Community Pediatric Residency Program Handbook

Policies, Procedures, and Program Requirements for Residents and Participating Faculty

2024 – 2025

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The Morehouse School of Medicine Community Pediatric Residency Program is committed to training excellent clinical pediatricians with an expertise in community-based health delivery and advocacy that is aimed at promoting lifelong health habits that decrease health disparities in poor, rural, racial, and economically disadvantaged populations.

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Community Pediatric Residency Program

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Contents

Introduction 1
- **Program Overview** 1
  - **Pediatric Evaluation Committee (PEC)** 4
  - **Clinical Competency Committee (CCC)** 5

Program Goals 5
- **Program Aims, Goals and Objectives** 5

New Resident Orientation 19
- **Duties and Responsibilities** 19
  - **How to Learn in a Residency** 20
  - **Problems or Difficulties—What to Do?** 21
  - **Harassment Policy** 22
- **Resident Leave Policy - Vacation, Holiday, Sick Leave, Call, and Availability** 23

Resident Evaluation, Progression, and Promotion 27

General Information 32
- **Nepotism Policy** 32
- **Dress Code** 33
- **Community Service** 34
- **Board Review Materials/Self Learning Materials** 34
- **Conference Policy** 35

Scheduled Rotations 22
- **Inpatient/ICU** 23
- **Outpatient/ED/Individualized Curriculum Options** 23
- **Longitudinal Ambulatory Experience (LAE)** 24

Educational Conference Requirements 24
- **Didactics** 24
- **Course Objectives** 25
- **Course Requirements** 26
- **Collaborative IRB Training Initiative (CITI)** 26
- **Patient Safety/Quality Improvement** 27

Study Program 28
- **Academic Preparation** 28
  - **Longitudinal Study Plan** 28
  - **In-Training Service Exams** 28
  - **Individual Learning Plan** 28

Time Management and Administrative Responsibilities 30
Clinical and Educational Work Hour Documentation 30
Clinical Experience and Education 31
Maximum Work Clinical Work and Education Period Length 31
Clinical Experience and Education Work Hours Policy 32
Fatigue Mitigation Policy 33
Patient Logs 33
Procedure Logs 33
Competencies, Record-keeping, and Evaluations 36
The Clinical Competency Committee (CCC) 36
Resident Evaluation and Promotion 37
Faculty and Program Evaluation 38
American Board of Pediatrics Evaluation Requirements 39
Support Services 41
Counseling Services 41
Infection Control, Occupational Safety and Health Administration (OSHA) Policies 41
Library Multi-Media Center 42
Concern and Complaint Policy 42
ACGME Professionalism Policy 43
ACGME Resident Wellbeing Policy 44
Appendix A: Policies 46
Backup Policy 48
Supervision of Pediatric Residents Policy 50
Transitions of Care Policy 56
Hand-Off Policy Checklist for Residents 58
Social Media Policy 59
Resident Job Description 62
Concern and Complaint (Grievance) Policy for Residents and Fellows 65
Resident & Fellow Eligibility, Selection, and Appointment Policy 70
Evaluation of Residents, Faculty, and Programs Policy 81
ACGME Board Pass Rate Requirements 85
Educational Program Requirements Policy 87
Mobile Device Security Policy 89
Resident Disaster Policy 90
Resident Closure Policy 92

Introduction

Welcome to the Community Pediatric Residency Program at Morehouse School of Medicine (MSM).

We are excited to have you as a member of our residency team. Our residency environment will provide you with the clinical experience and learning environment that will help you become an excellent clinician. After you have graduated from our program, you will have the skills, knowledge, and the confidence to enter the practice of general pediatrics, or pediatric subspecialty fellowship, as a competent, board-eligible physician.

Residency is much different from any prior training you may have experienced. It requires dedication and an unwavering commitment to perfecting your craft. Along the way you will have faculty, advisors, and mentors to help you develop your skills to diagnose and treat children and young adults with a wide variety of disorders. The skills you learn here will become the foundation of your medical career.

It should be your goal to acquire as much clinical experience and knowledge as you can during your residency training. You should develop a concentrated study program to ensure the steady accumulation of knowledge required to care for your patients.

In the following pages you will find suggestions for accomplishing your goal of becoming a competent, board-certified pediatrician. In addition to general program information, this manual provides goals and objectives for your rotations as well as policies and procedures for the residency. The manual is updated with new information, schedules, and department rosters as they are made available. As always, we welcome your input, constructive feedback, and comments.

Program Overview

Mission

Our mission is to train pediatric residents to provide excellent and quality healthcare to all children, especially the underserved. The Community Pediatric Residency Program is designed to provide a comprehensive learning experience that prepares pediatricians to meet the demands of contemporary pediatric practice. Emphasis is placed on the development of primary care pediatricians who have acquired their knowledge, skills, and competencies predominantly through community-based learning experiences.

This is a novel approach because our residents gain a significant amount of experience in the community as opposed to traditional residency programs that may focus more on the hospital environment. The program allows residents the opportunity to explore the many facets of pediatric care in the 21st century.

The city of Atlanta is a multicultural city with a variety of people from different races and ethnicities. The program benefits from this diversity. Residents benefit from a variety of patient experiences, whether patients are from the inner city, suburbia, foreign countries, or rural areas.

Program Overview

Graduates of the MSM Community Pediatric Residency Program, while expected to become excellent clinicians, are equipped to adapt to the rapidly evolving dynamics of healthcare. They will also possess the ability to assume leadership positions in the communities in which they practice healthcare service delivery, child advocacy, and child health policy.

MSM Diversity Statement

- Recruit trainees from all ethnicities, races, genders, gender identities, abilities, ages, sexual orientations, nationalities, and socioeconomic backgrounds.
- Emphasize minority representation within the training programs by promoting the recruitment and retention of qualified residents and faculty.
- Develop leaders in providing culturally sensitive care to our patient population.

Residency Setting

Our program hospital partners include:

- Children's Healthcare of Atlanta (CHOA)
- Emory Decatur Hospital (EDH)
- Grady Memorial Hospital (GMH)

In addition, we have a host of private and public-sector partners for our outpatient rotations.

Administrative Structure

The following sections describe the roles and responsibilities of the members of our administration.

Program Director

The program director provides the overall leadership, development, and implementation of the residency program. The program director ensures that the program is compliant with all requirements of the Accreditation Council for Graduate Medical Education (ACGME) for a pediatric residency training program. The program director is responsible for residents' progression and graduation from the program, ensuring that the residents meet or exceed all requirements as set forth by the program, MSM GME, ACGME and the American Board of Pediatrics (ABP).

Other responsibilities include:

- Overseeing all aspects of the residency program and resident education.
- Creating and maintaining the affiliation agreements and alliances with the necessary educational and clinical entities, hospitals, clinics, and individual physicians to provide the highest quality training opportunities in the field of pediatrics.
- Updating and modifying educational goals and curricula.
- Ensuring that faculty meet the requirements to teach in the program.
- Overseeing all learning environments.
- Directly supervising the program manager, program assistant, the core pediatrics faculty, and staff involved with the residency program implementation.

- Working closely with the department's chairperson and other officials at MSM to ensure that the program reflects the mission of the institution as well as that of the department.
- Overseeing the resident selection and promotion process.

Associate Program Director

The associate program director assists the program director in developing and implementing the program while completing specific assigned tasks. These tasks include developing and modifying the pediatrics residency curriculum, conducting semi-annual evaluations with residents, overseeing the program operations, and assisting with didactic teaching and conference schedules. In the absence of the program director, the associate program director represents the program at official meetings within the institution and externally, as needed.

Chief Resident

The chief resident serves as a liaison and advocate for the residents to the program. The chief resident supports resident teaching activities such as grand rounds, morning report, and weekly didactics. The chief resident supervises the development and modification of resident schedules, including vacation requests and arranging back-up coverage for unplanned absences. The chief resident attends faculty meetings of the department and serves as the resident liaison. A new chief resident is either appointed for each academic year from the graduating class or recruited from an outside institution. Interested candidates are encouraged to contact the program director as early as possible for consideration.

Program Manager

The program manager manages the daily operational activities of the residency program and interacts with different personnel at various affiliated institutions as needed. The program manager ensures that the residents complete all required paperwork, including obtaining evaluations. The program manager also ensures that residents' master files, evaluations, immunization certificates, visa documents, U.S. Medical Licensing Examination (USMLE) scores, and procedure and patient logs are kept up to date. The program manager is responsible for completing and filing all required paperwork and communications from internal and external entities (e.g., MSM Graduate Medical Education [GME] office, American Board of Pediatrics, American Academy of Pediatrics). The program manager coordinates the resident recruitment activities in conjunction with the program director.

Program Assistant

The program assistant provides administrative assistance to all program personnel. The program assistant coordinates all activities of this program:

- Maintains all files and folders, correspondence, schedules, and meeting minutes and notes.
- Maintains and distributes on-call and conference schedules to residents, faculty, and affiliates.
- Schedules meetings as directed.

The program assistant monitors incoming evaluations for the program director's perusal and files them along with other documents related to resident portfolios. They also are responsible for maintaining updated files in Medhub.

Resident Advisors

All residents are assigned a faculty advisor upon entering the program as interns. The advisor's role is to be the resident's mentor in issues of professional training and career planning, as well as to assist in the resident's ongoing training and evaluation process.

The faculty advisor undertakes the following primary responsibilities:

- Meets with his or her advisee for the academic year at a minimum of twice per year, focusing on individual plans for self-assessment and monitoring individual progress.
- Provides the resident with advice to help him or her study for the pediatric boards and prepare for in-service exams and quizzes starting early in their PGY-1. The advisor should also follow-up on these plans over time.
- Discusses the resident's performance on the ITE exam. For those residents who fall below the national mean, the faculty advisor will discuss the need for a tailored study and self-improvement plan.
- Guides the resident to an appropriate mentor for his or her research project. The goal is for each resident to develop a research interest and become involved in an independent research study under the guidance of his or her mentor. The mentor also assists the resident in becoming part of an ongoing project by the end of his or her PGY-1.
- Reviews copies of all the advisee's evaluations from different rotations and gives additional commendation and constructive criticism. The residency program office sends a form to document meetings with the resident at the beginning of each academic year. After each meeting, the form must be completed and sent back to the residency program office for placement in the resident's permanent file. The form includes space for additional comments.
- Provides career guidance to the resident advisee. After exploring his or her interests and career plans, it may be necessary to direct the resident to other faculty members who may be helpful in the resident's field of interest.
- Ensures that the resident advisee is on track with requirements such as USMLE Step 3, state medical licensure, and certifying examination applications.

Pediatric Evaluation Committee (PEC)

The Pediatric Evaluation Committee (PEC) is the advisory group to the program administration. The PEC is comprised of core members of the Department of Pediatrics as appointed by the program director and resident members (usually class representatives and chief residents).

The PEC meets up to 10 times each year and actively participates in the following activities:

- Planning, developing, implementing, and evaluating all significant activities of the residency program.

- Developing competency-based curriculum goals and objectives.
- Reviewing the program annually using evaluations from faculty, residents, and others.
- Ensuring that areas of non-compliance with ACGME standards are corrected.
- Participating in resident selection.

Through the PEC, the program monitors and tracks residents' performance, faculty performance, graduate performance (including performance of graduates on the certification examination), and program quality.

Clinical Competency Committee (CCC)

Residents' progression and evaluation is monitored by the Clinical Competency Committee (CCC). The CCC's composition includes at least three (3) members who are appointed by the program director.

The CCC should:

- Review all resident evaluations semi-annually.
- Prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and,
- Advise the program director regarding resident progress, including promotion, remediation, and dismissal.

The outcome of the CCC as agreed to by the program director, shall be communicated to each resident and his or her faculty advisor.

Program Goals

Program Aims, Goals and Objectives

The MSM Community Pediatric Residency Program develops pediatricians who are proficient in the details of medical management as well as sensitive and responsive to the circumstances that often prevail in medically underserved and disadvantaged communities.

As its primary goals, the program seeks to:

- Prepare pediatricians committed to the highest level of clinical acumen, communication, ethical principles, cultural competency, and professionalism for all populations of children, adolescents, and young adults.
- Prepare pediatricians to practice medicine in the 21st century by integrating their clinical knowledge with evidence-based medicine, quality improvement cycles, and technology for optimal patient care.
- Recruit, train, and disseminate to the community, physician leaders who understand that overall health is not only influenced by access to care but by the environment, community, and individual choices.
- Train pediatricians as leaders of intra-professional healthcare teams, where all healthcare team members are valued.
- Produce pediatricians who are efficient and who have an expressed commitment to serving the primary healthcare needs of the medically underserved.

Program Overview

- Develop pediatricians who practice their profession with the highest regard for professionalism, ethics, cultural diversity, and sensitivity to the healthcare needs of the medically underserved.
- Provide educational experiences that prepare residents to be competent general pediatricians who can provide comprehensive and coordinated care to a broad range of pediatric patients.
- Provide educational experiences that emphasize the competencies and skills needed to practice high quality general pediatrics in the community.
- Familiarize residents with the fields of subspecialty pediatrics to enable them to participate as team members in the care of patients with chronic and complex disorders.
- Function with other members of the healthcare team in a wide variety of settings to be competent leaders in the organization and in the management of patient care.

Program Aims

The Community Pediatric Residency Program at the Morehouse School of Medicine exists to:

- To prepare pediatricians who are committed to the highest level of patient care for all populations of children, adolescents, and young adults.
- To produce board certified physician leaders who will realize a successful career serving the medically underserved children in the state of Georgia, the nation, and the world.
- To recruit and train physician leaders who appreciate the impact of the social determinants of health on the overall wellbeing of children.

New Resident Orientation

Introduction

The purpose of this handbook is to help you embark on an exciting career and matriculate successfully. It is not a cookbook nor is it a textbook. It will help familiarize you with learning requirements and ACGME requirements.

Duties and Responsibilities

The following sections outline the general responsibilities and expectations of all residents.

Professional Conduct

Residents must conduct themselves in a professional manner at all times. This applies to interactions with attending physicians, peers, supervisors, professional staff, administrative staff, support services, members of the healthcare teams, and finally, patients and families. Residents are expected to dress professionally according to the dress code outlined in this handbook.

Reliability

Residents must present to their assigned duty on time, including daily rotations, shifts and conferences. The resident must be available for the entire assignment unless he or she has received permission in advance to miss any part of a responsibility. No other activity supersedes this requirement unless permission for absence is obtained from the program director. Residents should always have their cell phones during work hours so that they can be contacted if necessary.

Conference, Grand Rounds, and Didactics Attendance

Residents are expected to attend all educational sessions. Attendance is taken at each session, and 90% attendance at conferences is mandatory for all sessions that are possible. Only through attendance will maximal educational benefit be realized. Didactics sessions will be virtual for the first 3 Wednesdays of the block and in person on the 4th Wednesday of each block. The virtual sessions will be recorded. It is a requirement that all cameras be turned on during the virtual didactics sessions to receive credit for being present. In the instance of a rare scheduled absence from didactics (must be arranged ahead of time with the chief resident) the resident may view the recorded didactics session and receive credit for attending that session(s).

Communication

Residents must be available via work phone, cell phone and e-mail while on duty, except when on vacation or sick leave.

Residents are expected to check their MSM e-mail accounts at least once daily because

this is a primary mode of communication. They are expected to check and respond to phone calls and e-mails promptly. Technological problems with cell phones, iPads, and computers must be reported to the program office as soon as possible.

How to Learn in a Residency

Unlike other educational endeavors, a residency program is an apprenticeship for a particular profession. You are learning to become a competent pediatrician. Residency is a continuation of the life-long learning process begun in medical school and extending to the end of your career as a pediatrician.

Residency has a very steep learning curve. Residents are required to learn large amounts of information in a set period of 36 months of training. Before residents can progress to the next level of training, they must demonstrate adequate mastery of knowledge and skill appropriate to their current level of training. You should begin a regular study program early with input from your advisor.

An Individualized Learning Plan (ILP) is a requirement for each resident. It can be accessed through PediaLink or created without PediaLink. The ILP allows a resident to reflect on their strengths and weaknesses and determine how to achieve their goals. The ILP must be completed at the beginning of each academic year and reviewed with your advisor. See the ILP section of this handbook for further information.

All residents are provided access to pediatric books and journals, including Nelson Textbook of Pediatrics, Zitelli and Davis' Atlas of Pediatric Physical Diagnosis, and Pediatrics (journal). All residents have access to electronic books and databases through MSM and CHOA.

Your primary objective is to learn the appropriate amount of information and technical skills required to care for patients safely, adequately and independently. The pediatrician should be readily able to handle all common problems, be familiar with most uncommon problems, and know where and how to find necessary information rapidly for rare situations.

Residents should develop study habits that will carry over throughout their entire career. The information explosion in medicine will only increase over time. Residents must develop a plan to keep abreast of changes in the specialty.

At the start of training, residents are usually overwhelmed with the technical aspects of the specialty. Once daily routines and setups are learned through practice, establishing a sound database should be of primary importance. A regular reading program will help to ensure a methodical accumulation of information. Several texts are available today, as noted earlier in this document.

Techniques for rapid learning should be utilized as much as possible because of limited study time during a residency.

- Pre-scan a text chapter for an introductory statement, bold and italicized text, figures, and captions, and finally, chapter summaries and key points (if available).
- Next, rapidly scan the chapter.
- Finally, repeat the first step.

You will leave the study time with more information in long-term memory than if you had read the chapter slowly from start to finish.

General Information

We do not recommend reading extensively in the current literature until you establish a good solid textbook foundation. Review articles are the exception to that rule. Review articles are obtained through appropriate internet search engines, Pediatrics in Review journal, Pedialink.org, or from faculty.

As a resident, you can take the initiative to acquire as much information as possible from faculty, preceptors, and senior residents by being enthusiastic and asking questions. You will be surprised at the response and the information obtained. Conference attendance is also important and mandatory. Lack of attendance is recognized and examined by the program director, especially when a resident falters academically.

Faculty

Faculty members are board-certified or board-eligible general pediatricians and subspecialists. They may utilize various methods to teach residents and learn from residents in bidirectional education. Methods of teaching may include, but are not limited to being a role model for residents, formal and informal didactics, formative feedback, bedside rounds, etc. Program faculty members have a stake in your success, therefore extracting as much information as you can from them will make your transition much easier.

Problems or Difficulties—What to Do?

As a resident physician, you may encounter clinical problems or have personal problems arise that are difficult to handle. If you find you have issues, problems, or situations you find difficult to handle, please seek help and advice from your program director(s), advisor, faculty, or the program manager. It is important to remember that the program directors maintain an open-door policy toward all residents. We are here to assist you with any problem that arises. It is important to notify us so that we can help.

MSM also has additional resources outside of the program that include:

Student Psychological Services
Shawn Garrison, Ph.D. Director, Counseling Services
(404) 752-1789 (office)
sgarrison@msm.edu

Office of Disability Services (ODS) (part of Human Resources)
(404) 756-5200 or (404) 752-1871

Cigna Employee Assistance Program
As part of Cigna's Employee Assistance Program (EAP), you get access to licensed clinicians to help you with emotional, behavioral, and other issues you may be experiencing such as help with finding pet care, elder care and caregiver support. EAP services are available to anyone in your household as well. Please contact them directly to discuss services at 1-877-622-4327.

General Information

Harassment Policy

We have several policies to handle a variety of issues when it comes to Harassment, please see below:

- Social Media Policy – See page 58.
- Concern and Complaint (Grievance) Policy for Residents and Fellows – See page 64
- MSM GME Concern/Complaint Program Policy Manual Template – See page 67
- Resident & Fellow Eligibility, Selection, and Appointment Policy – See page 68

Morehouse School of Medicine Pediatric Residency Program Annual Leave Policy

A. Purpose

This policy aims to ensure a fair and equitable system to regulate residents' leave, optimize resident education, support resident wellness, and ensure safe patient care. This policy complies with the Accreditation Council for Graduate Medical Education (ACGME) requirements and the American Board of Pediatrics (ABP) certification policies.

B. Policy

The programs will abide by the ABP's Leave of Absence and Vacations policy, which states, "Up to one month per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities." Training must be extended to make up for any absences exceeding one month per year of training. Vacation leave is essential, should not be forfeited or postponed in any year of training, and cannot be used to reduce the required training period."

C. Application

This policy applies to all Morehouse School of Medicine Pediatric Residency Program residents.

The program extends three weeks of vacation, 8-9 days each per academic year. In addition, the program extends an additional 5 days for illness, personal appointments, parental or family leave, or pregnancy-related disabilities.

a. By working an additional shift(s) on the same service if possible. Make-up sessions must not violate duty hours.
b. By extending training by the number of shifts missed.

D. Professional Development

Professional Development Leave (fellowship/job interviews, conference attendance) is part of the medical education experience and is not counted towards the thirty (30) days of allowable leave. Please request this type of leave as far in advance as possible for planning purposes. Program leadership will make efforts to adjust schedules to optimize clinical coverage. These leave requests will be considered on an individual basis by the Program Director.

E. Departure from the above policies will be considered a violation of the Professionalism competency.

Resident . - Vacation, Holiday, Sick Leave, Work hours, and Availability

Residents are expected to perform their duties as resident physicians for a minimum of 11 months or 12 blocks each academic training year. Absences from the training program, including vacation, sick, and all other absences, should not exceed four (4) weeks per academic year. If absences exceed four (4) weeks, extra time will be needed to complete the program.

For successful completion of the program in time for board eligibility in July following graduation, the American Board of Pediatrics does not permit more than 30 days leave time per year. Leave time is any time away from the residency training program that is unrelated to educational purposes. Permission for leave time of more than 30 days and not covered by FMLA is at the discretion of the program director. Resident time may be added to the original date of completion in order to fulfill the 33 months of required training.

NOTE: As an employee of Morehouse School of Medicine you are also governed by the institution's leave policy.

Vacation will be scheduled in 3 separate 1-week intervals during different blocks. This is to ensure adequate planning for both the program and resident. Do not make any travel plans before your vacation request is approved.

All leave (vacation, sick, bereavement, and administrative) requires submission and approval of an official leave request form. The program manager will track hours in Kronos

Early Exit:

Residents/fellows who need to depart their training programs early to prepare for their next stage in training must follow a multi-step process that includes approval by the Program Director, the DIO, and HR.

- The resident/fellow must submit a letter requesting an early exit departure, which indicates the reason for leaving early and anticipated early exit date.
- The letter must be signed by the resident/fellow and submitted to the Program Director
- Documentation of the fellowship start date that necessitates early exit must accompany the resident's/fellow's letter.
- The Program Director must confirm and attest that the resident/fellow will have completed the required training time, case minimums, etc. by the proposed exit date before approving an early exit.
- The DIO must review the justification of early exit and the Program
- Director's attestation and approval and provide an approval of the early exit before the trainee may proceed to the early exit interview.

- The trainee must complete the early exit interview on the early exit date or the last business day before the exit date if it falls on a weekend.

- HR must confirm whether the resident/fellow will have enough vacation remaining to be compensated during the balance of the time between the early exit date and the final day of the current contract year; if the resident/fellow does not have enough vacation time remaining, then the resident/fellow will be categorized as "Leave Without Pay" (LWOP) and will not be compensated for any time for which no time is available.

Vacation

Each resident is allowed 15 days of vacation taken in 3 one-week intervals. Vacation requests are granted on a first-come, first-served basis and must be requested in writing using the program's official Request for Leave form. An email response to the chief resident's request for vacations is also acceptable.

Vacation time is scheduled during designated rotations. Vacation may be requested for the first or last week of the block but cannot be guaranteed. Any request for leave outside of designated rotations or blocks must be approved by the program director. All requests for exceptions should be in a letter addressed to the program director detailing the request and specific reasons for the deviation from the policies. If any changes in the on-call schedule are necessitated by a leave request, it is the resident's responsibility to secure coverage in advance. The names of the physicians covering the clinic or work hours must appear on the request form.

The first step is to submit the leave request to the program (chief resident or program designee) for approval. In most circumstances, we ask that residents submit his or her vacation request before the schedules are finalized (an announcement will be made). Requests will be considered in the order in which they are received.

NOTE: No travel plans should be made until the program director approves the request.

After approval, the vacation dates will appear on www.amion.com or on Medhub as part of the block schedule.

Vacation days not used will not carry over to the next academic year (they are not accrued). Vacation leave is not subject to an accumulated "pay out" upon the completion of training or upon a resident's termination from the program.

The designated blocks in which residents may take leave by post-graduate year include:

- PGY-1– One (1) week each during two individualized curriculum (IC) rotations and one (1) week during term nursery. The 4th week of term nursery will be completed during 2nd year.
- PGY-2—One (1) week each during two individualized curriculum rotation; and one (1) week during the advocacy rotation.
- PGY-3—One (1) week each during two individualized curriculum rotations and one (1) week during the special populations rotation.

NOTE: PGY-3's may take up to 3 days of additional time off in order to attend job/fellowship interviews. These must be approved by the chief resident or program director. Final approval is made by the program director.

Holidays

Approved MSM holidays do not apply to your rotation holidays. Check with your particular rotation to determine what days are considered holidays. For example, MSM celebrates Good Friday, but other practices may not. The rotation schedule supersedes any MSM holiday.

Sick Leave

Each resident is allowed a maximum of 20 paid sick days per academic year. This time can be taken for illness, injury, and medical appointments for the resident or for the care of an immediate family member. Sick leave can only be used for sick days. A missed shift for sick leave may be required to be made up. See Appendix A for more detailed policy on making up missed shifts.

Other than a missed shift, sick days may not be required to be made up if they do not prevent the resident from receiving a satisfactory evaluation and appropriate exposure to the rotation as determined by the course director, program director, and CCC. If the number of sick days results in a total number of missed days over the ACGME-allowed 30 days, then those days will be made up at the end of the given academic year. **It is the resident's responsibility to notify the chief resident by phone as early as possible when he/she will be out. This notification must be followed up by email, along with the submission of the sick leave request form.**

It is also the resident's responsibility to notify the corresponding faculty member and supervising resident of sick leave. Sick leave is not accrued from year to year.

See the GME Policy Handbook at 2024-2025 MSM GME Policy Maual.pdf

Sick leave that lasts three (3) or more days must be documented by a physician's Return to Work note.

Be advised that there is a minimum amount of time in which rotations must be completed for the resident to receive full credit for the rotation.

See Scheduled Rotations, page 22.

Emergency Back-up Call Schedule and Resident

When a resident has an unexpected absence from a night or weekend shift, scheduled shifts or other duties may need to be adjusted. If a resident is unable to trade shifts, the backup call resident may be used for night and weekend shifts. The resident on backup call is required to fill in for the absent resident. Backup call will be assigned to all residents and placed on amion.com. Residents who are covered by the backup resident should make every attempt to "pay back" the covering resident later. See appendix A for more detailed policy information on paying back shifts to a covering resident. We do not routinely provide daytime backup coverage, but it can be provided in special circumstances at the discretion of the program director.

General Information

Family and Medical Leave

The pediatrics residency program follows and complies with MSM Human Resources and GME Policies for Leave and Family Medical Leave. See the full GME Resident Leave Policy at http://www.msm.edu/Education/GME/index.php

Leave of Absence (without Pay)

Requests must be submitted in writing to the residency training director for disposition. The request shall identify the reason for the leave and the duration. Requests for a leave of absence without pay are approved only if the residency training director is reasonably sure that the resident's position is expected to be available when the resident returns. A leave of absence without pay when approved shall not exceed six (6) months in duration. If the absence extends over six months, the resident must re-apply to the residency program.

Other Leave

Other leave types are explained in detail in the MSM Human Resources employment manuals. The resident is advised to fulfill the special requirements of training and of

the specialty certification board, it may be necessary for a resident to spend additional time in training to make up for time lost while he or she used vacation, sick leave, the various types of emergency leave, or leave of absence without pay.

Residents are allowed three (3) days of administrative leave per academic year for fellowship interviews, job orientation, etc., and these administrative leave days must be approved by the chief resident or a program director. It is expected that switches be made with fellow residents before implementing the administrative leave option.

See the full GME Resident Leave Policy at 2024-2025 MSM GME Policy Maual.pdf

Moonlighting

Moonlighting is allowed for 2nd and 3rd year pediatric residents only. Please see the MSM GME requirements for moonlighting in the appendix section of this manual.

Work Hours

Unless otherwise specified by the faculty, the workday generally begins at 7:00 am and continues until the end of the clinical workday for the rotation. Refer to the inpatient work guidelines for additional details. Ending times may vary from rotation to rotation, but in general, the ending time is usually between the hours of 5:00 pm and 7:00 pm. Rotations with 12-14-hour shifts include the Intensive Care Units, and Inpatient. Residents may work 24 + 4 hours consecutively according to ACGME requirements. The final 4 hours include rounding and completing work plans. No new patients may be assigned during this final 4-hour period.

See clinical experience and education work hours on page 32.

Shift Hours

When pediatric residents are admitting new patients or are on night shifts, they are expected to remain on the hospital premises until they are relieved by the next shift of residents or an identified person who assumes full responsibility for patient care. If they are on other rotations and are starting shifts at the hospital, they are expected to arrive for the sign-out rounds at the designated sign-out time for that campus and remain there until the end of their shift.

Resident Evaluation, Progression, and Promotion

Several evaluation tools are used, including:

- Faculty, nurse, patient/family, and peer assessments.
- Direct resident observation.
- Procedure and case logs.
- Written examinations; and
- Presentation skills assessments.

Additionally, each resident will maintain and submit a portfolio of assessment tools to document the core competencies and all academic activity during residency. The portfolio is held by the program assistant.

Residents are evaluated by faculty at the end of each rotation. The evaluations reflect achievement of the six (6) core competencies:

- **Patient Care:**
  - Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
  - Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

- **Medical Knowledge:**
  - Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

- **Interpersonal Skills:** Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents must demonstrate competence in:
  - Communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
  - Communicating effectively with physicians, other health professionals, and health-related agencies.
  - Working effectively as a member or leader of a healthcare team or other professional group.
  - Educating patients, families, students, residents, and other health professionals.
  - Acting in a consultative role to other physicians and health professionals.
  - Maintaining comprehensive, timely, and legible medical records, if applicable.

  Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.

- **Practice-based Learning:** Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. Residents must demonstrate competence in:
  - Identifying strengths, deficiencies, and limits in one's knowledge and expertise.
  - Setting learning and improvement goals.
  - Identifying and performing appropriate learning activities.
  - Systematically analyzing practice, using quality improvement methods and implementing changes with the goal of practice improvement.
  - Incorporating feedback and formative evaluation feedback into daily practice.

  - Locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems.
  - Using information technology to optimize learning.

- **Professionalism: Resident** must demonstrate a commitment to professionalism and an adherence to ethical principles. Residents must demonstrate competence in:
  - Compassion, integrity, and respect for others.
  - Responsiveness to patient needs which supersedes self-interest.
  - Respect for patient privacy and autonomy.
  - Accountability to patients, society, and the profession.
  - Respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation.
  - Ability to recognize and develop a plan for one's own personal and professional well-being.
  - Appropriately disclosing and addressing conflict or duality of interest.

- **Systems-based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context and system of healthcare, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal healthcare. Residents must demonstrate competence in:
  - Working effectively in various healthcare delivery settings and systems relevant to their clinical specialty.
  - Coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty.
  - Advocating for quality patient care and optimal patient care systems.
  - Working in interprofessional teams to enhance patient safety and improve patient care quality.
  - Participating in identifying system errors and implementing potential systems solutions.
  - Incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate.
  - Understanding health care finances and its impact on individual patients' health decisions.

Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals.

Reviews are provided to each resident by the program director or Associate Program Director semi-annually unless issues arise necessitating more frequent evaluation. Each resident's progress is reviewed at least twice each year by the Clinical Competency Committee who then makes a recommendation to the program director about progression to the next level. The final decisions on promotion to the next level of residency are made by the program director. Resident promotion is determined by the following criteria.

From PGY-1 to PGY-2

Effective July 1, 2024, all PGY 1 Pediatric Residents must take and pass USMLE Step 3 by the final day of the intern year. If the intern is off cycle for any reason, the deadline for passing USMLE Step 3 will be the final day of their PGY 1 year. Failure to pass USMLE Step 3 by the deadline will

result in enhanced support in the form of an additional study plan (to be determined by the intern and the PD or faculty advisor) with a requirement to retake the exam within 6 months of the initial exam attempt. Institutionally, all residents must eventually pass USMLE Step 3 by the 20th month of training to be offered a contract for their final year of pediatric training.

The following promotion criteria apply to promotion from PGY-1 level to PGY-2 level. The resident must:

- Be approved by the CCC to be promoted based on the evaluation of the following elements:
    - Clinical performance)
        - ACGME core competencies by faculty, peers, ancillary staff, and patients
        - Ability to supervise interns and medical students
    - Professionalism
    - Completion of program-sponsored study plan
    - Attendance and participation in didactics and mandatory program requirements
    - Milestone rating review
- Successful completion of a direct observation exam.
- Absence of professionalism or ethical issues that preclude him or her from being moved to the next level of residency in the opinion of the program director.
- Be continually eligible to practice medicine on a limited training license in Georgia.
- Complete the GME returning resident orientation.
- Be compliant with all MSM Pediatric Residency Program policies including, but not limited to, being up to date with his or her work hours, procedure and patient logs.
- Be up to date on all required question banks and assignments.

From PGY-2 to PGY-3

The following promotion criteria apply to promotion from PGY-2 level to PGY-3 level. The resident must:

- Meet all of the requirements for PGY-1 stated above with the exception that the resident does not have to successfully complete a direct observation exam.
- It is strongly encouraged that USMLE Step 3 be taken in the first 12 months of the program.
- Have up-to-date PALS and NRP certification.
- Be up to date on all question banks and assignments.

From PGY-3 to Graduation

The following criteria apply to PGY-3 for graduation. The resident must:

- Meet all the requirements for PGY-2 stated above.
- Complete an approved scholarly activity.
- Complete an approved Patient Safety/Quality Initiative activity.
- Complete the GME/HR/ and MSM IM exit procedures.
- Perform satisfactory or above in all six ACGME competencies.

- Receive the program director's determination that the resident has had sufficient time to complete all required AGGME and ABP training at MSM and be assessed to be able to become an independent practitioner of Pediatrics.

NOTE: If the program director determines that the resident is performing with an *unsatisfactory* status in an ACGME competency it will be reported, as required, to the ABP.

The resident should review the status of his or her performance, progression, and promotion at least twice per year with his or her advisor and designated program director.

Upon a resident's successful completion of the criteria listed above, the residency program director will certify that the resident has successfully met the specialty requirements for promotion to the next educational level and file the semi-annual evaluations and the promotion documentation in the resident's portfolio. If the resident is a graduating resident, the program director should include the final summative assessment in the resident's portfolio as well. When a resident will not be promoted to the next level of training, or his or her appointment will not be renewed, the program will provide the resident with a written notice of intent no later than four (4) months prior to the end of the resident's current appointment agreement.

If the primary reason for non-promotion occurs within the last four (4) months of the appointment agreement period, the program will give as much written notice as circumstances reasonably allow.

For more information concerning adverse events, refer to the GME Adverse Academic Decisions and Due Process Policy.

Academic support and counseling is available to residents and it should be sought on an individual, as-needed basis.

Residents will complete peer and self-evaluations at least twice per year. Residents will also complete rotation and faculty evaluations at the end of each rotation. The evaluations will not be shared with the faculty members until the middle and the end of the academic year to maximize anonymity. In addition, residents will complete confidential evaluation surveys of the program on an annual basis which will come from ACGME and institutional GME.

Evaluations are accessed on Medhub by the residents and the preceptors. A composite will be compiled of evaluations from both the resident and preceptor. Evaluations will be available to the resident and his or her advisor in Medhub.

Preceptors' (faculty members) evaluation of a resident's performance is documented using questions related to the ACGME Pediatric Milestones. Using aggregate faculty reports of evaluations data and a review of other tools including CCC faculty members personal observations, the Clinical Competency Committee (CCC) then maps the information on the evaluations to the actual Milestones evaluation tool. The CCC then makes recommendations to the program director about each resident's progression and promotion at least twice per year. A resident's performance as it relates to the Pediatric Milestones is reported to the ACGME twice per year.

See Clinical Competency Committee, page 5.

For residents who are having academic difficulties as demonstrated by evaluations, feedback, Milestones performance review of the CCC, PEC, and program director, the resident may be subject to the Adverse Academic Action and Due Process Policy as outlined in the GME policy manual at 2024-2025 MSM GME Policy Maual.pdf

When to Call for Help

For clinical help, seek your supervising resident first. If the situation is not resolved or if no supervising resident is available, call the supervising faculty member.

For in-house patient emergencies at each CHOA campus, a rapid response team is available 24 hours a day, seven days each week, at (404) 785-TEAM.

Academic support and counseling is available to residents and should be sought on an individual, as-needed basis.

Conclusion

The residency program, staff, and faculty look forward to working with you and fostering your development as a general pediatrician. The resources in this training program are focused on supporting your clinical and research training. Remember that this is the time you learn how to practice medicine in your chosen field. Make the most of it!

General Information

Nepotism Policy

MSM permits the employment and/or enrollment for academic purposes of qualified relatives of employees as long as such employment or academic pursuit does not, in the opinion of the school, create actual conflicts of interest. Per the MSM Human Resources Nepotism policy: “no direct reporting or supervisor to subordinate relationship may exists between individuals who are related by blood, marriage or reside in the same household. For academic purposes, no direct teaching or instructor to resident or student relationship can exist – no employee is permitted to work within “the chain of command” when one relative’s work responsibilities, salary, hours, career progress, benefits, or other terms and conditions of employment could be influenced by the other relative.” Additionally, “each employee, student or resident has a responsibility to keep his/her supervisor, the appropriate Associate Dean or Residency Program Director and Human Resources informed of changes relevant to this policy”.

General Information

Work Cell Phones

Please see appendix A on page 89 for the Mobile Device Security Policy.

Dress Code

Residents are expected to abide by the MSM institutional guidelines on dress code and professional conduct and by those guidelines of the affiliate participating sites (hospital). Residents shall present themselves in a professional manner at all times. A lab coat is required along with your identifiable name badges (MSM and hospital ID) while within the hospital.

- Men should wear slacks, such as khakis or chinos, not jeans or jeans-style pants, with collared or mock-collared shirts. Ties are optional, unless required by the Attending physician. Shoes should be closed-toed dress or work shoes or clogs (CHOA mandate). Clean tennis shoes are acceptable during night shifts and certain day shifts.
- Women should wear professional-looking attire. This may be a dress or jumper, skirt knee-length or longer, or slacks (not jeans), with a sweater or blouse. Shoes should be closed-toed dress or work shoes or clogs (CHOA mandate). Clean tennis shoes are acceptable during night shifts and certain day shifts.
- Scrubs are permissible at appropriate times (inpatient day or night shifts, ED, or ICU) within the hospital.

The following clothing items are unacceptable:

- Flip-flops or sandals
- Jeans
- Suggestive, revealing, or tight-fitting clothing
- Mini skirts
- Camisole-type tops or other shirts that expose shoulders, bra straps, or midriff
- Any clothing with inappropriate pictures or slogans

The following guidelines apply when you are working in the hospital overnight and the following morning:

- Scrubs and comfortable shoes may be worn (sneakers are acceptable).
- Wear your white coat.
- Personal grooming is expected at all times.

Paychecks

Paychecks are available biweekly (26 paychecks per calendar year). If you have a direct deposit, the check stub is e-mailed directly to you from Payroll.

Parking

Parking cards for personal parking at Grady Hospital are issued during the Graduate Medical Education orientation. Residents must pay a $10 deposit and the first month's fee of $21. Subsequent months are paid through a payroll deduction. Free parking is available

at other work sites (CHOA at Egleston, CHOA at Scottish Rite, Emory Decatur) with your hospital ID badge.

Licensure

Residents are required to apply for a Georgia training permit upon entrance to the program. This is paid for by the institutional GME. Residents are required to take the U.S. Medical Licensing Examination (USMLE) Step 3 by the 18th month of training (middle of PGY-2) and pass USMLE Step 3 by the 20th month of training. It is strongly recommended that residents take this examination during the first 12 months of training.

NOTE: Residents who have not passed USMLE Step 3 by their 20th month of training will receive notice of non-renewal of contract until they pass USMLE Step 3. Failure to pass USMLE Step 3 by the end of the 24th month of training (usually June 30 of the PGY-2 year) will result in non-renewal of a contract and dismissal from the program. If dismissed, residents are required to re-apply to the program.

Certifications

Residents are required to be certified in Pediatric Advanced Life Support (PALS), Basic Life Support (BLS), and Neonatal Resuscitation Program (NRP) throughout their residency. Residents must apply for a National Provider Identifier number (NPI) and use this number for writing prescriptions.

Mailboxes

Resident mailboxes are located in the residency suite. It is expected that you purge your mailbox on a regular basis. We strongly encourage you to change all mailing addresses to your home address. Changing your address ensures that you receive important mailings in a timely fashion.

Professional Organizations

The program provides support for the resident's annual membership in the American Academy of Pediatrics, as well as in the Georgia Chapter of the AAP. Membership includes a yearly subscription to Pediatrics, Pediatrics in Review, PREP the Curriculum and Resident online courses and Residents as Teachers Toolbox. We strongly recommend that each resident become an active member of the Georgia AAP and take full advantage of educational resources such as Pedialink.org.

Community Service

We strongly encourage residents to complete 25 hours of community service each academic year for a total of 75 hours by the completion of residency.

Board Review Materials/Self Learning Materials

Each resident will be given $1200.00 a year to go towards purchasing study materials. These materials can be for board prep or self-study purposes. This will allow each of you

to choose what you think would work best for you. If your purchase is more than $1200.00/year, you will be responsible for the remainder of the bill. Venetta will coordinate your purchases so let her know what you would like. This will allow all residents the same opportunity to get board prep/self-study materials that are tailored to their specific needs. This money may not be used for conference attendance expenses or licensure exams. The money does not roll over year to year, so you must use it or lose it.

Conference Policy (Attendance and Program Payment)

- Conferences without a poster or platform presentation: Residents may attend 1 conference of this type in a 3-year period. The training program may not pay for this conference. Payment for this type of conference, including travel and lodging can be the sole responsibility of the resident. Every effort should be made to miss as few workdays as possible. Attendance at this type of conference will require prior approval from the program administration and may be approved or denied by the program director. The PD shall give explanations for any denied conference requests. The conference should be in line with career goals.
- Conferences with a poster or platform presentation: The training program will pay for at least 1 conference of this type over 3 years. If the resident is invited to present at a subsequent conference, the training program may help pay for this conference pending available funds. One exception is if the conference is a local one (In the metro Atlanta area), the residency program will pay for your registration. Attendance at this type of conference will require prior approval from the program administration and may be approved or denied by the program director. The PD shall give explanations for any denied conference requests. The conference should be in line with career goals.
- If conference attendance occurs during a resident's scheduled vacation time additional vacation time will not be granted.

We are limited in the amount of money available for conferences. However, we want to make sure that we support your academic pursuits optimally with the funds that we have.

Scheduled Rotations

The duration of each clinical rotation is a four-week block (28 days) and involves specific time scheduling and administrative requirements. The residency program office must be able to locate all residents during scheduled working hours or when assigned as a "back-up" resident. Outside of an emergency, should a resident fail to report to the scheduled rotation site during scheduled work hours without prior notification to the supervisor or approval, disciplinary measures will be taken that may include documentation of poor professional conduct in his or her permanent file, probation or dismissal from the program, if necessary. If a resident fails a rotation, this may result in remediation, probation or dismissal from the program.
See GME Adverse Academic Decisions and Due Process Policy:
2024-2025 MSM GME Policy Maual.pdf

Each resident will participate in an educational curriculum consistent with ACGME requirements, which will offer solid training in general pediatrics. Residents will also have the opportunity to participate in individual educational curriculum based on his or her career path.

Over the 3-year period, there are 6 Individualized Curriculum (IC) options. There are 2 options in the first year, 2 in the second year and 2 in the third year. These IC rotation choices should support a career in general pediatrics or chosen subspecialty training. These choices must be approved by the resident's advisor and program director.

For each resident to be successful and have an opportunity to gain the experience necessary for his or her career, the resident must discuss intended career plans with his or her advisor and the program director early and often.

For all ICs at an outside institution, residents are encouraged to inquire about the process and requirements at least six (6) months in advance. If there is a desired IC within the MSM or CHOA system, the resident shall directly inform the chief resident or assistant program director before proceeding.

Resident assignments for each post-graduate year are described in the following sections.

PGY - 1

- Inpatient/CHOA Hughes Spalding (three blocks), Dr. Senayit Demie
- Inpatient/CHOA Scottish Rite (two blocks), Dr. Chevon Brooks
- Individualized Curriculum Option (two blocks) - Various Faculty
- Emergency Medicine—CHOA Hughes Spalding (two blocks), Dr. Bolanle Akinsola
- Term Nursery—Emory Decatur Hospital (one block), Dr. Ghada Osko
- Developmental/Behavioral Pediatrics—various sites (one block), Dr. David O'Banion
- Adolescent Medicine—various sites (one block), Dr. Inwards-Breland

Scheduled Rotations

- Community Pediatrics (Social Determinants of Health) (2 weeks), Dr. Lynn Gardner
- Child and Adolescent Psychiatry—various sites (one week), Dr. Kamille Williams

PGY - 2

- Inpatient/CHOA Scottish Rite (two blocks), Dr. Chevon Brooks
- Individualized Curriculum Options (two blocks)—Various Faculty
- Emergency Medicine—CHOA Egleston (one block), Dr. Bolanle Akinsola
- PICU—CHOA Egleston (one block), Dr. Anna Grindy
- NICU—Grady Memorial Hospital (one block), Dr. Jessica Roberts
- Cardiology—various sites (one block), Dr. Andrea Kropf
- Pulmonology—CHOA Scottish Rite (one block), Dr. LaTresa Lang
- Pediatric Surgery—CHOA Scottish Rite (one block), Dr. Heather Short
- Hematology/Oncology—CHOA Scottish Rite (3 weeks) and Hughes Spalding (one week), Drs. Amy Tang and Jason Payne
- Float/Community Research—CHOA Hughes Spalding (one block), Drs. Senayit Demie and advisor
- Advocacy—various locations (one block), Megan Douglas JD

PGY - 3

- Inpatient/CHOA Hughes Spalding (three blocks), Dr. Senayit Demie
- Float/Quality Improvement—CHOA Hughes Spalding (one block), Dr. Lori Singleton
- Emergency Medicine—CHOA Egleston (one block), Dr. Bolanle Akinsola
- PICU—CHOA Egleston (one block), Dr. Anna Grindy
- Infectious Disease—CHOA Egleston (one block), Dr. Tom Fox
- Individualized Curriculum- (2 Blocks)- Various Faculty
- NICU—Grady Memorial Hospital (one block), Dr. Jessica Roberts.
- Gastroenterology- (1 block)- Drs. Ben Gold and Aminu Mohammed
- Board Review- (1 block)- Dr. Barbara Menchan
- Vulnerable/Special Populations – (1 block) – Various Faculty

Minimum Amount of Attendance to Receive Credit for Rotation

Inpatient/ICU

Residents are expected to be present at all scheduled inpatient shifts. Residents are required to work a minimum of 200 hours per rotation and no more than 320 hours per rotation. If a resident works less than 200 hours, he or she will be required to work additional hours to meet the 200-hour requirement. If a resident has worked greater than or equal to 200 hours, but the rotation preceptor determines that the resident's experience has been inadequate to fulfill the objectives of the rotation due to absence, the resident may be required to work additional hours, the amount which is to be determined by the program administration.

Outpatient/ED/Individualized Curriculum Options

Residents are expected to be present at all scheduled outpatient, emergency department, and

individualized curriculum shifts. Residents are required to work a minimum of 32 half-days

for 28-day rotations of the scheduled rotation time to receive credit for completion. If a resident works less than this, he or she will be required to work additional hours to reach the 85% requirement. If a resident has worked greater than or equal to 32 clinic sessions of the scheduled time, but the rotation preceptor determines that the resident's experience has been inadequate to fulfill the objectives of the rotation due to absence, the resident may be required to work additional hours, the amount which is to be determined by the program administration.

Longitudinal Ambulatory Experience (LAE)

LAE is an ACGME requirement. Each resident will attend LAE one (1) half-day per week for at least 36 sessions per year. These 36 sessions shall not be done in less than 26 weeks. Residents are expected to attend their assigned LAE on every rotation. The number of possible clinics per block will vary based on night shift schedules.

The only times when LAE is not expected are:

- Rural health
- Vacation weeks
- Sick leave
- Weeks when on night shifts

LAEs are located at various community pediatricians' offices and CHOA Hughes Spalding clinic. Interns have LAE at CHOA Hughes Spalding, and they transition to a community site in subsequent years. Residents are expected to attend clinic on their designated day and time when at all possible. Absences from LAE must be approved by a program director. Residents will maintain a patient log on Medhub of their LAE patients. Residents will be evaluated on their LAE performance by their preceptor 4 times per year. Residents may also have a structured clinical observation evaluation annually.

Dr. Anita Moton is the course director for LAE at CHOA Hughes- Spalding clinic. See the LAE Manual for more details.

Educational Conference Requirements

Didactics

The chart below shows regular journal clubs, seminars, rounds, and conferences that are a part of the pediatric training program.

Conference	Frequency	Location
Acute Care Series	Month of July	HSRB, simulcast to SR & HS
Didactic Conference	Weekly (Wednesday)	Residency Suite/SRMC/ Egleston/ Grady
Evidence-based Medicine	Quarterly	Residency Suite
Grand Rounds at HS	Weekly (1st, 3rd, and 4th Thursdays)	Zoom
Journal Club at Grand rounds	Monthly (2nd Thursdays)	Zoom
Grand Rounds at SRMC	Weekly (1st, 2nd, 3rd Tuesdays at noon)	SRMC auditorium
Morning Report at HS	Monday, Tuesday & Friday	Hughes Spalding inpatient
Board Review	Longitudinal	Residency Suite/Zoom
Noon Report at SRMC	Tuesday, Wednesday & Friday	SRPAC conference room

All conferences are mandatory for residents to attend. Residents are expected to attend a minimum of 90% of mandatory conferences. As special circumstances occur, trainees must notify the program director or associate director prior to the conference in order to be excused from a particular conference for personal reasons.

All didactic conferences will take place Wednesday afternoons from 2:00–5:00 pm (unless otherwise noted) in the residency suite, Scottish Rite, Egleston, or by Zoom.

Additional Educational Requirements

All residents are required to attend all Wednesday didactic sessions and they are excused from their rotation duties during that time. Exceptions to this requirement include:

- Sick leave
- Vacation

Educational Requirements

- Residents on NICU are excused from didactics (NICU didactics will be given on-site for the block)
- Residents on ER (if a shift is scheduled during the same time)
- If attendance would cause any work hour violation

All residents are expected to attend Grand Rounds, Grand Case Report, and Journal Club.

Exceptions to Thursday morning activities attendance include the following reasons:

- ER (if a shift is scheduled during the time)
- Scottish Rite (seniors will attend SRMC Grand Rounds)
- Residents on PICU (should watch via Zoom)
- Residents on rural health
- Anesthesia rotation
- Sick leave
- Vacation

Residents are required to sign in Via QR code. An attendance report is prepared for the program director in order to provide feedback to residents during semiannual program director meetings.

For missed conferences, residents should review the lecture handouts and cataloged videos available on our website. Credit for attendance will be given for watching the videos only if the absence was planned with and approved by the chief resident.

All residents who are on rotations at Scottish Rite (Pulmonology, Hematology/Oncology, Surgery, GI) are also expected to attend Grand Rounds and noon report at Scottish Rite unless it conflicts with rotation schedule.

Resident Evidence-based Medicine and Clinical Research (EBM/CR)

Course Objectives

The goal of this course is to provide all residents with the ability to critically evaluate current research literature—so that they are enabled to be lifelong learners and educate residents on the design of a clinical research project and to promote resident-driven clinical research.

Residents are required to participate in scholarly activities per ACGME. In the first year of training, residents learn fundamental clinical research principles through a basic course and become certified in human subject investigations through MSM. Residents then have an opportunity during their first, second, and third years of training to participate in ongoing research within the department, medical school, and affiliated institutions like the Centers for Disease Control and Prevention (CDC) in Atlanta and several research initiatives under the National Center for Primary Care on the MSM campus.

Educational Requirements

Over the course of residency, residents must develop and complete a research project, and present an oral presentation, as well as prepare case reports and posters. Residents will present an oral presentation during the PGY-3 year on their scholarly activity. The Float-Community Research (Float-CR) rotation is a concentrated opportunity for residents to work on their project. Details are provided in the course curriculum.

A four-week research individualized curriculum (IC) option is also available in which residents can further refine and progress on their research with direct supervision by faculty. **All research IC options and projects require prior approval by the faculty research mentor and residency program director.**

Residents are expected to present their scholarly findings either at a national or local scientific meeting or other acceptable venue such as the Frontiers of Science program or the annual Pediatric Academic Society meeting.

All scholarly activities should be catalogued for the resident's portfolio of scholarly activity. This includes abstracts and other scholarly activities that are submitted but not accepted for presentation.

Course Requirements

All residents, including interns, are required to attend and actively participate in the EBM/CRD course that is incorporated into the regular didactic schedule. During these sessions, residents learn how to appropriately evaluate articles from an evidence-based medicine perspective in a journal club format. During the process of clinical research design, residents are required to give presentations at various stages of their research project development.

Collaborative IRB Training Initiative (CITI)

The CITI program site provides a comprehensive selection of educational modules that can be used to satisfy institutional instructional mandates in the Protection of Human Research Subjects. The program can be accessed at www.citiprogram.org.

The following modules are included in the program:

- Seventeen basic modules focused on biomedical research
- Continuing education (CE) modules for biomedical researchers who have completed the basic modules

All residents are required to complete CITI training (Biomedical Sciences) as part of the Evidence-based Medicine course ***by the end of their first six (6) months of training.*** A copy of the completion confirmation will be placed in the resident's file. In addition, if the resident wants to become part of any research activity, the course is mandated by the IRB prior to approval.

Patient Safety/Quality Improvement

Residents will receive education on patient safety and quality improvement in line with ACGME requirements: ACGME Common Program Requirements (Residency) 2023 Revision.pdf

Residents are required to complete institutionally sponsored training on PS/QI. Residents will develop and complete a quality improvement project and are required to prepare a written report and an oral presentation before the end of their PGY-3 year. Details are provided in the course curriculum.

Scholarly activity Requirement

Each resident must be involved in scholarly activity as required by ACGME. This scholarly activity can include case reports, research projects or QI research. Each resident prepares a written report and an oral presentation before the end of their PGY-3 year. Details are provided in the course curriculum.

Note: Please see the ACGME's Educational Program Requirements in Appendix IV.D. on page 836.

Study Program

Academic Preparation

Longitudinal Study Plan (Practicing to Be Perfect)

All residents are expected to demonstrate medical knowledge adequate for their year of training on standardized (and similar) pediatric examinations. All residents are required to participate in the longitudinal board preparation program and meet the goals outlined by the program at the beginning of the academic year. The study program is a continuous cycle of improvement that may be modified based on the resident's performance on the national In Training Examination (ITE), faculty input, and resident input.

All residents participate in the program's designated longitudinal study plan. The plan can be adjusted based on resident performance and PEC input. The plan will be clearly outlined at the beginning of the academic year and discussed and updated throughout the year as needed.

Residents will take monthly self-assessment quizzes where a minimum score of 90% is required.

Residents will take quarterly self- assessment quizzes as preparation for their ITE. The minimum score requirement for this quiz is 85%.

Failure to achieve the minimum score on any self- assessment will result in a re-take of the quiz after one week.

Failure to achieve the minimum score on the repeated attempt will result in a write up of each question missed. An outline of the question and discussion of the correct answer will be required for each question missed on the quiz. This will be due 1 week after the failed re-take of the quiz.

Failure to produce the write up requirement will result in a Notice of Deficiency in the areas of Medical Knowledge and Professionalism. Part of the Performance Improvement Plan will be completion of the question write up requirement. Failure to do so may lead to probation, or ultimately dismissal from the program. See the Adverse Actions Section of the Handbook for more details.

In-Training Service Exams (ITE) performance

Each July, all residents participate in the national ITE for pediatric residents. The ITE is strongly correlated to an individual's likelihood of passing the American Board of Pediatrics Certifying Examination. In addition to participation in the program's study plan and the development of a study plan with their advisors, all residents who perform poorly on their In-Service Training exam (ITE) are strongly encouraged to have their test-taking skills evaluated by a professional.

Individual Learning Plan

An Individualized Learning Plan (ILP) is a tool used by residents to assess individual accomplishments and needs in essential knowledge, skills, and abilities. The plan is flexible and is tailored to meet the personal and professional needs of individuals.

The ILP provides a location for recording and prioritizing personal learning goals and goal achievements and is used to develop a personal portfolio for self-evaluation.

Being able to see what you have learned, achieved, and enjoyed helps you to take more control of your future.

Creating your plan can help you develop more confidence in your ability to tackle new things, become more employable, and get more out of life. To get started with your plan, consider some of the things that you have already learned and enjoyed. Write those experiences down and periodically remind yourself why they were each important to you and how they have helped you. Look forward in your life and identify your goals.

You should compare all you have already learned and achieved to what you hope to gain in the future. Set targets that will indicate that you are on your way to getting what you want or being where you want to be. This will provide the skeleton of your learning plan. Review what has helped or hindered your learning progress. Identify the support and guidance you will need.

Keep your plan updated. Read through your steps regularly and see if you can add anything. Review your plan regularly. Re-evaluate your plan. Do you still have the same goals?

In summary, ILPs include the following information:

- Your career goals
- Electives that help you progress toward your career goal
- Your learning objectives and strategies for achieving those learning objectives

Residents must update their ILP each year, designating three (3) specific areas for development, improvement, growth, and enrichment. The ILP must be reviewed with your faculty advisor annually.

ILPs allow you to:

- Analyze your learning needs in a systematic way.
- Create a plan for engaging in learning experiences based on these needs.
- Document your commitment to lifelong learning.
- Have a positive impact on your own clinical practice and professional development.

The ILP is located on the resident's center of PediaLink. PediaLink.org is an innovative, online tool that provides a path for learning and provides the following benefits:

- Encourages a systematic approach to practice reflection
- Helps guide you in prioritizing your learning needs
- Creates learning objectives to address those needs
- Records whether you're learning objectives were met
- Documents competence in PBLI, one of the required ACGME competencies
- Connects all the house staff in your program together as the ultimate "group practice" in measuring outcomes

You may also create your own ILP outside of PediaLink as long as you follow the basic construct as outlined above.

> **Note:** More information concerning the ACGME Board Pass Rate Requirements can be found in Appendix A, page 85.

Time Management and Administrative Responsibilities

In recent years, ACGME requirements have significantly changed, moving towards resident documentation of competencies and programs' verification of residents' competencies. In addition, work hours have become more restrictive to ease resident fatigue and optimize physical readiness of performing and learning.

Not only are residents and programs obligated to follow these rules, but often, credentialing agents request competency-based evaluation of former residents who are being presented before them. Because of this, it is very important that all of the administrative duties, logging of work hours, patient/procedure logs, and participation in learning opportunities are met and documented by the resident.

The following list shows requirements that residents are obligated to complete, being excused only per the policy outlined in this manual in the corresponding section:

- Clinical and educational work hours to be logged on a daily basis in Medhub Patient and Procedure Logs to be logged routinely
- Completion of ninety percent (90%) of study plan on a quarterly basis*
- Attendance at ninety percent (90%) of Grand Rounds and Didactics on a quarterly basis

Excused absences (e.g., sick, vacation, ER shifts, etc.) will not be counted against the resident.

Be advised that clinical experience and education (formerly work hours) do not include self-study activities.

It is strongly advised that you set aside a minimum of 2-3 hours per weekday (or 10-15 hours per week) to complete these administrative program requirements. Like all professionals, it is expected that residents manage their time appropriately. If you are feeling overwhelmed, we suggest setting up a designated time during the week to complete the activities, setting up your Microsoft Outlook calendar to send automated reminders, and meeting with your advisors and fellow residents for suggestions.

Also be advised that each of the listed responsibilities will be reconciled on a quarterly basis; the program director will collect and review the information to ensure that each resident is in compliance, except for clinical and educational work hours, which are monitored weekly.

Clinical and Educational Work Hour Documentation

It is the responsibility of each resident to document every hour worked on a rotation and to record that information in accordance with the policy of the institution or specific rotation. This information should be entered into the Medhub website daily. Failure to do so will result in disciplinary action against the resident in violation. Also, if there is a work hour violation, in any form, it is the responsibility of the resident with this knowledge to report it immediately to his or her Attending physician, the chief resident, or the program director. The program director reviews the work hour logs weekly.

Resident Clinical Experience and Education and the Working Environment

Time Management and Administrative Responsibilities

Providing residents with a sound didactic and clinical education must be a carefully planned process; it must also be balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Clinical Experience and Education assignments must reflect that faculty and residents collectively have responsibility for the safety and welfare of patients.

Clinical Experience and Education

It is ACGME policy that programs, in partnership with their sponsoring institution, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities. Clinical and educational work hours must be limited to no more than 80 hours per week, **averaged over a four-week period**. Clinical work done from home must be counted toward the 80-hour weekly maximum. Clinical work periods for all residents must not exceed 24 hours of continuous scheduled clinical assignments. Personal reading and study time does not count towards the 80 hour per week time limit.

The program must design an effective program structure that is configured to provide residents with educational opportunities as well as reasonable opportunities for rest and personal well-being.

Residents should have 8 hours off between scheduled clinical work and education periods.

There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than 8 hours free of clinical experience and education. This must occur within the context of the 80 hour and the one day off in seven requirements.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Residents must be scheduled for a minimum of 1 day in 7 free of clinical work and required education (**when averaged over 4 weeks**). At home call cannot be assigned on these free days.

Maximum Duty Clinical Work and Education Period Length

Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

Up to four (4) hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care and/or resident education.

Additional patient care responsibilities must not be assigned to a resident during this time. Clinical work and education hours do not include reading and preparation time spent away from the duty site.

Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities.

Time Management and Administrative Responsibilities

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on site in order to accomplish these tasks; however, this period of time must be no longer than an additional four (4) hours. Adjust your schedules accordingly. This includes time used for pre-rounds as well.

In rare circumstances, after handing off all other responsibilities, a resident, on his or her own initiative, may elect to remain or return to the clinical site in the following circumstances:

- To continue to provide care to a single severely ill or unstable patient
- To provide humanistic attention to the needs of a patient or family
- To attend unique educational events

Clinical Experience and Education Work Hours Policy

Clinical experience and education work hour logs are recorded daily in Medhub by residents. Failure to log work hours for seven (7) or more consecutive days may result in an administrative day for the resident.

Shifts

All rotation assignments are worked in shifts which can range from 8-16 hours.

Supervision of Residents

The following guidelines must be followed to ensure appropriate supervision of residents:

- Qualified faculty members must supervise all patient care.
- The program director must ensure, direct, and document adequate supervision of residents at all times.
- Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
- Faculty schedules must be structured to provide residents with continuous supervision and consultation.
- Faculty members and residents must be educated to recognize the signs of fatigue as well as adopt and apply policies to prevent and counteract its potential negative effects.

On-call Activities

We do not formally have “Call”. You are either working a day shift or a night shift.

At Home Call

Residents do not currently take At Home Call.

In-house call must occur no more frequently than every third night, averaged over a four-week period.

- At-home call (or pager call) is defined as a call taken from outside the assigned institution.
- The frequency of at-home call is not subject to the every third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with one (1) day in seven

(7) completely free from all educational and clinical responsibilities averaged over a four (4) week period.

- When residents are called into the hospital from home, the hours spent in the hospital are counted toward the 80-hour limit.
- The program director and faculty members must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and fatigue.
- Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for 1 day in 7 free of clinical work and education when averaged over 4 weeks.
- At-home call must not 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 provide direct care for new or established patients. These hours of in-patient patient care must be included in the 80-hour maximum weekly limit.

In-House Night Team Assignments

Night teamwork assignments must occur within the context of the 80-hour/wk averaged over 4 weeks and one (1) day off in seven (7) requirements.

Fatigue Mitigation Policy

Faculty will be educated to recognize the signs of fatigue and sleep deprivation in Grand Rounds, retreats, faculty development sessions, or faculty meetings.

Residents will be educated to recognize the signs of fatigue and sleep deprivation in Grand Rounds, retreats, and didactics held on sleep and fatigue during residency. See Sleep Deprivation and Fatigue Policy in the GME Policy Manual, 2024-2025 MSM GME Policy Maual.pdf

Patient Logs

Patient logs are to be recorded into Medhub for each patient seen in all LAE sessions. Patient logs allow the program to ensure that residents have the correct patient mix and patient number as well as session numbers.

Procedure Logs

All procedures, both real and simulated, performed and observed, will be tracked and monitored in Medhub. Residents must have an Attending verify his or her role in a specific procedure using his or her Procedure Log that is issued by the program. In addition, each resident will enter procedure logs into Medhub daily. The program director will check procedure logs on a quarterly basis and discuss issues with Residents as needed. The program director will suggest how to correct any deficiencies.

Below is the chart of the MINIMUM number of required procedures for all residents. Residents must also be certified as competent in each procedure by the time indicated on the chart. Both

the minimum number of procedures and certification of competent must be completed before the end of his/her residency.

Please be advised that most residents will do more or additional procedures in accordance with his/her individual educational curriculum. ALL procedures must be tracked and entered in Medhub.

Procedure	Minimum Number of Times Performed during Residency as determined by the residency program administration	Competency Designation Required by the End of PGY Level as determined by the residency program administration
bag-mask ventilation	5	PGY -2
bladder catheterization	2	PGY -2
IM injections	5	PGY -2
incision and drainage of abscess	5	PGY -1
lumbar puncture	8	PGY-3
neonatal endotracheal intubation	5	PGY-3
peripheral intravenous catheter placement	5	PGY -2
reduction of simple dislocation	3	PGY-3
simple laceration repair	3	PGY -1
simple removal of foreign body	3	PGY-3
temporary splinting of fracture	3	PGY -1
umbilical catheter placement	3	PGY-3
venipuncture	5	PGY -1

Competencies, Record-keeping, and Evaluations

The Accreditation Council for Graduate Medical Education (ACGME) has developed formal guidelines for competencies, both general and specialty-specific, as well as acceptable methods for evaluating these in-training programs across the United States. Competencies are to be described in a developmental pattern based on a resident's demonstrated and observed actions. A list of the critical information can be obtained from the ACGME website (http://www.ACGME.org). In addition, the pediatric Milestones can be found on Medhub and on the ACGME website. These competencies and Milestones should serve as a guide for the skills that you should strive to develop as you progress in your subspecialty education.

Medical Records Completion

Residents are expected to complete all medical records throughout their residency program promptly and accurately. Residents who do not promptly, and accurately complete medical records will not successfully complete rotations.

NOTE: To successfully complete any and all rotations, medical records must be fully and accurately completed prior to the end of the rotation.

Questions concerning the completion of medical records should be directed to the appropriate Attending physician or to a residency program director.

Resident Evaluation

Pediatric residents are evaluated throughout their three (3) years of training. The purpose of the evaluation process is to determine the value of the residency education process. The following sections outline the components of the evaluation system.

The Clinical Competency Committee (CCC)

The Clinical Competence Committee (CCC) for the Morehouse School of Medicine (MSM) Pediatrics Residency Program is charged with monitoring residents' performance and making appropriate recommendations to the program director regarding residents' progression, promotion, and disciplinary actions. At all times, the procedures and policies of the CCC will comply with those of the Graduate Medical Education Committee as outlined in the Graduate Medical Education Grievance Policy and Procedure.

The program director appoints all members and chairperson of the CCC. Members will include key clinical faculty members, who have experience in medical education and who work directly with the residents.

The committee meets a minimum of twice per year. In addition, the CCC may schedule ad hoc meetings to address urgent issues that cannot wait until the next regularly scheduled meeting.

Recommendations That Can Be Made by the CCC

The CCC will make recommendations of a resident's progression or promotion in accordance with GME's Resident Promotion Policy and Adverse Academic Decisions and Due Process Policy. For

any recommendations other than progression or promotion as deemed by the committee, the committee shall review the resident again within three (3) months or earlier as requested by the program director.

Resident Evaluation and Promotion

> **Note:** Please see appendix A for the ACGME's policy on Evaluation of Residents, Faculty, and Programs.

Resident evaluations are performed monthly and reflect achievement of the six (6) core competencies of Patient Care, Medical Knowledge, Interpersonal Skills, Practice-based Learning, Professionalism, and Systems-based Practice. A number of evaluation tools are used, including:

- Faculty, nursing, patient/family and peer assessments, and direct resident observation
- Procedure and case logs
- Written examinations
- Presentation skills assessment
- Professionalism evaluation

Additionally, each resident will maintain and submit a portfolio of assessment tools to document the core competencies and all academic activity during residency that is held by the program assistant.

Evaluations are accessed on Medhub by the residents and the preceptors. Evaluations from both the resident and preceptor will be compiled. An electronic copy will be sent to the resident and a hard copy will be placed in the resident's file.

Semi-annual evaluations will take place between each resident and a program director. These are formal sessions in which feedback is provided to the resident regarding performance. It is also an opportunity to get feedback from the resident regarding his or her self-evaluation of performance, the performance of the program, and any other concerns or issues of which the program directors should be aware of.

Residents are asked to sign the semi-annual to acknowledge the discussion of the evaluation. Information used in assessment of resident performance is derived from multiple sources, which may include:

- Performance evaluations by the preceptors
- Rotation evaluation by the resident
- Individualized Learning Plans (ILPs) accessed on PediaLink
- American Board of Pediatrics In-Service Training Exam results
- Other program quizzes
- Conference attendance records
- Feedback from clinical instructors, chief residents, and interaction with faculty members and advisors
- Letters of commendation, performance on special project (if any)

If a problem is identified with any aspect of the resident's performance or educational growth between formal evaluations, this information is shared promptly with the resident and pertinent faculty members and recorded in the resident's file. If the deficiency requires further action, as per the decision of the program director, a meeting with the resident in question will be arranged with notice to appropriate faculty members, in order to develop a remedial and corrective plan.

Such plans will contain measurable goals within a reasonable and achievable time frame for reevaluation. If the resident fails to show progress, correct the deficiencies, or fails to adhere to the corrective plan of action, the residency program will consider further prolongation of the probationary period or dismissal. Any time formal discipline is invoked, the resident has the right to due process, including appeal, as outlined in the MSM Graduate Medical Education Policies and Procedures.

Note: More information on ACGME's Semi-annuals evaluations review process can be found in Appendix A, on page 34

Faculty and Program Evaluation

Residents will also complete anonymous rotation and faculty evaluations at the end of each 4-week block rotation. Evaluations will be held and not given to the faculty member until mid- year and end-of-year. In addition, residents will complete an anonymous evaluation of the program annually from the residency program, ACGME, and institutional GME.

Resident Job Description

Basic expectations of effective job performance are listed in the Resident Job Description on page 61.

American Board of Pediatrics Evaluation Requirements

NOTE: This is ABP policy, not that of the individual program.

The American Board of Pediatrics (ABP) certification ensures the public and the medical profession that a certified pediatrician has successfully completed an accredited educational program and an evaluation, including an examination, and possesses the knowledge, skills, and experience requisite to the provision of high-quality care in pediatrics.

The program director provides ongoing evaluations of each resident in components of clinical competence that cannot easily be assessed by a written examination. These components of competence include clinical judgment, clinical skills, technical skills, professional attitudes and behavior, moral and ethical behavior, and humanistic qualities.

The program director evaluates cognitive knowledge. This is in keeping with the evaluation process described in the RRC special requirements for all pediatrics residency training programs. These annual evaluations by program directors are part of the certifying process of the ABP. The ABP recognizes that evaluation of non-cognitive skills such as medical judgment, communication, moral and ethical behavior, and behavioral skills are essential components in the verification of clinical competence in pediatrics.

The program director will indicate annually whether each resident's performance is satisfactory, marginal, or unsatisfactory. A marginal evaluation is a temporary evaluation and eventually must be changed to a satisfactory or unsatisfactory rating. If a resident's performance rating is satisfactory, credit will be given for the year in question (e.g., PGY-1 year).

If the rating is marginal, the program director will complete an individual evaluation form indicating the resident's level of performance and status in the program. The resident is required to sign this form, which is then returned to the ABP. Six months later, the program director will re-evaluate residents with marginal evaluations. Residents who receive an unsatisfactory rating at the end of the first year may be terminated by the program director or given the option to repeat the PGY-1 year. The same applies for the PGY-2 and PGY-3 years if the resident receives an unsatisfactory evaluation.

At 18 months, the resident with a marginal rating must be evaluated again. The program director must rate the resident as satisfactory or unsatisfactory. If the resident is rated satisfactory at the 18-month evaluation, he or she will receive credit for the year in question (e.g., PGY-1 year). If the resident receives an unsatisfactory rating, the program director may terminate the resident or give him or her the option to stay in the program and continue the remediation program.

If the resident receives a satisfactory evaluation at 24 months, he or she will receive credit for only the year in question (e.g., the PGY-1 year). It is necessary for residents to satisfactorily complete a PGY-2 and PGY-3 year and receive satisfactory ratings for each year. If a resident receives an unsatisfactory rating, he or she may be terminated or given the option to repeat the year in question (e.g., the PGY-1 year). He or she is required to satisfactorily complete both PGY-2 and PGY-3 years.

If the resident elects to transfer to a new program at the 18-month evaluation, the program director will inform the ABP of the transfer. The ABP will inform the new program director that the previous program director should be contacted to discuss previous evaluations and remediation. The new

program director is responsible for continuing a remediation program and evaluating the resident at the 24-month evaluation.

The program director must state whether the resident's performance is satisfactory or unsatisfactory at that time. If the resident's performance is rated as satisfactory, credit is given for the year in question (e.g., PGY-1 year). If the performance is rated as unsatisfactory, the resident may be terminated or given the option to repeat the year in question (e.g., PGY-1 year) as described previously. If a resident elects to transfer to a new program at any time during his or her training, the program director must send a transfer notice to the ABP to ensure that the resident continues the evaluation system. The new program director is encouraged to talk with the previous program director to continue remediation, if necessary.

Throughout the evaluation process, the problem resident should receive appropriate remediation so the problems may be corrected. The resident with a problem has the responsibility to work with the program director to develop an appropriate remediation program.

Although program directors are primarily responsible to keep residents informed about their evaluations, residents are responsible to stay informed about their individual evaluations. They should request feedback when it is not given by the program director. As previously emphasized, a resident must have satisfactory evaluations for each year of training for permission to take the pediatric general certifying examination.

The ABP believes that this system of evaluation will directly benefit the resident by identifying problems early so that remedial measures are started when a problem arises. Both verbal and written feedback is vital to your education and continuing professional growth. Each year, preferably more often, your program director or designee should meet independently with you to review your progress in the program. It is also your responsibility to take every opportunity to ask your program director, Attending physician, and chief resident for their assessment of your performance.

It is the primary responsibility of the program director to complete and send the annual evaluation summary to the ABP. However, it is the resident's responsibility to ensure that the evaluation is submitted to the training institution with a signed consent form.

In the case of adverse actions (marginal, unsatisfactory) by the program director, the institution must have a mechanism in place for appeal (or due process). The ABP also has an appeal process; however, appeals should be initiated at the institution where the adverse action took place. The ABP will hear candidate appeals only after all local remedies to resolve disputes over adverse judgments are exhausted.

The ABP requires that residents complete 33 months of training to be eligible to take the certifying exam in general Pediatrics. All absences in excess of 3 months must be made up. Any variation from this must be approved by the ABP.

> **NOTE:** All leave taken away from the program (e.g., vacation, sick, bereavement, maternity, or paternity leave, etc.) is subtracted from the total training time and is considered absence.

Support Services

Counseling Services

The stress associated with residency programs is well recognized. MSM offers an Employee Assistance Program (EAP) through the insurance carrier Cigna. The EAP provides confidential assistance to all MSM employees and their families. Through the EAP, residents and their families can receive confidential, professional help.

To make inquiries regarding assistance, contact MSM's Human Resources Department.

Infection Control, Occupational Safety and Health Administration (OSHA) Policies

The offices of Infection Control at MSM (Ms. Sarita Cathcart, R.N., 404-756-1353 and Grady Health System, 404-616-3598, work in close collaboration to provide the necessary services for the house staff according to written institutional policies.

The primary focus of these policies is to establish procedures in accordance with OSHA Blood Borne Pathogen Standard (1910.1030) which will protect MSM staff and employees from the hazards related to occupational exposures to blood borne pathogens and other potentially infectious materials. An infection control handbook was developed to help provide a safe work and learning environment for MSM staff, students, faculty members, and house staff.

> **NOTE:** All MSM departments and patient care facilities are responsible for standard operating procedures that will comply with this policy.

This policy is reviewed on an annual basis, or more frequently as new information becomes available.

The initial resident training during orientation includes the OSHA requirements for HCW, the IC Handbook, TB fit testing, hand washing, and the Exposure Control Plan. In addition, any specific policies and protocols related to all clinical rotation sites must be followed as needed. The Office of Infection Control started implementation of the needleless system following the National Institute for Occupational Safety and Health safety device directive in the summer of 2000; this is also included in the training. This device is a syringe in which the needle actually retracts back into the barrel after use to prevent needle sticks and blood borne pathogen exposures.

All residents are required to be up to date on their immunizations, must obtain current immunization certificates from the Office of Infection Control at MSM, and make the certificates available to the Office of Residency Program for their files. In addition, Occupational Safety and Health Administration training and TB testing must be up to date.

Hepatitis B Vaccination and Post-exposure Evaluation

As required by school policy on HIV and Hepatitis B Virus (HBV), all house staff, faculty members, and staff who have direct patient contact, who perform or take part in exposure-prone procedures (as defined in the School Policy on HIV and HBV), or who have contact with potentially infectious body fluids or laboratory materials must be immunized against hepatitis B

or demonstrate immunity. In accordance with this standard, each unit is responsible for establishing procedures such that all employees who have occupational exposure can obtain hepatitis B vaccinations at no cost. The vaccination is available after the employee receives training in accordance with this policy and within 10 working days of assignment to duty, unless immunity is established, or the vaccine is contraindicated for medical reasons.

Failure to comply with the recommendations from the Office of Infection Control may result in disciplinary action by the residency program.

For additional questions, refer to the Infection Control Handbook developed by the Office of Infection Control at MSM or consult with the Manager of the Office of Infection Control at (404) 756-1353 (Ms. Sarita Cathcart, R.N.).

Library Multi-Media Center

The MSM Multi-media Center is located on campus in the Medical Education Building. The library's collection includes textbooks, monographs, reference books, journals, videos, audiotapes, color slides, and Grateful Med. A qualified medical librarian staffs the library full time. The MSM Multi-media Center and the Atlanta University Center Woodruff Library are available for residents.

Computers

The computers located in the residency suite are available for residents to use for word processing and referencing materials. Users must leave the computers as they found them without changing settings. Loading personal software is not permitted.

Concern and Complaint Policy

> **Note:** Please see the GME Concern and Complaint Policy – for Residents and Fellows in Appendix A.

ACGME Professionalism Policy

The learning objectives of the program must:

- Be accomplished without excessive reliance on residents to fulfill non-physician service obligations and,
- Ensure manageable patient care responsibilities.

Residents and faculty members must demonstrate an understanding of their personal role in the following instances:

- Provision of patient- and family-centered care
- Safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events
- Assurance of their fitness for duty work, including:
    - Management of their time before, during, and after clinical assignments o Recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the healthcare team
- Commitment to lifelong learning
- Accurate reporting of duty, clinical, and educational work hours, patient outcomes, and clinical experience data

Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their sponsoring institutions, should have in place a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.

ACGME Resident Wellbeing Policy

Programs, in partnership with their sponsoring institutions, have the same responsibility to address wellbeing as they do to evaluate other aspects of resident competence. This responsibility must include:

- Efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships.
- Attention to scheduling, work intensity, and work compression that impacts resident wellbeing.
- Evaluating workplace safety data and addressing the safety of residents and faculty members.
- Policies and programs that encourage optimal resident and faculty member wellbeing; and, residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
- Attention to resident and faculty member burnout, depression, and substance abuse.

The program, in partnership with its sponsoring institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including the means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care.

The program, in partnership with its sponsoring institution, must:

- Encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.
- Provide access to appropriate tools for self-screening and provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

The program, in partnership with its sponsoring institution, must:

- Encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.
- Provide access to appropriate tools for self-screening and provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have corresponding policies, learning, and working environment requirements, and coverage of patient care if a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.

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Appendix A: Policies

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION PEDIATRICS RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	PED-01
		EFFECTIVE DATE	07/01/2018
		PAGE(S)	02
	SUBJECT BACKUP POLICY	SUPERSEDES	N/A

Backup Policy

I. PURPOSE:

This policy applies to situations in which a resident calls out of a shift. The following chart shows the policies in place for such situations.

Description of Shift	Intern or Resident Calls Out. Call in Backup?
HS day intern	Contact chief resident and attending to determine if back up is needed.
HS night intern	YES
HS day senior	Contact chief resident and attending to determine if back up is needed.
HS night senior	YES
HS float	NO
ED intern	Contact ED rotation course director to determine if backup is needed
ED senior resident	Contact ED rotation course director to determine if backup is needed
SRMC intern (both days and nights, weekdays and weekends)	YES
SRMC senior resident (both days and nights, weekdays and weekends)	YES
PICU	Contact PICU rotation course director to determine if backup is needed
NICU day intern	NO
NICU day senior	NO
Term nursery	NO

II. PAYING BACK A BACKUP SHIFT:

2.1. If backup is called in, the resident who called out must pay back that shift. For example, resident A calls out of the PICU and resident B is called in to back up. In the future, resident A will work a PICU shift that resident B was originally scheduled to work.

2.2. Even if backup is not called in for any of the shifts in the chart above, the resident who called out will still be required to make up the shift at a later time. For example, if resident A calls out of an ED shift and backup is not called in, resident A still must take an additional ED shift in the future. This is at the discretion of the rotation preceptor and Program Director.

2.3. The only exceptions to this are the following instances:

2.3.1. For PICU, the course director would be contacted to determine if another shift could even be scheduled.

2.3.2. For term nursery, whether the resident must make up the missed shift or not is at the discretion of the program director.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION PEDIATRICS RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	PED-02
		EFFECTIVE DATE	07/01/2017
		PAGE(S)	06
	SUBJECT SUPERVISION OF PEDIATRIC RESIDENTS POLICY	SUPERSEDES	10/01/1992 07/01/2017

Supervision of Pediatric Residents Policy

I. PURPOSE:

The purpose of this policy is to ensure that the quality of Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) meets the standards outlined in the **Graduate Medical Education Directory**: "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition) and the specialty program goals and objectives. The Pediatric Resident Physician is expected to progressively increase his or her level of proficiency with the provision of predetermined levels of supervision.

II. SCOPE:

All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents and accredited affiliates, shall understand and support this policy and all other policies and procedures that govern both GME programs and Resident appointments at MSM.

III. POLICY:

III.1. Supervision in the setting of graduate medical education has the following goals:

III.1.1. To ensure the provision of safe and effective care to the individual patient

III.1.2. To ensure the development of each Pediatric Resident's skills, knowledge, and attitudes required to enter the unsupervised practice of medicine

III.1.3. To establish a foundation for continued professional growth

III.2. In the clinical learning environment, each patient must have an identifiable, appropriately credentialed, and privileged Attending physician (or licensed independent practitioner) who is ultimately responsible for that patient's care. This information should be available to Pediatric Residents, faculty members, and patients.

III.3. Pediatric Residents and faculty members should inform patients of their respective roles in each patient's care.

III.4. The program must demonstrate that the appropriate level of supervision is in place for all Pediatric Residents who care for patients.

III.4.1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each Pediatric Resident must be assigned by the Program Director and faculty members.

III.4.2. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each Pediatric Resident. Faculty members functioning as supervising physicians should delegate portions of care to Pediatric Residents based on the needs of the patient and the skills of the Pediatric Residents.

III.4.3. Senior Pediatric Residents should serve in a supervisory role of junior Pediatric Residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual Pediatric Resident.

III.4.4. Programs must set guidelines for circumstances and events in which Pediatric Residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

Scenarios Requiring Resident to Contact Supervising Attending

1. Concern that patient at Hughes Spalding ED is not appropriate for admission at Hughes Spalding inpatient
2. Clinical deterioration of patient
3. The patient admitted to Hughes Spalding inpatient needs transfer to ICU
4. Unplanned/unanticipated discharge during night shift
5. Uncertainty about the immediate plan of care for the patient
6. Nurse, RT, or other ancillary staff reluctant to carry out orders
7. Consultant recommendations disagree with the primary team
8. Social issues such as family wanting to leave Against Medical Advice (AMA) or needing to invoke the Terrell Peterson Act

III.4.5. Each Pediatric Resident must know the limits of his or her scope of authority, and the circumstances under which he or she is permitted to act with conditional independence. In particular, PGY-1 Pediatric Residents should be supervised either directly or indirectly with direct supervision immediately available.

III.4.6. Faculty and Pediatric Residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

IV. LEVELS OF SUPERVISION:

IV.1. To ensure appropriate pediatric resident supervision and oversight, graded authority, and responsibility, the program must use the following classifications of supervision:

IV.1.1. Direct Supervision: the supervising physician is physically present with the resident and patient.

IV.1.2. 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.

IV.1.3. 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.

IV.1.4. Oversight: the supervising physician is available to provide review of procedures and encounters with feedback provided after care is delivered.

V. SUPERVISION OF PROCEDURAL COMPETENCY:

5.1. Residents shall obtain competence in pediatrics to be able to treat and manage patients in a qualified manner.

5.2. This competence shall be evaluated and documented as to success and qualifications.
The following protocol is used for administration of certifying pediatric residents' procedural competency.

5.2.1. Pediatric residents must be instructed and evaluated in procedural techniques by a licensed independent practitioner (LIP) who is certified as competent independently perform that

procedure or who has been credentialed by the Medical Staff Office to perform that procedure.

5.2.2. The Attending physician or program director is responsible for assessing procedural competency based on direct observation and/or identifying the number of procedures which must be completed successfully to grant proficiency.

5.2.3. The program director for each training program will be responsible for maintaining an updated list of pediatric residents who have been certified as competent to perform procedures independent of direct supervision.

5.2.4. The program director must also develop a method for surveillance of continued competency after it is initially granted.

5.2.5. The ability to obtain and document informed consent is an essential component of procedural competency. The supervising LIP must also supervise and attest to the trainee's competence in obtaining and documenting informed consent.

5.2.6. Until a pediatric resident trainee is judged competent in obtaining informed consent, he or she may only obtain informed consent while supervised by an individual with credentials in that procedure.

Graduated Responsibility and Supervision Policy in Ambulatory Settings

The supervising attending will be available as a resource and consultant for Pediatric Residents of all training levels. The attending will review and sign all charts.

Privileges may be revoked at any time according to the judgment of the supervising attending.

Amount of Training	Supervision Required
0-6 months	Each patient will be discussed with the Attending physician immediately after being seen by the Resident physician. Each patient (parent) will be interviewed and examined by the Attending physician personally to verify key findings presented by the Resident.
7-12 months	Each patient will be discussed with the Attending physician immediately after being seen by the Resident physician. Key portions of the history and physical will be repeated by the Attending physician.
13-24 months	Each patient will be discussed with the Attending physician immediately after being seen by the Resident physician. Key portions of the history and physical will be repeated by the Attending physician as the Attending physician deems necessary.
>24 months	The Resident may work independently during the clinical session with a discussion of each patient with the Attending before the close of the clinical session. Attending physicians may repeat the key portion of the history and physical examination of severely ill and/or complex patients, at his or her discretion.

VI. Graduated Responsibility and Supervision Policy in Inpatient Care Settings

Inpatient Care Setting	Procedure	Documentation
New Admission	Residents will notify the attending physician upon patient admission. The urgency of notification is based on the severity and acuity of the patient. The attending physician must see and evaluate the patient within one calendar day of admission	Resident Documentation of attending physician supervision (e.g., "I have seen and/or discussed the patient with my attending physician, Dr. 'X,' who agrees with my assessment and plan.").
Continuing Care	Attending physician is personally involved in ongoing care.	Resident documentation of Attending physician supervision, e.g., "I have seen and/or discussed the patient with my departmental Attending physician, Dr. X, who agrees with my assessment and plan."
Intensive Care	Because of the unstable nature of patients in ICUs, involvement of the Attending physician is expected on admission and on a daily basis.	Resident documentation of Attending physician supervision, e.g., "I have seen and/or discussed the patient with my departmental Attending physician, Dr. X, who agrees with my assessment and plan."
Hospital Discharge/ Transfer	The Attending physician must be involved in the decision to discharge or transfer the patient.	Resident documentation of Attending physician supervision, e.g., "I have seen and/or discussed the patient with my departmental Attending physician, Dr. X, who agrees with my assessment and plan."

All pediatric residents involved in inpatient care of patients have faculty supervision. PGY-1 residents are directly supervised by senior pediatric residents (PGY-2 or PGY-3) and by an Attending faculty physician.

Amount of Training	**Supervision Required**
0-6 months	Each new admission will be interviewed and examined alongside a senior resident (>12 months experience) or an Attending physician, or immediately after being seen by the intern. Inpatients will be interviewed and examined alongside a senior resident (>12 months experience) or an Attending physician, or within four (4) hours after being seen by the intern. The intern's H&P, progress notes, and orders must be personally verified by the senior resident (or Attending).
Amount of Training	**Supervision Required**
7-12 months	Each new admission will be interviewed and examined by a senior resident (>12 months experience) or an Attending physician soon after being seen by the intern. Inpatients will be interviewed and examined by a senior resident or Attending physician within four (4) hours after being seen by the intern. The intern's H&P, progress notes, and orders must be personally verified by the senior resident (or Attending).
13-24 months	Each new admission (those who have already been examined by an ER Attending physician immediately before admission) will be discussed with and examined by an inpatient Attending physician within 18 hours of being admitted. Inpatients will be interviewed and examined by an Attending physician within 24 hours after being seen by the resident. H&Ps, progress notes, and orders will be verified by the Attending.

>24 months	Each new admission (those who have already been examined by an ER Attending physician immediately before admission) will be discussed with and examined by an inpatient Attending physician within 18 hours of being admitted. Inpatients will be interviewed and examined by an Attending physician within 24 hours after being seen by the resident. H&Ps, progress notes, and orders will be verified by the Attending.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION PEDIATRICS RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	PED-03
		EFFECTIVE DATE	07/01/2017
		PAGE(S)	05
	SUBJECT PATIENT HAND-OFF POLICY	SUPERSEDES	N/A

Transitions of Care Policy

I. PURPOSE:

The purpose of this policy is to define a safe process to convey important information about a patient's care when transferring care responsibility from one physician to another.

II. BACKGROUND:

2.1. In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. Hand-off refers to the orderly transmittal of information, face to face, that occurs when transitions in the care of the patient are occurring.

2.2. A proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during that shift. In summary, the primary objective of a hand-off is to provide complete and accurate information about a patient's clinical status, including current condition and recent and anticipated treatment. The information communicated during a hand-off must be complete and accurate to ensure safe and effective continuity of care.

III. SCOPE:

These procedures apply to all MSM physicians who are teachers or learners in a clinical environment and have responsibility for patient care in that environment.

IV. POLICY:

4.1. **Transitions of Care -** The Sponsoring Institution must facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care and in partnership with its ACGME-accredited program(s), ensure and monitor effective structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites.

4.2. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.

4.3. Programs and clinical sites must maintain and communicate schedules of Attending physicians and residents currently responsible for care.

4.4. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in ACGME Common Program Requirement VI.C.2 (Resident Well-Being), if a resident is unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.

A Sample Hand-Off Format

Shift Date: _____/_____/_____ **Shift Time (24 hour): _____**

By my signature below, I acknowledge that the following events have occurred:

1. Interactive communications allowed for the opportunity for questioning between the giver and receiver about patient information.

2. Up-to-date information regarding the patient's care, treatment and services, condition, and any recent or anticipated changes was communicated.

3. A process for verification of the received information, including repeat-back or readback as appropriate, was used.

4. An opportunity was given for the receiver of the hand-off information to review relevant patient historical information, which may include previous care and/or treatment and services.

5. Interruptions during hand-offs were limited in order to minimize the possibility that information would fail to be conveyed, not be heard, or forgotten.

_____ _____

Receiving Resident's Name and Signature Date/Time

_____ _____

Departing Resident's Name and Signature Date/Time

Hand-Off Policy Checklist for Residents

The following checklist of elements should be included in written and verbal hand offs.

I	Illness Severity	☐ Stable, “watcher,” unstable
P	Patient Summary	☐ Summary statement ☐ Events leading up to admission ☐ Hospital course ☐ Ongoing assessment ☐ Plan
A	Action List	☐ To-do list ☐ Timeline and ownership
S	Situation Awareness and Contingency Planning	☐ Know what’s going on ☐ Plan for what might happen
S	Synthesis by Receiver	☐ Receiver summarizes what was heard ☐ Asks questions ☐ Restates key action/to-do items

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION PEDIATRICS RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	PED-04
		EFFECTIVE DATE	07/01/2017
		PAGE(S)	03
	SUBJECT SOCIAL MEDIA POLICY	SUPERSEDES	N/A

Social Media Policy

I. PURPOSE:

Online social media allow faculty, staff, and residents to engage in professional and personal conversations. These guidelines apply to residents participating in the Morehouse School of Medicine (MSM) Community Pediatric Residency Program (MSMCPRP), who identify themselves with MSM and/or use their MSM e-mail address in social media platforms such as professional society blogs, LinkedIn, Facebook, etc. for deliberate professional engagement or casual conversation. These guidelines apply to private and password-protected social media platforms as well as to open social platforms.

II. SCOPE:

2.1. In general, Morehouse School of Medicine Community Pediatric Residency Program (MSMCPRP) views Internet social networking sites positively. This includes Facebook, MySpace, Twitter, YouTube, and LinkedIn, as well as personal websites, podcasts, wikis, and blogs (individually and collectively considered "social media") among others. MSMCPRP respects the right of residents to use them as media of self-expression.

2.2. However, social media can also be abused by individuals who enter information on it or by those who access and read it with a result that MSMCPRP or its affiliates could be viewed negatively or be subject to other adverse consequences.

2.3. The term "affiliate" means any entity or person that works directly with the MSMCPRP or MSM to supervise residents or deliver services and goods to the program.

III. POLICY:

The following guidelines apply to any MSMCPRP resident who engages in the use of social media:

3.1. Residents must be respectful in all social media communications. Residents should not use obscenities, profanity, or vulgar language, nor may they engage in threatening behavior online or make defamatory statements.

3.2. Residents should only use their work e-mail for work-related forums (e.g., following a professional organization, like MSM, on Facebook). Otherwise, we strongly suggest using personal e-mail for personal communication.

3.3. "Friending" is a way to establish online communication with others on social media sites. It is highly recommended that you do not allow patients (former or current) to be added to your personal friend list. This may compromise patient privacy and confidentiality as well as overstep appropriate physician-patient boundaries. It is always acceptable to refuse inappropriate "friend" requests.

3.4. Residents may not comment through social media in any manner that conveys an impression that he or she is acting as a representative or spokesperson for MSMCPRP, MSM, or any of its affiliates. The social media policy applies to personal activity and/or professional activity that is not part of official MSMCPRP communication, and where the affiliate identifies him- or herself as an MSMCPRP resident, either through a bio, comments, or by using an MSM e-mail address.

3.5. The following disclaimer should be added to any communication whenever you identify yourself as part of MSM while not officially acting on behalf of the medical center:

> *The views and opinions expressed here are not necessarily those of Morehouse School of Medicine nor its affiliates, and they may not be used for advertising or product endorsement purposes.*

3.5.1. If you list Morehouse School of Medicine as your employer on your Facebook info tab, you must add the disclaimer on the tab as well.

3.5.2. If you do not identify yourself as being affiliated in any way with MSMCPRP, MSM, nor any of its affiliates, the policy does not apply (Vanderbilt).

3.6. Residents must not use social media to disparage the MSM faculty, program, other residents, or other affiliates of MSMCPRP, or its parent institution, Morehouse School of Medicine.

3.7. Residents must follow the same MSM guidelines in regard to:

3.7.1. Compliance (HIPAA and the protection of patient information)

3.7.2. Conflict of Interest Policy

3.8. Residents must follow general civil behavior guidelines with respect to:

3.8.1. Copyrights

3.8.2. Disclosures

3.8.3. Refraining from revealing proprietary financial or intellectual property

3.8.4. Refraining from revealing information about patient care or similar sensitive or private content (Vanderbilt)

3.9. Residents must not use social media to harass, threaten, or intimidate others. Behaviors that are prohibited include, but are not limited to:

3.9.1. Comments that are derogatory regarding race, sex, religion, color, age, disability, or any other protected status

3.9.2. Any sexually suggestive, humiliating, or demeaning comments

3.9.3. Threats or bullying comments (such as threats to stalk, haze, or physically injure others)

3.10. Residents must not use social media to discuss or engage in conduct that is prohibited by MSMCPRP and MSM policies, including but not limited to:

3.10.1. The improper or illegal use of drugs or alcohol

3.10.2. Any harassing, discriminatory, or retaliatory behavior that might violate MSMCPRP and MSM policies against harassment and discrimination

3.11. Residents must not post pictures or videos of faculty, program staff, other residents, patients, or any affiliates on a website or other social media venue without first obtaining written permission from the person or entity whose picture or video is being used.

3.12. Residents should be aware that pictures, videos, and comments posted on social media sites are often available for viewing by third parties and could be considered detrimental to MSMCPRP, MSM, or our affiliates. Therefore, in addition to the other requirements of this policy, residents must review their privacy settings on the various social media sites they use and make any adjustment to those settings or edit the content of those sites in order to be in full compliance with this policy.

3.13. Residents must comply with any applicable federal or state trademark, copyright, trade secret, or other intellectual property laws.

3.14. The use of MSMCPRP and MSM name, logo, or any copyrighted material of our organization is not allowed without prior written permission of MSM.

3.15. Remember that all content contributed on any platform becomes immediately searchable and can be immediately shared. This content immediately leaves the contributing individual's control forever. In addition, others can associate your identity to pictures.

3.15.1. If a social media posting causes you to hesitate, seriously reconsider posting the materials.

3.15.2. Likewise, if you consider posting photos or videos you would not want MSMCPRP, MSM, its affiliates, or colleagues to see, reconsider posting in order to protect the person in the photo or video or the person posting the photo or video.

3.16. If someone from the media or press contacts you about posts made in online forums that relate to MSMCPRP or MSM in any way, notify the program director and MSM Marketing and Communication before responding.

3.17. Violation of any MSMCPRP and MSM policy is inappropriate and may result in disciplinary action, up to and including termination of employment. Refer to:

3.17.1. Human Resources Performance Improvement Counseling Policy HR-014

3.17.2. Human Resources Discharge Policy HR-015

3.18. Any violation of this policy should be immediately reported to the program director.

IV. References:

4.1. http://www.scribd.com/doc/28484057/Sample-Social-Media-Policy

4.2. http://www.mc.vanderbilt.edu/root/vumc.php?site=socialmediatoolkit&doc=26923 **4.3.** http://www.umm.edu/gme/pdf/social_media.pdf

PEDIATRICS RESIDENCY PROGRAM

Resident Job Description

Effective: 3/01/2018

General Principles of the Training Program for Residents in Pediatrics at Morehouse School of Medicine:

1. The house staff physician (resident) meets the qualifications for resident eligibility outlined in the Essentials of Accreditation Council of Graduate Medical Education.
2. The house staff physician (resident) meets the qualifications for resident eligibility as outlined by Morehouse School of Medicine.
3. The position of house staff physician entails the provision of care commensurate with the house staff physician's level of training and competence, under the supervision of appropriately privileged attending teaching staff. This includes:
    - Participation in safe, effective and compassionate patient care
    - Assuming the progressive responsibility for patient care with appropriate supervision (see Appendix A)
    - Developing an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and how to apply cost containment measures in the provision of patient care
    - Participation in the educational activities of the training program and, as appropriate, the assumption of responsibility for teaching and supervising other residents and students
    - Participation in institutional orientation and education programs and other activities involving the clinical staff
    - Participation in institutional committees and councils to which the house staff physician is appointed or invited
    - Performance of these duties in accordance with the established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the house staff physician is assigned; including, state licensure requirements for physicians in training, where these exist
    - Following the rules and guidelines as directed by the MSM Pediatrics Residency Handbook.

Appendix A: Policies

Graduated Levels of Responsibility

Graduate medical education is based on the principle of progressively increasing levels of responsibility in caring for patients, under the supervision of the faculty. The faculty are responsible for evaluating the progress of each resident in acquiring the skills necessary for the resident to progress to the next level of training. Factors considered include the evaluation of the six ACGME competencies through the resident's clinical experience, professionalism, cognitive knowledge, and technical skills. These levels are defined as postgraduate years (PGY) and refer to the clinical years of training that the resident is pursuing. The requirements for training in categorical pediatrics is three years. At each level of training, there is a set of competencies that the resident is expected to master. As these are learned, greater independence is granted to the resident in the routine care of the patient at the discretion of the faculty who always remain responsible for all aspects of the care of the patient. Examples of expected competencies and responsibilities for each level follow.

Position Descriptions for Resident Physicians Specific to Level

PGY I
Individuals in the PGY I year are closely and directly supervised by senior level residents and/or faculty. Examples of tasks that are expected of PGY I physicians include (but not limited to):

- Performance of a history and physical exam with the development of an assessment and plan for each patient encountered
- Start intravenous lines
- Perform intravenous blood draw
- Order medication and diagnostic tests
- Collect and analyze test results and communicate those to the other members of the team and faculty
- Obtain informed consent
- Perform those skills and procedures, in which the ACGME requires competency during training (and other procedures as deemed important or necessary for individual career development), under the direct supervision of the faculty or senior residents at the discretion of the responsible faculty member.

The resident is expected to exhibit a dedication to the principles of professional preparation that emphasizes the primacy of patient as the focus for care. The first-year resident must develop and implement a plan for self-directed learning, reading, and research of selected topics that promote personal and professional growth and be able to demonstrate successful use of literature in managing patients. The resident should be able to communicate with patients and families about the disease process and the plan of care as outlined by the attending. The resident should also model positive behavior for medical students. At all levels, the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost-effective care.

PGY II
Individuals in the second postgraduate year are expected to perform independently the duties learned in the first year with direct supervision immediately available or indirect supervision and may supervise routine activities of the first-year residents. The PGY II should be able to demonstrate continued sophistication in the acquisition of knowledge and skills in pediatrics and further ability to function

independently in evaluating patient problems and developing a plan for patient care. In addition to the skills and knowledge expected of a PGY I, a PGY II may also:

- Respond to consults and learn the elements of an appropriate response to consultation in conjunction with the faculty member
- Order restraints or seclusion
- Perform the same procedures as the PGY I independently with indirect supervision, that he/she has achieved competency
- Perform more advanced procedures with direct (on-site) supervision of senior resident/fellow or faculty such as insertion of central lines, arterial lines, diagnostic peritoneal lavage, chest tube insertion or placement of PA catheters
- Manage critically ill patients including initial trauma care, ventilator management, resuscitation from shock, and anti-arrhythmic therapy
- Perform procedures and under the direct supervision of faculty or senior level residents

The resident should take a leadership role in teaching the PGY I and medical students the practical aspects of patient care and be able to explain complex diagnostic and therapeutic procedures to the patient and family. The resident should be adept at the interpersonal skills needed to handle difficult situations. The PGY II should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team.

PGY III

In the third year, the resident should be able to manage patients with virtually any routine or complicated condition and able to supervise the PGY I and PGY II in their daily activities. The resident is responsible for coordinating the care of multiple patients on the team assigned. The PGY III can perform progressively more complex procedures under the direct (on-site) supervision of the faculty. It is expected that the third-year resident is adept in the use of the literature and routinely demonstrates the ability to research selected topics and present these to the team. At the completion of the third year, the resident should be ready to practice pediatrics independently.

All Years

Residents at every level are expected to treat all other members of the health care team with respect and with recognition of the value of the contribution of others involved in the care of patients and their families. The highest level of professionalism is expected at all times. Residents shall follow hospital policies and procedures and support the mission, vision, and values of the facility. Residents shall always maintain a professional appearance. The resident is expected to develop an individualized learning plan. In addition to general reading in pediatrics, residents should engage in daily directed reading about problems they encounter in patient care. Residents are expected to attend all relevant conferences that are part of the educational program. The didactic portion of the educational program is designed to augment clinical experience and individual reading. Lastly, residents are required to complete all required administrative tasks, such as evaluations completion, patient logs, work hours logging, etc., in a timely manner.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-03
		EFFECTIVE DATE	07/01/2020
		PAGE(S)	03
	SUBJECT RESIDENT/FELLOW CONCERN AND COMPLAINT POLICY	SUPERSEDES	08/14/2018 06/01/2014

Concern and Complaint (Grievance) Policy for Residents and Fellows

1. **PURPOSE**:

   The Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level that minimizes conflicts of interest. (ACGME Institutional Requirements IV.D.).

   The purpose of this policy is to provide guidelines for communication of resident and fellow concerns and complaints as related to residency/fellowship training and learning environment, and to ensure that residents/fellows have a mechanism through which to express concerns and complaints.

   Note: For purposes of this policy, a concern or complaint involves issues relating to personnel, patient care, and matters related to the program or hospital training environment including professionalism and adherence to clinical and educational work (duty hour) standards.

2. **SCOPE**:
   1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, fellows and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.
   2. All residency and fellowship programs must have a program level Concern and Complaint (Grievance) policy that aligns with this GMEC policy and is included in the program's policy manual.
   3. Residents, fellows and faculty agree to work in good faith to resolve any problems or issues that distract from optimal training.

3. **CONCERN AND COMPLAINT (GRIEVANCE) POLICY**:
   1. Morehouse School of Medicine and affiliated hospitals encourage resident/fellow participation in decisions involving educational processes and the learning environment. Such participation should occur in both formal and informal interactions with peers, faculty, and attending staff.
   2. Efforts should be undertaken to resolve questions, problems, and misunderstandings as soon as they arise. Residents/fellows are encouraged to initiate discussions with appropriate parties for the purpose of resolving issues in an informal and expeditious manner.
   3. With respect to formal processes designated to address issues deemed as complaints (grievances) under the provisions of this policy, each program must have an internal process, known to residents, through which residents may address concerns. The program director should be designated as the first point of contact for this process.

4. A grievance is defined as a complaint that directly and adversely affects a residents/fellows' education, training, or professional activities as a result of an arbitrary or capricious act, or failure to act, or a violation of School policy or procedure, by the school or anyone acting officially on behalf of the school.
5. Matters that are not grievable include probation and corrective actions as detailed in the GME Adverse Academic Decisions and Due Process Policy, salary and benefits, and issues **not** relating to personnel, patient care, program or hospital training environment including professionalism and adherence to clinical and educational work (duty hour) standards.
6. If the complaint is to formally notify the institution of an incident involving harassment or discrimination, see the Morehouse School of Medicine Sex/Gender, Non-Discrimination, Anti-Harassment, and Retaliation Policy for procedures to be followed. Contact person for this policy is Marla Thompson, Title IX Coordinator for MSM, 404-752-1871, mthompson@msm.edu.

4. **CONCERN AND COMPLAINT PROCEDURE**:
    1. Reporting Structure "chain of command" for resident/fellow concerns and complaints (grievances)
        1. Step 1 - Residents and Fellows should first talk to program level persons to resolve problems and concerns. The program's chief resident(s) should be the first point of contact. If the resident/fellow believes their concern is not adequately addressed or there is a conflict of interest, then the resident/fellow should discuss their concerns with the program director or associate program director.
        2. Step 2 - If the resident/fellow is not satisfied with the program-level resolution, the individual should discuss the matter with the department chair or service director or chief of a specific hospital.
        3. Step 3 - If no solution is achieved, the resident/fellow may seek assistance from the Graduate Medical Education (GME) Designated Institutional Official (DIO), Dr. Chinedu Ivonye at civonye@msm.edu
    2. **Other Grievance Resources and Options** - If for any reason the resident does not want to discuss concerns or complaints with the chief resident, program director, associate program director, department chair, service director or chief, or Designated Institutional Official (DIO), the following resources are available:
        1. For issues involving program concerns, training matters, professionalism, or work environment, residents can contact the Graduate Medical Education Executive Director Ms. Susan Ratliff at (470) 670-670-6962 or sratliff@msm.edu.
        2. For problems involving interpersonal issues, the resident/fellow may be more comfortable discussing confidential informal issues apart and separate from the resident/fellow's parent department with the Resident Association President or President Elect.
            1. Any resident or fellow may directly raise a concern to the Resident Association Forum.
            2. Resident Association Forums and meetings may be conducted without the DIO, faculty members, or other administrators present.
            3. Residents and fellows have the option to present concerns that arise from discussions at Resident Association Forums to the DIO and GMEC.
        3. Residents and fellows can provide anonymous feedback, concerns, and complaints by completing the GME Feedback form at http://www.msm.edu/Education/GME/feedbackform.php.
            1. Comments are anonymous and cannot be traced back to individuals.
            2. **Personal follow-up regarding how feedback, concerns, or complaints**

have been addressed by departments and/or GME will be provided

only if the resident/fellow elects to include his or her name and contact information in the comments field.

4. MSM Office of Compliance and Corporate Integrity http://www.msm.edu/Administration/Compliance/index.php.
    1. The MSM Compliance Hotline 1 (855) 279-7520 is an anonymous and confidential mechanism for reporting unethical, noncompliant, and/or illegal activity.
    2. Call the Compliance Hotline or email www.msm.ethicspoint.com to report any concern that could threaten or create a loss to the MSM community including:

- Harassment—sexual, racial, disability, religious, retaliation
- Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical, and waste management safety issues
- Other reporting purposes:
    - Misuse of resources, time, or property assets
    - Accounting, audit, and internal control matters
    - Falsification of records
    - Theft, bribes, and kickbacks

Refer to the current version of the MSM 2024-2025 MSM GME Policy Maual.pdf
for detailed information regarding the Adverse Academic Decisions and Due Process Policy for matters involving resident/fellow suspension, non- renewal, non-promotion, or dismissal.

Appendix A: Policies

MSM GME Concern/Complaint Program Policy Manual Template

PROGRAM CONCERN AND COMPLAINT PROCESS

Program Name_____

Concern and Complaint Process – for Residents and Fellows
To ensure that residents and fellows can raise concerns and complaints and to provide feedback without intimidation or retaliation, and in a confidential manner as appropriate, the following options and resources are available and communicated to residents, fellows and faculty members annually.

Step One
Discuss the concern or complaint with your chief resident, service director, program manager, associate program director, and/or program director as appropriate.

Step Two
If the concern or complaint involves the program director and/or cannot be addressed in step one, residents have the option of discussing issues with the department chair or service chief of a specific hospital as appropriate.

Step Three
If you are not able to resolve your concern or complaint within your program, the following resources are available:

- For issues involving program concerns, training matters, or work environment, residents can contact the Graduate Medical Education Director (470-670-6962 or sratliff@msm.edu .

- For problems involving interpersonal issues, the Resident Association President or President Elect may be a comfortable option to discuss confidential informal issues apart and separate from the resident's parent department.

I.1.1. Residents can provide anonymous feedback/concerns/complaints to any department at Morehouse School of Medicine by completing the GME Feedback form http://www.msm.edu/Education/GME/feedbackform.php

I.1.1.1. Comments are anonymous and cannot be traced back to individuals.

I.1.1.2. **Personal follow-up regarding how feedback/concerns/complaints have been addressed by departments and/or GME will be provided only if the resident elects to include his or her name and contact information in the comments field**.

I.1.2. MSM Office of Compliance and Corporate Integrity http://www.msm.edu/Administration/Compliance/index.php
MSM Compliance Hotline 1 (855) 279-7520 is an anonymous and confidential mechanism for reporting unethical, noncompliant, and/or illegal activity. Call the Compliance Hotline or email to www.msm.ethicspoint.com to report any concern that could threaten or create a loss to the MSM community including:

- Harassment—sexual, racial, disability, religious, retaliation
- Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical, and waste management safety issues
- Other reporting purposes:
  - Misuse of resources, time, or property assets
  - Accounting, audit, and internal control matters
  - Falsification of records
  - Theft, bribes, and kickbacks

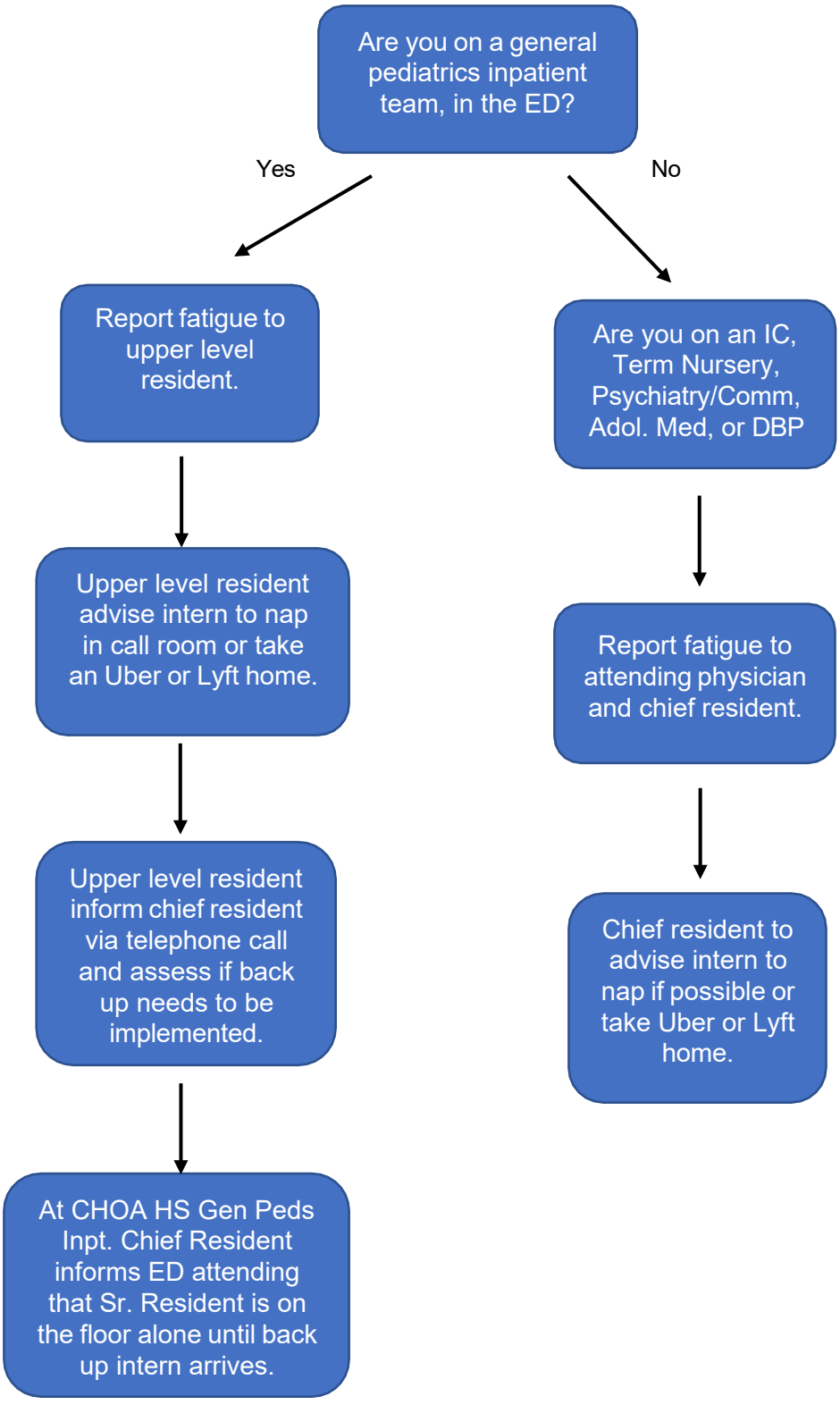
Refer to the version of the MSM 2024-2025 MSM GME Policy Maual.pdf for detailed information regarding the Adverse Academic Decisions and Due Process Policy.

MSM Pediatrics Residency Program

Process for Patient Care Handoffs When Excessively Tired

INTERNS

If circumstances arise where you are too fatigued, or sleepy to provide safe, effective patient care, please use the following algorithm:

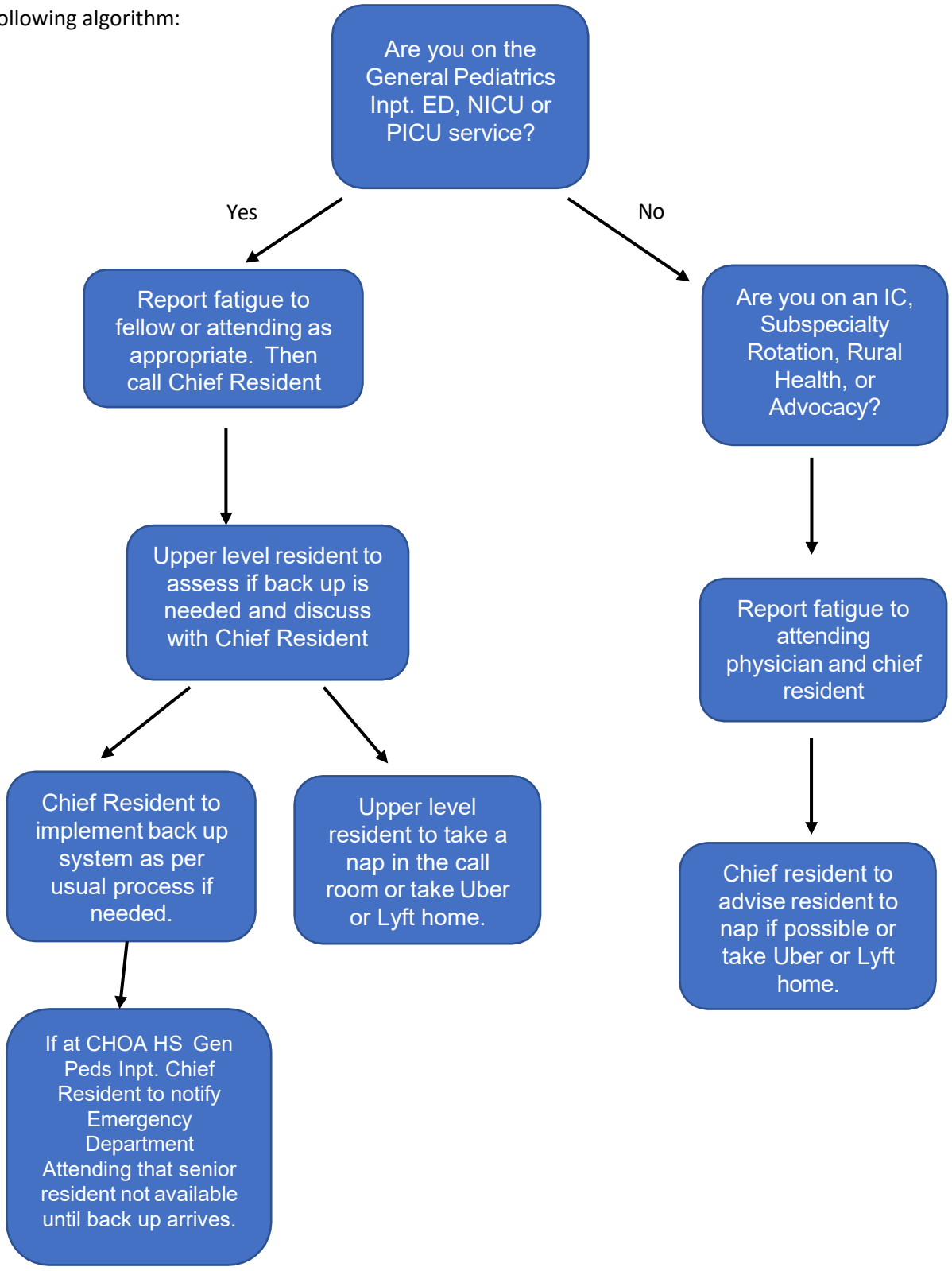


MSM Pediatrics Residency

Process for Patient Care Handoffs When Excessively Tired

2nd AND 3rd YEAR RESIDENTS

If circumstances arise where you are too fatigued, or sleepy to provide safe, effective patient care, please use the following algorithm:



Resident & Fellow Eligibility, Selection, and Appointment Policy

1. PURPOSE:

The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) comply with the Accreditation Council for Graduate Medical Education (ACGME) requirements and meet standards outlined in the Graduate Medical Education Directory: "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition). The processes for the selection of residents and fellows at MSM shall adhere to ACGME requirements, the standards outlined in the "Essentials", and this policy.

2. SCOPE:

All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and accredited affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident/fellow appointments at Morehouse School of Medicine.

3. POLICY:

3.1. This policy is bound by the parameters of residency and fellowship education and is also affected by MSM Human Resources policies. Applicants to Morehouse School of Medicine (MSM) residency and fellowship programs must be academically qualified to enter into a program.

3.2. The institution shall participate in the National Resident Matching Program (NRMP). All MSM Post-Graduate Year One (PGY-1) resident positions shall be made available for application by all students graduating from United States and Canadian accredited medical schools as determined by the NRMP. Other applicants eligible to enter the "match," including International Medical School Graduates (IMGs), may also apply.

3.3. MSM residency and fellowship programs will select from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they have applied. Aptitude, academic credentials, the ability to communicate effectively, personal characteristics such as motivation and integrity, and the ability to function within parameters expected of a practitioner in the specialty shall be considered in the selection process.

3.4. Programs must include the following GME Programs' Technical Standards and Essential Functions for Appointment and Promotion information:

3.4.1. Introduction

3.4.1.1. Medicine is an intellectually, physically, and psychologically demanding profession. All phases of medical education require knowledge, attitudes, skills and behaviors necessary for the practice of medicine and throughout a professional career. Those abilities that residents must possess to practice safely are reflected in the technical standards that follow. These technical standards/essential functions are to be understood as requirements for training in all Morehouse School of Medicine residencies and are not to be construed as competencies for practice in any given specialty.

3.4.1.2. Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.

3.4.1.3. Residents and Fellows in Graduate Medical Education programs must be able to meet these minimum standards with or without reasonable accommodation (*see* Section 3.4.7).

3.4.2. Standards**—Observation**

3.4.2.1. Observation requires the functional use of vision, hearing, and somatic sensations. Residents must be able to observe demonstrations and participate in procedures as required.

3.4.2.2. Residents must be able to observe a patient accurately and completely, at a distance as well as closely.

3.4.2.3. They must be able to obtain a medical history directly from a patient while observing the patient's medical condition.

3.4.3. Standards**—Communication**

3.4.3.1. Communication includes speech, language, reading, writing, and computer literacy.

3.4.3.2. Residents must be able to communicate effectively and sensitively in oral and written form with patients to elicit information as well as perceive non-verbal communications.

3.4.4. Standards—**Motor**

3.4.4.1. Residents must possess sufficient motor function to elicit information from the patient examination by palpation, auscultation, tapping, and other diagnostic maneuvers.

3.4.4.2. Residents must also be able to execute motor movements reasonably required for routine and emergency care and treatment of patients.

3.4.5. Standards—**Intellectual: Conceptual, Integrative, and Quantitative Abilities**

3.4.5.1. Residents must be able to measure, calculate, reason, analyze, integrate, and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions, which are critical skills demanded of physicians.

3.4.5.2. In addition, residents must be able to comprehend three-dimensional relationships and to understand spatial relationships of structures.

3.4.6. Standards—**Behavioral and Social Attributes**

3.4.6.1. Residents must possess the psychological ability required for the full utilization of their intellectual abilities for: the exercise of good judgment; for the prompt completion of all responsibilities inherent to diagnosis and care of patients; and for the development of mature, sensitive, and effective relationships with patients, colleagues, and other health care providers.

3.4.6.2. Residents must be able to tolerate taxing workloads physically and mentally and be able to function effectively under stress.

3.4.6.3. They must be able to adapt to a changing environment, display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of patients.

3.4.6.4. Residents must also be able to work effectively and collaboratively as team members.

3.4.6.5. As a component of their education and training, residents must demonstrate ethical behavior consistent with professional values and standards.

3.4.7. Standards—**Reasonable Accommodation**

3.4.7.1. MSM will make reasonable accommodations available to any qualified individual

with a disability who requests accommodation. A reasonable accommodation is designed to assist an employee or applicant in the performance of the essential functions of his or her job or MSM's application requirements.

3.4.7.2. Accommodations are made on a case-by-case basis. MSM will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in a given situation. Complete information is found on the MSM Human Resources Office of Disability Services web page at http://www.msm.edu/Administration/HumanResources/disabilityservices/index.php.

3.4.7.3. In most cases, it is the responsibility of the employee or applicant to begin the accommodation process by making MSM aware of his or her need for a reasonable accommodation. See the full MSM Accommodation of Disabilities Policy for information on how to request a reasonable accommodation.

Note: The MSM enrollment of non-eligible residents may be cause for withdrawal of residency program accreditation.

3.4.8. Title IX Compliance

3.4.8.1. The residency education environment shall be free of undue harassment, confrontation, and coercion because of one's gender, cultural and religious beliefs, other individual traits, and status or standing.

3.4.8.2. Therefore, in compliance with the Title IX of the Education Amendments of 1972, Morehouse School of Medicine (MSM) does not discriminate on the basis of sex in its education programs and activities, and is required under Title IX and the implementing regulations not to discriminate in such a manner. The prohibited sex discrimination covers sexual misconduct including, but not limited to, sexual harassment and sexual violence, and extends to employment in and admission to such programs and activities.

3.4.8.3. Also in compliance with federal law, including Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act (and ADAAA amendments), it is the policy of MSM that discrimination against any person or group of persons on the basis of race, color, national origin, religion, gender, sexual orientation, marital status, ancestry, genetic information, age, disability, veteran or military status, or any other legally protected characteristic is specifically prohibited.

3.4.8.4. MSM also prohibits retaliation against members of the MSM community who raise concerns about or report incidents of discrimination based on legally protected characteristics. The following persons have been designated to handle inquiries about and reports made under MSM's Sex/Gender Nondiscrimination and Sexual Harassment policy. Please contact HR for current policy.

Marla Thompson, Title IX Coordinator, Direct Dial (404) 752-1871, Fax (404) 752-1639; e-mail: mthompson@msm.edu

Morehouse School of Medicine, 720 Westview Drive, SW Harris Building, Atlanta, GA 30310

4. RESIDENT/FELLOW ELIGIBILITY CRITERIA:

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) Institutional Requirements Section IV.A. Institutional GME Policies and Procedures –

Resident/Fellow Recruitment, and the ACGME Common Program Requirements – Resident/Fellow Appointments/Eligibility/Transfers – section III.A-C. Sponsoring Institutions are required to have written policies and procedures for resident/fellow recruitment and must monitor each of its ACGME accredited programs for compliance.

Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

4.1. graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or,

4.2. graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or,

4.3. graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:

4.3.1. holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or,

4.3.2. holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty-/subspecialty program; or,

4.3.3. has graduated from a medical school outside the United States and has completed a Fifth Pathway program provided by an LCME-accredited medical school.

4.4. An applicant invited to interview for a resident/fellow position must be informed in writing or by electronic means, of the most current terms, conditions, and benefits of appointment to the ACGME-accredited program.

4.4.1. Information must include financial support; vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents.

4.5. Each resident/fellow in our programs must be a United States citizen, a lawful permanent resident, a refugee, an asylee, or must possess the appropriate documentation to allow the resident to legally train at Morehouse School of Medicine.

4.6. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.

4.6.1. Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from prior training program upon matriculation.

4.7. A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.

4.8. Resident Eligibility Exceptions per ACGME specialty review committees. See specialty-specific

requirements.

5. FELLOW APPOINTMENTS - ELIGIBILITY CRITERIA

5.1. Each ACGME Review Committee to choose one of the following: (please review the specialty specific eligibility criteria)

5.1.1. Option 1: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)- accredited residency program located in Canada.

5.1.1.1. Fellowship programs must receive verification of each entering fellow's level of competence in the required field, upon matriculation, using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program.

5.1.2. Option 2: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program or an AOA-approved residency program.

5.1.2.1. Fellowship programs must receive verification of each entering fellow's level of competence in the required field, upon matriculation, using ACGME Milestones evaluations from the core residency program

5.2. Fellow Eligibility Exceptions per ACGME specialty review committees. See subspecialty-specific requirements.

6. GMEC and ACGME Program Positions and Appointment Approval

6.1. Program Directors must not appoint more residents/fellows than approved by the ACGME Review Committee.

6.2. Available MSM resident positions are dependent upon the following criteria:

- The current number of residency program positions authorized by the Accreditation Council for Graduate Medical Education (ACGME)
- The space available in the Post-Graduate Year
- Funding and faculty resources available to support the education of residents/fellows according to the "educational requirements" of the specialty program.

6.3. All complement increases must be approved by the GMEC and the ACGME Review Committee. Any program requests for an official adjustment to the program's "authorized" resident complement shall be evaluated and approved by the GMEC through the Designated Institutional Official (DIO) prior to submission to the ACGME Review Committee.

7. Resident/Fellow Transfers

7.1. The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation signed by the previous program director prior to acceptance of a transferring resident/fellow, and Milestones evaluations upon matriculation.

7.1.1. Residents are considered transfer residents under several conditions including moving from one program to another within the same or different sponsoring institution and when entering a PGY-2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the match (e.g.: accepted to both programs right out of medical school). Before accepting a transfer resident, the program director of the "receiving program" must obtain written or

electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current program director.

7.1.2. The term "transfer resident" and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program. However, MSM residency programs shall identify all residents who would begin the residency program and would have to continue beyond the "Initial Residency Period."

Note: The Initial Residency Period is the length of time required to complete a general residency program (e.g.: Internal Medicine—3 years; Psychiatry—4 years).

8. For any applicant to be eligible for appointment to an MSM residency/fellowship program, the following requirements must be met along with the eligibility criteria stated above:

8.1.1. All MSM residency and fellowship programs shall participate in the National Resident Matching Program (NRMP) for PGY-1 level resident positions. All parties participating in the match shall contractually be subject to the rules of the NRMP. This includes MSM, its residency/fellowship programs, and applicants. Match violations will not be tolerated.

8.1.2. All applicants to MSM residency and fellowship programs must apply through the Electronic Residency Application Service (ERAS). This service shall be used to screen needed information on all applicants. All applicants shall request that three (3) letters of professional and/or academic references, current as of at least 18 months, be sent to the residency program administration via ERAS.

8.1.3. Programs may establish additional selection criteria (e.g.: determine specific minimum scores for the USMLE). Specific criteria must be published for applicants to review as part of the required program-level policy on eligibility and selection.

8.1.4. Residency program directors and their Residency Committees shall have program standards and criteria to review MSM residency program applications in order to ensure equal access to the program. Eligible resident/fellow applicants shall be selected and appointed only according to ACGME, NRMP, and MSM's requirements and policies.

8.1.5. Applicants from United States or Canadian accredited medical schools shall request that an original copy of a letter of recommendation or verification from the dean of the medical school be sent to the program administration via ERAS.

8.1.6. Selectees from a United States LCME- or AOA-accredited medical school shall provide proof of graduation or pending "on-time" graduation. They shall request that official transcripts, diplomas, or "on-time" letters be sent to the program via ERAS.

8.1.7. Selectees must provide official proof of passing both USMLE Step 1 and USMLE Step 2 (CK and CS) before they are eligible to begin their appointment in MSM residency programs.

8.1.8. The State of Georgia and MSM consider any time spent in a residency program as time that must be declared by the applicant when applying for a Temporary Resident Postgraduate Training Permit. This time is applicable whether the applicant completed the period of residency or not. A letter of explanation/verification is required by the applicant and the past residency program director.

8.1.9. Applicants who have not graduated from a United States or Canadian accredited medical school shall request certification of completion (by seal) by an official of the medical school. If the medical school is not in the United States, such official letters shall be in English and/or have a certified or notarized English translation of the content.

8.1.10. A current (stamped indefinite) certificate from the Educational Commission on Foreign Medical School Graduates (ECFMG) must also be submitted with ERAS documents. Initial ECFMG Certificates should not be pending when applicants are reporting to a residency program. Failure to obtain an ECFMG Certificate by the start date of the resident appointment will void both NRMP and MSM resident/fellow agreements.

8.1.11. Program directors must ensure that IMG/FMG candidates are eligible for J-1 Visa sponsorship before ranking these candidates in NRMP.

8.1.12. All selectees shall complete an MSM Non-Faculty Employment Application. The Human Resources Department is available for assistance.

8.1.13. Upon selection, all academic and employment documents referenced within this section and other documents requested by the residency program must be presented to the program administrator in their original form.

8.1.13.1. As a part of credentials authentication, documents shall be screened for authenticity and must be void of alterations.

8.1.13.2. Program administrators shall screen for signatures, seals, notarization, and other official stamps as being original.

8.2. An applicant invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment. Information that is provided must include: financial support; vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability, and other insurance accessible to residents/fellows and their eligible dependents.

8.2.1. Personal interviews of applicants shall be conducted by at least two (2) faculty members assigned to the program. These interviews should be documented for the residency program files and be retained for the period determined by MSM management policies. These interviews also become a permanent part of a selected applicant's file.

8.2.1.1. If telephone interviews are performed, the same standards and documentation criteria must be used to record the interview.

8.2.1.2. In MSM programs, the applicant's credentials and the faculty interview summary are formally presented to the Residency Program Advisory Committee (RAC) or equivalent.

8.2.2. A faculty consensus is formed on the selections for entry into the NRMP Rank Order Listing or for departmental selection for those positions not placed in the match (i.e.: PGY-2). Final disposition for applicant selection and ranking is done by the residency program director and/or department chairperson.

9. NON-IMMIGRANT APPLICANTS TO RESIDENCY PROGRAMS:

9.1. MSM supports the AAMC recommendation that the J-1 Visa is the more appropriate visa for non-immigrant International Medical School Graduates (IMGs) seeking resident positions in MSM-sponsored programs (Reference: AAMC Legislative and Regulatory Update, October 15, 1993).

9.2. All IMGs shall provide a current (stamped indefinite) certificate of proof of meeting the Educational Commission for Foreign Medical Graduates (ECFMG) requirements for clinical proficiency.

9.3. The Exchange Visitor Program is administered by the United States Department of State. The ECFMG is the sponsoring institution for alien physicians in GME programs under the Exchange

Visitor Program.

9.3.1. Applicants may be considered for selection by the residency/fellowship program based on their academic qualifications and eligibility for sponsorship by the ECFMG.

9.3.2. The MSM Human Resource (HR) and GME offices are the school liaisons for processing applications for ECFMG sponsorship of non-immigrants for J-1 status.

9.4. Applicants seeking residency positions that have other non-immigrant status such as Transitional Employment Authorization Documents, Asylum status, etc., may need to seek legal counsel to effect entry into a residency program. This review will be coordinated through the MSM HR and GME offices along with the MSM-International Programs office for final determination.

9.5. Visa categories for international-born or -educated physicians applying to United States Graduate Medical Education programs

9.5.1. Residency programs that employ individuals on visas will be responsible for an annual fee for each visa, effective each July 1.

9.5.2. Consular processing of physician visas

9.5.2.1. United States embassies/consulates require face-to-face interviews for all initial visa stamps and in some instances for the renewal of the same visa stamp.

9.5.2.2. It can take several months for a person to receive an appointment at the embassy/consulate to apply for the visa stamp.

9.5.2.3. Embassy/consulate security checks take about one (1) month.

9.5.2.4. If an applicant is selected for a security check in Washington, DC, then the process could take up to five (5) months.

9.5.2.5. After this process is started, no one can interfere.

9.5.3. The J-1 Exchange Visitor Visa

9.5.3.1. Sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG), this is the most common type of visa category used by institutions offering graduate medical education training (residency or fellowships) to international medical graduates (IMGs).

9.5.3.2. IMGs who seek to obtain this type of visa must first apply to the ECFMG for certification.

9.5.3.3. ECFMG offers the USMLE exams and is the sponsoring organization providing assurance to residency programs that the candidates meet defined qualifications equivalent of a United States medical degree. See **www.ecfmg.org**.

9.5.3.4. IMGs applying to residency programs requiring the J-1 Visa must contact the specific residency program and the Office of Graduate Medical Education where they have been accepted in a program to coordinate the J-1 Visa sponsorship with the ECFMG. ECFMG will issue the visa document (DS-2019) after the institution submits the individual's application to ECFMG.

9.5.3.5. An ECFMG Certificate is not required if the physician is a graduate of a Canadian or United States medical school. Canadian medical school graduates must have passed the equivalent Canadian medical licensing exam.

9.5.3.6. An ECFMG Certificate is not required for physicians who are graduates of LCME-accredited schools in Puerto Rico.

9.5.3.7. A visa is required if the physician is not a Unites States citizen or permanent resident

of the United States.

9.5.4. Summary of J-1 Visa for IMGs

9.5.4.1. SEVIS fee must be paid by the accepted applicant prior to the Unites States embassy interview in the applicant's home country.

9.5.4.2. Applicant is responsible for the annual application process and the corresponding fee.

9.5.4.3. J-2 dependents must enter with their own DS-2019.

9.5.4.4. The visa provides possible tax advantages (for a limited period of time).

9.5.4.5. The visa is recognized and accepted by most institutions for IMG residency training.

9.5.4.6. The applicant's spouse may seek work permission while in the United States (must process USCIS Form I-765 after entry into the United States).

9.5.4.7. The applicant must receive J-1 Visa status while in his or her home country; it is strongly recommended that status change does not occur in the United States.

9.5.4.8. The visa has a mandatory two-year foreign residency requirement (Section 212[e]) for all IMGs attending graduate medical education programs in the United States at the completion of training.

9.5.4.9. Obtaining a waiver of the foreign residency requirement is both troublesome and costly.

9.5.4.10. The visa may be extended only for Board Certification; during this time, the J-1 visitor cannot work.

9.5.4.11. The DS-2019 (J-1 application) is renewed yearly with a seven (7)-year limit or length of residency program, whichever comes first.

9.5.4.12. The J-1 Exchange Visitor may enter the United States 30 days prior to the start of the J-1 Visa and cannot be paid prior to the start date. The J-1 visitor must NOT enter the United States 30 days AFTER the start date listed on form DS-2019.

9.5.4.13. After the J-1 period ends, the exchange visitor has 30 days to exit the United States and cannot work during this "grace period."

9.5.4.14. Under this visa status, moonlighting is not permitted.

9.5.4.15. It is very difficult to process J-1 Visa applications to non-accredited residency/fellowship programs. The ECFMG uses the ACGME's Green Book for reference of accredited programs and their program duration.

9.5.4.16. The J-2 visa status is acceptable for Graduate Medical Education training at Morehouse School of Medicine (MSM) but can create problems since the J-2 depends on the J-1 Visa primary holder. The J-2 must have a valid EAD card and must also maintain the EAD card.

The H-1B Visa – Morehouse School of Medicine does not support or sponsor H-1B Visas for residency or fellowship training programs.

Appendix A: Policies

Evaluation of Residents, Faculty, and Programs Policy

I. PURPOSE:

The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition); and that MSM GME residents, fellows, and faculty, and training programs are evaluated as required in the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common, and Specialty/subspecialty specific Program Requirements.

II. SCOPE:

II.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, fellows and accredited affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.

II.2. All MSM residency and fellowship programs must:

II.2.1. Have a program-level evaluation policy and procedures for assessment and evaluation of residents, fellows, faculty, and program that are compliant with ACGME Common and Specialty Specific Requirements.

II.2.2. Utilize the Medhub System for all required evaluation components.

II.3. The GME Office will monitor all evaluation components, set up, and completion rates and provide programs with a minimum of quarterly delinquent/compliance reports.

II.4.

III. RESIDENT/FELLOW EVALUATION – Feedback and Evaluation:

III.1. Faculty Evaluation of Residents and Fellows

III.1.1. Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment

III.1.2. Evaluation must be documented at the completion of the assignment

III.1.2.1. For block rotations more than three months in duration, evaluation must be documented at least every three months.

III.1.2.2. Continuity clinic and other longitudinal experiences in the context of other clinical responsibilities, must be evaluated at least every three months and at completion

III.2. Clinical Competency Committee (CCC)

III.2.1. A Clinical Competency Committee must be appointed by the program director.

III.2.2. At a minimum the Clinical Competency Committee must include three (3) members of the program faculty, at least one of whom is a core faculty member.

III.2.3. Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents/fellows.

III.2.4. The Clinical Competency Committee must:

III.2.4.1. Review all resident/fellow evaluations at least semi-annually

III.2.4.2. Determine each resident's/fellow's progress on achievement of the specialty-specific

Milestones.

III.2.4.3. Meet prior to the resident's/fellow's semi-annual evaluations and advise the program director regarding each resident's/fellow's progress.

IV. RESIDENT/FELLOW ASSESSMENT AND EVALUATION:

IV.1. Evaluation concerning performance and progression in the residency program shall be provided to the resident throughout the duration of the program. Assessments and evaluations will measure performance against curricular standards.

IV.2. One activity within a residency program is to identify deficiencies in a resident's academic performance. This requires ongoing monitoring for early detection, before serious problems arise. The requirement is to provide the resident with notice of deficiencies and the opportunity to cure.

IV.3. The resident will be provided with a variety of supervisors, including clinical supervisors, resident trainers, and faculty advisors, with whom to discuss professional and personal concerns.

IV.4. Besides personal discussions, the resident will receive routine verbal feedback and periodic written evaluations on his or her performance and progress in the program. These measurements should highlight both positive performance and deficiencies.

IV.5. There must be an opportunity to review evaluations with supervisors and to attach a written response, preferably in the form of reflection and planning for improvement.

IV.6. At the end of each rotation, the resident will have an ACGME, competency-based, global assessment of performance for the period of assignment.

IV.6.1. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation within 14 days of completion of the rotation/assignment.

IV.6.2. Evaluations must be immediately available for review by the resident. Resident notification of completed evaluations should be set up in Medhub by requiring that residents sign off electronically on the evaluation.

IV.7. In addition to the global assessment evaluation by faculty members, multisource methods and evaluators will be used to provide an overall assessment of the resident's competence and professionalism.

IV.8. The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones and must use multiple methods and evaluators to include:

- Narrative evaluations by faculty members and non-faculty evaluators
- Other professional staff member evaluations
- Clinical competency examinations
- In-service examinations
- Oral examinations
- Medical record reviews
- Peer evaluations
- Resident self-assessments
- Patient satisfaction surveys
- Direct observation evaluation

4.8.1 This information must be provided to the CCC for its synthesis of progressive resident/fellow performance and improvement toward unsupervised practice.

IV.9. Non-cognitive skills and behaviors are observed and measured as an integral part of the evaluation process. Professionalism must be demonstrated, including the possession of a positive attitude and behavior along with moral and ethical qualities that can be objectively measured in an academic/clinical environment.

IV.10. A resident will be assigned supervisory and teaching responsibilities for medical students and junior residents as they progress through the program.

IV.11. Residents will be evaluated on both clinical and didactic performance by faculty, other residents, and medical students.

IV.11.1. **Semi-Annual Evaluation**—At least twice in each Post-Graduate Year, the residency/fellowship director or their designee, with input from the Clinical Competency Committee, must:

IV.11.2. Meet with and review with provide each resident/fellow their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones.

IV.11.3. Assist residents/fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and

IV.11.4. Develop plans for residents/fellows failing to progress, following institutional policies and procedures.

IV.12. Resident Progression Evaluation – At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program.

IV.13. Documentation of these meetings, supervisory conferences, results of all resident evaluations, and examinations will remain in the resident's permanent educational file and be accessible for review by the resident/fellow.

IV.14. ***Final Evaluation (end of residency/fellowship)***

IV.14.1. The program director must provide a final evaluation for each resident/fellow upon completion of the program.

IV.14.2. The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure that residents and fellows are able to engage in autonomous practice upon completion of the program.

IV.15. The final evaluation must:

IV.15.1. Become part of the resident's/fellow's permanent record maintained by the program with oversight of institution, and must be accessible for review by the resident/fellow in accordance with institutional policy;

IV.15.2. Verify that the resident/fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice

IV.15.3. Consider recommendations from the CCC

IV.15.4. Be shared with the resident/fellow upon completion of the program

V. FACULTY EVALUATION:

V.1. Faculty evaluations are performed annually by department chairs, in accordance with the faculty bylaws.

V.2. The program director must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually and include a review of the faculty member's

clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.

V.2.1. This evaluation must include written, anonymous, and confidential evaluations by the residents and fellows.

V.2.1.1. Programs must not allow faculty members to view these individual evaluations by residents/fellows. These evaluations of faculty must be aggregated and made anonymous and provided to faculty members annually in a summary report. This summary may be released as necessary, with program director review and approval in instances where evaluations are required for faculty promotions.

V.2.2. In order to maintain confidentiality of faculty performance evaluations, small programs with four or fewer residents/fellows may use the following:

V.2.2.1. Generalize and group residents' comments to avoid identifying specific resident feedback.

V.2.2.2. Aggregate faculty performance evaluations across multiple academic years.

V.3. Program directors must maintain continuous and ongoing monitoring of faculty performance. This may include automated alerts regarding low evaluation scores on end-of-rotation evaluations by residents, regular surveillance of end-of-rotation evaluations, and regular verbal communication with residents regarding their experiences.

V.4. Department chairs should be notified by the program director when faculty receive unsatisfactory evaluation scores. Faculty performance must be reviewed and discussed during the annual faculty evaluation review process conducted by the chair or division.

V.5. Faculty members must receive feedback on their evaluations at least annually

V.6. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.

VI. PROGRAM EVALUATION AND IMPROVEMENT:

VI.1. Program directors must appoint the Program Evaluation Committee (PEC) to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.

VI.1.1. The PEC must be composed of at least two core faculty members, at least one of whom is a core faculty member, and should include at least one resident/fellow.

VI.1.2. PEC responsibilities must include:

VI.1.2.1. Acting as an advisor to the program director, through program oversight

VI.1.2.2. Review of the program's self-determined goals and progress toward meeting them

VI.1.2.3. Guiding ongoing program improvement, including development of new goals, based upon outcomes

VI.1.2.4. Review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.

VI.2. The PEC should consider the following elements in its assessment of the program:

- Curriculum
- Outcomes from prior APEs

- ACGME LONs including citations, areas for improvement, and comments
- Quality and safety of patient care
- Aggregate resident and faculty:
    - Well-being
    - Recruitment and retention
    - Workforce diversity
    - Engagement in PSQI
    - Scholarly activity
    - ACGME Resident and Faculty Surveys and
    - Written evaluations of the program (annual GME survey)
- Aggregate resident
    - Achievement of the Milestones
    - In-training examinations
    - Board pass and certification rates
    - Graduate performance
- Aggregate faculty
    - Evaluation
    - Professional development

The PEC must evaluate the program's mission and aims, strengths, areas for improvement, and threats

The annual review, including the action plan must:

- Be distributed to and discussed with the members of the teaching faculty and the residents/fellows
- Be submitted to the DIO

The program must complete a Self-Study prior to its 10-year accreditation site visit. A summary of the self-study must be submitted to the DIO

ACGME Board Pass Rate Requirements – Section V.C.3

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

V.C.3.a - For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

V.C.3.b - For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

V.C.3.c - For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

V.C.3.d - For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

V.C.3.e - For each of the exams referenced in V.C.3.a-d, any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.

V.C.3.f - Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.

Educational Program Requirements Policy

Per ACGME Common Program Requirements Section IV. - accredited programs are expected to define their specific program aims consistent with the overall mission of their Sponsoring Institution, the needs of the community they serve and that their graduates will serve, and the distinctive capabilities of physicians it intends to graduate.

IV.A. All MSM GME programs' curriculum must contain the following educational components:

1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates;
    a. The program's aims must be made available to program applicants, residents/fellows, and faculty members.
2. Competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice.
    a. These must be distributed, reviewed, and available to residents/fellows and faculty members.
3. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision.
4. A broad range of structured didactic activities
    a. Residents/fellows must be provided with protected time to participate in core didactic activities
5. Advancement of residents'/fellows' knowledge of ethical principles foundational to medical professionalism.
6. Advancement in the residents'/fellows' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care.

IV.B. ACGME Competencies – referenced and provided in detail previously near the beginning of this policy manual.

IV.C. Curriculum Organization and Resident Experiences – MSM GME Programs must:

1. Ensure the program curriculum is structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity.
2. Provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of addiction.

IV.D. Scholarship

1. Program Responsibilities include:
    a. Demonstrating evidence of scholarly activities consistent with its mission(s) and aims.
    b. In partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities
    c. Advancing residents' knowledge and practice of the scholarly approach to evidence-based patient care.
2. Faculty Scholarly Activity (both core and non-core faculty) – programs must demonstrate accomplishments in at least three of the following domains:
    a. Research in basic science, education, translational science, patient care, or population health
    b. Peer-reviewed grants
    c. Quality improvement and/or patient safety initiatives

   d. Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
   e. Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
   f. Contribution to professional committees, educational organizations, or editorial boards
   g. Innovations in education
   h. All MSM GME Programs must demonstrate dissemination of scholarly activity within and external to the program by the following methods:
      i. Faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor
      ii. Peer-reviewed publication
3. Resident/Fellow Scholarly Activity
   a. Residents and Fellows must participate in scholarship activity.

Appendix A: Policies

	MOREHOUSE SCHOOL OF MEDICINE POLICIES AND PROCEDURES Information Technology	POLICY NUMBER	10.10.10
		EFFECTIVE	05.13.2019
	SUBJECT Mobile Device Security Policy	PAGES	2

SECTION 1: PURPOSE

Mobile devices, such as smartphones and tablet computers, are important tools for the organization and their use is supported to achieve business goals. However mobile devices also represent a significant risk to information security and data security as, if the appropriate security applications and procedures are not applied, they can be a conduit for unauthorized access to MSM's data and IT infrastructure. This can subsequently lead to data leakage and system infection.

SECTION 2: POLICY STATEMENT

MSM has a requirement to protect its information assets in order to safeguard its customers, intellectual property and reputation. This policy outlines a set of practices and requirements for the safe use of mobile devices.

SECTION 3: SCOPE OF POLICY

All mobile devices, whether owned by MSM or owned by employees, that have access to networks, data and systems, not including institutional IT-managed laptops. This includes smartphones and tablet computers.

Exemptions: Where there is a business need to be exempted from this policy (too costly, too complex, adversely impacting other business requirements) a risk assessment must be conducted being authorized by security management.

SECTION 4: DEFINITIONS

Jailbreak- To jailbreak a mobile device is to remove the limitations imposed by the manufacturer. This gives access to the operating system, thereby unlocking all its features and enabling the installation of unauthorized software.

SECTION 5: POLICY

1.1 Technical Requirements

1. Devices must use the following Operating Systems: Android 7.1 or later, IOS 10.x or later.
2. Devices must store all user-saved passwords in an encrypted password store.
3. Devices must be configured with a secure password that complies with MSM's password policy. This password must not be the same as any other credentials used within the institution.
4. With the exception of those devices managed by IT, devices are not allowed to be connected directly to the internal organization network.
5. Devices must use MSM mobile device management software MAS360.

1.2 User Requirements

1. Users must only load data essential to their role onto their mobile device(s).
2. Users must report all lost or stolen devices to MSM IT immediately.
3. If a user suspects that unauthorized access to company data has taken place via a mobile device, they user must report the incident in alignment with MSM's incident handling process
4. Devices must not be "jailbroken" * or have any software/firmware installed which is designed to gain access to functionality not intended to be exposed to the user.
5. Users must not load pirated software or illegal content onto their devices.
6. Applications must only be installed from official platform-owner approved sources. Installation of code from un-trusted sources is forbidden. If you are unsure if an application is from an approved source, contact MSM IT.
7. Devices must be kept up to date with manufacturer or network provided patches. As a minimum, patches should be checked for weekly and applied at least once a month.
8. Devices must not be connected to a PC which does not have up-to-date and enabled antimalware protection, and which does not comply with corporate policy.
9. Devices must be encrypted in line with MSM's compliance standards.
10. Users must be cautious about the merging of personal and work email accounts on their devices. They must take particular care to ensure that company data is only sent through the corporate email system. If a user suspects that company data has been sent from a personal email account, either in body text or as an attachment, they must notify MSM IT immediately.

I have received the following Morehouse School of Medicine electronic devices/equipment/accessories:

☐ Apple iPhone 7

☐ Apple charger

☐ Otterbox iPhone 7 case

Signature: _____

Printed Name: _____

Date _____

Contact Information:

Name:_____

Address: _____

Phone: _____

Resident Disaster Policy

Children's Healthcare of Atlanta (CHOA) Emergency Preparedness:
Physician's Role in Emergency Preparedness

- In the event of an emergency, Children's requests that physicians follow the direction of staff, listen for instructions over the public address system, and respond accordingly.
    - If you are not actively engaged in patient care, check with the charge person in your primary area of care to see if there is anything you can do to help.

- In the event of a mass casualty incident, all available physicians may be asked to report to a personnel pool for possible emergency assignments.
    - In such instances, specific instructions and the location of the personnel pool will be announced overhead.

Resident Closure Policy

In the event of inclement weather:

Residents who are on outpatient services or clinics that are closed are to remain at home for the days of closure unless instructed by the chief resident to do otherwise.

Residents who are on inpatient and emergency medicine services are to await instructions from either the Program Director, Associate Program Director or Chief Resident on whether to report for duty. Every effort will be made for the residents to report to their clinical service. Residents may be instructed to arrive at their clinical site the evening before the predicted inclement weather. In this event, the resident would be expected to sleep at the hospital overnight and then report for duty the next morning.

Under no circumstances is any resident to leave the hospital unless patient hand offs have been performed/completed to the provider who will assume care for your patients.

The resident is to contact the chief resident with questions or for clarifications.

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