.A.1.) and promotes patient safety and resident well-being in a supportive educational environment. (VI.A.2.)

The program director will ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty will demonstrate an understanding and acceptance of their personal role in:

- assurance of the safety and welfare of patients entrusted to their care;
- assurance of their fitness for duty;
- management of their time before, during, and after clinical assignments;
- recognition of impairment, including illness and fatigue, in themselves and in their peers;
- honest and accurate reporting of duty hours. (VI.A.5.)

Our physicians recognize that, under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (VI.A.6.)

Duty Hours Requirements

The Child Abuse Fellowship Training Program (under the leadership of the Program Director) oversees residents' duty hours and working environment. During all clinical rotations within the training program including rotations within other departments (such as Critical Care, Child Psychiatry, Behavior & Development, Forensic Pathology, and Emergency Medicine), trainees and staff conform to existing ACGME, RC, and institutional duty hours policies. Duty hours include activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, provision for transfer of patient care, call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

All Child Abuse Fellows must log their duty hours in New Innovations daily.

The program's policies and procedures, including this policy, are distributed to residents and faculty annually and after each policy change via electronic distribution of the policy in the fellowship handbook, via initial discussion of the policy with the program director during fellowship orientation, and via recurrent visitation of the topic during semi-annual and annual evaluations with the program director.

In the process of implementing these requirements for the Child Abuse Fellowship Training Program, the following guidelines will be used:

- Patient care is always the ultimate responsibility of the assigned Division faculty member, and a faculty member will always be assigned to assist and supervise the Child Abuse Fellow.
- Fellows will take at home call only with rare needs to go into the hospital after hours in the evening or on the weekend, except during the Trauma Emergency Department rotation.

Specific Duty Hours Limitations

Maximum Hours of Work per Week (VI.G.1)

Residents will not exceed 80 hours of duty per week, averaged over a 4-week period inclusive of all in-house call activities and moonlighting.

Moonlighting (VI.G.2)

Moonlighting will not interfere with the ability of the resident to achieve the goals and objectives of the training program.

Time spent by residents in any moonlighting activity is counted toward the 80 hour maximum weekly hour limit.

Mandatory Time Free of Duty (VI.G.3.)

Residents will be scheduled for a minimum of one 24-hour period per week free of duty (averaged over 4 weeks). At-home call is not assigned on these free days.

Maximum Duty Period Length (VI.G.4.)

Duty periods of PGY 4 level or beyond residents will not exceed 24 hours in duration, with limited and unusual exceptions as outlined below.

In unusual circumstances, PGY 4 level or beyond residents, on their own initiative, may remain beyond their scheduled period of duty (which is a routine 8 to 10 hour work day) or return to work to continue to provide care to a patient(s). Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under those circumstances, the resident will:

- appropriately hand over the care of all other patients to the attending responsible for their continuing care; and,
- document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director in New Innovations.

The program director will review each submission of additional service, and track both individual resident and program-wide episodes of additional duty in New Innovations.

Minimum Time Off Between Scheduled Duty Periods (VI.G.5.)

Residents in the final years of education (defined as PGY-4 level and beyond) must be prepared to enter the unsupervised practice of medicine and must be prepared to care for patients over irregular or extended periods.

This preparation will occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have 8 hours free of duty between scheduled duty periods, there may be circumstances (reasons of required

continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family) when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education are monitored by the program director in New Innovations.

At-Home Call (VI.G.8)

Time spent in the hospital by residents on at-home call is counted toward the 80-hour maximum weekly duty hour limit. At-home call will not be assigned on a resident's one-day-in-seven free from duty.

At-home call is assigned so as not to be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care is counted toward the 80-hour weekly maximum in New Innovations.

Duty Hours Policy Compliance Monitoring

Duty hours must be logged contemporaneously in New Innovations, per institutional policy.

The program director and faculty monitor compliance with this policy by monitoring call and duty schedules, direct observation of residents, interviews/discussions with residents, review of residents' evaluation of rotations, and by monitoring duty hours logs in New Innovations. Residents are instructed to notify the Program Director or the GME Assistant Dean (Dr. Nolan) if they or other residents are requested or pressured to work in excess of duty hour limitations.

The Program Director is electronically alerted by the New Innovations system of any duty hours violation. For all violations, the Program Director establishes the presence or absence of a justification in the New Innovations system and by discussion with the resident. All faculty members in the division maintain an open-door policy so that any resident with a concern can seek immediate redress with the faculty member he/she feels most comfortable confiding in. If problems are suspected, the division faculty member or Program Director will notify the Designated Institutional Official and gather direct duty hour data to clarify and to resolve the problem. In addition, the GMEC's Duty Hours Subcommittee will confirm program compliance during its biannual duty hours surveys of all programs. The residents are also provided with the UTHSCSA hotline in the event that they need to report duty hour violations confidentially.

10) **Contingency Plan Policy**

Contingency Plan and Recognition of Fatigue and Countermeasures

Faculty and residents are educated to recognize the signs of fatigue and sleep deprivation.

Residents are provided with didactic instruction and small group discussion of fatigue and sleep deprivation during their first year of fellowship (during orientation). Faculty and residents are required to complete computer-based learning modules (created by the GME office) annually. And, finally, residents are routinely informally educated by faculty on the negative effects of fatigue and sleep deprivation during one-on-one interactions in the course of clinical care.

To prevent and counteract the potential negative effects of fatigue, the following measures have been implemented:

- 1) As detailed above, faculty and the residents are provided didactic and computer-based instruction on self and colleague-monitoring of fatigue and sleep deprivation;
- 2) Faculty will actively monitor the residents for signs of fatigue and/or sleep deprivation;
- 3) Residents are advised that if they are called into the hospital after hours, and they may be fatigued and/or sleep deprived, they can avail themselves of the following options:
 - a. Utilize the in-hospital call rooms for sleep/rest;
 - b. Contact the back-up attending-on-call for a ride home; or
 - c. Take a taxi home and receive reimbursement from the program for that expense.
- 4) The program director will ensure a contingency plan/backup system is in place for occasions where resident fatigue or sleep deprivation is suspected.

The program director has set up a contingency plan or backup system that enables patient care to continue during periods of heavy use, unexpected resident shortages, or other unexpected circumstances. The program director and supervising faculty are engaged in actively monitoring residents for the effects of sleep loss and fatigue, and take appropriate action in instances where overwork or fatigue may be detrimental to residents' performance and the well-being of the residents or the patients or both.

In particular regards to the Child Abuse Pediatrics fellowship, the faculty are always immediately available. When the resident is fatigued or sleep deprived, or when the resident needs to leave because of the work hours limitations, the attending physician will take over the responsibilities of the resident. On days post call for the resident, the schedule will be adjusted in the event of evening requirements to be at the hospital. It is the responsibility of the on service faculty physician to monitor the particular resident's compliance with the work hours limitations, and the program director will be responsible for monitoring the compliance of the faculty and the residents with the requirements of this policy.

12) Resident Supervision Policy

Introduction

Careful supervision and observation are required to determine a fellow's abilities to manage patients. Subspecialty fellows are licensed practitioners, but are supervised in the management of child abuse consultations until the subspecialty training is completed.

Purpose

This policy will establish the minimal requirements for resident supervision in teaching hospitals of The University of Texas Health Science Center at San Antonio (UTHSCSA). A UTHSCSA teaching hospital may have additional requirements for resident supervision as they pertain to that specific hospital. Individual training programs may also have more requirements for their attendings and trainees.

Definitions

The following definitions are used throughout the document:

Resident/Fellow – a professional post-graduate trainee in a specific specialty or subspecialty

Licensed Independent Practitioner (LIP) – a licensed physician, dentist, podiatrist, or optometrist who is qualified usually by board certification or eligibility to practice his/her specialty or subspecialty independently

Credentialed Staff Provider or Medical Staff – a LIP who has been credentialed to provide care in his/her specialty or subspecialty by a hospital

Staff Attending – the immediate supervisor of a resident who is credentialed in his/her hospital for specific procedures in their specialty

Levels of Supervision:

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 within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

Indirect 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.

Oversight—the care given by the fellow is reviewed by the staff, usually by chart review, after the patient interaction is complete.

Supervision of Trainees Performing Procedures:

- A. Subspecialty Residents are supervised by credentialed providers (“staff attendings”) who are licensed independent practitioners on the medical staff of the UTHSCSA teaching hospital in which they are attending. The staff attendings are credentialed in that hospital for the specialty care and diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising staff attending is ultimately responsible for the care of the patient.
- B. The Program Director will ensure that this supervision policy is distributed to, and followed by, fellows and the faculty supervising the fellows. Compliance with this supervision policy will be monitored by the Program Director.
- C. A fellow will be considered qualified to perform a procedure with indirect supervision available only if, in the judgment of the supervising staff and his/her specific training program guidelines, the fellow is competent to perform the procedure safely and effectively. The Division of Child Abuse requires that fellow colposcopies be documented and tracked with a procedure log maintained in the division clinic. The use of the rape kit will be documented by the fellow on a log and submitted to the program director at the conclusion of each Forensic Nurse Examiner rotation. (PGY4 & 5). In general, a fellow must be observed participating/performing at least 5 rape kits and 50 colposcopies successfully and proficiently before they can be approved to perform a given procedure independently or supervise another resident/fellow performing that procedure. For instance, a colposcopy that was difficult for the operator but ultimately successful may have been successful but without proficiency. When in the opinion of the supervising staff the fellow is capable of performing future procedures independently, the supervisor will communicate this proficiency in writing to the Program Director. The PD may then assign approvals for less-than-direct supervision for the performance of those particular procedures (colposcopy, and use of Rape Kits). At the semi-annual fellow evaluations, the Program Director will determine if fellows can progress to the next higher level of training. The requirements for progression to the next higher level of training will be determined by standards set by the Program Director (see promotion policy). This assessment will be documented in the semi-annual evaluation of the fellows.

Validation of Independent Procedure performance by Ancillary Personnel:

The Joint Commission (TJC) requires that nurses and other ancillary personnel can confirm at any time that a resident:

1. is approved to perform a procedure with indirect supervision only
2. is approved to supervise another resident in the performance of a procedure

The nursing staffs at University Hospital and Children's Hospital of San Antonio will be provided with a link (to New Innovations) that allows them to review and confirm the approvals for procedural performance with indirect supervision only. When in the opinion of a nurse or ancillary personnel, the fellow is not capable of performing such procedures independently, the nurse/ancillary personnel must discuss this assessment with a supervising staff, and the supervising staff must communicate this proficiency in writing to the Program Director. At no time should a fellow perform a procedure independently or supervise a procedure unless he/she has been approved to do so by the Program Director.

Supervision of Trainees on Inpatient Consult Teams

All inpatient consultations performed by trainees will be documented in writing, with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally by the fellow doing the consult within an appropriate period of time, generally defined as no later than the same day of consultation if done before close of business, or immediately if emergent.

PGY-4- Inpatient Consultant

PGY-4 residents (1st year fellows) always consult on inpatients under the supervision of an experienced PGY-6 resident (3rd year fellow) or a credentialed staff provider. Initially, during the first three to six months of the PGY-4 resident year, PGY-4 residents will conduct inpatient consultations under the direct supervision of an experienced PGY-6 resident or a credentialed staff provider. When, in accordance with the promotion policy, the PGY-4 resident has demonstrated sufficient proficiency in conducting consultations such that increased authority, responsibility and independence should be afforded to the resident, all supervising staff faculty will discuss the clinical progression of the resident and will notify the Program Director of such. The Program Director will then make a written notation of such in the resident's portfolio and notify the PGY-4 resident that he/she may conduct inpatient consultations with indirect supervision (**with Direct Supervision immediately available**). In the course of consults, the PGY-4 resident must discuss all recommendations with the staff attending before the consulting physician is spoken with and an attending note must be included on the patient's chart within 24 hours of the request.

The PGY-4 resident on inpatient consultations is expected to function as the primary consultant. This responsibility necessitates a comprehensive knowledge of the status, lab data, and plan for each of those patients at all times. The PGY-4 resident will have a central role in the formulation, implementation and documentation of health care as well as communication of information to patients/families, supervisors and to other involved providers and multi-disciplinary personnel. These responsibilities include:

1. Complete all assigned patient evaluations, to include written documentation, in an appropriate format on the day of consultation.
2. Discuss patient care issues with the consulting physician/team and the supervising staff on the day of consultation.

3. Document the patient on the division patient tracker and be prepared to discuss the patient on weekly scheduled clinical rounds.
4. Immediately notify supervisor(s) of any significant change in patient status (including following up on requested labs and/or imaging) and document such changes in the patient record (when appropriate).
5. Maintain appropriate communication and rapport with multidisciplinary members (CPS, law enforcement, etc) regarding the patient.
6. Teach and supervise medical students/residents assigned to the inpatient service.

PGY-5 or PGY-6 Inpatient Consultant

The PGY-5 resident inpatient consultant will not only be expected to complete all the responsibilities of the PGY-4 resident inpatient consultant (listed above), but will also be expected to conduct a more comprehensive assessment of all consults, commensurate with the abilities of an advancing and more experienced resident. The PGY-5 resident inpatient consultant will conduct all assessments under indirect supervision with direct supervision immediately available. When, in accordance with the promotion policy, the PGY-5 resident has demonstrated sufficient proficiency in conducting consultations such that increased authority, responsibility and independence should be afforded to the resident, all supervising staff faculty will discuss the clinical progression of the resident and notify the Program Director of such. The Program Director will then make a written notation of such in the resident's portfolio and notify the PGY-5 resident that he/she may conduct inpatient consultations with indirect supervision (**with Direct Supervision available**). In the course of consults, the PGY-5 resident must still discuss all recommendations with the staff attending before the consulting physician is spoken with and an attending note must be included on the patient chart within 24 hours of the request.

The PGY-6 resident inpatient consultant is expected to achieve the proficiency of an independent practitioner. Thus, the PGY-6 resident inpatient consultant will not only be expected to complete all the responsibilities of the PGY-4 & 5 resident inpatient consultant (listed above), but will also be expected to eventually function as a staff attending. The PGY-6 resident inpatient consultant will conduct all assessments under indirect supervision with direct supervision available. When, in accordance with the promotion policy, the PGY-6 resident has demonstrated sufficient proficiency in conducting consultations such that increased authority, responsibility and independence should be afforded to the resident, all supervising staff faculty will discuss the clinical progression of the resident and notify the Program Director of such. The Program Director will then make a written notation of such in the resident's portfolio and notify the PGY-6 resident that he/she may conduct inpatient consultations independently. Since a staff attending is ultimately still responsible for the patient, the PGY-6 independent resident must discuss the patient with a staff attending within 24 hours of the patient consultation so that the staff attending may countersign the PGY-6 resident's note (**oversight supervision**). As a function of assuming the duties of an independent practitioner/staff attending, the PGY-6 resident will be expected to supervise the activities of a junior PGY-4 resident consultant. Consequently, the PGY-6 independent resident will be expected to provide the junior PGY-4 resident with appropriate knowledge, guide critical thinking and decision-making, assure that junior resident is accomplishing his/her tasks appropriately and in a timely manner, and review all orders and chart entries of the PGY-4 resident for completeness and accuracy.

Attending Physicians – Inpatient Services

1. The attending physician is ultimately responsible for all patient care by residents and medical students on his/her team. He/she will be actively involved in all aspects of patient care and needs to be kept informed of all significant patient care issues (status changes, complaints, etc.)
2. The attending physician will be readily available for supervision of consultations on the ward.
3. In accordance with the promotion policy, the attending physician will examine, in a timely fashion (no later than 24 hours of the time of consult), all patients consulted on by PGY-4, PGY-5, and non-independent PGY-6 residents.
6. The attending physician will assure that the parents/patient are adequately informed of pertinent aspects of the consult, and be available to answer any questions the parents/patient may have.
7. The attending physician will write a consult note, in the service appropriate format, on each patient consulted on by PGY-4, PGY-5, and non-independent PGY-6 residents within 24 hours of the consultation. The attending physician will countersign the consultation note of all independent PGY-6 residents within 24 hours of the consultation. All written documentation must comply with applicable compliance requirements. All written documentation must be dated, timed, and legibly signed.
8. Although PGY-4, PGY-5, and non-independent PGY-6 residents are the primary consultants on consultations, the attending physician is ultimately responsible for ensuring that the consulting physician is kept informed of the pertinent aspects of the consultation impression and recommendations.
9. The attending physician will complete, in a timely manner, an electronic evaluation through the *New Innovations* system on the resident performing inpatient consultations.

Supervision of Trainees in Outpatient Clinics

As with inpatient consultations, all outpatient visits provided by fellows (PGY-4, PGY-5, and PGY-6 residents) will be conducted under the supervision of a staff provider. For the first three to six months of the PGY-4 resident's training, every clinic patient must be directly supervised by the staff attending. Thereafter, when the PGY-4 resident has demonstrated sufficient proficiency in conducting outpatient clinic visits such that increased authority, responsibility and independence should be afforded to the resident, all supervising staff faculty will discuss the clinical progression of the resident and will notify the Program Director of such. The Program Director will then make a written notation of such in the resident's portfolio and notify the PGY-4 resident that he/she may conduct outpatient clinic visits with indirect supervision (with Direct Supervision immediately available).

The PGY-5 resident will perform all outpatient clinic visits with indirect supervision (with direct supervision immediately available). The goal of the PGY-5 resident's training year is to attain such clinical skill and proficiency such that the PGY-5 resident progresses from indirect supervision (with direct supervision immediately available) to indirect supervision (with direct supervision available); this will generally occur between 3 and 6 months into the PGY-5 year. This increased authority, responsibility, and independence will only be afforded to the resident once all supervising staff faculty discuss the clinical progression of the resident and then notify the Program Director of such.

The PGY-6 resident will perform all outpatient clinic visits with indirect supervision (with direct supervision available). The goal of the PGY-6 resident's training year is to attain such clinical skill and proficiency such that the resident is able to act like an independent practitioner/staff attending.

The increased authority, responsibility, and independence of an independent practitioner will only be afforded to the resident once all supervising staff faculty have discussed the clinical progression of the resident and are comfortable with his/her ability to do so. This will then be communicated to the Program Director, who will make a written notation of such in the resident's portfolio, and then notify the resident of his/her ability to act independently. As with inpatient consultations, although the PGY-6 resident will be functioning independently, a staff attending is still ultimately responsible for the patient. Thus, the PGY-6 resident must, within 24 hours, still discuss outpatients seen with a staff attending so that the staff attending may countersign the resident's clinic notes. (**oversight supervision**)The clinic staff attending may also interview and examine the patient at the staff's discretion, at the fellow's request, or at the patient's request.

PGY-4,5,& 6 Residents in Outpatient Clinics

1. As with inpatient consultations, residents will be the primary providers for direct patient care in the outpatient setting. The resident will evaluate and treat outpatients with proper consultation and supervision by staff preceptors in accordance with his/her level of experience, level of skill, and judgment of the staff. The staff supervisor will interview and examine the patient consistent with the applicable compliance requirements.
2. The resident will document all patient encounters in the required format and include a legible, concise chart entry for each patient seen. Residents will assure medical charts contain completed growth charts and problem sheets and meet TJC standards, consistent with the policies of the Pediatric Department and the Child Abuse Division.
3. PGY-4, PGY-5, and non-independent PGY-6 residents will present each patient encounter to a staff preceptor. The clinic staff attending will retain ultimate responsibility for all patient care in outpatient settings.
4. Maintain appropriate communication and rapport with primary care physicians and multidisciplinary members (CPS, law enforcement, etc) regarding the patient.
5. Teach and supervise medical students/residents assigned to the outpatient clinic.
6. Document the patient on the division patient tracker and be prepared to discuss the patient on weekly scheduled clinical rounds.

Staff Attendings in Outpatient Settings

1. The attending physician is ultimately responsible for all patient care by residents that he/she is precepting. He/she will be actively involved in all aspects of patient care and needs to be kept informed of all significant patient care issues.
2. The attending physician will be readily available for supervision in the clinic.
3. The attending physician should be constantly aware of the experience and skill level of the residents under his/her supervision. He/she should regularly review the care given by the resident for to evaluate the 6 core competencies. In accordance with the promotion policy, the attending physician will allow for a level of supervision commensurate with the resident's level of skill and experience.
4. The attending physician will be responsible for providing appropriate feedback to the resident on his/her performance.
4. The attending physician will be expected to review each patient encounter with the PGY-4, PGY-5, and non-independent PGY-6 resident before the patient leaves the clinic area.
5. The attending physician will contribute to the writing of an evaluation on the *New Innovations* web-based system for each resident at the end of his/her rotation.

Supervision of Trainees in Serious Bodily Injury/Child Death Cases

Since the overall consequences in serious bodily injury and child death cases are greater, the supervision of resident interaction in such consultations will at all times be at least indirect supervision (with direct supervision immediately available). In such cases, the PGY-4, PGY-5, and non-independent PGY-6 resident shall not communicate with the consulting physician/team or other multi-disciplinary partners without having first discussed the case with a staff attending. Again, in such cases, documentation is of paramount importance, and the resident shall pay particular attention to his/her documentation. In cases of serious bodily injury, the PGY-6 resident may attain sufficient clinical skill and proficiency such that he/she may conduct those evaluations either with indirect supervision (with direct supervision available) or independently. However, all consultations where child death has occurred or is imminent will be immediately reviewed with a staff attending and shall not be conducted independently by a resident.

Proposed to GMEC Supervision Policy Subcommittee, November 2012

13) Transition of Care Policy

In general, care of child abuse patients is not a longitudinal experience. Much like other pediatric subspecialties (such as infectious disease), patient interaction is on a limited basis, either through inpatient or outpatient consults, or case reviews. After the limited patient interaction, longitudinal patient care is returned to the primary care physician. The resident bears primary responsibility for ensuring that transition of care (back to the primary care physician) flows smoothly, properly and thoroughly. Although the resident bears primary responsibility for that transition of care back to the primary care physician, ultimately, the staff attending bears final responsibility for ensuring proper transition of care from the consultant to the primary care physician has occurred.

In the course of limited patient care interactions as a consultant, there may be occasion where transition of care must occur from one consulting child abuse provider to another. In those uncommon circumstances, proper and thorough communication of patient information is the primary responsibility of the resident. However, ultimate responsibility for ensuring proper transition of care of the patient lies with the staff attending, and should also occur at an attending to attending level.

In order to facilitate proper and thorough communication of patient information amongst team members, all patients will be tracked on an excel spreadsheet, labeled "patient tracker", on the CHRISTUS Children's Hospital of San Antonio share drive ("S drive"), within the CFM folder, under the subfolder labeled "patient tracker". Maintaining such information on the CHRISTUS Children's Hospital of San Antonio share drive not only ensures medical providers have access to this patient information, but also other multidisciplinary personnel (such as social workers) as well. This is a secure server, ensuring patient privacy and compliance with HIPAA. The first year CAP fellow will assume primary responsibility for maintaining the patient tracker.

The residents will be primarily responsible for ensuring patient information is entered onto that excel spreadsheet. On a weekly basis, the most recent patients consulted on during the week will be discussed by the team at weekly clinical rounds, and the patient tracker will be reviewed and updated by the residents.

