



**Family Medicine Residency Program  
Policies and Procedures &  
Program Handbook**

**Academic Year  
2017-2018**


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## Table of Contents

Table of Contents .....	i
Legends .....	ii
Adverse Action and Due Process Policy .....	1
Program Concern and Complaint Policy .....	2
Eligibility, Selection, and Appointment Policy .....	4
Clinical Environment and Educational Work Hour Policy .....	12
Leave Policy .....	20
Evaluation Policy .....	25
Physician Impairment and Health (Substance Abuse) Policy .....	43
Professionalism and Ethics Policy .....	44
Supervision Policy .....	47
Transitions of Care Policy .....	56
USMLE & COMLEX Examination Policy .....	59
Patient Safety & Quality Improvement Policy .....	60
Research & Scholarly Activity Policy .....	63
Procedure Requirements and Logging Policy .....	66
Patient Encounter Requirements and Logging Policy .....	69
Moonlighting Policy .....	71
Well-Being Policy .....	73
ACGME Program Specific Requirements .....	75

**Legends**

<b>Acronym/ Indicator</b>	<b>Title or Signifier</b>
ACGME	Accreditation Council for Graduate Medical Education
C.P.R.	Common Program Requirements
GME	MSM Graduate Medical Education Department
PGY-1	Post Graduate Year one also known as “intern,” first year resident, or R1
PGY-2	Post Graduate Year two, second year resident, or R2
PGY-3	Post Graduate Year three, third year resident, or R3

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-01
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	01
	<u>SUBJECT:</u> ADVERSE ACTION AND DUE PROCESS POLICY	SUPERSEDES	

## **Adverse Action and Due Process Policy**

### **I. BACKGROUND**

Our goal is to assist residents to avoid situations requiring adverse academic decisions and actions. However, in instances of significant deficiencies in the core competencies or other causes for concern regarding a resident's performance or progression in the program, an adverse action may become necessary. Given the short and long term consequences of an adverse action, it is important that program have a process for deciding on the appropriate action. It is equally important that residents have a process for appealing certain types of adverse action.

### **II. PURPOSE**


The purpose of this policy is to outline the procedures that govern adverse action decisions and due process procedures relating to residents during their appointment periods. Actions addressed within this policy shall be based on the program's established evaluation and review system.

### **III. SCOPE**

All MSM Department of Family Medicine administrators, faculty, staff, residents, and administrators and faculty of MSM departments through which Family Medicine residents rotate and at participating affiliates shall understand and shall comply with this policy. Residents shall be given a copy of this Adverse Academic Decisions and Due Process policy at the beginning of their training and shall receive updates to the policy, if made, at the beginning of each postgraduate year.

### **IV. POLICY**

When situations requiring adverse action occur, the program follows the GME Adverse Academic Decisions and Due Process Policy and related MSM Human Resource policies as documented in the GME Policies link at <http://www.msm.edu/Education/GME/index.php>.

	MOREHOUSE SCHOOL OF MEDICINE INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-02
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	02
	<u>SUBJECT:</u> PROGRAM CONCERN AND COMPLAINT POLICY	SUPERSEDES	

## Program Concern and Complaint Policy

### I. BACKGROUND

Although the Program works proactively to avoid causes for concern or complaints among residents, in the event that a resident does have a complaint or concern pertaining to personnel, patient care, the program, or the hospital training environment, the Program has developed a process that ensures that residents can raise these concerns/complaints and provide feedback without intimidation or retaliation. The policy includes a mechanism for communicating concerns and complaints confidentially, as appropriate.


### II. PURPOSE

The purpose of this process is to outline the program's process for addressing concerns and complaints.

### III. POLICY

- 3.1. The process and resources available for reporting concerns and complaints are detailed below.
- 3.2. This process is reviewed annually with residents and faculty.
- 3.3. The steps of the policy are outlined below:
  - 3.3.1. Discuss the concern or complaint with the chief resident, clinical service director, program manager, associate program director, and/or program director as appropriate.
  - 3.3.2. If the concern or complaint involves the Program Director and/or cannot be addressed in Step 1, residents have the option of discussing issues with the Department Chair, Dr. Folashade Omole at [fomole@msm.edu](mailto:fomole@msm.edu) or (404) 756-1206 or the service chief of a specific hospital as appropriate.
  - 3.3.3. If the resident is not able to resolve the concern or complaint within the Program or Department, the following resources are available:
    - 3.3.3.1. For issues involving program concerns, training matters, or the work environment, residents can contact the Graduate Medical Education Director, Tammy Samuels at [tsamuels@msm.edu](mailto:tsamuels@msm.edu) or (404) 752-1011

- 3.3.3.2.** For problems involving interpersonal issues, the Resident Association President or President-Elect is available to discuss confidential informal issues that arise outside of the Department of Family Medicine (issues within the Department should first be discussed with one of the Family Medicine Chief Residents if comfortable)
- 3.3.3.3.** Anonymous feedback/concerns/complaints can be provided at any time by completing the online GME Feedback form available at the following website:  
<http://fs10.formsite.com/bbanks/form33/index.html>.
- 3.3.3.3.1.** Comments made on this site are anonymous and cannot be traced back to an individual. However, a resident may elect to provide his/name and contact information if he/she desires personal follow-up regarding how feedback/concerns/complaints have been addressed by the Departments and/or the GME office.
- 3.3.3.4.** For issues involving compliance, the MSM Compliance Hotline at (855) 279-7520 and on-line reporting portal at <https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html> are available. These are anonymous and confidential mechanisms for reporting unethical, noncompliant, and/or illegal activity and should be used to report any concern that could threaten or create a loss to the MSM community, including the following:
- Harassment- sexual, racial, disability, religious, retaliation
  - Environmental Health and Safety- biological, laboratory, radiation, laser, occupational chemical, and waste management and safety issues
  - Other- misuse of resources, time, or property assets; accounting, audit and internal control matters; falsification of records; theft, bribes, and kickbacks

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-03
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	08
	<u>SUBJECT:</u> ELIGIBILITY, SELECTION, AND APPOINTMENT POLICY	SUPERSEDES	

## Eligibility, Selection, and Appointment Policy

### I. BACKGROUND

- 1.1. Resident recruitment, selection, and appointment are an essential component of the MSM Family Medicine Program.
- 1.2. The Family Medicine Program adheres to all applicable Morehouse School of Medicine, Graduate Medical Education, and Accreditation Council for Graduate Medical Education (ACGME) regulations.

### II. PURPOSE

The purpose of this policy is to establish a program policy regarding the selection and appointment of residents.

### III. POLICY

#### 3.1. Resident Eligibility

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) "Institutional Requirements" of the "Essentials of Accredited Residencies in Graduate Medical Education."

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

- 3.1.1. Graduates of medical schools in the United States accredited by either the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA); graduates of Canadian medical schools approved by the Licentiate of the Medical Council of Canada (LMCC)
- 3.1.2. Graduates of medical schools outside the United States and Canada who have a current and valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment or who have a full and unrestricted license to practice medicine in a United States licensing jurisdiction in their current ACGME specialty/subspecialty program
- 3.1.3. United States citizen graduates from medical schools outside the United States and Canada who have successfully completed the licensure examination (USMLE Step 3) in a United States jurisdiction in which the law or regulations provide that a full and unrestricted license to practice



will be granted without further examination after successful completion of a specified period of Graduate Medical Education

- 3.1.4.** Graduates of medical schools in the United States and its territories not accredited by the LCME but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described in the paragraph above
- 3.1.5.** Those who have completed the fifth pathway, a period of supervised clinical training for students who obtained their premedical education in the United States, received medical undergraduate abroad, and passed Step 1 of the United States Medical Licensing Examination
  - 3.1.5.1.** After these students successfully complete a year of clinical training sponsored by an LCME-accredited United States medical school and pass USMLE Step 2 components, they become eligible for an ACGME-accredited residency as an international medical graduate.
  - 3.1.5.2.** The Fifth Pathway program is not supported by the American Medical Association after December 2009.
- 3.1.6.** Applicants who have passed United States Medical Licensing Examination (USMLE) Steps 1 and 2—Clinical Knowledge (CK) and Clinical Skills (CS), or have a full, unrestricted license to practice medicine issued by a United States State licensing jurisdiction.
  - 3.1.6.1.** Preference for ranking is placed on applicants with a minimum passing score of 215 on Step 1 and 230 on Step 2.
  - 3.1.6.2.** Selectees cannot begin MSM residency programs prior to passage of the Step 2 Clinical Skills (CS) examination.
  - 3.1.6.3.** This expectation must be met by the time of the MSM-GME Incoming Resident orientation.
- 3.1.7.** Each resident 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.
- 3.2.** The program director (PD) is responsible for verification of the applicants' credentials. Applicants who do not meet the criteria above cannot be considered for the Residency Program.
- 3.3.** The PD and APDs review applicants and are responsible for selection of applicants for interview.
- 3.4.** The Residency Program shall hold a meeting at the end of the interview season with the faculty members and residents who participated in the interview process to determine the final choice of applicants to be ranked in the NRMP match.

**3.5. Resident Selection**

- 3.5.1.** Applicants are selected on the basis of preparedness, ability, aptitude, academic credentials, communications skills, and personal qualities such as motivation and integrity.
- 3.5.2.** Academic credentials include medical school grades and performance as reflected in documentation received directly from the medical school, and United States Medical Licensing Examination (USMLE) scores.
- 3.5.3.** Prior graduate medical education training, where applicable, will also be considered.
- 3.5.4.** Formal educational and/or testing results submitted by the applicant may also be considered. Letters of reference from supervisors, educators, and peers, when appropriate, serve to provide additional information on personal characteristics, and are required and evaluated as well.
- 3.5.5.** The selection committee then invites selected candidates for an individual interview which is conducted in person. The interview allows in-person confirmation of information provided in the written application as well as an opportunity to assess communication and other non-cognitive skills.
- 3.5.6.** Confidential evaluations by each applicant interviewer will be collected and reviewed by the selection committee and become part of the application file.
- 3.5.7.** The committee and the PD are responsible for the final ranking of candidates in the National Resident Matching Program. All current fourth year medical students from United States medical schools are required to apply through the NRMP process or other appropriate match processes. MSM participates in the NRMP All In Policy and programs will only review applications through ERAS.
- 3.5.8. NRMP Match:**
  - 3.5.8.1.** The NRMP All In Policy requires any program participating in the Main Residency Match to register and attempt to fill all positions through the Main Residency Match or another national matching plan.
  - 3.5.8.2.** This includes all positions that may begin at the PGY-1.
  - 3.5.8.3.** The NRMP will only consider certain exceptions.
  - 3.5.8.4.** Program directors and administrators are required to review the terms and conditions of the applicable Match Participation Agreement for their specialty each year and comply with applicable match policies and the Match Commitment, which addresses violations of NRMP Policy.

- 3.5.8.5.** As noted in the Match Participation Agreement, program directors are prohibited from offering positions to ineligible applicants and must use the Applicant Match History in the Registration, Ranking, and Results (R3SM) System to determine an applicant's eligibility for appointment.
- 3.5.8.6.** As per the Match Participation Agreement, the following actions constitute a breach of the applicable Match Participation Agreement:
  - 3.5.8.6.1.** A program requesting applicants to reveal ranking preferences;
  - 3.5.8.6.2.** An applicant suggesting or informing a program that placement on a rank order list or acceptance of an offer during the Supplemental Offer and Acceptance Program (SOAP) is contingent upon submission of a verbal or written statement indicating the program's preferences;
  - 3.5.8.6.3.** A program suggesting or informing an applicant that placement on a rank order list or a SOAP preference list is contingent upon submission of a verbal or written statement indicating the applicant's preference;
  - 3.5.8.6.4.** A program requiring applicants to reveal the names or identities of programs to which they have or may apply; or
  - 3.5.8.6.5.** A program and an applicant in the Matching Program making any verbal or written contract for appointment to a concurrent-year residency or fellowship position prior to the release of the List of Unfilled Programs.
- 3.5.9.** All candidates who are interviewed shall be given a copy of the MSM appointment agreement and a copy of this policy. The program will document that the candidate has received a copy of the appointment agreement by obtaining their signature at the time of interview.
- 3.6.** Appointment: The following procedure is required before any resident can officially be appointed as a resident:
  - 3.6.1.** Primary verification of all credentials is required.
    - 3.6.1.1.** The Residency Program in conjunction with the Office of GME and the Human Resources office will conduct this verification.
    - 3.6.1.2.** It is the responsibility of the resident to provide sufficient information to allow these verifications to be conducted.

- 3.6.2.** At a minimum, the MSM Family Medicine Residency Program must be able to obtain primary source verification of the following elements:
  - 3.6.2.1.** Certification of graduation from any accredited medical school or ECFMG-certified medical institution. This documentation must be submitted directly from the academic institution granting the degree or from ECFMG directly to the residency program.
  - 3.6.2.2.** ECFMG Certification must be current—certification stamped *indefinite* must be submitted with ERAs documents.
  - 3.6.2.3.** Letters of recommendation.
  - 3.6.2.4.** Documentation accounting for any lapses between the end of medical school and the present. Large gaps of time exceeding one month that are not verifiable will disqualify candidates for consideration for a GME program.
  - 3.6.2.5.** Proper documentation of employment and/or work performed since graduation from medical school. The standard for proper documentation will be imposed by the GME program.
  - 3.6.2.6.** Passing a criminal background check.
  - 3.6.2.7.** Passing of all six competencies in a summative evaluation from the program director for any resident or fellow completing training or transferring from preliminary training or another institution.
- 3.6.3.** Applicants who do not meet the criteria stated above cannot be appointed to any graduate medical educational program at the Morehouse School of Medicine.
- 3.6.4.** Completion of primary source verifications renders an applicant eligible for appointment but does not in and of itself result in automatic appointment. Residents are eligible to proceed through the appointment process.
- 3.6.5.** The official start date is contingent upon the resident completing all required paperwork (demographic/tax form, etc.) clearance by employee health service (resident must submit a complete history and physical form), and appropriate visa, if applicable.
- 3.7.** Monitoring: This process has been reviewed by members of the Graduate Medical Educational (GME) Committee, and agreed upon as a uniform approach to evaluation and selection of residency applicants.
- 3.8.** Ensuring compliance with the eligibility and selection criteria as described above is the responsibility of each program director. Oversight for GME is the responsibility of the designated institutional official (DIO) who monitors program compliance through regular annual program accreditation review and the GMEC who reviews policies and procedures on a regular basis.

## **IV. TECHNICAL STANDARDS AND ESSENTIAL FUNCTIONS FOR APPOINTMENT AND PROMOTION**

### **4.1. BACKGROUND**

- 4.1.1.** Family 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 throughout a professional career.
- 4.1.2.** Those abilities that residents must possess to practice safely are reflected in the technical standards that follow.
- 4.1.3.** These technical standards and 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. Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.
- 4.1.4.** Residents in Graduate Medical Education programs must be able to meet these minimum standards, with or without reasonable accommodation.

### **4.2. STANDARDS**

#### **4.2.1. Observation**

- 4.2.1.1.** Observation requires the functional use of vision, hearing, and somatic sensations.
- 4.2.1.2.** Residents must be able to observe demonstrations and participate in procedures as required.
- 4.2.1.3.** Residents must be able to observe a patient accurately and completely, at a distance as well as closely.
- 4.2.1.4.** They must be able to obtain a medical history directly from a patient, while observing the patient's medical condition.

#### **4.2.2. Communication**

- 4.2.2.1.** Communication includes: speech, language, reading, writing, and computer literacy.
- 4.2.2.2.** Residents must be able to communicate effectively and sensitively in oral and written form with patients to elicit information, as well as to perceive non-verbal communications.

#### **4.2.3. Motor Functioning**

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

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

**4.2.4. Intellectual—Conceptual, Integrative, and Quantitative Abilities**

- 4.2.4.1.** 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.

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

**4.2.5. Behavioral and Social Attributes**

- 4.2.5.1.** 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 healthcare providers.

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

- 4.2.5.3.** Residents 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.

- 4.2.5.4.** Residents must also be able work effectively and collaboratively as team members. As a component of their education and training, residents must demonstrate ethical behavior consistent with professional values and standards.

**4.2.6. Accommodations**


- 4.2.6.1.** MSM will make a reasonable accommodation available to any qualified individual with a disability who requests an accommodation.

- 4.2.6.2.** 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.

- 4.2.6.3.** 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. An accommodation need not be the most expensive or ideal

accommodation, or the specific accommodation requested by the individual, so long as it is reasonable and effective.

- 4.2.6.4.** MSM will not provide a reasonable accommodation if the accommodation would result in undue hardship to MSM or if the employee, even with reasonable accommodation, poses a direct threat to the health or safety of the employee or other persons.
- 4.2.6.5.** Any decision to deny a reasonable accommodation on the basis of cost will be reviewed and approved by the Chief Financial Officer and Senior Vice President for Administration of MSM.
- 4.2.6.6.** In most cases, it is an employee's or applicant's responsibility 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.
- 4.2.6.7.** NOTE: It is important to note that the MSM enrollment of non-eligible residents may be cause for withdrawal of residency program accreditation.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-04
		EFFECTIVE DATE	06/01/2017
		PAGE(S)	08
	SUBJECT: CLINICAL ENVIRONMENT AND EDUCATIONAL WORK HOUR POLICY	SUPERSEDES	01/21/2015

## Clinical Environment and Educational Work Hour Policy

### I. **BACKGROUND**

The Family Medicine Residency Program strictly follows the Work Hour Rules as mandated by the ACGME and in keeping with the GME Resident Learning and Working Environment Policy as documented in the GME Policy Manual at <http://www.msm.edu/Education/GME/index.php>.

### II. **PURPOSE**

- 2.1. The purpose of this process is to outline the program's monitoring and oversight of work hours and document how work hour logging issues and/or violations are addressed by the Program.
- 2.2. Work hours are defined as time spent on all clinical and academic activities related to the residency program, such as patient care (both in-patient and out-patient), administrative duties related to patient care, the provision for transfer of patient care, in-house call activities, and scheduled academic conferences/didactics. Hours spent moonlighting must also be included in the work hour calculation. Work hours do not include reading and academic preparation time spent away from the work site.
- 2.3. The ACGME considers clinical and educational work hour limits to be an important element of its comprehensive approach to promote high quality education, wellness, and safe patient care. Residents must adhere to all work hour requirements as detailed below:
  - 2.3.1. Maximum Hours of Clinical and Educational Work per Week
    - 2.3.1.1. Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
  - 2.3.2. Mandatory Time Free of Clinical Work and Education
    - 2.3.2.1. 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.)



**2.3.2.2.** Residents should have eight hours off between scheduled clinical work and education periods.

**2.3.2.2.1.** There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight 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.

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

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

**2.3.3. Maximum Clinical Work and Education Period Length**

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

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

**2.3.3.1.2.** Additional patient care responsibilities must not be assigned to a resident during this time.

**2.3.4. Clinical and Educational Work Hour Exceptions**

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

**2.3.4.1.1.** to continue to provide care to a single severely ill or unstable patient;

**2.3.4.1.2.** humanistic attention to the needs of a patient or family; or,

**2.3.4.1.3.** to attend unique educational events

**2.3.4.2.** These additional hours of care or education will be counted toward the 80-hour weekly limit

**2.3.4.3.** A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

**2.3.4.3.1.** In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures.

**2.3.4.3.2.** Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.

### **III. PROGRAM DUTY HOUR MONITORING AND REPORTING PROCESS**

- 3.1.** Reporting of resident work hours is required by the residency accrediting agency, the ACGME/Residency Review Committee, and therefore, are not optional. Daily work hour logging in New Innovations is expected and logging within 5 days is required.
- 3.2.** The following guidelines apply to logging duties:
  - 3.2.1.** Logging should be continuous with no gaps (for example for lunch or travel between clinical sites).
  - 3.2.2.** Conferences should be logged contiguous with other duties with no gaps in between.
  - 3.2.3.** For in-house call, log work type "Call". For back-up call assignments when the resident has to go into the hospital, log work type "Back Up-Called In". NOTE: Back-up residents do not log if they do not go into the hospital.
  - 3.2.4.** If your 24-hour shift is extended work to post-call transitions of patient care or mandatory conferences, avoid a violation by logging the following two work types (1) post-call and (2) conferences for the hours that extend beyond the 24-hour period.
  - 3.2.5.** Log appropriate work types for moonlighting, vacation, holiday/day off, or sick days.
  - 3.2.6.** Each resident must enter written justification or cause in the event of a violation.
    - 3.2.6.1.** Justifications apply to violations of 24+ or short break rule.
    - 3.2.6.2.** Causes apply to any violation.
    - 3.2.6.3.** These must be submitted to the program director
- 3.3.** Work hour logging is monitored by the Program Manager who provides a weekly logging status report to the Program Director.
  - 3.3.1.** In the absence of a report, a review of the New Innovations Dashboard is performed weekly to assess compliance with work hour logging and to determine if any work hour violations have occurred since the last review.

- 3.3.2.** If a resident has not logged in one week or more, he/she will receive a notification from the Program Manager to encourage immediate logging. If work hours are not logged after notification from the Program Manager, the Program Director will contact the resident and a written explanation of why the work hours have not been logged must be submitted by the resident and placed in his/her file.
    - 3.3.3.** Repeated or prolonged work hour logging delinquency may result in disciplinary action as appropriate for deficiency in the Professionalism competency.
  - 3.4.** In the event that a work hour violation occurs, the resident's log is immediately flagged at which time the resident must provide a justification or explanation for the violation in New Innovations.
    - 3.4.1.** Duty hour violations are monitored and recorded in New Innovations and are automatically reported to the Program Director, Associate Program Director, and Program Manager electronically.
    - 3.4.2.** The Program Director must then review the violation and the resident's explanation of the causal circumstances to determine whether or not the violation was justified.
    - 3.4.3.** In the case of an unjustifiable violation, the Program Director must provide education to the resident, faculty member, and service involved to avoid future violations.
- 3.5.** This procedure will allow the Program Director and/or the Program Manager to both provide necessary education to individual residents and to determine if there are systemic scheduling patterns that must be adjusted.
- 3.6.** In the short term, however, work hour restrictions should not serve as a reason to jeopardize patient safety.

#### **IV. ALERTNESS MANAGEMENT & FATIGUE MITIGATION**

- 4.1.** Annually, residents and faculty are provided with education on identifying and mitigating fatigue. Fatigue in a resident can be identified either by the resident him- or herself, a fellow resident, or a faculty member. In either case, when recognized, the resident may be offered time for rest, especially if he/she has been on work for more than 16 hours continuously. In this case, appropriate patient handoff must occur before respite time begins. In the case of fatigue or anticipated fatigue due to unexpected work as in the case of labor and delivery management of a continuity patient prior to a call, a resident may discuss this with his/her chief resident(s) to develop a solution which may include a call switch or coverage of a portion of a call by another resident as long as this does not cause a work hour violation for the covering resident. Additionally, when creating the night float, call, and clinic schedules, the chief residents also assign a backup resident who is available for coverage in these situations or to come in to assist a resident on in-hospital work who is overwhelmed with an unexpected increase in patient volume or acuity.

- 4.2.** A “Safe Ride Home” policy addresses the situation in which a resident is excessively fatigued upon completion of his/her work. The policy is detailed below.
- 4.2.1. Purpose** - To outline a process whereby residents who feel too fatigued to safely drive home after a rotation day can feel encouraged to call a cab for a safe ride home from rotation and back again to retrieve their vehicle or report for work the next day and be reimbursed for the expense. The resident may in the absence of the ability to return to the original location to pick up his or her vehicle after appropriate rest obtain a cab ride back to the original destination and submit that receipt for reimbursement.
- 4.2.2. Process** - If a situation arises in which a resident is unable to safely drive home at the end of his/her shift due to extreme fatigue or the late hour, the resident is encouraged to take a nap prior to driving home if possible given the physical location and access to a secure location for sleeping. In the absence of sleeping as an option, the resident should contact a local taxi company for a safe ride home. The resident should keep the receipt from the ride and bring it to the program office within 30 days of the ride for reimbursement of 100% of the fare (tip not included). The receipt must be accompanied by a description of the circumstances that caused the fatigue and required the use of the safe drive home. All current MSM reimbursement policies apply.
- 4.2.3. Responsibility** - The program offers this service as a way to encourage a resident who is too fatigued to safely drive home to obtain a cab ride home by offering to reimburse the resident for cost of cab fare plus tip per MSM guidelines. The resident holds the responsibility in knowing when he or she needs to utilize this service. The system is not to be abused and must be utilized when absolutely necessary.

## **V. PROGRAM CALL POLICY/GUIDELINES**

- 5.1. Night Float/Call Responsibilities (5:00 p.m. to 7:00 a.m.):**
- 5.1.1.** PGY2 and PGY3 residents are assigned to the night float schedule by the Program Manager.
- 5.1.2.** Night float assignments are based on resident availability and current rotation assignments.
- 5.1.3.** Residents are not eligible for night float during the following rotation: FM Wards, ECC, Urology/Radiology, ENT/Ophthalmology, and Peds at GEP or during any month during which the attending has vacation.
- 5.1.4.** Additionally, night float assignment during the same month that a resident has a vacation is avoided although it may occur in rare instances if there are no other residents available.
- 5.1.5.** Although every effort is made to ensure equitable assignment of night float weeks, the situation occasionally arises when one resident may

have more night float sessions than another. In all cases, work hour rules are followed.

- 5.1.6.** During the week of night float, the assigned resident will cover the Family Medicine Inpatient Service at AMC-South from 5:00pm to 7:00am from Sunday to and including Friday. The resident shall not report to his/her assigned rotation during the night float week.
- 5.1.7.** During the night float shift, the night float resident assumes responsibility for the care of the patients carried by the inpatient team at the time of sign out including but not limited to ordering and reviewing lab tests and studies, reviewing notes from consultants, evaluating patients, as needed, responding to calls from nurses and the answering service, and admitting patients to the Morehouse Family Medicine and hospitalist services in accordance with established patient cap agreements.
  - 5.1.7.1.** After performing the history and physical, the resident must call the attending on call to discuss the history, physical, assessment, and proposed management for approval in order to finalize the admission orders.
  - 5.1.7.2.** Direct admissions are discouraged in the interest of patient safety. However, if an attending proposes to admit a patient directly, he/she must first discuss the patient with the inpatient attending to determine whether initial evaluation and management in the emergency department is more appropriate.
- 5.1.8.** The resident will spend the remaining three (3) to three and a half (3.5) weeks with his or her duties divided between his or her rotation and the family medicine continuity clinic.

**5.2. Long Call and Short Call**

- 5.2.1.** Residents on VA rotations who are not assigned to night float during a given month are eligible to be assigned to one long call and one short call during that month.
  - 5.2.1.1.** Long call is defined as a 24 hour call at AMC-South from 7:00 am Saturday morning to 7:00 am Sunday morning.
  - 5.2.1.2.** Short call is described as a 12-hour shift on Sunday from 7:00am to 7:00pm.
  - 5.2.1.3.** The responsibilities of the long call and short call resident are the same as the resident responsibilities described in the Night Float section above.
- 5.2.2.** In addition to the aforementioned responsibilities, the night float, short call, and long call residents are responsible for receiving, addressing, and documenting all after-hours phone calls from the FMP.

**5.2.3.** The resident will contact the FMIS attending if he or she needs any assistance or has any questions.

**5.2.4.** All phone calls must be documented in the office Electronic Health Record and the patient's primary care provider should be copied on the documentation of the conversation.

## **VI. UNUSUAL RESIDENT-INITIATED EXTENSIONS – ADDITIONAL DUTY**

**6.1.** Residents must not be assigned additional clinical responsibilities after 24 hour of continuous in-house work.

**6.2.** However, in unusual circumstances, a resident on his/her own initiative may remain at the clinical site beyond the 24 hour period to provide care to a single patient. In these cases, the following justification for extending work must meet one of the following conditions:

- provision of continuity of care for a severely ill, complex, or unstable patient
- provision of continuity for a maternity care continuity delivery patient with whom the resident has been involved
- provision of humanistic attention to the needs of a patient or family

**6.3.** In each circumstance, the following actions must be taken:

**6.3.1.** The resident must appropriately hand over the care of all other patient to the team responsible for their continuing care

**6.3.2.** The resident must document the reasons for remaining to care for the patient in New Innovations

**6.3.3.** The Program Director must review each submission of additional service and track both individual resident and program-wide episodes of additional work.

**6.4.** This program policy is consistent with Morehouse School of Medicine GME policies 7.2.2 and 7.2.3

## **VII. SENIOR RESIDENT & FELLOW – PREPARATION TO ENTER UNSUPERVISED PRACTICE OF MEDICINE**


**7.1.** Consistent with the MSM GME Policy and the ACGME Program Requirement VI.G.5.c, residents in the final year (PGY-3) of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

**7.2.** Per the ACGME Policy, this preparation must occur within the context of the following work hour rules: 80-hour work week, maximum work period length, and one-day-off-in seven.

**7.3.** However, while it is desirable that PGY-3 residents have eight hours free of work between scheduled work periods, there may be circumstances when

these residents must stay on work to care for their patients or return to the hospital with fewer than eight hours free of work.

- 7.4.** As defined by the Residency Review Committee in section VI.G.5.c.(1).(b), these circumstances are those which require continuity of care for a severely ill or unstable patient, a complex patient, a maternity care continuity delivery patient with whom the resident has been involved; events of exceptional educational value; or humanistic attention to the needs of a patient or family.
- 7.5.** These circumstances must be monitored by the Program Director.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-05
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	05
	<u>SUBJECT</u> : LEAVE POLICY	SUPERSEDES	

## Leave Policy

### I. BACKGROUND

- 1.1. The ACGME Family Medicine Program Requirements dictate that no more than 30 days may be taken away from the program during a single program year. Time away from the program for more than thirty days during a program year will result in an extension of training dates.
- 1.2. Leave time is any time away from the residency training program not related to educational purposes. Leave time does not carry over from one contract year to another.

### II. PURPOSE

The purpose of this policy is to outline the leave time that residents are eligible for and highlight the processes and procedures that need to be undertaken with various leave types.

### III. POLICIES

- 3.1. The MSM Department of Family Medicine Residency Leave Policies are consistent with the MSM Human Resources and GME Leave Policies. Please reference the GME Policy Manual at <http://www.msm.edu/Education/GME/index.php>.
- 3.2. Holidays
  - 3.2.1. Morehouse School of Medicine observes the following eleven days as official holidays: New Year's Eve, New Year Day, MLK Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving, the day after Thanksgiving, Christmas Eve, and Christmas Day.
  - 3.2.2. All Morehouse Healthcare clinics and administrative offices are closed on these days.
  - 3.2.3. Time off for a holiday is based on a resident's rotation assignment. When rotating on a clinic or service that closes due to a holiday, the resident may take that time off as paid holiday leave with approval of the program Director. Conversely, if a clinic or service is open on a holiday, the resident will be expected to be at the clinical site if assigned for work on that day.



- 3.2.4.** As hospitals are considered essential services, a resident may be required to work on a holiday.
- 3.2.5.** The resident must clarify with his/her assigned service whether or not he/she is required to work on a holiday.

### **3.3. Vacation**

- 3.3.1.** Each resident is given 15 days of vacation annually.
- 3.3.2.** Vacation may be taken in 5-day increments.
- 3.3.3.** Vacation is not permitted on half-month block rotations.
- 3.3.4.** Vacation cannot be taken during the following restricted rotations:
  - Family Medicine Wards Service
  - ICU
  - Pediatric Wards
  - Pediatric ER
  - Internal Medicine Wards
- 3.2.5** Leave requests must be submitted 110 days prior to the anticipated leave.
- 3.2.6** A fair and equitable manner will be used when approving time off requests.
- 3.2.7** Vacations must be taken in the academic year for which the vacation is granted; vacation periods do not carry over from one year to another.
  - 3.2.7.1** No two vacation periods may be concurrent from one PGY year into the next (e.g., last month of the PGY-2 year and first month of the PGY-3 year in sequence).

### **3.4. Sick Time**

- 3.4.1.** Compensated Sick Leave is 15 days per year.
- 3.4.2.** This time can be taken for illness for the resident or for the care of an “immediate” family member.
- 3.4.3.** Sick leave is not accrued from year to year.
- 3.4.4.** Available sick leave, 15 days maximum, and/or available vacation leave, 15 days maximum, may be used to provide paid leave in situations requiring time off for the purpose of caring for oneself or an immediate family member due to serious health conditions.

### **3.5. Administrative Leave**

- 3.5.1.** Administrative leave may be granted at the discretion of the program director.

**3.5.2.** Administrative leave may not exceed ten (10) days per twelve-month period.

**3.5.3.** Third-year residents can take up to five (5) days for exploring employment opportunities.

**3.5.3.1.** Time needed in excess of five (5) days should be taken from vacation time.

**3.6.** Educational Leave

**3.6.1.** Time away from the residency program for educational purposes, such as workshops or CME activities, are not counted as absences, but should not exceed five days annually.

**3.6.2.** The Program Director must approve educational conferences three (3) months (90 days) before the month in which the conference is to take place.

**3.6.3.** The total time away within any academic year cannot exceed 30 days as per ACGME requirements.

**3.6.4.** The program assistant in the Residency Office handles travel arrangements for CME.

**3.7.** Family and Medical Leave

**3.7.1.** MSM provides job-protected family and medical leave to eligible residents for up to 12 workweeks of unpaid leave during a 12-month period based on the following qualifying events:

**3.7.1.1.** Incapacity due to pregnancy, prenatal medical care, or child birth;

**3.7.1.2.** Care for the employee's child after birth, or placement for adoption or foster care;

**3.7.1.3.** Care for the employee's spouse, son, daughter, or parent, who has a serious health condition; or

**3.7.1.4.** A serious health condition that makes the employee unable to perform the employee's job.

**3.7.2.** Eligible residents who care for covered service members may also be eligible for up to 26 workweeks of unpaid leave in a single 12-month period.


**3.7.3.** Residents are eligible for FMLA leave if they have worked for MSM for at least one (1) year, have worked 1,250 hours over the previous 12 months, and have a qualifying event as outlined above.

**3.7.4.** Residents must direct all questions about FMLA leave to the Human Resources Department.

**3.8.** Leave Without Pay

- 3.8.1.** Requests for leaves of absence without pay shall be submitted in writing to the Program Director far in advance of the proposed leave, when possible. Such requests must include the reason and duration for the proposed leave.
- 3.8.2.** The Program Director must discuss the implications of the leave, including possible prolongation of the program and should ensure that the resident understands these implications.
- 3.8.3.** If the resident decides to move forward with the request, the MSM Human Resources Department must review the request for feasibility and applicable criteria before the leave is granted.
- 3.8.4.** The Office of Human Resources shall also advise the Program Director and Resident of all details and procedures.
- 3.9.** Other Types of Leave
  - 3.9.1.** All other leave types (e.g., military, bereavement, jury duty, etc.) are explained in detail in MSM's Policy Manual which is available on the Human Resources Department Intranet webpage.
- 3.10.** Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc. must not exceed a combined total of one (1) month per academic year.
- 3.11.** The resident must complete a Leave Request form for any time off. Forms must be completed by the resident and submitted to the chief resident for approval. It is the resident's responsibility to get the chief resident's signature and forward the forms to the residency program manager and the director for approval.
- 3.12.** If any changes in night call schedule are necessitated by the leave time, it is the resident's responsibility to contact the chief resident and arrange for coverage.
  - 3.12.1.** The names of the physicians covering call and clinic responsibilities must appear on the Leave Request Form and must be signed by the resident(s) agreeing to cover the call or clinic responsibility. Notification must be given to the appropriate contact person(s) at the affected clinical site(s) or CFHC front office staff.
  - 3.12.2.** Third-year residents are advised that there may be no leave during the last three weeks of residency except for extreme circumstances. Director approval is required.
- 3.13.** Return to Duty
  - 3.13.1.** For leave due to parental or serious health conditions of the resident or a family member, a physician's written "Release to Return to Duty" or equivalent is required with the date the resident is expected to return to resume his or her residency. This information is submitted to the Human Resources Department (HRD).

- 3.13.2.** When applicable, the residency program director will record in writing the adjusted date required for completion of the PGY and/or the program because of extended resident leave. One copy is placed in the resident's educational file and a copy is submitted to the Office of Graduate Medical Education (GME) to process the appropriate Personnel Action.
- 3.14. Program Leave Limitations**
  - 3.14.1.** Leave away from the training program includes the total of all leave categories taken within an academic year. This includes uncompensated Federal Family and Medical Leave and other Leave without Pay (LWOP). All/any should not exceed 30 days per year.
  - 3.14.2. The resident may be required to make up some portion of his or her share of call nights upon return to work.** Advanced notification of anticipated leave will enable the chief resident to incorporate the resident's absence into the clinic and call schedule and hopefully arrange full coverage. The chief resident will make any reassignments of call, as needed.
  - 3.14.3.** For successful completion of the program on time, and for Board eligibility in April of the PGY3 year, the American Board of Family Medicine does not permit more than 30 days leave time per year. Time away of more than 30 days will result in ineligibility to sit for the ABFM Board Examination in April of the PGY3 year. In rare instances, the PD may, at her discretion, override this rule and permit a resident to take the exam with his/her class. Leave time greater than 30 days per academic year is at the discretion of the director.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-06
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	18
	<u>SUBJECT</u> : EVALUATION POLICY	SUPERSEDES	

## Evaluation Policy

### I. **BACKGROUND**

The ACGME requires that faculty provide feedback on their performance to residents in a timely manner while during rotations, continuity clinic, and other educational assignments, and must submit a formal written evaluation at the completion of the assignment.

### II. **PURPOSE**

The purpose of this policy is to outline the procedures and processes for evaluation of residents, faculty, and the program per ACGME evaluation requirements.

### III. **POLICY**

#### 3.1. Resident Performance Evaluation

- 3.1.1. The Program assures that all residents are systematically evaluated on their knowledge, skills, performance, and professional growth on an ongoing basis throughout their training.
- 3.1.2. Each form of evaluation is designed to assess the resident using the 6 core competencies of Patient Care, Medical Knowledge, Systems Based Practice, Problem Based Learning, Professionalism, and Interpersonal Skills and Communication and assesses progression along the ACGME required Milestones.
- 3.1.3. While on clinical rotations all residents receive written and/ or verbal formative evaluations and written and verbal summative evaluation. Residents also receive feedback on their performance globally through semi-annual evaluations which provide formative evaluation throughout the course of residency training and a summative evaluation at the end of training. All information is compiled in New Innovations.
- 3.1.4. The Program has numerous evaluations in place to help assess the acquisition of the knowledge, skills, and abilities needed to independently practice clinical medicine. Evaluation tools include:
  - Direct observation
    - During continuity clinic and inpatient encounters
    - During OSCE

- Multi-Source 360 Evaluations
  - Peer to Peer
  - Clinic Staff of Resident
  - Medical Student of Resident
  - Self-Evaluation
  - Patient Satisfaction
- Faculty Evaluation of Residents on clinical rotations
- Faculty Evaluation of Resident Clinical Performance
- Milestone Evaluation/Assessment
- Semi-annual evaluation using tools listed above, ITE performance, advisor input, and resident log data
- Summative Evaluation (final evaluation of performance prior to completion of training)
- QI project participation and performance

**3.2. Clinical Competency Committee (CCC)**

**3.2.1.** The MSM Family Medicine Residency Program's Clinical Competency Committee (CCC) is charged with monitoring resident performance and making appropriate recommendations to the Program Director for a formative milestone-based evaluation of each resident based on a review of all forms of resident evaluations every six months.

**3.2.2.** At all times the policies and procedures of the CCC will comply with those of the Morehouse School of Medicine Office of Graduate Medical Education (GME) regarding promotion and dismissal and the requirements of the ACGME.

**3.2.3. CCC Composition and Membership**

**3.2.3.1.** The program director appoints all four to six members and the chairperson of the CCC.

**3.2.3.2.** The members are key faculty members involved in direct resident teaching, one of whom must be the associate or assistant program director.

**3.2.3.3.** The Family Medicine Residency program manager shall serve as a member.

**3.2.3.4.** The members are appointed for one (1) year and membership may be renewed annually.

**3.2.4. Committee Responsibilities:** The Family Medicine Residency Clinical Competency Committee will:

**3.2.4.1.** Attend all standing and ad hoc CCC meetings.

- 3.2.4.2.** Sign the confidentiality policy prior to the first CCC meeting of each academic year and must abide by said policy at all times.
  - 3.2.4.3.** Review the following documentation of resident performance at each standing meeting: evaluations by all evaluators, In-Training Exam scores, OSCE performance, research progress, advisor documentation, program director documentation, procedure logs, teaching activity, and record of remediation where applicable.
  - 3.2.4.4.** Make recommendations to the program director and associate program director (APD) for resident progress including promotion, remediation, and dismissal, in accordance with GME policies as outlined in the MSM GME Policy Manual.
- 3.2.5.** The committee chairperson will:
  - 3.2.5.1.** Comply with all responsibilities described above.
  - 3.2.5.2.** Review and edit, as needed, detailed minutes of meetings as prepared by the Program Manager of Program Assistant and disseminate the minutes to all committee members, the program director and the department chairperson.
  - 3.2.5.3.** Prepare a written recommendation of progression, promotion or adverse action to the program director.
  - 3.2.5.4.** Prepare the required semi-annual summative report of each resident's performance for each Milestone to the Family Medicine Residency program director who will review the recommended Milestone assignments, revise as needed, and submit to the ACGME by ACGME-established deadlines.
- 3.2.6.** The Family Medicine Residency program manager will maintain a file of all CCC reports and recommendations for each resident.
- 3.2.7.** Meeting Frequency
  - 3.2.7.1.** The CCC will meet four (4) times per year on the fourth Wednesday of the month.
  - 3.2.7.2.** Standing meetings shall be held in August, November, February and May.
  - 3.2.7.3.** Additionally, the committee chair may schedule ad hoc meetings at the request of the program director to address urgent matters that must be handled before the next regularly scheduled meeting.
    - 3.2.7.3.1.** Reasons for ad hoc meetings may include but are not limited to consistently low performance or unsatisfactory evaluation scores of a resident; consistent lack of adherence to program

requirements; or a specific incident that requires CCC review for possible probation or dismissal.

**3.2.7.4.** The residency program manager or designee will document each CCC meeting with meeting minutes. Minutes will be reviewed for accuracy at subsequent meetings.

**3.2.7.5.** In addition, the CCC's review and recommendation of each resident will be documented in the online residency management system, New Innovations.

**3.2.8. Procedure for Review**

**3.2.8.1.** The CCC shall evaluate the residents on a quarterly basis in order to produce a consensus recommendation on each resident. In reviewing each resident, the CCC shall consider the following evaluation tools.

**3.2.8.2.** In addition, if any resident is having academic problems or issues, he or she will be reviewed in discussion at the meeting.

**3.2.8.3.** Assessment tools and evaluation measures include:

- Rotation evaluations
- 360 evaluations (including peer, self, clinical staff)
- In-Training Exam scores
- OSCE performance reports
- Research progress
- Advisor documentation
- Program director documentation
- Procedure logs
- Noon conference attendance
- Teaching activity
- Any reports of unprofessional behavior as submitted by the program director, faculty or peers
- Record of remediation, where applicable

**3.2.8.4.** The CCC can set thresholds for remediation, probation, and dismissal.

**3.2.8.4.1.** The CCC will complete a "Notice of Deficiency Form" for all residents who receive an adverse recommendation that will be sent to the PD and designated APD.



**3.2.8.4.2.** The PD or designated APD will meet with each resident and communicate the recommendation and design a remediation or improvement plan.

**3.2.9.** Recommendations—Based on the comprehensive review of each resident’s record of performance, in the case of inadequate performance, the CCC may recommend probation with remediation or delay or deny promotion or board recommendation as appropriate for the deficiencies identified. In accordance with MSM’s “Resident Promotion Policy” and “Adverse Academic Decisions and Due Process Policy, the CCC may make the following recommendations to the PD and APD:

**3.2.9.1.** Progression—Resident is performing appropriately at current level of training with no need for remediation.

Resident should continue with the current curriculum.

**3.2.9.2.** Promotion—Resident has demonstrated performance appropriate to move to the next level of training without the need for remediation.

Resident should progress with next PGY level as scheduled.

**3.2.9.3.** Notice of Deficiency—Resident has demonstrated performance below the expected level in a specific competency across multiple evaluations, but does not require remediation.

**3.2.9.3.1.** The resident must submit a corrective action plan to eliminate the deficiency.

**3.2.9.3.2.** The CCC will prepare a statement for the grounds for Notice of Deficiency, including identified deficiencies or problem behavior.

**3.2.9.3.3.** Notice of Deficiency may be removed from the resident file if the resident is performing at satisfactory level and deemed to have corrected his or her deficiency within a time frame defined by the CCC, not to exceed six (6) months.

**3.2.9.4.** Notice of Deficiency with Remediation—Resident has demonstrated performance below the expected level in a specific competency and requires remediation.

**3.2.9.4.1.** Notice of Deficiency **REQUIRES** the resident (in conjunction with the PD and advisor) to develop a **REMEDIATION** plan to cure the deficiency.

**3.2.9.4.2.** The CCC will prepare a statement for the grounds for Notice of Deficiency and Remediation, including identified deficiencies or problem behaviors.

- 3.2.9.4.3.** The CCC must review the resident's performance every three (3) months to determine if the resident is meeting the terms of the remediation plan.
  - 3.2.9.4.4.** Remediation (total time) shall not exceed six (6) months in an academic year.
  - 3.2.9.4.5.** This recommendation remains on the resident's permanent record.
  - 3.2.9.4.6.** Failure to successfully remediate and cure the deficiency could result in extended remediation, additional training time, non-renewal, or dismissal from the program.
- 3.2.9.5.** Immediate Suspension—Resident has performed serious misconduct or has posed a threat to colleagues, faculty, staff, or patients.
  - 3.2.9.5.1.** This may result from gross unprofessional or unethical behavior, misconduct, or the serious threat to the safety of patients such that continuation of clinical activities by the resident is deemed potentially detrimental or compromising to patient safety or the quality of patient care, or threatening to the well-being of staff or the resident.
  - 3.2.9.5.2.** The CCC will prepare a statement for the grounds for suspension, including the identified deficiencies or problem behaviors.
  - 3.2.9.5.3.** Suspension shall not exceed 30 days. The CCC must conduct a review in 30 days if additional time is recommended.
  - 3.2.9.5.4.** This recommendation remains on the resident's permanent record.
- 3.2.9.6.** Probation—Resident has demonstrated challenges in specific competencies that are disruptive to the program.
  - 3.2.9.6.1.** This may result when, after documented counseling, a resident continues not to perform at an inadequate level of competence; demonstrates unprofessional or unethical behavior; engages in misconduct that could bring harm to patients, negatively impact the function of the healthcare team, or cause residency program dysfunction; or otherwise fails to fulfill the responsibilities of the program.

- 3.2.9.6.2.** The CCC will prepare a statement for the grounds for probation, including identified deficiencies or problem behaviors.
  - 3.2.9.6.3.** Probation (total time) shall not exceed six (6) months in a calendar year.
  - 3.2.9.6.4.** This recommendation remains in the permanent record.
- 3.2.9.7.** Non-Promotion—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. Resident's current level of training will be extended. Action remains in permanent record.
  - 3.2.9.7.1.** Based on repeated demonstration of deficiency(ies), the resident will not be promoted to the next level of training.
  - 3.2.9.7.2.** The CCC will prepare a statement for the grounds for non-promotion, including identified deficiencies or problem behaviors.
  - 3.2.9.7.3.** The resident's current level of training will be extended as recommended by the CCC.
  - 3.2.9.7.4.** The resident's contract shall be renewed for the next academic year.
  - 3.2.9.7.5.** This recommendation remains in the permanent record.
- 3.2.9.8.** Non-Renewal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies.
  - 3.2.9.8.1.** Based on repeated demonstration of deficiency(ies) the resident will not be promoted to the next level of training.
  - 3.2.9.8.2.** The CCC will prepare a statement for the grounds for non-renewal, including identified deficiencies or problem behaviors.
  - 3.2.9.8.3.** The resident's contract shall expire at the end of the academic year, without renewal.
  - 3.2.9.8.4.** This decision may be appealed by the resident in accordance to GME policies of Due Process ("Adverse Academic Decisions and Due Process Policy").
  - 3.2.9.8.5.** This recommendation remains on the resident's permanent record.

- 3.2.9.9.** Dismissal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies; the resident will be dismissed from the program. Action remains in permanent record.
  - 3.2.9.9.1.** Based on repeated demonstration of deficiency(ies) the resident will be immediately dismissed from the program.
  - 3.2.9.9.2.** The CCC will prepare a statement for the grounds for dismissal, including identified deficiencies or problem behaviors.
  - 3.2.9.9.3.** The decision may be appealed by the resident in accordance to GME policies of due process (“Adverse Academic Decisions and Due Process Policy”).
  - 3.2.9.9.4.** This recommendation remains on the resident’s permanent record.
- 3.2.9.10.** The CCC consensus recommendation for each resident will be submitted to the residency program director using the Clinical Competency Committee Report Form as completed by the CCC chair.
- 3.2.9.11.** All residents who receive an adverse recommendation shall also receive written notice of the CCC recommendation of adverse action form.
- 3.2.9.12.** The program director shall review all recommendations, and the PD and APD will meet with each resident to communicate his or her recommendation.
- 3.2.9.13.** A copy of all adverse decisions shall also be sent to the affected resident’s advisor for review.
- 3.2.9.14.** The advisor will then work in concert with the program director and resident to develop the remediation plan.
- 3.2.10.** Faculty Development
  - 3.2.10.1.** In order to ensure the greatest usefulness of the data reviewed by the CCC, the CCC will conduct, with the assistance of the Morehouse School of Medicine Office of Graduate Medical Education; two faculty development sessions will be held annually.
    - 3.2.10.1.1.** One will cover completing resident evaluations
    - 3.2.10.1.2.** One will cover the Family Medicine residency milestones.

- 3.2.10.2.** Prior to each evaluation session, a faculty committee meets to discuss the resident's performance and to arrive at the summary with specific recommendations.
- 3.2.10.3.** The results of the faculty appraisal are shared with each resident individually by the resident faculty advisor.
- 3.2.10.4.** The resident is asked to sign the summary form to acknowledge discussion of the evaluation.
- 3.2.10.5.** Information used in assessment of resident performance is derived from multiple sources, which may include:
  - 3.2.10.5.1.** If any time, at or between the formal six-month evaluations a problem is identified with any portion of the resident's performance and educational growth, this information will be shared promptly with the resident.
  - 3.2.10.5.2.** The information will be documented. If there is a deficiency that the faculty or the program director decides requires further action, a future meeting will be arranged with the appropriate faculty members and the resident to devise a plan of corrective action. Such plans will contain measurable goals and a specific timeframe for re-evaluation.
  - 3.2.10.5.3.** If the resident fails to show progress in correcting the deficiencies or fails to adhere to the plan of corrective actions, further recommendations, including possible probation or dismissal from the program, may ensue.
  - 3.2.10.5.4.** Any time formal discipline is invoked, the resident has the right to due process, as outlined in the Morehouse School of Medicine Graduate Medical Education Policies and Procedures.

### **3.3. Semi Annual Evaluations**

- 3.3.1.** Semi-annual evaluations are conducted by the PD and/or APD with each resident and are required by the ACGME.
- 3.3.2.** These are formal sessions in which feedback is provided to the resident regarding his/her overall performance from July to December and from January to June.
  - 3.3.2.1.** During the Semi-annual evaluation, the resident must also be prepared to discuss his/her self-evaluation and individualized education plan.

- 34

- [illegible]

**3.4.3. Promotion Criteria from PGY-2 to PGY-3**

**3.4.3.1.** Following at least 20 months of training, the Clinical Competency Committee will make a recommendation for promotion to PGY-3 status based on the following criteria:

**3.4.3.2. Patient Care**

**3.4.3.2.1.** Be a role-model of competent and compassionate whole person care to junior residents and medical students.

**3.4.3.2.2.** Have documented participation in adequate continuity deliveries to assure a total of 20 by graduation OR will participate in a plan to achieve this goal.

**3.4.3.2.3.** Demonstrate the ability to supervise a complete history and physical exam and oversee appropriate orders for hospital care.

**3.4.3.2.4.** Assume an active role in diagnosis and treatment plans which is based on sound medical knowledge.

**3.4.3.2.5.** Have documented adequate procedural competency to supervise the in-patient team adequately, including competency on knowledge and skill domains on EKG interpretation, ICU management, code management, etc.

**3.4.3.3. Medical Knowledge**

**3.4.3.3.1.** Satisfactorily pass all required rotations. Evaluations from each rotation must be received. A verbal report from the preceptor of his or her intent to give a passing grade may be taken for the final rotation of the year, if the committee meets prior to the completion of that rotation.

**3.4.3.3.2.** Have achieved at least 25th percentile on the composite score of the Family Medicine In-Training Exam OR be participating in a program for academic enhancement.

**3.4.3.3.3.** Have passed USLME Step 3 by his or her 20th month of training.

**3.4.3.4. Practice-Based Learning and Improvement**

**3.4.3.4.1.** Demonstrate the ability to give and receive feedback and make improvements in their patient care and practice.



**3.4.3.4.2.** Demonstrate an ability to independently locate, assimilate, and apply medical information to patient care.

**3.4.3.4.3.** Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

**3.4.3.5.** Interpersonal and Communication Skills

**3.4.3.5.1.** Have the ability to role-model respectful and effective communication with patients, faculty, staff, and colleagues.

**3.4.3.5.2.** Facilitate continuity of care through communication and documentation skills such as patient handoffs, on- and off-service notes, and telephone/message documentation.

**3.4.3.5.3.** Demonstrate teaching and management skills to effectively coordinate the teaching service and to teach junior residents and student learners

**3.4.4.** Program Graduation Criteria

**3.4.4.1.** The following graduation criteria apply to the PGY-3 level. The resident must:

**3.4.4.1.1.** Complete and pass all required rotations.

**3.4.4.1.2.** Not have any professionalism or ethical issues that preclude him or her from being an independent practicing physician in the opinion of the CCC.

**3.4.4.1.3.** Be continually eligible to practice medicine on a limited license in Georgia.

**3.4.4.1.4.** Be compliant with all MSM Family Medicine Residency Program policies including, but not limited to, being up to date with his or her work hour logging.

**3.4.4.1.5.** Have completed and presented an approved research project.

**3.4.4.1.6.** Have completed and logged all required procedures.

**3.4.4.1.7.** Have seen and documented at least 1,650 continuity patients.

**3.4.4.1.8.** Have completed all clinic patient notes and be cleared by the medical records department.

**3.4.4.1.9.** Complete the GME, HR, and MSM Family Medicine exit procedures.

**3.4.4.1.10.** Have achieved milestone levels for all competencies and subcompetencies demonstrating the ability to practice independently.

**3.4.4.2.** The program director must determine that the resident has had sufficient training to practice medicine independently as evidenced by meeting the goals above and a final summative assessment.

**3.4.4.3.** Upon fulfillment of these criteria, the program director must certify that the resident has fulfilled criteria, including the program-specific criteria, to graduate. The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities in an academic and/or clinical environment. The resident must satisfactorily meet all ACGME standards as outlined in the program requirements.

**3.4.4.4.** To signify completion of the listed criteria, the program director will certify that the resident has completed all ACGME and program-specific requirements for graduation and that he/she has been determined by the Program faculty, faculty advisor, and CCC to be competent for independent practice.

### **3.5. Faculty Evaluations**

#### **3.5.1. ACGME Requirement**

**3.5.1.1.** As per the ACGME requirements, at least annually, the program must evaluate faculty performance as it relates to the educational program.

**3.5.1.2.** These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the education program, clinical knowledge, professionalism, and scholarly activities.

**3.5.1.3.** This evaluation must include at least annual written confidential evaluations by the residents.

**3.5.1.4.** In compliance with this requirement, the MSM Family Medicine Residency Program follows the following process for faculty evaluation.

#### **3.5.2. Program-Specific Process**

**3.5.2.1.** Departmental residency faculty members are evaluated by residents on a quarterly basis using the Resident Evaluation of Faculty tool in New Innovations.

**3.5.2.2.** Individual means for each domain are calculated for each faculty member and are compared to the overall faculty means.

- 3.5.2.3.** Inpatient attendings are also evaluated by residents each time they rotate on the Family Medicine Wards service using the Inpatient Attending Evaluation Form.
- 3.5.2.4.** Written feedback is provided to each faculty member every six months in the form of the Semi-Annual Evaluation of Faculty Member by Residency Program form, which can be found in the Appendix of this document.
- 3.5.2.5.** The evaluation is designed to assess faculty members' clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activity.
- 3.5.2.6.** Annually, during the months of April-June, the Program Director discusses the form with each Program faculty member and a faculty development plan is devised as needed based on the content of the evaluation.
- 3.5.2.7.** These evaluations and development plans are remitted to the Department Chair for integration as part of the faculty members' evaluations by the Chair.
- 3.5.2.8.** Quarterly batching of evaluations and semi-annual reporting to faculty of aggregated evaluations is done to assure residents of the anonymity of their evaluations.
- 3.5.2.9.** Residents are encouraged to immediately communicate pressing concerns regarding attending performance to the Program Director or, if anonymity is desired, using the "on the fly" option for the NI faculty evaluation.
- 3.5.2.10.** Such reports are handled with the individual faculty member or the faculty as a whole as is appropriate to provide necessary faculty development by the Program Director.
- 3.5.2.11.** Serious concerns may require intervention by the Department Chair.
- 3.5.2.12.** This exception is intended to allow for timely correction of faculty member deficiencies.

### **3.6.** Program Director Evaluations

- 3.6.1.** The program director reports directly to the Chair of the Department of Family and indirectly to the Associate Dean for Graduate Medical Education.
- 3.6.2.** The Program Director is evaluated by the residents through the annual Institutional GME Survey and by the Chair of the Department of Family Medicine. Both are confidential evaluations.

### **3.7.** Program Evaluations

- 3.7.1.** The Morehouse School of Medicine Office of Graduate Medical Education maintains oversight of the program evaluation process, as detailed in the section 4.2.3 of the MSM GME Policy Manual.
- 3.7.2.** All MSM programs are evaluated confidentially and anonymously by the residents and the faculty on an annual basis under the oversight and direction of the GME Office.
- 3.7.3.** The results of this annual evaluation are used by the Family Medicine Residency Program develop an annual program improvement plan which is monitored and, when appropriate, adjusted by the Program Evaluation Committee, which meets quarterly.
- 3.7.4.** The Program Evaluation Committee (PEC) is an ACGME-mandated committee which, along with the Program Director, is responsible for generating the Annual Program Evaluation and Improvement Report which documents the program's extensive review of resident performance, faculty development, graduate performance, program quality, and program compliance with ACGME Requirements based on its ongoing monitoring process.
- 3.7.5.** The PEC then uses this document over the course of the year as a guide to for its ongoing evaluation of program effectiveness, compliance, quality, and efficiency.
- 3.8.** MSM Family Medicine Residency Program Evaluation Committee
  - 3.8.1.** The ACGME requires that the program is evaluated and that the program director appoint a Program Evaluation Committee (PEC) to assist in reviewing the program on an annual basis.
  - 3.8.2.** The purpose of the Program Evaluation Committee (PEC) for the Morehouse School of Medicine (MSM) Family Medicine Residency Program is to oversee and participate actively in all aspects of the program quality and improvement process.
  - 3.8.3.** At all times, the procedures and policies of the PEC will comply with those of the Graduate Medical Education Committee as outlined in the Graduate Medical Education Policy and Procedure Manual and with those stipulated by the Accreditation Council for Graduate Medical Education (ACGME) as outlined in Section V.C.1.a of the ACGME Program Requirements for Graduate Medical Education in Family Medicine.
  - 3.8.4.** Membership
    - 3.8.4.1.** The program director shall appoint and the department chairperson shall approve all members of the PEC, including the committee chairperson.
    - 3.8.4.2.** The committee shall consist of no fewer than two (2) core program faculty members and at least one (1) resident.

**3.8.5. Responsibility of Members**

**3.8.5.1.** Committee members are expected to participate actively in the following duties in accordance with the ACGME program requirements:

**3.8.5.1.1.** Planning, developing, implementing, and evaluating educational activities of the program;

**3.8.5.1.2.** Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;

**3.8.5.1.3.** Addressing areas of non-compliance with ACGME standards; and


**3.8.5.1.4.** Reviewing the Program annually using evaluations of faculty, residents, and others, as specified below:

**3.8.5.1.4.1.** Document formal, systematic evaluation of the curriculum at least annually, and render a written and Annual Program Evaluation (APE) based on its review and analysis of tracking in each of the following areas

- Resident performance
- Faculty development
- Graduate performance, including performance of program graduates on the certification examination
- Program quality
- Progress on the previous year's action plan(s).
- The Program, through the PEC must:

**3.8.5.2.** Prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored (per Section V.C.3 of the ACGME Program Requirements for Graduate Medical Education in Family Medicine); and attain approval of the action plan by the teaching faculty.

- 3.8.5.3.** Review and address deficiencies in the following ACGME program requirements.
  - 3.8.5.3.1.** At least 95 percent of the program's eligible graduates from the preceding five (5) years must have taken the American Board of Family Medicine (ABFM) certifying examination.
  - 3.8.5.3.2.** At least 90 percent of the program's graduates from the preceding five (5) years who take the ABFM certifying examination for the first time must pass.
  - 3.8.5.3.3.** Every five-year survey of program graduates.
  - 3.8.5.3.4.** Assessment of resident attrition and the presence of a critical mass of residents with a goal of no more than 15%.
- 3.8.6.** Meetings
  - 3.8.6.1.** Scheduled Meetings
    - 3.8.6.1.1.** The PEC will meet a minimum of four times per year.
    - 3.8.6.1.2.** The PEC, in entirety or in subcommittees, will meet at least annually to document the systematic and formal evaluation of the curriculum and produce a written APE.
  - 3.8.6.2.** Ad Hoc Meetings
    - 3.8.6.2.1.** The program director or committee chairperson may request an ad hoc meeting of the PEC or subcommittee to address urgent resident performance issues and those who are engaged in the grievance process for an adverse academic decision.
    - 3.8.6.2.2.** At all times, the committee will adhere to the GME policies and procedures of the "Adverse Academic Decisions and Due Process Policy."
- 3.8.7.** PEC Procedures
  - 3.8.7.1.** The PEC shall evaluate the Program on an ongoing basis and make recommendations to the Program.
  - 3.8.7.2.** All PEC meetings shall be documented with agendas and meeting minutes as appropriate.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-07
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	01
	<u>SUBJECT:</u> PHYSICIAN IMPAIRMENT AND HEALTH (SUBSTANCE ABUSE) POLICY	SUPERSEDES	

## Physician Impairment and Health (Substance Abuse) Policy

### I. **BACKGROUND**


The stress associated with residency is well recognized. Morehouse School of Medicine offers an Employee Assistance Program (EAP) through Care24, which is available to residents and their family member by self-referral. Services provided in the EAP include but are not limited to mental health, family counseling, and drug awareness and assistance. Additional information about the program is available in the Human Resources Department at 404-756-1600 or 404-752-1846, or directly from CARE 24 at 1-888-887-4114. ) 271-7788.

### II. **PURPOSE**

The purpose of this policy is to provide the resources available to residents who are in need of assistance for impairment and health problems.

### III. **POLICY**

The Family Medicine Residency complies with the GME Physician Impairment and Health (Substance Abuse) Policy that can be found on the website at <http://www.msm.edu/Education/GME/index.php>.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-08
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	03
	<u>SUBJECT:</u> PROFESSIONALISM AND ETHICS POLICY	SUPERSEDES	

## Professionalism and Ethics Policy

### I. BACKGROUND

- 1.1. The MSM Family Medicine Residency Program adheres to the GME Professionalism policy which can be found at <http://www.msm.edu/Education/GME/index.php> through the GME Policy link on the GME webpage.
- 1.2. Ethics is the systematic application of values.
  - 1.2.1. Medical ethics focuses on the prevention, recognition, clarification, and resolution of conflicts associated with medical issues and emphasizes the basic values that underlie clinical interactions, such as honesty, integrity, the primacy of the commitment to the patient's well-being, and compassion.

### II. PURPOSE

The purpose of this policy is to set forth the guidelines and requirements for professionalism to be adhered to by all family medicine residents.

### III. POLICY

- 3.1. Professionalism—Code of Conduct
  - 3.1.1. Residents should:
    - 3.1.1.1. Know how to inform patients and obtain voluntary consent for the general plan of medical care and specific diagnostic and therapeutic interventions
    - 3.1.1.2. Know what to do when a patient refuses a recommended medical intervention in both emergency and non-emergency situations
    - 3.1.1.3. Know what to do when a patient requests ineffective or harmful treatment
    - 3.1.1.4. Be able to assess a patient's decision-making capacity
    - 3.1.1.5. Know how to select the appropriate surrogate decision-maker when a patient lacks decision-making capacity



- 45

**3.2.1.4.** Emergency Medical Treatment and Active Labor Act (EMTALA)—all patients must receive emergency medical treatment regardless of ability to pay; can be transferred only after being stabilized;

**3.2.1.5.** Health Insurance Portability and Accountability Act (HIPAA)—ensure the confidentiality and privacy of protected health information (PHI) and electronic PHI

**3.3.** Dress Code

**3.3.1.** Standard dress while on work consists of professional-appearing clothes and a clean white lab coat.

**3.3.2.** The MSM ID badge should be worn as part of the uniform.

**3.3.3.** Scrubs should not be worn in public establishments nor in continuity clinic.


**3.3.3.1.** Hospital scrub suits are permissible at appropriate times within the following areas of the hospital:

- Obstetrics,
- Labor and Delivery,
- Emergency Room, Surgery, and
- While on call at night.

**3.3.4.** Male residents are to wear dress shirts and tie or shirt-jacket; clean, unwrinkled slacks (no jeans).

**3.3.5.** Female residents are to wear dresses, skirts, pantsuits, or slacks with modest and professional-appearing blouses, hosiery, and closed toe/heel shoes appropriate for professional wear.

**3.3.6.** Residents must abide by MSM, GME, and participating sites' (hospitals) dress codes, rules and standards. The MSM GME dress code is documented in the GME Policy Manual.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-09
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	08
	<u>SUBJECT</u> : SUPERVISION POLICY	SUPERSEDES	

## Supervision Policy

### I. BACKGROUND

- 1.1. Supervision in the context of Graduate Medical Education has the goals of assuring the provision of safe and effective care to the individual patient; assuring the resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.
- 1.2. The ACGME requires that all patient care must be supervised by approved clinical faculty. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
- 1.3. The Program Director and MSM Graduate Medical Education Committee (GMEC) will ensure that supervision is consistent with provision of safe and effective patient care and the educational needs of residents.

### II. PURPOSE

- 2.1. The purpose of this supervision policy is to ensure oversight of resident supervision and progressive levels of authority and responsibility.
- 2.2. The program uses the following classifications of levels of supervision, consistent with ACGME guidelines.
  - 2.2.1. Direct Supervision—The supervising physician is physically present with the resident and patient.
  - 2.2.2. Indirect Supervision with Direct Supervision Immediately Available—The supervising physician is **not** physically present, but is immediately available to provide direct supervision or available to by phone and/or electronic modalities.
  - 2.2.3. Oversight—The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

### III. DEFINITIONS

- 3.1. Direct Supervision- the supervising physician is physically present with the resident and patient
- 3.2. Indirect Supervision

- 3.2.1.** 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
- 3.2.2.** 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.
- 3.3.** Oversight- the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

#### **IV. PROGRAM SUPERVISION POLICY**

- 4.1.** The Program Director will perform ongoing assessment for adequate and appropriate supervision of residents at all times.
- 4.2.** All patient care is supervised by qualified faculty physicians who are appropriately credentialed and privileged.
- 4.3.** The faculty physician is ultimately responsible for patient care.
- 4.4.** Information to identify and contact the appropriate supervising faculty physician in the Comprehensive Family Healthcare Center (CFHC) is available at all times via the schedule in New Innovations. A schedule is also posted in the CFHC nurse's station.
  - 4.4.1.** All faculty contact numbers are posted in the Departmental Directory which is circulated by email annually and after each update.
  - 4.4.2.** The directory is also posted in the Comprehensive Family Healthcare Center resident work area, the call room, and the Residency office.
- 4.5.** Residents and faculty members should inform patients of their respective roles in patient care.
- 4.6.** Residents will be provided with rapid, reliable systems for communicating with supervising faculty.
  - 4.6.1.** Faculty preceptors are physically present in the preceptors' room in the CFHC for immediate communication between residents and supervising faculty.
  - 4.6.2.** In the inpatient setting, the supervising faculty meeting is either physically present or immediately available at the phone number listed on the resident sign-out list and posted in the call room.
- 4.7.** Faculty schedules are structured to provide residents with appropriate supervision and consultation.
  - 4.7.1.** A minimal faculty to resident ratio of 4:1 is maintained at all times in the continuity clinic (CFHC)
- 4.8.** Supervision is exercised through a variety of methods.

- 4.8.1.** Some activities require the physical presence of the supervising faculty member.
- 4.8.2.** For some aspects of patient care, the supervising physician is a more advanced resident.
- 4.8.3.** Supervision can be provided via the immediate availability of the supervisor or, in some cases, by phone or electronic modalities.
- 4.8.4.** On rare occasions, supervision may include post-hoc review of resident-delivered care with feedback.
- 4.9.** Direct supervision is required for all procedures in the CFHC continuity clinic and AMC-S Family Medicine Ward service.
- 4.10.** Lack of supervision or access to attendings must be reported to the Program Director and/or Department Chairperson.

## **V. PROGRESSIVE AUTHORITY & RESPONSIBILITY**

- 5.1.** Preceptors are expected to teach and provide appropriate and timely feedback to the Family Medicine residents in the preceptor's room.
- 5.2.** If for any reason the preceptor cannot be on time, he or she should contact the clinic. If no one in the office can be contacted, the preceptor should then contact the Program Director directly so necessary arrangements can be made.

## **VI. LEVELS OF SUPERVISION**

- 6.1.** Levels of supervision are outlined in the following table.

	Direct			Indirect			Oversight		
	PGY1	PGY2	PGY3	PGY1	PGY2	PGY3	PGY1	PGY2	PGY3
<b>OB</b>									
High-Risk Patient	X	X	X	R	RA	A	N	N	N
Admission	X	X	X	RXAB	RXAB	SAB	N	N	N
Labor Check	X	X	X	RXAB	RXAB	XAB	N	N	N
2 <sup>nd</sup> Stage of Labor	X	X	X	X	X	X	N	N	N
Change of Condition	X	X	X	RXAB	RXAB	XAB	N	N	N
<b>Inpatient</b>									
Admission	X	X	X	RXAB	RXAB	XAB	N	N	N
Change of Condition	X	X	X	RAB	RXAB	XAB	N	N	N
Transfer to New Level of Care	X	X	X	XABR	RABX	XAB	N	N	N
Hospital Transfer	X	X	X	XRA	XRAB	XAB	N	N	N
Pediatrics	X	X	X	XRAB	XRAB	XAB	N	N	N
Surgery (procedures)	X	X	X	N	N	N	N	N	N
Emergency	X	X	X	XAR	XAR	XA	N	N	N
<b>Ambulatory</b>									
FMP	X	X	X	XA	XAB	XAB	N	N	N
Other (MSK, Behav, etc.)	X*	X*	X*	XA	XA	XA	N	N	N
Home Visits	X	X	X	N	XAB	XAB	N	X	X
SNF	X	X	X	N	XAB	XAB	N	X	X

Key:

- A- Indirect supervision with direct supervision immediately available
- B- Indirect supervision with direct supervision available
- X- Appropriate level of supervision
- N- Not appropriate for level of training
- R- Advanced level resident may immediately supervise (Attending must still be contacted and participate in decision making)
- \* - All procedures must be directly supervised

- 6.2. All patient care **must be** supervised by approved clinical faculty. Faculty schedules are structured to provide residents with **continuous supervision and consultation**. Lack of supervision or access to attendings must be reported to the program director and/or department chairperson.

**VII. GUIDELINES FOR WHEN RESIDENTS MUST COMMUNICATE WITH THE ATTENDING**

- 7.1. Residents must communicate with the attending to discuss all hospital admissions at the time of admission.
- 7.2. Each patient seen in the clinic must be discussed with the supervising attending during the visit or before the end of the clinic session as appropriate.
- 7.3. If the resident is uncomfortable or uncertain about how to manage a patient due to the patient's acuity or the resident's level of medical knowledge or experience, the resident must communicate with the attending if guidance from an upper level resident is not sufficient.
- 7.4. All procedures must be directly supervised by the attending physician.

**VIII. RESIDENT JOB DESCRIPTIONS BY PGY LEVEL**

PGY-1 Resident Job Descriptions	
<u>Prerequisites</u>	
<ul style="list-style-type: none"> <li>• Medical doctorate from an allopathic or osteopathic medical school</li> <li>• Passing scores on the USMLE I, USMLE II CK, and USMLE II CS</li> <li>• Foreign medical graduates: complete all ECFMG requirements</li> <li>• Eligibility for State of Georgia Family Physician training licensure</li> <li>• Application through Electronic Resident Application System (ERAS)</li> </ul>	
<u>Qualities</u>	
<ul style="list-style-type: none"> <li>• Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.</li> <li>• Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.</li> <li>• Work within multiple teams that include inpatient rounding teams, class peers, curriculum development teams, outpatient care teams, and support groups.</li> <li>• Communicate effectively in English both verbally and in writing.</li> </ul>	

<b><u>Management of Physical and Mental Demands, Environment, and Working Conditions</u></b>
<ul style="list-style-type: none"> <li>• Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.</li> <li>• Move around the hospital and its campus adequately to address routine and emergency patient care needs.</li> <li>• Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.</li> <li>• Read patient charts and monitoring equipment.</li> <li>• Manage multiple patient care duties simultaneously.</li> <li>• Use judgement and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.</li> <li>• Have the capacity to see five (5) or more outpatient cases in a three-hour clinic session, four (4) or more hospital admissions in a 12-hour period, and have the ability to complete appropriate documentation in a timely fashion.</li> <li>• Work shifts up to 16 hours on inpatient services.</li> <li>• Use computers for literature review, patient care data retrieval, and procedure documentation.</li> <li>• Communicate complex medical information rapidly and effectively with other members of a health care team.</li> </ul>
<b><u>Performance Responsibilities and Job Functions</u></b>
<p><b><u>Outpatient Care</u></b></p> <ul style="list-style-type: none"> <li>• Provide longitudinal primary medical care to a panel of outpatients.</li> <li>• Learn to perform procedures essential to family medicine including male infant circumcision, endometrial biopsy, colposcopy, IUD insertion and removal, and OB ultrasound.</li> <li>• Work effectively within a patient-care team.</li> <li>• Complete clinic notes, procedure notes, referral requests, L&amp;D evaluations, and other required documentation in a timely fashion.</li> <li>• Work effectively with medical staff on specialty outpatient rotations.</li> </ul>
<p><b><u>Inpatient Care</u></b></p> <ul style="list-style-type: none"> <li>• Perform complete H&amp;Ps on new hospital admissions and patients presenting for emergency evaluation.</li> <li>• Perform CPR on infants and adults as indicated.</li> <li>• Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric attending.</li> <li>• Administer injections, take blood samples, and learn to insert arterial and central lines.</li> <li>• Write and dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation.</li> <li>• As necessary, write orders for physical and chemical restraints and seclusion.</li> </ul>
<b><u>Educational Mission</u></b>
<ul style="list-style-type: none"> <li>• Present educational material in formats appropriate adjusted for the audience (i.e. medical students, peers, medical staff, or community groups)</li> <li>• Complete and pass all required rotations.</li> <li>• Provide feedback to the program both spontaneously and when requested.</li> <li>• Perform an academic self-assessment at least twice per year.</li> <li>• Participate in curriculum development through the work of standing committees.</li> <li>• Develop continuing quality improvement projects in conjunction with residency and faculty.</li> </ul>

<b>PGY-2 Resident Job Descriptions</b>	
<b><u>Prerequisites</u></b>	
<ul style="list-style-type: none"> <li>Completed and passed all PGY-1 rotations and met all PGY-1 requirements Has met the minimum competency skills needed to teach students and peers</li> </ul>	
<b><u>Qualities</u></b>	
<ul style="list-style-type: none"> <li>Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.</li> <li>Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.</li> <li>Work within multiple teams that include inpatient rounding teams, class peers, curriculum, development teams, outpatient care teams, and support groups.</li> </ul>	
<b><u>Management of Physical and Mental Demands, Environment, and Working Conditions</u></b>	
<ul style="list-style-type: none"> <li>Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.</li> <li>Move around the hospital and its campus adequately to address routine and emergency patient care needs.</li> <li>Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.</li> <li>Read patient charts and monitoring equipment.</li> <li>Manage multiple patient care duties simultaneously.</li> <li>Use judgment and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.</li> <li>Have the capacity to see 10 or more outpatient cases in a three-hour clinic session, 12 or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion.</li> <li>Work shifts up to 24 hours when taking call on the inpatient services.</li> <li>Use computers for literature review, patient care data retrieval, and procedure documentation.</li> <li>Communicate complex medical information rapidly and effectively with other members of a healthcare team.</li> </ul>	
<b><u>Performance Responsibilities and Job Functions</u></b>	
<b><u>Outpatient Care</u></b>	
<ul style="list-style-type: none"> <li>Provide longitudinal primary medical care to a panel of outpatients.</li> <li>Provide longitudinal primary medical care to a panel of nursing home patients.</li> <li>Learn to perform procedures essential to family medicine including male infant circumcision, colposcopy, IUD placement and removal, endometrial biopsy, and OB ultrasound.</li> <li>Work effectively within a patient-care team.</li> <li>Complete clinic notes, procedure notes, referral requests, L&amp;D evaluations, and other required documentation in a timely fashion.</li> <li>Work effectively with medical staff on specialty outpatient rotations.</li> <li>Periodically teach medical students basic history and physical skills during continuity clinic</li> </ul>	
<b><u>Inpatient Care</u></b>	



<ul style="list-style-type: none"> <li>• Manage the care of ward and critical care patients under the supervision of a family physician or medical attending.</li> <li>• Perform complete H&amp;Ps on new hospital admissions and patients presenting for emergency evaluation.</li> <li>• Run the code team (second and third year of program).</li> <li>• Perform CPR on infants and adults as indicated.</li> <li>• Intubate infants, children, and adults as indicated.</li> <li>• Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric attending.</li> <li>• Independently manage precipitous deliveries.</li> <li>• Assist with major surgeries and C-sections.</li> <li>• Administer injections, take blood samples, and learn to insert arterial and central lines.</li> <li>• Write or dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation.</li> <li>• As necessary, write orders for physical and chemical restraints and seclusion.</li> </ul>
<b><u>Educational Mission</u></b>
<ul style="list-style-type: none"> <li>• Present educational material in formats appropriate adjusted for the audience (i.e. medical students, peers, medical staff, or community groups)</li> <li>• Supervise the hospital care provided by R-1.</li> <li>• Complete and pass all required rotations.</li> <li>• Provide feedback to the program both spontaneously and when requested.</li> <li>• Perform an academic self-assessment at least twice per year.</li> <li>• Participate in curriculum development through the work of standing committees.</li> <li>• Develop continuing quality improvement projects in conjunction with residency and faculty.</li> </ul>

<b>PGY-3 Resident Job Descriptions</b>
<b><u>Prerequisites</u></b>
<ul style="list-style-type: none"> <li>• Completed and passed all rotations and requirements of a PGY-2</li> <li>• Taken and passed USLME III</li> <li>• Has met the minimum competency skills needed to teach students and peers</li> </ul>
<b><u>Qualities</u></b>
<ul style="list-style-type: none"> <li>• Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.</li> <li>• Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.</li> <li>• Work within multiple teams that include inpatient-rounding teams, class peers, curriculum, development teams, outpatient care teams, and support groups.</li> </ul>
<b><u>Management of Physical and Mental Demands, Environment, and Working Conditions</u></b>
<ul style="list-style-type: none"> <li>• Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.</li> <li>• Move around the hospital and its campus adequately to address routine and emergency patient care needs.</li> <li>• Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.</li> <li>• Read patient charts and monitoring equipment.</li> </ul>

- Manage multiple patient care duties simultaneously.
- Use judgment and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.
- Have the capacity to see 10 or more outpatient cases in a three-hour clinic session, 12 or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours when taking call on the inpatient services.
- Use computers for literature review, patient care data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a healthcare team.

### ***Performance Responsibilities and Job Functions***

#### ***Outpatient Care***

- Provide longitudinal primary medical care to a panel of outpatients.
- Provide longitudinal primary medical care to a panel of nursing home patients.
- Learn to perform procedures essential to family medicine including male infant circumcision, endometrial biopsy, IUD insertion and removal, colposcopy, and OB ultrasound.
- Work effectively within a patient-care team.
- Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion.
- Work effectively with medical staff on specialty outpatient rotations.
- Periodically teach medical students basic history and physical exam skills during continuity clinic


#### ***Inpatient Care***

- Manage the care of ward and critical care patients under the supervision of a family physician or medical Attending.
- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Run the code team (second and third year of program).
- Perform CPR on infants and adults as indicated.
- Intubate infants, children, and adults as indicated.
- Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric Attending.
- Independently manage precipitous deliveries.
- Assist with major surgeries and C-sections.
- Administer injections, take blood samples, and learn to insert arterial and central lines.
- Write or dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation. As necessary write orders for physical and chemical restraints and seclusion.
- Serve as a team leader for two (2) months during senior year.

### ***Educational Mission***

- Present educational material in formats appropriate adjusted for the audience (i.e. medical students, peers, medical staff, or community groups)
- Supervise the hospital care provided by R-1, R-2, and medical students
- Complete and pass all required rotations.
- Provide feedback to the program both spontaneously and when requested.
- Perform an academic self-assessment at least twice per year.
- Participate in curriculum development through the work of standing communities.

- Develop continuing quality improvement projects in conjunction with residency and faculty
- Complete required research project

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-10
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	03
	<u>SUBJECT</u> : TRANSITIONS OF CARE POLICY	SUPERSEDES	

## Transitions of Care Policy

### I. BACKGROUND

- 1.1. The primary objective of a “hand-off” is to provide accurate information about a patient’s care from one physician to another physician who is assuming responsibility for the care of the patient to ensure safe continuity of care. Information transmitted in the handoff includes treatments, services, current condition, any recent or anticipated changes, and a to-do list for tasks that should be completed during the time that the resident will be caring for the patient.
- 1.2. The information communicated during a hand-off must be accurate in order to ensure patient safety goals.
- 1.3. This policy conforms to the Joint Commission’s National Patient Safety Goal 2E.

### II. SCOPE

- 2.1. This policy applies to Family Medicine resident physician hand-offs whenever there is a change in medical personnel charged with the medical care of the patient. Information transmitted during physician hand-off is stated in the “Background” section. Opportunities to ask and respond to questions must be provided during hand-off.

### III. HAND-OFF COMMUNICATION PROCEDURE


- 3.1. Assignment of the newly admitted patient to the Family Medicine service.
  - 3.1.1. When a patient is admitted to the Family Medicine service, the Emergency Department (ED) attending contacts the Family Medicine Attending to provide handoff.
  - 3.1.2. If the attending accepts the patient to the service based on sign-out from the ED physician, he/she will contact the resident on duty to evaluate and admit the patient.
  - 3.1.3. In the event that the appropriateness for admission is not clear based on the report from the ED attending, the FM attending will contact the resident on duty to evaluate the patient and discuss the patient with the attending who will determine whether admission or clinic follow-up and outpatient management is most appropriate.

- 3.1.4. Upon accepting the patient, the attending will formally assume responsibility for the care of the patient and transfer of care from the ED to the appropriate hospital unit occurs.
      - 3.1.5. On Monday to Friday, between 7:00 a.m. and 5:00 p.m. the resident referenced above will be the resident designated to admit the next patient as agreed by the team. On Monday to Friday between 5:00 p.m. and 7:00 a.m., this will be the night float resident.
  - 3.2. Transfer of patients between the daytime team and night float resident.
    - 3.2.1. Hand-off communication occurs at 5:00 p.m. and at 7:00 a.m. between the daytime and night float teams (daytime team signs off to the night resident at 5:00 p.m. and vice-versa at 7:00 a.m.).
    - 3.2.2. Both verbal and written communication is conducted. All patients are documented in the electronic sign-out list and distributed to the covering team. This will also be an opportunity to ask and respond to questions.
  - 3.3. Transfer of patients to new rotating residents.
    - 3.3.1. On the last day of the rotation, the inpatient team writes “off service notes” on all patients. The note includes each patient’s initial presentation, hospital course, pertinent lab and study results, and current status including any pending results or consults.
    - 3.3.2. A verbal sign-out is also given at 6:00 p.m. on the night before the new team begins.
    - 3.3.3. The outgoing PGY-3 resident signs out all patients to the oncoming PGY-3 and highlights the patients that he or she is following.
    - 3.3.4. The PGY-2 also signs out his or her patients to the oncoming PGY-2.
    - 3.3.5. Any changes that occur overnight will be communicated by the night float resident to the oncoming day team as previously described.

#### **IV. EVALUATION METHODS**

- 4.1. The Attending must observe at least one change of shift handoff in person and two by telephone.
- 4.2. Each resident is evaluated based on hand-off expectations in the following areas: environment, standard handoff time, use of the SBAR transition of care presentation format, appropriately identifying patient details requiring special attention by the receiving resident, and confirmation that receiving resident understands the SBAR content on all patients by presenting back.
- 4.3. The Attending is expected both to give immediate informal feedback on the witnessed handoffs and to complete the formal Hand-off evaluation form and submit it to the Program Manager. The Program Assistant will transfer data from the Hand-off evaluation into New Innovations.

- 4.4.** If any resident is not considered to be competent to give or receive handoff after the required minimum of observed handoffs by the attending, the senior resident and attending must provide additional education to the resident. The attending must continue to observe handoffs until each inpatient team resident demonstrates the ability to give hand off competently. The ability to give competent handoff is a requirement of passing the Family Medicine Wards rotation.
- 4.5.** Residents should anonymously report breakdowns/problems in the handoff process for continued improvement by reporting the feedback and dropping it off in the comment/suggestion box located in the resident area of WellStar Atlanta Medical Center South. Feedback will be collected on a regular basis and reviewed at the following PEC meeting.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-11
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	01
	<u>SUBJECT:</u> USMLE & COMLEX EXAMINATION POLICY	SUPERSEDES	

## USMLE & COMLEX Examination Policy

### I. PURPOSE


- 1.1. 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 Family Medicine Residency Program goals and objectives.
- 1.2. A resident who will be prepared to undertake independent medical practice shall have completed requirements to obtain a physician’s license.

### 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

- 3.1. Family Medicine residents must sit for the USMLE or COMLEX Step 3 by their 12<sup>th</sup> month of residency.
- 3.2. Family Medicine residents must present the official results of their USMLE/COMLEX Step 3 examination to the residency program before the last working day of the resident’s 20<sup>th</sup> month which is, in a normal appointment cycle, February.
  - 3.2.1. Family Medicine residents who have not passed Step 3 by the end of the 20<sup>th</sup> month will not receive a letter of non-renewal of contract, in a normal appointment cycle on March 1<sup>st</sup>.
  - 3.2.2. Family Medicine residents who pass Step 3 between the 21<sup>st</sup> and 24<sup>th</sup> month, will receive a reappointment letter to the residency program at the time of receipt of the results, if this is the sole reason for non-renewal..

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-12
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	02
	<u>SUBJECT:</u> PATIENT SAFETY & QUALITY IMPROVEMENT POLICY	SUPERSEDES	

## Patient Safety & Quality Improvement Policy

### I. BACKGROUND

- 1.1. Training in Patient Safety and Quality Improvement is an essential component of family medicine residency education.
- 1.2. It is the focus of the Systems Based Practice -2 (SBP-2) subcompetency. As such, participation in the following PS/QI activities is required.

### II. PURPOSE

The purpose of this policy is to outline the program process regarding training in patient safety and quality improvement.

### III. POLICY

#### 3.1. Patient Safety

**3.1.1. Culture of safety** is defined as a culture of safety which requires continuous identification of vulnerabilities and a willingness to deal with them transparently.

**3.1.2.** An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety to identify areas for improvement.

**3.1.2.1.** The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.

**3.1.2.2.** The program must have a structure that promotes safe, inter-professional, team-based care.

#### 3.1.3. Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.


#### 3.1.4. Patient Safety Events

**3.1.4.1.** Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program.



- 61

- 3.2.3.** Engagement in Quality Improvement Activities—Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.
  - 3.2.3.1.** Residents must have the opportunity to participate in inter-professional quality improvement activities.
  - 3.2.3.2.** This should include activities aimed at reducing healthcare disparities.
- 3.3.** Annually, residents are required to complete Institution of Healthcare Improvement (IHI) Open School PSQI modules. Instructions for module completion and the link for access to these modules are provided by the Program through the GME office. Modules must be completed before the posted deadlines.
- 3.4.** A PS/QI project must be completed as part of the Practice Management and Community Health Rotations
- 3.5.** After each month on the Family Medicine Wards service at Atlanta Medical Center-South, a case report must be presented during Wednesday didactics. The report must include a discussion of PS/QI issues related to the case.
- 3.6.** As a requirement of program completion, each resident must complete a research project, described in the Research/Scholarly Activity Guidelines section of this document. These projects are expected to have a PS/QI implication.
- 3.7.** Residents must report negative events and near misses that occur in the hospital through the respective hospital's formal reporting mechanism, including documenting the event through the hospital's electronic reporting portal.
- 3.8.** Negative outcomes/events that occur in the Comprehensive Family Healthcare Center should be reported through the MSM Office of Compliance hotline at (855) 279-7520 and [on-line reporting system](https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html) at <https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html>.
- 3.9.** Physician-to-Physician patient handoffs must occur at each change of shift, change of service, transfer of care (including outpatient office to hospital transfers). A full discussion of patient handoffs is included in the Transition of Care section of this document.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-13
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	03
	<u>SUBJECT:</u> RESEARCH & SCHOLARLY ACTIVITY POLICY	SUPERSEDES	

## Research & Scholarly Activity Policy

### I. BACKGROUND

The Family Medicine Residency Program at Morehouse School of Medicine requires that each resident complete a scholarly project in order to successfully complete the program and graduate. The project is within the bounds and scope of the Accreditation Council for Graduate Medical Education.

### II. PURPOSE


The purpose of this policy is to set the standards for the program's research curriculum.

### III. STANDARDS

- 3.1. A scholarly project is required of each resident prior to completion of residency training. Residents will not be approved for graduation without the project being received and approved by the director of research based on criteria communicated to residents. The resident is responsible for selecting the faculty who will be assisting with his or her scholarly activities through the research director.
- 3.2. Required Deadlines by PGY level are outlined below
  - 3.2.1. PGY1- By the end of the PGY1 year, each resident must have developed a research question
  - 3.2.2. PGY2- By December, the resident must have developed a methodology. By the end of the PGY2 year, IRB approval must be obtained
  - 3.2.3. PGY3- By December, data collection must be complete. The research project must be completed by June 1<sup>st</sup> but earlier completion is highly encouraged.
- 3.3. Each resident is required to have a faculty discussant for his or her QI/Research project.
- 3.4. During the Research Forum, held in June, each resident will receive 15 minutes to present, followed by a 10-minute discussion.
  - 3.4.1. Faculty research advisors are expected to participate in the discussion.
- 3.5. Presentations should be developed in the following format:
  - 3.5.1. Introduction:

- 3.5.1.1.** Question addressed and its importance stated
    - 3.5.1.2.** Conceptual model
    - 3.5.1.3.** Testable hypothesis(es)
  - 3.5.2.** Methods:
    - 3.5.2.1.** Sample—who was studied?
    - 3.5.2.2.** Dependent/outcome variable
    - 3.5.2.3.** Independent variable(s)—what predicts or is associated with the outcome variable?
    - 3.5.2.4.** Co-variables—did you control for variables (factors) that might affect the association between the independent and dependent (outcome) variable?
    - 3.5.2.5.** Measurement—how were variables measured? What are the validity and/or reliability of measurement tool?
    - 3.5.2.6.** Analysis—what statistical analytic methods were used to describe your sample, determine the distribution of responses, and test the hypothesis(es)?
  - 3.5.3.** Results:
    - 3.5.3.1.** Characteristics of sample
    - 3.5.3.2.** Distribution of responses for independent/dependent/co-variables, i.e., what percentage of residents vs. faculty responded to a different domain:
    - 3.5.3.3.** Of the variables
    - 3.5.3.4.** Results of test of hypothesis(es)
  - 3.5.4.** Discussion:
    - 3.5.4.1.** A brief restatement of findings (results)
    - 3.5.4.2.** Interpretation of results—what do they suggest?
    - 3.5.4.3.** How are they consistent with what is known?
    - 3.5.4.4.** How do they differ with what is known and why?
    - 3.5.4.5.** What are the study’s strengths and limitations?
  - 3.5.5.** Conclusion: Recommendations based on results
- 3.6.** In addition to the scholarly research project described above, each resident completes a PSQI “mini-project” during the PGY-1 Practice Management and PGY-2 Community Health rotations.
  - 3.6.1.** For these projects, the resident identifies an issue in the clinic with a patient safety implication and develops an intervention to improve patient safety related to the issue.

- 3.7.** Residents are also required to complete all Institute for Healthcare Improvement (IHI) Open School PHQI modules during each year of training.
- 3.8.** Writing for publication is highly encouraged through authorship of case reports on patients managed on the Family Medicine wards service.
  - 3.8.1.** Each faculty member is expected to identify, with the resident team, at least one patient during his/her coverage of the service whose case can be presented in a case report.
  - 3.8.2.** The attending-resident co-authored case reports are to be written within 6 weeks of completing the inpatient service.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-14
		EFFECTIVE DATE	04/21/2017
		PAGE(S)	03
	<u>SUBJECT:</u> PROCEDURE REQUIREMENTS AND LOGGING POLICY	SUPERSEDES	

## Procedure Requirements and Logging Policy

### I. BACKGROUND

- 1.1. The practice of family medicine requires a broad range of skills, including procedural skills, and successful completion of residency requires demonstration of competency across a range of different procedures.
  - 1.1.1. Some of this competency will be gained by the resident during the natural course of rotations.
  - 1.1.2. Other procedural competencies must be specifically demonstrated as the resident's exposure to these may be variable (e.g., successful completion of ACLS demonstrates competency in adult resuscitation skills).
  - 1.1.3. Finally, some procedures are less commonly performed by family physicians, but are still within the purview of the family physician, and require additional experience to gain proficiency (e.g., vasectomy).
  - 1.1.4. Residents will be exposed to these procedures, but would need to independently seek opportunities to perform more of these to gain proficiency in residency.

### II. PURPOSE

- 2.1. The purpose of this policy is to describe procedures residents will perform during residency and how proficiency in those procedures will be determined.
- 2.2. Residents record procedures in their log book as directed.
  - 2.2.1. If the log contains PHI such as a medical record number, then the log must be kept secure at all times.
  - 2.2.2. After they have been logged, procedures are signed off by a supervising resident or an Attending physician.
  - 2.2.3. Residents are to also log their procedures in New Innovations and this is the preferred method of logging. Residents can log their procedures into New Innovations as often as they like, but it must be done at least monthly.
  - 2.2.4. Procedures will be tracked by the residency program every month by the first day of the following month to ensure compliance. If there are required procedures in which residents do not appear to be getting

enough experience, the Program will work with residents, faculty, and staff to expand exposure to those procedures.

### **III. POLICY**

- 3.1.** Faculty members, peers and nursing staff expect residents to have knowledge of procedures prior to performing them. Thus, it is the resident's responsibility to familiarize himself/herself with the procedure about to be performed. If the resident is about to perform a procedure for the first time, he/she should read about it and/or watch videos about it and/or ask faculty members for reference material before performing the procedure. Even if performed several times, refreshing one's knowledge of a procedure is good practice. Sources generally recommended for primary care procedures include:
- Pfenninger's Procedures for Primary Care Physicians (Mosby)
  - [NEJM's Videos in Clinical Medicine](#)
- 3.2.** It is the resident's responsibility to ensure that his/her procedures are correctly documented in the medical record and in New Innovations.
- 3.3.** All procedures must be logged in New Innovations. It is the resident's responsibility to ensure that logging is up to date. All procedures for a given month must be logged by the tenth day of the next month (e.g., All April procedures must be logged by May 10<sup>th</sup>)
- 3.4.** Clinical Procedures
- 3.4.1.** Procedures are to be entered into the log books provided by the Residency Program and signed by the immediate supervisor of the procedure
- 3.4.2.** PHI is not to be documented in log books
- 3.4.3.** All procedure log data is to be transferred (documented) in the Procedure Logger section of New Innovations.
- 3.5.** The following is a list of procedures that will be encountered in residency. It is not an exhaustive list but does include most procedures our residents experience:

<b>Procedure Name</b>	<b>Independent Target</b>
Amniotomy	3
Anoscopy	1
Arterial Blood Gas	2
Arterial Line Placement	1
Bladder Catheterization	1
Central Line Placement	2
Cesarean Section Assist	5
Chest X-ray interpretation	30


### *Procedure Requirements and Logging Policy*

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Circumcision	5
Colposcopy	3
Delivery Vacuum Extraction	1
Delivery, normal vaginal	20
ear irrigation	2
EKG Interpretation	30
Endometrial Biopsy	3
Episiotomy 1st, 2nd Deg Rep	1
Fetal Scalp Electrode	1
I&D Abscess	5
Induction/Augmentation of Labor	1
IUD Insertion	1
IUD Removal	1
IUPC Placement	1
joint aspiration	10
joint injection	10
Laceration Repair, Simple	2
Lumbar Puncture	2
Newborn Exams	40
non -ob surgery assist	5
OB Nonstress Test	20
OB Ultrasound	5
pap smear	30
Skin Tag removal	1
Suture	5
Wet Mount	10

- 3.6.** Residents must continue to log procedures in New Innovations even after the independent targets have been met.



	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-15
		EFFECTIVE DATE	04/21/2017
		PAGE(S)	02
	<u>SUBJECT:</u> PATIENT ENCOUNTER REQUIREMENTS AND LOGGING POLICY	SUPERSEDES	

## **Patient Encounter Requirements and Logging Policy**

### **I. BACKGROUND**

The Accreditation Council for Graduate Medical Education (ACGME) requires a diverse variety of patients be seen across a number of practice settings. The program complies with all the requirements of the ACGME. It is the resident's responsibility to ensure that all patient encounters and procedures are logged appropriately in New Innovations.

### **II. PURPOSE**

The purpose of this policy is to describe patient encounter requirements as set forth by the ACGME and the method by which residents should log the encounters for tracking and compliance purposes.


### **III. POLICY**

- 3.1. All clinical procedure and patient encounters must be logged in New Innovations. It is the resident's responsibility to ensure that logging is up to date. All patient encounters and procedures for a given month must be logged by the tenth day of the next month (e.g., All April encounters and procedures must be logged by May 10<sup>th</sup>)
- 3.2. The following is a list of patient encounters that residents must have. The numbers of required encounters listed are minimums. Encounters above the minimum listed are highly encouraged. The list also details the rotation name and location at which the patient encounter can be experienced as well as the module in New Innovations to log the encounter.

## Patient Encounter Requirements and Logging Policy

Patient Encounter Type	# of Encounters	Rotation	Rotation Location	Where to Log in New Innovations
# of patient encounters in FMP site	1,650	CFHC/Clinics CBOC VA GYN Home Visits	CFHC	Continuity Clinics
Patients <10	165			
Patients >60	165			
# of patient encounters of hospitalized adults	750	FM Wards IM Wards	AMC South Grady Main	Log Books
Care of ICU patients	15	FM Wards IM Wards	AMC South Grady Main	Log Books
# of Patient encounters of acutely ill or injured patients in ER Setting	250	ECC	Grady Main	Log Books
# of patient encounters dedicated to the care of the older patient	125	Geriatrics	Crestview	
# of patient encounters dedicated to the care of ill child patients in the hospital and/or ER setting	250	Peds Wards Peds ER	HSCH/CHOA	Log Books
Inpatient encounter minimum	75	Peds Wards	HSCH/CHOA	Log Books
ER encounter minimum	75	Peds ER	HSCH/CHOA	Log Books
# of patient encounters of children and adolescents in an ambulatory setting (includes well, acute and chronic care)	250	Peds GEP Peds Harbin	GEP Harbin Clinic	Continuity Clinics Log Books
# of newborn patient encounters (well and ill)	40			
# of patient encounters dedicated to the care of women with GYN issues	125	VA GYN OB/GYN	Atlanta VA AMC North	Log Books

The patient encounters listed in black text are currently included in required reporting to the ACGME. The patient encounters listed in blue text are ACGME-required minimums that are not currently requested for reporting to the ACGME. All required encounters are tracked by the program to ensure adequate resident training and for ready accessibility in the event that the numbers requested by the ACGME and for the purposes of documentation required by credentialing requests from future employers.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-16
		EFFECTIVE DATE	06/01/2017
		PAGE(S)	01
	<u>SUBJECT</u> : MOONLIGHTING POLICY	SUPERSEDES	06/01/2014

## **Moonlighting Policy**

### **I. BACKGROUND**

- 1.1. Moonlighting is clinical work done outside the scope of our program by a resident. Its advantages (extra income, experience in other settings, etc.) must be weighed against potential negatives (less free time, sleep, and time with significant others).
- 1.2. As stipulated by the ACGME Family Medicine Residency Program Requirements, moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- 1.3. Moonlighting activities are monitored by the program director to ensure that the quality of patient care and the resident's educational experience are not compromised.
- 1.4. The MSM Family Medicine Residency Program moonlighting policy is consistent with the policy outlined in the GME Policy Manual.


### **II. PURPOSE**

The purpose of this policy is to describe the qualifications and process for moonlighting for MSM Family Medicine residents.

### **III. POLICY**

- 3.1. Moonlighting is permitted for PGY-2 and PGY-3 residents in good standing, with an independent medical license and proper malpractice coverage.
- 3.2. Residents wishing to moonlight must obtain written permission from the program director.
- 3.3. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety.
- 3.4. The following conditions must be met in order for the program director to consider approving a resident request to moonlight:
  - 3.4.1. The resident must be in good academic standing in the program; he or she must not be in academic remediation or probation. The resident must also fulfill all administrative requirements of the program (e.g., prompt dictations, clinic note completion, work hour and patient logging, handling phone messages and lab results in a timely manner, etc.).

- 3.4.2.** The training license and training DEA number may not be used to practice medicine outside of the residency program.
- 3.4.3.** The resident must have:
  - 3.4.3.1.** Valid, full medical license from the State Medical Board of Georgia, as residents may not practice medicine outside of our residency program under the State of Georgia Training Certificate; and
  - 3.4.3.2.** A personal DEA certificate/number (the DEA number issued by the hospital for residents may be used only in carrying out clinical duties that are part of the residency program, and may not be used for moonlighting purposes).
- 3.4.4.** The resident must arrange for his or her own malpractice insurance; the resident can either pay for this insurance personally or it can be provided by the entity employing the resident for the moonlighting. The Morehouse School of Medicine malpractice insurance plan does not cover any activities outside of a residency program.
- 3.4.5.** Moonlighting is restricted to one (1) shift per week. It should not interfere with patient care nor be so excessive that the resident is too tired to learn and/or to perform the residency requirements. The combined hours of residency and moonlighting should not exceed 80 hours per week.
- 3.4.6.** The resident may not moonlight during normal work hours, as defined by his/her rotation. Further, the resident is not permitted to moonlight between 7:00 a.m. and 5:00 p.m. on Monday through Friday, while on call, or on the day post-call.
- 3.5.** The resident who meets the conditions above and desires to moonlight must submit a moonlighting request form to the program director to receive permission to moonlight. This request must document that the resident meets the conditions and that he or she will follow the moonlighting policy. The resident must also provide details as to where and how many hours each week he or she plans to moonlight. The program director will then review the request; if there are no concerns, the program director will give the permission to moonlight.
- 3.6.** When considering the request, the program director will take into account the resident's workload, academic standing, and compliance with residency requirements. If the resident is given permission, he or she must follow all rules and policies as established by the program. Privileges may be rescinded if the rules are not followed, if the resident does not include moonlighting hours in his/her work hour log, if moonlighting activities are deemed to be excessive, or if the resident is placed on academic remediation or on probation.
- 3.7.** The Moonlighting Request form can be found in the Program Handbook.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-17
		EFFECTIVE DATE	06/01/2017
		PAGE(S)	02
	<u>SUBJECT</u> : WELL-BEING POLICY	SUPERSEDES	

## Well-Being Policy

### I. **PURPOSE:**

The Morehouse School of Medicine Family Medicine Residency Program follows the ACGME's requirements in terms of resident well-being. The program also adheres to the well-being measures as instituted by the Morehouse School of Medicine Graduate Medical Education Office.

### II. **SCOPE:**

Per ACGME - in the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is a vital component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.

### III. **POLICY:**

**3.1.** In partnership with the Graduated Medical Education Office, the program shares the responsibility of resident well-being to include:

**3.1.1.** efforts to enhance the meaning that each resident finds in the experience of being a physician

**3.1.2.** including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships

**3.1.3.** attention to scheduling, work intensity, and work compression that impacts resident well-being


**3.1.4.** evaluating workplace safety data and addressing the safety of residents and faculty members' policies and programs that encourage optimal resident and faculty member well-being; and,

**3.1.4.1.1.** Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours

**3.1.5.** attention to resident and faculty member burnout, depression, and substance abuse.

**3.1.5.1.** 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 means to assist those who experience these conditions.

- [illegible]

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	N/A
		EFFECTIVE DATE	06/23/2017
		PAGE(S)	01
	<u>SUBJECT:</u> ACGME PROGRAM SPECIFIC REQUIREMENTS	SUPERSEDES	06/01/2014

### **ACGME Program Specific Requirements**

The program adheres to all common program requirements and program specific requirements of the Accreditation Council for Graduate Medical Education (ACGME). The requirements can be found at:

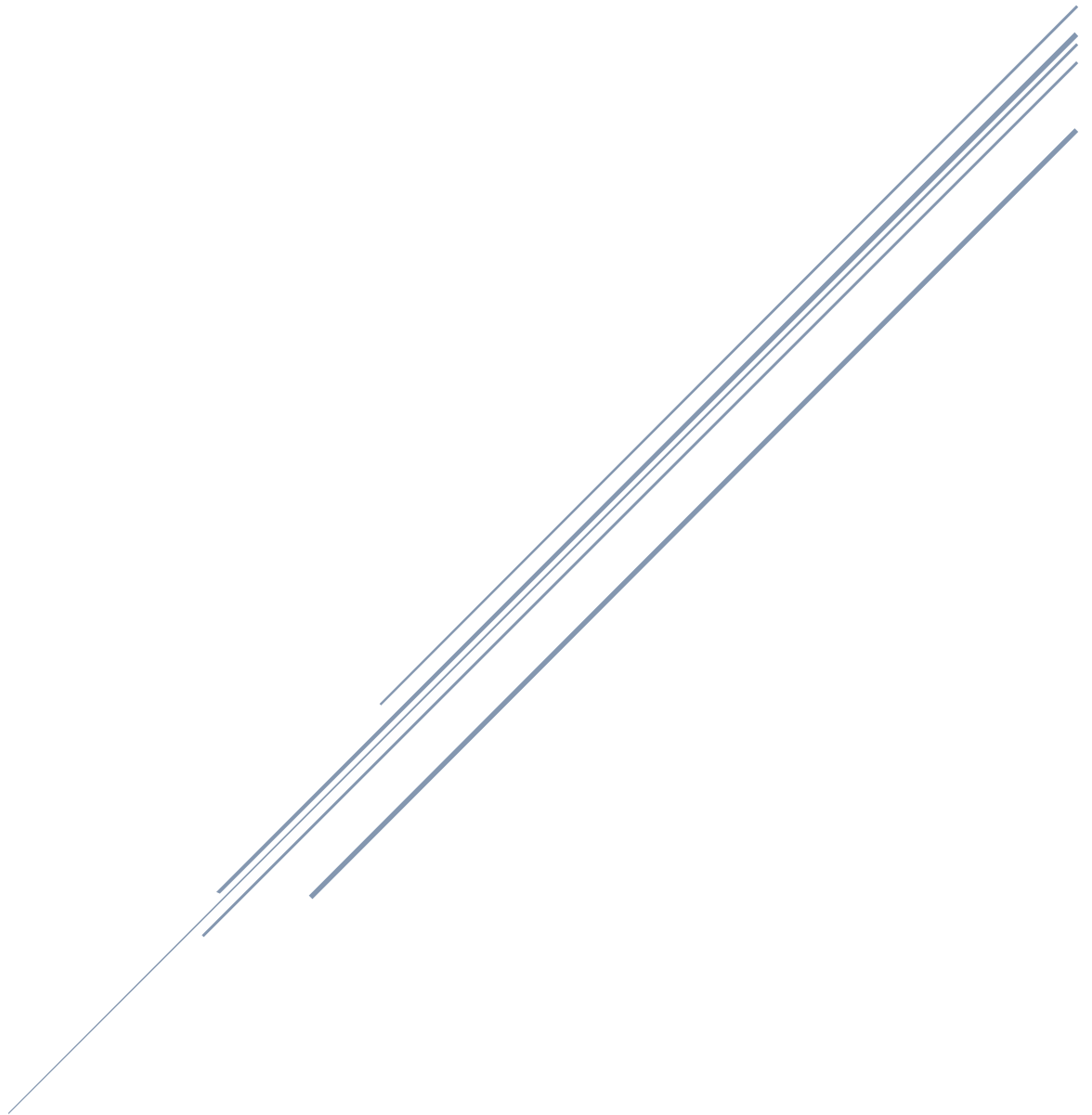
[Common Program Requirements](#)

[Family Medicine Program Specific Requirements](#)

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FAMILY MEDICINE RESIDENCY  
PROGRAM HANDBOOK  
2017-2018 ACADEMIC YEAR  
MOREHOUSE SCHOOL OF MEDICINE



## Table of Contents

Preface .....	3
Morehouse School of Medicine (MSM) Vision and Mission .....	3
MSM Vision .....	3
MSM Mission .....	3
MSM Graduate Medical Education (GME) Goals and Objectives .....	3
The MSM Family Medicine Residency Program .....	3
History .....	3
Mission .....	4
Training Goals .....	5
Program Contact, Administration, Faculty & Clinical Staff Information .....	6
Residency Program Location Contact Information .....	6
Program Administration and Leadership .....	6
Program Faculty and Clinical Staff .....	8
Clinical Faculty .....	8
Non-Clinical Faculty .....	8
Clinical Staff .....	8
Program Elements .....	10
Morning Report .....	10
Conferences/Didactic Sessions .....	10
Clinical Rotations .....	11
Continuity Clinic .....	11
Scholarly Activity .....	11
Benefits .....	11
Continuing Medical Education (CME)/Book Allowance .....	11
Professional Organizations .....	12
Pagers .....	12
Vacation/Sick/CME Leave .....	12
Rotation Contact Information .....	13
Appendix .....	18
APPENDIX A: Moonlighting Form .....	18
APPENDIX B: Hand-off Form .....	18
APPENDIX C: Acknowledgement of Promotion and PGY2-Specific Requirements .....	18

APPENDIX D: Acknowledgement of Promotion and PGY3-Specific Requirements ..... 18

APPENDIX E: Evaluation of Faculty by Residency Program Form ..... 18

APPENDIX F: Resident Leave Request Form ..... 18

APPENDIX G: Inpatient Survival Guide ..... 18

APPENDIX H: A Survival Guide for the Intern..... 18

# Preface

## Morehouse School of Medicine (MSM) Vision and Mission

### MSM Vision

Leading the creation and advancement of health equity by:

- Translating discovery into health equity
- Building bridges between healthcare and health
- Preparing future health learners and leaders

### MSM Mission

We exist to:

- Improve the health and wellbeing of individuals and communities;
- Increase the diversity of the health professional and scientific workforce;
- Address primary health care needs through programs in education research and service with emphasis on people of color and the underserved urban and rural populations in Georgia, the nation, and the world.

## MSM Graduate Medical Education (GME) Goals and Objectives

GME is an integral part of the Morehouse School of Medicine medical education continuum. Residency is an essential dimension of the transformation of the medical school graduate into the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

Residency education at MSM has the following five goals and objectives for residents:

- To obtain the clinical knowledge, competencies, and skills required for the effective treatment and management of patients;
- To prepare for licensure and specialty certification;
- To obtain the skills to become fully active participants within the United States healthcare system;
- To provide teaching and mentoring of MSM medical students and residents;
- To directly support the school's mission of providing service and support to disadvantaged communities.

## The MSM Family Medicine Residency Program

### History

The MSM Family Medicine Residency Program is located in metropolitan Atlanta, Georgia, a city which is an economic and cultural center for not only the southeastern United States, but also the world at large. Morehouse School of Medicine opened in September 1978 as part of Morehouse College, with Dr. Hugh Gloster as President and Dr. Louis Sullivan as Dean of the medical school. The Department of Family Medicine, the first clinical department, was established in July 1979. In 1981, the Department started the school's first residency program. The department has been an integral part of the development of the school and is a critical link in the school's educational programs. The residency program serves a significant role in Georgia as a producer of family physicians who practice among underserved populations with more than 60% of its graduates remaining in the state after training. The program is accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Our program aims to be the best and most effective program in the southeast in developing superb family physicians for practice in underserved communities. We offer training in all aspects of family medicine including office procedures, community outreach, preventive medicine, and women's health care. In our 35-year history, we have successfully recruited well-qualified graduates of accredited medical schools. To date, there are a total of 156 graduates from our program, many of whom have received recognition at the state and national level for their outstanding contributions. A full complement of the brightest, most competent and compassionate students from around the nation and abroad join our residency training program.

The Morehouse Family Medicine Center, the Comprehensive Family Healthcare Center, is a model office that provides a setting that fosters educational excellence, provides research opportunities, and sets the pace for ambulatory office operations. Our faculty is a group of highly-trained, dedicated, and enthusiastic teachers who are effective in motivating their learners. They are involved in regular scholarly activities and are committed to maintaining excellence in education. Our faculty includes 22 physicians and four non-physician clinicians.

### **Mission**

The mission of the Morehouse School of Medicine's Family Medicine Residency is to:

- Train residents to become excellent family physicians who care for underserved populations;
- Provide training in behavioral medicine and family dynamics to foster the physician's awareness of the importance of the family unit in treating the patient;
- Provide physicians training experiences in both inpatient and outpatient care; and
- Provide residents with basic skills necessary to implement preventive care and to consistently educate patients about health and wellness.

Morehouse Family Medicine Residency is a community-based residency program that is affiliated with Atlanta Medical Center, Atlanta Veterans Affairs, Children's Healthcare of Atlanta, and Grady Memorial Hospital. The residency program director, Riba Kelsey-Harris, MD, is responsible for all resident-related policies and procedures. Overall residency program administration policy development is a shared responsibility of a leadership group including the director, associate director, and the members of the executive committee chaired by Dr. Folashade Omole (Chair of the Department of Family Medicine). Key administrative and curricular components of the program are overseen by assigned faculty, clinical and administrative/support staff.

The business operation of the center is the responsibility of the senior department administrator, Mrs. Jamie Baker. The operation of the clinical area is the responsibility of the medical director, Michelle Nichols, MD. The Residency Program administrative staff oversees many of the administrative tasks related to residents.

Hospital affiliates include:

- Grady Memorial Hospital (GMH)
- Children's Healthcare of Atlanta (CHOA)
- Atlanta Veteran's Affairs Hospital (VA)
- Atlanta Medical Center Main and South (AMC)

Residents in our program also obtain education from a number of physicians in the private and public sectors for outpatient rotations.

#### Training Goals

The MSM Family Medicine Residency Program goals are listed below:

- Provide the Family Practice resident with the knowledge, skills, and attitudes to competently manage medical patients with simple and complex problems.
- Provide a foundation which can be expanded and refined during medical subspecialty rotations.
- Provide the resident with knowledge about how family dynamics and behavioral medicine principles apply to the hospitalized medical patient.
- Teach the resident to utilize the concept of the “healthcare team” whereby the physician is the coordinator of the health team’s efforts, calling upon support and input from personnel in nursing, social work specialty clinics, nutrition, administration, and chaplain staff.
- Teach the resident to recognize the limits of one’s own knowledge and skills and institute timely and appropriate consultation.
- Teach the resident to exhibit patterns of inter-professional collaboration and cooperation which enhance patient care.
- Teach the resident to recognize that hospital care is merely one phase on a continuum of longitudinal and continuous medical care.
- Train family physicians to provide comprehensive, continuing care to all of their patients.
- Stimulate the analytical attitude toward the most efficient and effective use of the physician’s time, personnel, and facilities in order to provide optimal care to patients.
- Implement preventive services and consistently educate patients about health.
- Train Family Medicine residents in the six core competencies, as identified by the ACGME:
  - Patient care
  - Medical knowledge
  - Practice-based learning and improvement
  - Interpersonal and communication skills
  - Professionalism
  - Systems-based practice

## Program Contact, Administration, Faculty & Clinical Staff Information

### Residency Program Location Contact Information

The Morehouse School of Medicine Family Medicine Program is physically located in East Point, GA. Our contact address is 720 Westview Drive, SW, Atlanta, GA 30310. Our phone number is 404-756-1230.

Further information in relation can be found on our website at

<http://www.msm.edu/Education/GME/FMResidencyProgram/index.php>.

### Program Administration and Leadership

*Program Director – Dr. Riba Kelsey-Harris*

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 Accreditation Council for Graduate Medical Education (ACGME) requirements for a family medicine residency training program. The program director is responsible for residents' progression and matriculation from the program and for the information that is communicated to residents, mainly via semi-annual resident evaluations. The program director tracks and reviews all resident evaluations, procedure and patient logs, and duty hours to ensure overall resident and program compliance.

Other responsibilities include:

- Oversight of 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 family medicine
- Updating and modifying educational goals and curricula
- Overseeing and approving topics for lectures and instruction as deemed fit by the program and the emerging guidelines of the Residency Review Committee (RRC) and the American Board of Family Medicine
- Directly supervising the program manager, the core family medicine 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 the department
- Overseeing the resident selection and promotion process

*Associate Program Director – Dr. Folashade Omole*

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 family medicine residency curriculum, conducting semi-annual evaluations with residents, overseeing the program operations, and assisting with didactic teaching and conference schedules. The associate program director also represents the program at official meetings within the institution and outside, as needed, in the absence of the program director.

*Assistant Program Director – Dr. Walkitria Smith*

The assistant program director assists the residency program director and associate program director in program operations. The assistant program director schedules and conducts resident educational conferences such as Grand Rounds, Morning Report and mock code, and weekly didactic lectures. The assistant program director assists with the resident selection process, maintains the evaluation system

for residents and preceptors, and oversees the chief residents in development and maintenance of the resident master schedule.

*Program Manager – Colleen Stevens, MBA*

The program manager manages the daily operational activities of the residency program and interacts with personnel at affiliated institutions, as needed. The program manager ensures that the residents complete all required paperwork, including obtaining completed evaluations. The program manager also ensures that residents' master files, evaluations, immunization certificates, visa documents, United States 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 Family Medicine, American Academy of Family Physicians). The program manager coordinates the resident recruitment activities in conjunction with the program director.

*Program Assistant – Etinosa Evbuomwan*

The program assistant provides administrative support to the program director, associate program director and program manager. The program assistant provides professional and prompt completion of data entry, expense requests, travel support, program documentation and meeting logistics.

*Chief Residents – Drs. Onyinye Iheaku and Oluwaseun Odewole*

The chief residents support resident teaching activities such as Grand Rounds, Morning Report, and weekly didactics. The chief residents supervise the development and modification of resident schedules, review vacation requests for feasibility, and arrange back-up coverage for unplanned absences. The chief residents attend faculty meetings of the department and serves as the resident liaison. The chief residents are appointed from the rising graduating class by February of the academic year. The appointed chiefs must be in good standing for the most recent 18 months at the time of chief resident selection.

*Resident Advisors*

Each resident is assigned to a family medicine faculty advisor for the duration of his or her training. The advisor's role is to monitor the resident's progress in training and provide guidance in his or her clinical and scholarly pursuits throughout residency.

Residents are strongly encouraged to initiate and maintain contact with their advisors from the time of orientation and throughout the duration of their residency training. Advisors are expected to document meetings with their resident advisee. Topics discussed should be noted and the entire report should be forwarded to the program director's office for placement in the resident's file. Residents should meet with their resident advisors at least once every three months.

The resident advisor should assist the resident with adapting a study plan for the three years of residency. The resident advisor will also review the resident's Individual Education Plan (IEP), give feedback on adjustments, and monitor the resident's progress on goals. The resident advisor should discuss the resident's performance on rotations, review his or her rotation evaluations, and provide strategies for improving weaknesses.

The resident advisor should also review the resident's in-training exams and guide the resident's study plan. The resident advisor also represents the resident in cases of due process and provides information



about career paths. The resident advisor should also monitor the resident's quality improvement and research projects.

## Program Faculty and Clinical Staff

### Clinical Faculty

<u>Faculty Member Name</u>	<u>Board Certification</u>	<u>Email</u>
Nicole Ash-Mapp, MD	Family Medicine	<a href="mailto:nashmapp@msm.edu">nashmapp@msm.edu</a>
Dolapo Babalola, MD	Family Medicine	<a href="mailto:dbabalola@msm.edu">dbabalola@msm.edu</a>
Denise Bell-Carter, MD	Family Medicine	<a href="mailto:Dbell-carter@msm.edu">Dbell-carter@msm.edu</a>
Kitty Carter-Wicker, MD	Family Medicine	<a href="mailto:kcwicker@msm.edu">kcwicker@msm.edu</a>
Kirstie Cunningham, MD	Obstetrics & Gynecology	<a href="mailto:kcunningham@msm.edu">kcunningham@msm.edu</a>
Jennifer Fowlkes-Callins, MD	Pediatrics	<a href="mailto:jfcallins@msm.edu">jfcallins@msm.edu</a>
Anne Gaglioti, MD	Family Medicine	<a href="mailto:agaglioti@msm.edu">agaglioti@msm.edu</a>
Janice Herbert-Carter, MD	Internal Medicine	<a href="mailto:jherbertcarter@msm.edu">jherbertcarter@msm.edu</a>
Riba Kelsey-Harris, MD, MSCR	Family Medicine	<a href="mailto:rkelsey@msm.edu">rkelsey@msm.edu</a>
Dominic Mack, MD, MBA	Family Medicine	<a href="mailto:dmack@msm.edu">dmack@msm.edu</a>
Yuan Xiang Meng, MD, PhD, MSCR	Family Medicine	<a href="mailto:ymeng@msm.edu">ymeng@msm.edu</a>
Michelle Nichols, MD, MS	Family Medicine	<a href="mailto:mnichols@msm.edu">mnichols@msm.edu</a>
Isioma Okwumabua, MD	Family Medicine	<a href="mailto:iokwumabua@msm.edu">iokwumabua@msm.edu</a>
Lawrence Powell, MD	Family Medicine	<a href="mailto:lpowell@msm.edu">lpowell@msm.edu</a>
Walkitria Smith, MD	Family Medicine	<a href="mailto:wasmith@msm.edu">wasmith@msm.edu</a>
Charles Sow, MD, MSCR, CPEHR	Family Medicine	<a href="mailto:csow@msm.edu">csow@msm.edu</a>
Gregory Strayhorn, MD	Family Medicine	<a href="mailto:gstrayhorn@msm.edu">gstrayhorn@msm.edu</a>
Robert Williams, MD	Obstetrics & Gynecology	<a href="mailto:rwilliams@msm.edu">rwilliams@msm.edu</a>

### Non-Clinical Faculty

<u>Faculty Member Name</u>	<u>Area of Focus</u>	<u>Email</u>
Marietta Collins, PhD	Behavioral and Mental Health	<a href="mailto:mcollins@msm.edu">mcollins@msm.edu</a>
Susan Robinson, PA-C	Geriatrics	<a href="mailto:srobinson@msm.edu">srobinson@msm.edu</a>
Arlatha Williams-Livingston, PhD	Community Health	<a href="mailto:awlivingston@msm.edu">awlivingston@msm.edu</a>

### Clinical Staff

<u>Name</u>	<u>Role</u>
<b><i>Front Office Staff</i></b>	
Althea Brathwaite	Patient Service Representative
Judy Cooper	Supervisor, Medical Records
Latoyia Douglas	Patient Service Representative
Natasha Ibarra	Patient Service Representative
Keema McClean-Hayes	Medical Records
Linda Robinson	Supervisor, Front Office
Nico Smith	Patient Service Representative
<b><i>Referral Coordinators</i></b>	
Stephanie Robertson	Referral Coordinator
Kimberly White	Referral Coordinator
Melinda Morgan	Care Coordinator

<b><i>Back Office Clinical Staff</i></b>	
Barbara Cobb, LPN	LPN
Alysia Coleman, CCMA	CCMA
Mercedes Parks, LPN	LPN
Michelle Remis, LPN	LPN
Shanikka Springer, RMA	RMA
Taisha Alves, RMA	RMA
Teyunna Stephens, CMA	CMA
<b><i>Support Staff</i></b>	
Carmen Coggins, RN	Practice Manager
Lisa Jackson	LabCorp
Officer Phillip Lewis	MSM Police
Keith Charles	MSM Cleaning Services

## Program Elements

### Morning Report

- Morning Report occurs Fridays at 8:00 a.m. at Atlanta Medical Center South.
- Residents on the inpatient service and all residents assigned to the CFHC are required to attend.
- Night float residents are required to attend Morning Report post-shift.

### Conferences/Didactic Sessions

- In accordance with ACGME requirement IV.A.3, the program holds regularly scheduled didactic sessions on Wednesdays from 12:30pm to 5:00pm. These sessions are required for all residents except those rotating on certain rotations or under certain circumstances as outlined below.
- When urgent clinical responsibilities or official residency functions preclude a resident from attending a required conference, the residency program director, the associate residency director or the program manager must be contacted to “excuse” the absence.
- Scheduled vacations, out-of-town rotations, and Continuing Medical Education (CME).
- Residents on the following rotations (see below).
  - Internal Medicine (Grady Wards)
  - Intensive Care Unit (ICU)
  - Peds ER (only when scheduled to work a shift)
  - Surgery
  - Pediatric Wards
  - Nursery
- Didactics-Related Expectations:
- The resident must submit an electronic evaluation of each session attended through New Innovations (NI).
- While on rotations on which the resident is not required to attend the Family Medicine Wednesday conferences, the resident is expected to attend the regularly scheduled conferences provided by the respective department unless otherwise assigned by the rotation director
- Family Medicine places high emphasis on the quality of its didactic programs. Our expectation is that residents who are scheduled to speak or present will do so in a professional and timely fashion. In the unfortunate event that a resident foresees that he or she will not be able to present (on vacation, CME, etc.), it is expected that the resident will contact the chief resident and the program assistant, who coordinates didactics, to reschedule and ensure that the time will be covered with another well-prepared lecture.
- When a resident is scheduled to present, he/she must request an attending physician to be a discussant on the chosen topic. The resident must send the presentation must be sent to the Attending two weeks in advance for critical appraisal.
- When a resident is scheduled to present, he/she is required to provide topics with well thought out objectives to the program assistant two weeks in advance. Any additional articles that must be provided to the attendees of the didactic session should be sent to the Program Assistant a week in advance of the lecture.

- Attendance sheets are posted in the back of the conference room and it is the responsibility of each resident to sign into every didactic session. Sign-in sheets should reflect hourly attendance. Therefore, for any given Wednesday didactic, attendance will be taken for four (4) separate didactic hours. To get credit for attending a given didactic hour, the resident should be present for at least 80% (roughly) of that session.

## Clinical Rotations

- ACGME-required and carefully selected program-required clinical rotations are essential to the development of the clinical and interpersonal skills necessary for future independent practice. The required clinical rotation experiences are described in section IV.A.6.b-k of the ACGME Program Requirements for Graduate Medical Education in Family Medicine.
- Milestone-based goals and objectives have been developed for all rotations and are accessible to residents and faculty through the Resources tab in New Innovations.

## Continuity Clinic

- Central to the training of a Family Physician is the establishment of a panel of continuity patients in the ambulatory setting. As such, each resident sees patients in the Morehouse Healthcare Comprehensive Family Healthcare Center, our established Family Medicine Practice (FMP) site, throughout all three program years. Required visit numbers and types of patients are detailed in section IV.A.6.a).(5) of the ACGME Program Requirements for Graduate Medical Education in Family Medicine

## Scholarly Activity

- The program provides a longitudinal research curriculum that prepares residents to produce quality scholarly activity.
- Residents are required to complete a PSQI “mini-project” during their Practice Management rotation and a larger research project in fulfillment of their PGY3 research requirement.
- Aside from meeting these requirements, the program encourages scholarly activity in the form of letters to the editor, case reports, conference presentations, non-required PSQI projects, and the like to foster a sense of inquiry and establish the habit of contributing to the body of knowledge in our discipline.

## Benefits

### Continuing Medical Education (CME)/Book Allowance

Each year, all PGY-2 and PGY-3 residents receive CME funds for educational purposes. Due to a vigorous schedule, first year residents are not granted continued education conference time. However, first year residents receive technological equipment purchased by the department. Second and third year residents may take up to five educational days for travel to present scholarly work and research. CME funds are allocated according to the following schedule:

PGY-1	Laptop provided by the department
PGY-2	AAFP Board Review Course OR \$750
PGY-3	AAFP Board Review Course OR \$750

PGY-2 and PGY-3 residents have the option to take the Board Review Course in either the Spring of their 2<sup>nd</sup> or the Fall of their 3<sup>rd</sup> year. Whichever year the Board Review course is not take, the resident has an

allotment of \$750. All CME requests must be made by April 15<sup>th</sup> of the PGY-2 or PGY-3 year. Examples of items that can be purchased with CME funds are medical books related to Family Medicine only, stethoscopes, scrubs, medical software for handheld devices, and CME conferences. CME funds cannot be used for computers, computer equipment, or personal device accessories. The residency office should be consulted prior to purchase in cases of uncertainty about eligibility for CME funds.

Additionally, up to \$1,000 of the ABFM exam registration fee is reimbursed upon taking the exam by the 34th month of training and passing on the first attempt pending availability of funds.

All CME funds must be used in the current fiscal year, no later than April 15th. CME funds do not rollover.

### **Professional Organizations**

The program provides residents membership in the American Academy of Family Physicians (AAFP) and Georgia Academy of Family Physicians.

### **Pagers**

The department provides pagers to residents at no charge. However, there is a \$50.00 charge to replace lost or stolen pagers, which is the responsibility of the resident. If a pager is lost or stolen, the resident must notify residency administrative office immediately to arrange for a replacement.

The program will cover pagers for residents up until the end of the second year of residency since it is the last year in which a rotation on an inpatient or emergency medicine service at Grady Memorial Hospital occurs. Upon successful completion of the 2<sup>nd</sup> year, residents are required to turn in their pagers to the residency office.

Morehouse School of Medicine also uses the Spok paging system at Grady Memorial Hospital, which allows pages to be received directly on each resident's smart phone. Enrollment in the Spok paging system will occur during new resident orientation. Prompt response to pages and text messages while on duty is mandatory and is part of the Professionalism competency.

### **Vacation/Sick/CME Leave**

Each resident is receives up to 15 days of vacation, 15 days of sick leave, 10 days of administrative leave, 5 days of educational (CME) leave, and holiday leave depending on the current rotation at the time of a recognized holiday. Residents are required to notify the chief residents, the program manager, and their rotation director of any unplanned absences from their rotation. A completed leave request form is due to the program manager upon return from work for any unplanned absences, such as call out for being sick. A leave request form can be found in the appendix section of the program handbook.

## Rotation Contact Information

PGY-1 Resident Rotations			
Rotation	Rotation Days	Continuity Clinic Days	Contact Information
*IM Wards Grady*	Daily – No FM Didactics	Mondays	Dr. Cinnamon Bradley - Site Director <a href="mailto:cbradley@msm.edu">cbradley@msm.edu</a>  IM Chief Resident: Paula Adamson <a href="mailto:padamson@msm.edu">padamson@msm.edu</a>
*ICU Grady*	As scheduled – No FM Didactics	Mondays	Dr. Cinnamon Bradley - Site Director <a href="mailto:cbradley@msm.edu">cbradley@msm.edu</a>  IM Chief Resident: Paula Adamson <a href="mailto:padamson@msm.edu">padamson@msm.edu</a>
Surgery Grady	Daily	Tuesdays	Dr. Clarence Clark - Site Director <a href="mailto:cclark@msm.edu">cclark@msm.edu</a>  Chief Residents: Cooper Moungar <a href="mailto:cmoungar@msm.edu">cmoungar@msm.edu</a>  Carolyn Moore <a href="mailto:cmoore@msm.edu">cmoore@msm.edu</a>
L&D Grady	Daily	Thursdays	Dr. Franklin Geary - Site director <a href="mailto:fgeary@msm.edu">fgeary@msm.edu</a>  OB Chief Resident: Christina Cox <a href="mailto:ccox@msm.edu">ccox@msm.edu</a>
OB/Gyn AMC	Tues (AM), Thur (PM), Fri (AM) Mon AM @ CFHC Tues (AM), Thurs (PM), Fri (AM) @ WJF Deliveries @ AMC Main	Tues (PM), Thurs (AM)	Dr. Kirstie Cunningham Email: <a href="mailto:kcunningham@msm.edu">kcunningham@msm.edu</a> Cell: 770-851-4976
Neuro VA Atlanta VA Medical Center	Mon, Tues, Thur, Fri	Wed (AM)	Dr. William Tyor - Site Director  Charlyn Thomas - Neurology Rotation Coordinator 404-321-6111, ext. 5142
ECC Grady	As scheduled	Wed (AM)	Dr. <b>James O'Shea</b> - Site Director DeMarlo West - Program Coordinator <a href="mailto:demarlo.west@emory.edu">demarlo.west@emory.edu</a>

*Peds Wards Hughes Spalding*	Daily for 3 weeks. NO FM didactics!!!	1 week of clinic (beginning or end of month)	Dr. Chevon Brooks - Site Director <a href="mailto:cbrooks@msm.edu">cbrooks@msm.edu</a>  Peds Chief: <a href="mailto:pedschief@msm.edu">pedschief@msm.edu</a>
*Peds ER Hughes Spalding*	As scheduled. No FM Didactics when on a scheduled shift	Thursday	Dr. Funmi Salami - Site Director Donna Stringfellow – Program Coordinator <a href="mailto:dstring@emory.edu">dstring@emory.edu</a> If the need arises to call out from a shift, follow the below: o Call our chiefs and residency admin o Call Peds ED directly and notify attending for the day 404-785-9662 (unit secretary ask of the attending on duty)
FM Wards	Daily	Tues (PM) or Thurs (PM)	Various FM Attendings
CFHC	Varies (May cover VA Gyn)	All Days	NONE
Nursery	Daily		Dr. Letita Mobley
PGY-2 Resident Rotations			
Rotation	Rotation Days	Clinic Days	Contact Information
Peds GEP	Mon, Wed (AM), Fri	Tues, Thurs (PM)	Dr. Jennifer Fowlkes-Callins <a href="mailto:jfcallins@msm.edu">jfcallins@msm.edu</a> Cell: 678-468-4981
Peds Harbin	Mon, Tues	Thurs, Fri	Dr. Robersteen Howard - Site Director Email: <a href="mailto:rhoward@harbinclinic.com">rhoward@harbinclinic.com</a>  Shawn McGarity - Manager <a href="mailto:smcgarity@harbinclinic.com">smcgarity@harbinclinic.com</a>  Harbin Clinic Pediatrics 330 Turner McCall Blvd. Physician Center, Suite 4000 Rome, GA 30165 706-238-8030
GYN (VA/WHC)	Mon, Wed (AM), Thurs	Tues, Fri	<b>D'Nyce Williams, MD</b> <a href="mailto:dnyce.williams@va.gov">dnyce.williams@va.gov</a> 404-735-1040
CFHC	Varies (May cover VA Gyn)	All Days	NONE

CBOC	Mon, Tues, Thurs	Wed (AM), Fri	Dr. Kitefre Oboho <a href="mailto:kitefre.oboho@va.gov">kitefre.oboho@va.gov</a> 678-232-6619  VA Fort McPherson 1701 Hardee Ave., SW Atlanta, GA 30310
FM Wards	Daily	Tues (PM) or Thurs (PM)	Various FM Attendings
Geriatrics	Varies (Must have Thurs or Mon AM)	Varies	Mrs. Susan Robinson, PA <a href="mailto:srobinson@msm.edu">srobinson@msm.edu</a> 404-405-6234
ECC Grady	As scheduled	Wed (AM)	<b>Dr. James O'Shea</b> - Site Director DeMarlo West - Program Coordinator <a href="mailto:demarlo.west@emory.edu">demarlo.west@emory.edu</a>
Orthopedics	Mon, Thurs, Fri 8:30a – 5:00p  Monday: AM -- Stockbridge PM -- Buckhead  Thursday: Stockbridge AM / PM (Kevin only)  Friday: AM/PM -- Buckhead	Tues, Wed	Attending: Dr. Raj Pandya Email: r2d2p2@aol.com  PA: Kevin Hartman (copy Kevin on email) <a href="mailto:hartmankb@gmail.com">hartmankb@gmail.com</a> Karen Langford: <a href="mailto:kwlangford@gmail.com">kwlangford@gmail.com</a> (Stockbridge) Stockbridge Office 1035 Southcrest Drive Suite 100 Stockbridge, GA 30281 Phone: 770-389-9005  Buckhead Office (located in Palisades at West Paces) 3200 Downwood Circle, NW Suite 400 Atlanta, GA 30327 Phone: 404-352-4779
	Mon (all day): Kane Tues (PM): 1-4pm Powell	Tues AM, W-F	Attending: Dr. Steven Kane Email: <a href="mailto:stevenm.kane@tenethealth.com">stevenm.kane@tenethealth.com</a>  Assistant: Mandie Lozano (copy her) Office: 404-265-4255 Email: <a href="mailto:mandie.lozano@tenethealth.com">mandie.lozano@tenethealth.com</a> <b>Dr. Kane's cell: 404-368-3832</b>  320 Parkway Drive, NE on the 3rd floor. (Park by the building, not at main campus)  Lawrence Powell Clark Atlanta Campus <a href="mailto:lpowell@msm.edu">lpowell@msm.edu</a> 678-358-5864
Endocrinology	Tues, Weds, Thurs	Mon, Fri	Dr. Peter Thule - Site Director <a href="mailto:peter.thule@va.gov">peter.thule@va.gov</a>



PGY III ROTATIONS			
Rotation	Rotation Days	Clinic Days	Contact Information
Dermatology	Tues/Thurs (all day)	Mon, Wed, Fri (PM)	<p>Dr. Jamie MacKelfresh - VA Site Director  <a href="mailto:jpbower@msm.edu">jpbower@msm.edu</a></p> <p>Elise Core-Sanders – PA  <a href="mailto:edsande@emory.edu">edsande@emory.edu</a></p> <p>250 N. Arcadia Ave 2nd Floor Decatur, GA  T: 404-727-3669 or  T: 404) 321-6111 ext 6380</p>
ENT	ENT: Tues/Thur all day	Weds AM, Fri (all day)	<p>ENT: Dr. Carrie Flanagan  <a href="mailto:carrie.flanagan@va.gov">carrie.flanagan@va.gov</a></p>
Ophthalmology	Ophth: Mon, Tues, Thur (all day)	Weds AM, Fri (all day)	<p>Ophth: Dr. Urken - VA Site Director  <a href="mailto:steven.urken@va.gov">steven.urken@va.gov</a></p> <p>1670 Clairmont Road  Atlanta, GA  T: (404) 321-6111 ext 7422</p>
Cardiology	Varies: In the AM meet in Nuclear Medicine in Radiology on 1st floor between 8 and 830	Varies	<p>Dr. Patrick A. Egbe - Site Director  <a href="mailto:pegbe@me.com">pegbe@me.com</a></p> <p>Stephanie Scott - PA  <a href="mailto:sscott@atlantaheartassociates.com">sscott@atlantaheartassociates.com</a></p> <p>Atlanta Medical Center Medical Arts Building  1136 Cleveland Avenue, Suite 205  East Point, GA 30344  Office: 404-761-9339  Email: <a href="mailto:pegbe@me.com">pegbe@me.com</a></p>
CBOC	Mon, Tues, Thurs	Wed (AM), Fri	<p>Dr. Kitefre Oboho  <a href="mailto:Kitefre.oboho@va.gov">Kitefre.oboho@va.gov</a>  678-232-6619</p> <p>VA Fort McPherson  1701 Hardee Ave., SW  Atlanta, GA 30310</p>
Urology / Radiology	Tues, Weds, Thurs	Mon, Fri	<p>Radiology  Dr. Ronald Mixon  <a href="mailto:Ronald.Mixon@va.gov">Ronald.Mixon@va.gov</a>  Office: 404-321-6111 ext. 2360</p> <p>Urology  Dr. Donald Finnerty  Email: <a href="mailto:donald.finnerty@va.gov">donald.finnerty@va.gov</a>  Office: 404-321-6111 Ext. 6601</p>
MH/HB	Tues, Weds, Thurs AM	Mon, Fri	<p>Dr. Marietta Collins – Rotation Director  <a href="mailto:mcollins@msm.edu">mcollins@msm.edu</a></p>

Research / Oral Health	Mon/Tues/Fri AM	Mon/Tues PM Thur (all day)	Research: Dr. Gregory Strayhorn <a href="mailto:gstrayhorn@msm.edu">gstrayhorn@msm.edu</a> Cell: (404) 664-5916 Ofc: (404) 756-1284  Oral Health: Dr. W. Kevin Dancy, DDS 3752 Cascade Road, Suite 190 Atlanta, GA T: (678) 836-2118 F: (404) 472-6887
Rheumatology	Tues/Thurs clinics	Mon, Wed (AM), Fri	Dr. Karen Atkinson, Director <a href="mailto:kvatkin@emory.edu">kvatkin@emory.edu</a>  Dr. Ayesha Iqbal <a href="mailto:aiqbal@emory.edu">aiqbal@emory.edu</a>
FM Wards	Daily	Tues (PM) or Thurs (PM)	Various FM Attendings
Elective Rotations			
Rotation	Rotation Days	Clinic Days	Contact Information
Family Planning Grady OB Department	Mon (AM), Tues (PM), Thurs	Mon (PM), Tues (AM), Fri	Attending: Dr. Hedwige Saint-Louis <a href="mailto:hsaintlouis@msm.edu">hsaintlouis@msm.edu</a>
Nephrology	Mon, Fri	Tues, Thurs	Dr. Lynn Schlanger <a href="mailto:lynn.schlanger@va.gov">lynn.schlanger@va.gov</a>
CAM	Tues (all day), Wed (AM), Thu PM (Chiro and Aesth) Thur AM: VA CAM with Dr. Omole	Mon/Fri	Dr. Edward Cordovado (Chiropractor) Park Ridge Wellness Center 2896 Chamblee Tucker Rd Ste 4, Chamblee, GA 30341 (770) 457-0584  Dr. Mayisha Clairborne (Aesthetics) Mind Body Spirit Wellness 2801 Buford Hwy., Suite T-30 Atlanta, GA 30329 (404) 478-9868  MUST call Dr. Clairborne the day before planning to show up as she sees patients on a PRN basis
Pulmonary	Mon, Fri	Tues, Thurs	Dr. RuxSadikot - Site Director <a href="mailto:ruxana.sadikot2@va.gov">ruxana.sadikot2@va.gov</a>

### Family Medicine In-Patient Service Guidelines

The Department of Family Medicine is responsible for the design and implementation of the Family Medicine In-Patient Service (FMIS). The Family Medicine In-Patient Service (FMIS) consists of patients who are admitted from the FMP and select patients admitted by the Eagle Hospital Physicians (EHP) group. Resident coverage for the teaching service is provided on a 24-hour-a-day, year-round basis.

All residents and interns on Family Medicine In-Patient Service are required to follow their patients at AMC-S with daily rounds and notes.

Please reference the Inpatient Survival Guide in the Appendix Section for additional information.

## Appendix

APPENDIX A: Moonlighting Form

APPENDIX B: Hand-off Form

APPENDIX C: Acknowledgement of Promotion and PGY2-Specific Requirements

APPENDIX D: Acknowledgement of Promotion and PGY3-Specific Requirements

APPENDIX E: Evaluation of Faculty by Residency Program Form

APPENDIX F: Resident Leave Request Form

APPENDIX G: Inpatient Survival Guide

APPENDIX H: A Survival Guide for the Intern

**Morehouse School of Medicine  
Family Medicine Residency Program  
Moonlighting Privileges Request Form**

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_

I am requesting permission to moonlight. I currently meet the following conditions:

- ☐ I am a resident in good academic standing in our program. I am not on academic remediation or probation, and I have promptly fulfilled all administrative requirements of the program.
- ☐ I have a valid Georgia medical license and DEA number (copies are attached).
- ☐ I have arranged for my own malpractice insurance for this moonlighting. I understand that Morehouse School of Medicine will not provide this coverage.
- ☐ I will not moonlight excessive hours. I will not allow it to interfere with my patient care nor will it be so excessive that I am too tired to learn and/or to perform the requirements of the residency. The combined hours of my residency and moonlighting will not exceed 80 hours per week, and I will not moonlight more than one shift per week.
- ☐ I understand that I may not moonlight while on call duty or during normal duty hours, as defined by the rotation I am on. I will not moonlight between 7:00 a.m. and 5:00 p.m., Monday through Friday (except for holidays), and I may not moonlight on the day after I am on call.
- ☐ I will arrange coverage for my continuity obstetrical patients while moonlighting.
- ☐ I agree to follow all rules and policies as established by the residency and understand that failure to do so may result in revocation of moonlighting privileges and/or other disciplinary action.

**Moonlighting Details:**

Location and Type of Practice: \_\_\_\_\_

Point of Contact (Name and Phone #): \_\_\_\_\_

Number of Hours Planning to Work Each Week: \_\_\_\_\_ Each Month: \_\_\_\_\_

\_\_\_\_\_  
Signature of Resident

\_\_\_\_\_  
Date

\_\_\_\_\_  
To be Completed by the Program Director upon Review with the Faculty Committee

The Faculty Committee and I reviewed your above request on \_\_\_\_\_.

- ☐ Your request is granted. You must follow the rules as outlined by our program and by Morehouse School of Medicine. You must submit a monthly report to me using the required form, and must notify me in advance of any changes in your moonlighting activities other than described above.
- ☐ Your request is denied for the following reason(s): \_\_\_\_\_

\_\_\_\_\_  
Signature of Program Director

\_\_\_\_\_  
Date

**Morehouse School of Medicine  
Family Medicine Residency Program  
Assessment of Resident Giving Handoff**

Attending Name \_\_\_\_\_ Date \_\_\_\_\_

Resident Name \_\_\_\_\_ PGY Level \_\_\_\_\_

**On the Scale below please rate 1) poor, (2) fair, (3) good, (4) very good and (5) excellent;**

**Format**

Verbal Mnemonic	Description	(5)	(4)	(3)	(2)	(1)
<u>S</u> ituation	Included patient's diagnosis, current treatment, and current complaints					
<u>B</u> ackground	Vital signs, code status, medication list, pertinent labs					
<u>A</u> ssessment	Synthesis of status, anticipation of changes					
<u>R</u> ecommendation	Clear indication of tests/labs/consults to follow up. To-do list for next shift/overnight. Recommendation for future care					
<u>D</u> ischarge Planning Status						

Quality Markers	Yes	No
Actively engages receiver to ensure shared understanding of the patient (Encouraged questions, asked questions, etc.)		
Appropriately prioritizes key information, concerns, or actions		
Were if/then scenarios used in the to-do list?		
To-do list limited to items that should be accomplished in next shift/overnight		
Any miscommunications or transfer of erroneous information?		
Any omissions of important information?		
Any tangential or unrelated information?		

Resident is competent to perform handoffs independently ☐Yes ☐No

If no, please provide recommendations for improvement \_\_\_\_\_

\_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Morehouse School of Medicine**  
**Family Medicine Residency Program**  
**Promotion Criteria PGY-1 to PGY-2 Form**

Promotion Criteria from PGY-1 to PGY-2

Following at least twelve (12) months of training, the Residency Advisory Committee will make a recommendation for promotion to PGY-2 status based on the following criteria:

Patient Care

Regarding patient care, the intern will:

- Role-model competent whole person care to other residents and medical students.
- Have documented participation in at least 20 deliveries prior to assuming continuity maternity patient coverage OR participate in an active plan to ensure adequate total deliveries (such as an elective in OB).
- Demonstrate the ability to independently perform a complete history and physical exam, write appropriate orders, and appropriately document the hospital course for inpatients.
- Have demonstrated competency in basic procedures to include Pap smears, I&D, suturing, and wet preps as confirmed by clinical preceptors.

Medical Knowledge

Regarding medical knowledge, the intern will:

- Satisfactorily pass all required rotations.
- Have achieved at least 10th percentile on the composite score of the Family Medicine In-Training Exam or demonstrated equivalent level performance on a program-administered reassessment.
- Have achieved a minimum of the level 2 milestone on the MK-1 and MK-2 subcompetencies.
- Have taken the USMLE Step III examination by the last day of the 12<sup>th</sup> month of training.

Practice-Based Learning and Improvement

Regarding practice-based learning and improvement, the intern will:

- Demonstrate the ability to give and receive feedback and make improvements in his/her patient care.
- Demonstrate an ability to assimilate and apply medical information to patient care.
- Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the intern will:

- Demonstrate the ability to communicate respectfully and effectively with patients, faculty, staff, and colleagues in a manner that will be conducive to assuming a supervisory role by October of the second year.
- Demonstrate adequate documentation skills to include checkouts, on- and off-service notes, and outpatient charting.

Professionalism

Regarding professionalism, the intern will:

- Have demonstrated adequate participation in academic and professional activities such as conferences, rounds, and meetings, and pursuit of certification exam completion.

- Model professional behavior to students in clinic and rotations.
- Have achieved at least the minimum required conference attendance of 75%.
- Demonstrate adherence to policies regarding procedural documentation.

#### Systems-Based Practice

Regarding systems-based practice, the intern will:

- Demonstrate ability to coordinate care with case managers and other resources.
- Demonstrate cooperation within the medical system to ensure excellent patient care as seen by timely completion of medical records, charting, and follow-up.

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

We, as members of the faculty of Morehouse School of Medicine Family Medicine Residency, verify the accuracy of the above information and believe that this Intern HAS/HAS NOT demonstrated sufficient professional ability to be promoted to PGY-2.

\_\_\_\_\_  
 Program Director

\_\_\_\_\_  
 Faculty Advisor

I have reviewed this document and understand that it is the basis for either my promotion or remediation plan. In addition, I have read and am in understanding of the expected PGY Level Responsibilities and Duties as found in the Family Medicine Program Manual.

\_\_\_\_\_  
 Resident

\_\_\_\_\_  
 Date

**Morehouse School of Medicine  
Family Medicine Residency Program  
Acknowledgement of Promotion and PGY-3 Duties  
PROMOTION CRITERIA FROM PGY-2 TO PGY-3**

Patient Care

Regarding patient care, the resident will:

- Be a role-model of competent and compassionate whole person care to junior residents and medical students.
- Have documented participation in adequate continuity deliveries to assure a total of 20 by graduation OR will participate in a plan to achieve this goal.
- Demonstrate the ability to supervise a complete history and physical exam and oversee appropriate orders for hospital care.
- Assume an active role in diagnosis and treatment plans which is based on sound medical knowledge.
- Have documented adequate procedural competency to supervise the in-patient team adequately, including competency on knowledge and skill domains on EKG interpretation, ICU management, code management, etc.

Medical Knowledge

Regarding medical knowledge, the resident will:

- Satisfactorily pass all required rotations. Evaluations from each rotation must be received. A verbal report from the preceptor of his or her intent to give a passing grade may be taken for the final rotation of the year, if the committee meets prior to the completion of that rotation.
- Have achieved at least 25<sup>th</sup> percentile on the composite score of the Family Medicine In-Training Exam OR be participating in a program for academic enhancement.
- Have passed USLME Step 3 by his or her 20<sup>th</sup> month of training.

Practice-Based Learning and Improvement

Regarding practice-based learning and improvement, the resident will:

- Demonstrate the ability to give and receive feedback and make improvements in their patient care and practice.
- Demonstrate an ability to independently locate, assimilate, and apply medical information to patient care.
- Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the resident will:

- Have the ability to role-model respectful and effective communication with patients, faculty, staff, and colleagues.
- Facilitate continuity of care through communication and documentation skills such as patient handoffs, on- and off-service notes, and telephone/message documentation.
- Demonstrate teaching and management skills to effectively coordinate the teaching service and to teach junior residents and student learners

**Comments:** \_\_\_\_\_



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We, as members of the faculty of Morehouse School of Medicine Family Medicine Residency, verify the accuracy of the above information and believe that this Intern HAS/HAS NOT demonstrated sufficient professional ability to be promoted to PGY-3.

---

Program Director

---

Faculty Advisor

I have reviewed this document and understand that it is the basis for either my promotion or remediation plan. In addition, I have read and am in understanding of the expected PGY Level Responsibilities and Duties as found in the Family Medicine Program Manual.

---

Resident

---

Date



## SEMI-ANNUAL EVALUATION OF FACULTY MEMBER BY RESIDENCY PROGRAM

Faculty Name: \_\_\_\_\_

Evaluation Period: \_\_\_\_\_

As faculty members in the MSM Family Medicine Residency Program, this is your Annual Evaluation and Performance Feedback by the program. This evaluation is designed to reflect your teaching abilities and active participation in the all aspects of resident education and experience. If you have any questions, please forward them to the Program Director.

	YOU	Average of all ACGME Faculty	Minimum requirement (if any)
<b>A. AGGREGATE EVALUATION BY RESIDENTS*</b>			
1. Please rate your overall experience of the rotation/in the clinic under the supervision of this Preceptor.			
2. Please rate the availability of this Preceptor			
3. Please rate the approachability of this Preceptor			
4. Please rate the professionalism displayed by this preceptor through his/her interactions with you, peers, staff, patients, and families.			
5. How well did the preceptor practice sound ethical principles?			
6. How well did the preceptor clearly state his/her expectations of your performance at the beginning of the rotation/clinic session?			
7. How well did the preceptor teach office procedures?			
8. Did the preceptor give you midpoint feedback (either written or verbal) of your performance?			
9. Please rate the TEACHING you received by this Preceptor.			
Total Number of evaluations			
Resident evaluation completion within 2 weeks (%)			
If PEC Member, attendance %			
If CCC Member, attendance %			
# of hours of Resident lectures **			
Serves as a Course Director	Y / N	N/A	
If course director what was average course rating (on scale of 1-5)			

Served as a resident advisor	Y / N		
Served as a resident research mentor	Y / N		
Board Certification status in Family Medicine /Internal Medicine/Peds/ OB-Gyn as applicable			
% Grand Rounds attended			
Involved with PS/QI			
Conference presentations			
Peer-Reviewed publications			
Other publications and presentations			

Comments:

\* The rating scale for **Section A** (Aggregate Evaluation by Residents):

**1= Needs major improvement, 2 = Needs minor improvement, 3= satisfactory, 4 = good, 5 =excellent**

**\*\* EXCLUDES meeting as a program/institutional official**

**\*\*\*"Average of all faculty" reflects only MSM residency faculty members**

PD Signature and date: \_\_\_\_\_

Faculty Signature and date: \_\_\_\_\_

Chairperson Signature and date: \_\_\_\_\_

**MOREHOUSE SCHOOL OF MEDICINE  
FAMILY MEDICINE RESIDENCY PROGRAM  
REQUEST FOR LEAVE FORM**

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

***TYPE OF LEAVE REQUESTED***

ANNUAL \_\_\_\_\_

SICK \_\_\_\_\_

CME LEAVE \_\_\_\_\_

FLEX/NATIONAL BOARDS \_\_\_\_\_

ADMINISTRATIVE LEAVE \_\_\_\_\_

COURT/JURY LEAVE \_\_\_\_\_

BEREAVEMENT LEAVE \_\_\_\_\_

LEAVE WITHOUT PAY \_\_\_\_\_

REASON FOR REQUEST (If other than stated above) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DATES OF LEAVE REQUESTED:**

FROM: \_\_\_\_\_ TO: \_\_\_\_\_ TOTAL DAYS: \_\_\_\_\_

\_\_\_\_\_  
RESIDENT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CHIEF RESIDENT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PROGRAM MANAGER'S SIGNATURE

\_\_\_\_\_  
DATE

# MOREHOUSE FAMILY MEDICINE RESIDENCY INPATIENT SURVIVAL GUIDE

*2<sup>nd</sup> Edition*

2017-2018 ACADEMIC YEAR

## Table of Contents

Sound Physicians (Eagle) Hospitalist Service .....	2
Eagle Attendings: .....	2
Surge Attendings:.....	2
Attendings' Schedule .....	2
Eagle's Contribution .....	2
Eagle Rounds.....	3
Morehouse Service .....	4
Morehouse Rounds.....	4
Answering Service.....	4
1.    PRESCRIPTIONS!!!!!! .....	4
2.    OB Calls: .....	5
3.    Grady East Point Critical Labs: .....	5
4.    Calls from AMC Nursery.....	5
How to Contact PCPs .....	5
CFHC Patients.....	5
Howell Mill Patients .....	6
Grady East Point Patients/Morehouse Grady patients.....	6
Resident Responsibilities .....	6
Floor Team: .....	6
Night Float.....	8
Weekend Calls.....	8
Holiday Call .....	9
Admissions: .....	9
Emergency Consults .....	11
Discharges .....	11
Miscellaneous: .....	12
Resident Call Rooms.....	13

## Sound Physicians (Eagle) Hospitalist Service

### Eagle Attendings:

Dr. Maduka (Co-director)  
Dr. Landrum (Co-Director)  
Dr Mann  
Dr Gopireddy  
Dr Singh  
Dr Faiyaz  
Dr Keer  
Dr Osinuga  
Dr. Sikod

### Surge Attendings:

Dr Obiekwe  
Dr Adetuyi  
Dr Agbeyegbe  
Dr Castro- Revaldo  
Dr Goodlow  
Dr. Mabo

### Attendings' Schedule

7 days on and 7 days off

7am – 7pm / Tuesday -Monday

You will be working with the Eagles Attendings (including the surge Attendings) every day of the week, including weekends

Rounds begin promptly at 7:30am every day, unless otherwise specified

### Eagle's Contribution

The hospitalists do NOT get paid to work with the residents.

They VOLUNTEER to work with us, to improve our educational experience and boost our inpatient numbers.

The hospitalist service is VERY BUSY! The Attending is responsible for 25-30 patients daily.

Working with residents slows them down. It is very important that we are *respectful* of their time and commitment to our educational experience!

We show our respect by: (1) Being on time and (2) Being prepared for rounds.

## Eagle Rounds

Depends on the attending who is assigned to the patient.

Dr. Maduka : 7:30am sharp.

- Rounds take place in the hospitalist office on the 1<sup>st</sup> floor unless otherwise stated. Please be on time, the attending will not call you for rounds, it is expected that residents will be in their office at 7:30am.
- This time also provides an opportunity to go over the list and find out if attending assignments have changed for the patients which we share with them.
- If the hospitalist Attendings are unavailable at 7:30am, please call their spectra link phones or cellphones to discuss your patients, these numbers are listed on the hospitalist sign-out.

Dr. Landrum: 7:30am

○ If Dr. Landrum is not present at 7:30am on the 1st floor, wait until he arrives. Sometimes he may call you when he is ready to round.

### **Rounds Presentation**

○ You are to present the pertinent details of the SOAP note you have written.

○ Remember, the Attending is responsible for 25-30 pts per day. They do not have time to listen to a lengthy, in-depth, presentation. Keep it brief, but pertinent.

○ KNOW THE PATIENT and READ UP ON YOUR PATIENT!

If patient was admitted for Chest Pain r/o ACS, then read about the TIMI score, HEART Score. Know the EKG findings, Troponin trend etc.

If patient admitted for Pneumonia, know the types of pneumonia, CURB-65 Score, PORT Score, what antibiotics are used to treat the type of pneumonia the patient has.

○ BE PREPARED TO PRESENT THE TOPIC YOU WERE ASSIGNED!!!!!! As well as the other topics mentioned. Dr. Maduka expects everyone to know something about all the topics.



## Morehouse Service

Patients from these locations are admitted to our service:

- CFHC
- Grady East Point
- Morehouse Healthcare, Howell Mill location.
- Morehouse patients seen at Grady.
- Patients of Private Attendings like Dr. Houser and Dr. Michelle Cooke
- Future: Morehouse Health care is now part of an Accountable Care Organization (ACO)\*\*\* with Southside clinic, Grady and a few others. The terms of the contract are still under negotiation but the end result is that patients from all participating clinics/hospitals will be admitted under the Morehouse Service at Atlanta Medical Centre South. \*\*\*

\*\*\***Accountable care organizations (ACOs)** are groups of doctors, hospitals and other health care providers who join together to coordinate care for patients. The purpose of an ACO is to reduce the cost of care by eliminating duplication of efforts and increasing the quality of services\*\*\*

## Morehouse Rounds

- Morehouse Rounds should begin by 9/10am.
- The Attending may call the day prior to or the morning of rounds to confirm time.
- Rounds are attending Dependent---Some like bedside rounds while most like to pre-round in the resident's Lounge or hallway and subsequently do a brief bedside round.
- Usually attending dependent---Ask attending how they want the information presented. Some may just want a comment on any new changes while others may want some more detail. Be prepared to succinctly present old patients in SOAP format and for the new patients to do a quick H&P with emphasis on pertinent information and the current plan of care.

## Answering Service

This is the after-hours service for all Morehouse clinics. Patient calls are answered by the answering service between the hours of 5PM and 9AM.

Major Call Types:

### 1. PRESCRIPTIONS!!!!

- a. These calls are usually from patients just seen in clinic who stopped by the pharmacy after their visit and their prescriptions were not received.
- b. Issue: Medicaid and Medicare Patients:
- c. Residents' NPI numbers no longer valid for these two payers. Sometimes the Attending NPI is not included in the prescription.

**Solution:** Open the patient's chart for the day of service in Practice partner. On the 3<sup>rd</sup> line is the ".PV " (Provider) which will have the abbreviated code for the name of Attending the resident worked with. (Check your email for a list of Abbreviated codes for Attendings). Google the NPI of that attending and call the pharmacy with this information.

**Caveat:** If no prescription is entered into the patient's chart or you are not clear about the prescription you may have to review the note or contact the resident who saw the patient to either have them clarify for you or call in the prescriptions themselves.

## 2. OB Calls:

Pregnant patients may call when they are having any kind of symptoms, or if they just have questions.

- I. Be sure to get patient's name, DOB, gestational age, contact number, EDD
- II. Ask patient who their doctor is.
- III. Check medical record for the last visit.
- IV. ALWAYS ask the cardinal review of systems questions for OB:
  1. Fetal movement
  2. Vaginal bleeding
  3. Vaginal discharge.
  4. Leakage of fluid
  5. Contractions—Frequency, duration etc.

## 3. Grady East Point Critical Labs:

When you receive a call from the Grady lab regarding a critical result:

- i. Look up the patient in Epic. (Lab staff usually gives patient's MRN.)
- ii. Address the lab you are called about.
- iii. Call the patient with the recommendations
- iv. Call the Attending on call if you have questions.
- v. Send a message to the PCP in Epic. \*\*

**\*\* Please use when in EPIC, click on the encounter tab, then click on telephone encounter and document your conversation with the patient. Documenting in the staff message does not store permanently in the patient record. Documenting in the phone call section does.**

## 4. Calls from AMC Nursery

- i. Ask for MRN
- ii. Ask for name of attending
- iii. If a critical lab, please call attending once and leave a message if they don't pick up. If no response, please send a text message and also sign information out to the day team (if call is at night)

## How to Contact PCPs

When patients are admitted to the MH service, it is imperative that the floor team or admitting resident contact the patient's primary care provider, to inform him/her of the patient's admission. For residents, ACGME requires that we visit our patients in multiple settings, to satisfy the continuity of care requirement.

## CFHC Patients

- Check the sign-out sheet for Attending contact numbers.
- May text or email residents and attendings (at a reasonable hour)

- May send an email or Practice Partner Message.

### Howell Mill Patients

- May send a Practice Partner Message.

### Grady East Point Patients/Morehouse Grady patients

- May contact PCP by sending a secure message through EPIC.
- Log into EPIC
- Click on 'In Basket' link on the top menu
- Click on 'New message' on the top left of that page
- Type the PCP name in the TO field and click enter to search
- Type patient name or MRN in the PATIENT field and search for patient
- Write and send your message
- You may prioritize message based on acuity of patient or request

### Other PCPs like Dr. Houser/ Dr. Michelle Cooke:

- Courtesy Phone call. Numbers can be found on the Sign out.

## Resident Responsibilities

### Floor Team:

The floor team is typically comprised of 2 residents who are primarily responsible for the patients on the floor for the entire month. Duties are Monday through Sunday. The floor team will serve as back up on the weekends to be called in by the weekend resident (either Night float or 24-hour call resident) to come in and do notes only when there are more than 8 patients on the floor.

- Start a census sheet in google docs at the beginning of the month and share with all 3 msmfm Gmail addresses (msmfmpgy1@gmail.com, msmfmpgy2@gmail.com, [msmfmpgy3@gmail.com](mailto:msmfmpgy3@gmail.com)) so everyone can edit it
- The floor team is expected to be punctual to sign-out at 6AM to enable Night float to get out early.
- Pre-round on MH and Eagle patients
- Daily progress notes
- Round with Eagle team at 7:30AM. MH rounds per Attending discretion.
- Admissions:
  - 2 total admissions per day from the Eagles team. Find out who the admitting attending is during rounds. May call to remind them about admissions.
  - See admission protocol for details.
- Multi-disciplinary rounds (MDRs): All Physician providers at AMC are expected to participate in the Multi-disciplinary rounds with a team of Case managers, Social Workers and Nurse Managers.

The meeting is held at the end of 3 North Corridor, towards the Dialysis unit.

Time: 10AM daily except on Tuesdays(11AM).

The goal is to discuss potential barriers to timely discharge. Excellent opportunity to expedite ancillary services for your patients.

Format for discussion:

- Name of patient, Room/Floor, Admission diagnosis.
- PT/OT needs if any (Make sure orders for PT/OT are already placed).
- Case Mgt needs if any for example, Skilled Nursing for Heart failure education. (Orders should be in the system already).
- Discharge disposition—Home, SAR, LTAC as determined by MD or recommended by PT.

## Discharges

- Prescriptions
- Arrange f/u appointments
- Medication reconciliation
- Dictation/Free type discharge summary within 48 hours.

## Medical Student Education.

- New set of med students are on the floor every week all day on Mondays and Tuesdays.
- On Mondays, they are expected to arrive at 6 AM and are there all-day till after sign-out.
- They also arrive at 6 AM on Tuesdays but are scheduled to be at Buggy works from 11AM to 2PM for lectures so should be excused at about 10:30 to allow them to get there in a timely manner. They are expected to return from 5pm to 8pm to pay back the time spent at Buggy works.
- Assign new patients to them—You may call Eagles Attending to request admissions. The expectation is that they do at least 1 H&P and 1 SOAP note while on the floor.
- Review H&P Review and provide constructive feedback regarding their presentations. Assign topics related to their patients.
- Don't forget to fill out their evaluations.

## Other tasks:

- The floor team should also update relevant members of patient care team regarding plan
  - Nurses
  - Consultants
  - Therapists
- Call consultants
  - Place order for consults
  - If urgent, MUST call consultant immediately. You may look on the sign out or call floor clerks for consultant numbers
  - Routine consult simply need the order and reason

- Follow up studies, labs, consultant recs.

## Night Float

Night float is an overnight service which runs from Sunday to Friday. It is broken up in 1 week blocks and staffed by 1 resident per week who reports to the Attending on service. Night float serves as cross cover plus admissions for all Morehouse Patients and the Eagles/Sound patients whom the Residents co-manage with the Hospitalists. There are 4 Night float residents per month.

HIGH YIELD!

Starts on **Sunday at 7pm (PM Sign out) to 6AM (AM Sign out)**

**Mondays through Friday---Night float resumes at 5PM for Sign out till 6AM**

- Night float is expected to do all the Notes on Saturday Morning. May choose to call in the Floor team if there are more than 8 patients on the floor\*\*\*
- Night Float is expected to take 2 admissions from the Eagles on Even nights. Even nights are defined by the date being an even number. Pushing back on admissions is very much frowned upon and should be under dire circumstances, for example a Morehouse patient is coding or very critical, respectfully explain to the Attending why the admission cannot be taken at that time.
- There is no cap to the number of Morehouse admissions.
- Be present for sign-out ON TIME.
- Do Interval ICU notes on ICU patients before midnight.
- F/U critical labs, results.
- Admissions.
- Possible late discharges----Floor team should have prepared patient for discharge (prescriptions, medication reconciliation, follow up). If not already done, respectfully request the floor team to do it before they leave. Night float should only have to write discharge order.

## Weekend Calls

Saturday Call/Long Call: This is a 24-hour call, 7AM to 7PM (Rule is 24 + 4). Resident may leave after sign out on Sunday.

- Duties start at 7AM, receive Sign out from Night float.
- Round with Eagles and Morehouse.
- Follow up pending labs, studies
- Admissions
- Discharges
- Answering Service Calls
- Grady Critical Lab Calls

- Write all Notes on Sunday morning

Sunday AM Shift: This is a 12-hour shift. 7AM to 7PM.

- Duties start at 7AM
- Round with Eagle and Morehouse
- Follow up pending labs, studies
- Admissions
- Discharges
- Answering Service Calls
- Grady Critical Lab Calls
- Sign out to Night Float at 7PM

## Holiday Call

Call is from 7am-5pm, responsibilities are the same as with Sunday short call

## Admissions:

### Call for Admission

- You will receive a call from the attending (either Morehouse or eagles) to go down to the ED and evaluate the patient.
- Do NOT accept an admission from the ED Physician. They are to call the attending physician directly.
- Patients must be evaluated within 30 minutes of receiving the call from the ED
- Determine the patient's PCP and review either EPIC or Practice Partner records to help get a better picture of the patient.
- Also, if relevant, review old hospital records (AMC or Grady) for pertinent information.
- After physical examination, call the attending and present the patient ... Have assessment and plan prepared!

**Orders:** All can be found under the order tab in Cerner/Power chart

- **Step 1: Place an admission order**
  - 23hr Observation Admission = 'Admit to Outpatient' or Inpatient Admission = 'Admit to Inpatient'
  - Choose appropriate level of care: Telemetry / Med-Surg / Intermediate Care (PCU) / Intensive Care
  - Add the name of the attending provider
  - Once you click submit, it will prompt you to document the admission diagnosis, you will not be able to sign your orders until you do so.
- **Step 2: 'Document Medication by Hx':** usually this has already been done by the ER nurse, however if it hasn't been done, then you will have to do it yourself.

- Step 3: Admission medication reconciliation
- Step 4: Place Orders
  - Use Power Plans to make things easier for yourself!
  - Start with the admission general-New power plan if patient is going to the floor because it has a lot of orders including code status, VTE, fluids, nutrition, PTOT, future labs and consults
  - There is a power plan for ICU admissions and there are various disease specific power plans including CHF, AFIBB, Pneumonia etc.
  - Always add a 'VTE power plan' [DVT prophylaxis]
  - Place individual medication/labs/imaging/ consult orders not included in the power plan
- Step 5: Discharge Planning: DISCHARGE PLANNING BEGINS AT ADMISSION!!! This means thinking about what services are available on the weekdays vs. the weekend, and putting in consults early.
  - Please fill out and update the discharge planning table /bullets in your notes daily so that night float/weekend crossover will know what your patient needs for discharge
  - CHF and COPD patients need a case management consult for home health skilled nursing, be sure to place this at the time of admission

**Note:**

- You can either free type your note or dictate it.
- Your note must be available for cosigning within 24 hours of admitting the patient!
- Attendings are penalized and may be charged \$300 per patient per day for incomplete medical record beyond this timeframe.
- If your dictation has not showed up in the chart after 24 hours, please call/go down to medical records to get things fixed.
- Dictation instructions:
  - Step 1: Call 1-877-477-6503. If in the hospital, dial 56005 from the hospital phone.
  - Step 2: Enter 357#
  - Step 3: Enter your personal user ID. Example 123#
  - Step 4: Enter Attending ID. Example 456#
  - Step 5: Enter Work Type: 1 – H&P; 4 – Discharge Summary
  - Step 6: Enter Patient's Acct number
  - Step 7: Press 2 to start dictation
  - Function Keys: 1 Pause; 2 Dictate; 3 Five second rewind; 5 End Report (WRITE DOWN CONFIRMATION NUMBER!!!)

**Special Circumstances:**

Discharging Patient from the ED

Sometimes, a patient may be 'discharged' from the ED without admission per Attending's Approval, under certain conditions.

- Please first let ED physician know of the plan not to admit
- Write a brief SOAP note in Cerner/power chart
- Write any needed prescriptions
- Send message to PCP regarding prompt follow up
- ED doc enters discharge order. Resident does not do discharge summary

## Emergency Consults

All urgent or stat consults, should immediately be followed by a call to the consultant!!!!  
Urgent means it cannot wait until the morning!!!!

- Ask ED secretary for number for the ON-CALL provider for a particular specialty. Providers alternate call days. (If it is after hours, it is best to call answering service).
- Please be prepared to briefly present the patient to the consultant, with relevant details including physical exam, labs, imaging and other findings.
  - Nephrology: Urgent hemodialysis
  - Cardiology: Concerning EKG changes in patient with chest pain and high risk for CVD
    - If ED doc is concerned for STEMI or NSTEMI, they usually will have already called Cardiology
    - If you are concerned that a patient may have had a STEMI based on EKG changes, you should inform the ED secretary to 'Call a STEMI ALERT'. This mobilizes a rapid response team to assess patient and call Cardiology and get patient prepped for Cath lab.
  - Neurology: Stroke, TIA
    - As above, if stroke suspected, ED doc should have already alerted Neurology
    - STROKE ALERT should be called on any patient with acute changes suggestive of CVA. Again, if in the ED, inform the secretary to 'Call a Stroke Alert'. This alert mobilizes the Stroke team to get patient to CT, MRI, and to assess for eligibility for TPA versus non-TPA treatment protocol.

## Discharges

### Depart Process:

In Cerner:

1. Click on 'Depart' link on the top menu or click on the 'Discharge Summary' link on the LEFT side menu



2. On the 'Depart' screen, the menu on the LEFT shows tasks that are to be completed by physician, nurse, or both. For physician-only tasks, once complete, the circle will turn blue.
  - a. Discharge diagnoses
  - b. Follow up Care
    - i. F/u with PCP, specialists, etc.
    - ii. Instructions (CHF care, DM care, UTI, post op care, etc.)
  - c. Medication reconciliation
    - i. Handwritten prescriptions must still be entered patient chart
    - ii. Enter new prescriptions here before signing
  - d. Discharge order
    - i. Go to orders and enter: discharge patient

**Do not forget to get a follow up appointment for patient before discharge.**

#### Discharge Summary:

Discharge summary must be free typed or dictated within 48hrs of discharge!!!! Attendings are penalized and may be charged \$300 per patient per day for incomplete medical records, beyond this timeframe.

Dictation instructions are the same as found in the admissions section

#### Miscellaneous:

##### Special Orders

- Stress Test
  - This is an order set
  - Choose exercise versus Lexiscan
  - o NPO order included
- AFB
  - Be sure to select: AFB Culture and Sputum (NOT blood)
  - Must place THREE separate orders
  - Must place THREE separate sputum culture orders
  - MUST label orders, 1 through 3 (in comments section)
    - AFB #1
    - Sputum culture for AFB
  - Must order sputum induction by respiratory therapy
    - Includes an order for nebulized saline
  - Results:
    - Preliminary: 3-5 days
    - Final: up to 6 weeks
- Vas Cath or Central Line
  - IR Insert Non-Tunnel CVC > 5y
- PICC Line:

- PICC Line Insertion >5y by Physician
- Paracentesis o IR ABD Paracentesis with Image Guidance
- Barium Swallow:
  - Modified Barium Swallow Careset
- ABG
  - ABG w/O2 Sat Calculated
- Blood Products: Must place 4 separate orders!
  1. Antibody screen
  2. ABORH type
  3. RBC product
  4. Transfuse order
- Lower Extremity Doppler for DVT
  - Peripheral Venous Extremity Study
- VQ Scan
  - NM V/Q Scant
  - Order STAT

## Resident Call Rooms

### Main Lounge:

- Room number: 2017
- Room Code: 215
- Phone: 404-466-2260 (2261)

### Workroom/Medical student's room:

- Room Number: 2018
- Room Code: 215
- Phone: 404-466-2262 (2263) S

### Sleep Rooms

- Female: 2009, Code: 152
- Male: 2247 Code: 215

# A **SURVIVAL** GUIDE FOR THE INTERN

MOREHOUSE FAMILY MEDICINE  
ACADEMIC YEAR 2017-2018



PREPARED AND COMPILED BY  
CLASS OF 2019

### **BEFORE EACH ROTATION:**

1. Coordinate with the contact person for each rotation and inform them about your arrival, 2-3 weeks prior to your starting date.
2. The contact person designated for most of the rotations are the respective Chief Residents.
3. Review your schedule and inform about any conflicts with your clinic days, vacation, and didactic days.
4. **KNOW THAT YOU DO NOT GO TO WEDNESDAY DIDACTICS ON CERTAIN ROTATIONS!!!**
  - a. Internal Medicine
  - b. ICU
  - c. Peds Wards
  - d. Peds ER (only when scheduled for a shift, if not scheduled, then you are expected to be in didactics)
2. Obtain feedback and reviews from the person who has already completed the rotation.
3. Review some general topics and cases that you are likely to encounter during the rotation.
4. Check [www.new-innov.com](http://www.new-innov.com) for the official curriculum.
5. Make sure your ID badges and Parking Badges have been activated
6. Contact Ms. Colleen Stevens to forward your requests for the mid-month and end of rotation evaluations in a timely manner. Though not necessary, you may remind your evaluators via email if they have not been completed in time after you leave the rotation.
7. Know your clinic days: These are your scheduled clinic days for each rotation.
  1. Internal Medicine: *Monday\**
  2. ICU: *Monday*
  3. Peds Wards: 1 week of clinic at beginning or end of month then at Peds for 3 weeks
  4. Peds ER: *Thursday*
  5. Surgery: *Tuesday\**
  6. OB Grady: *Thursday*
  7. VA Neurology: *Wednesday*
  8. ECC Grady: *Wednesday*
  9. CFHC/FM Wards: *varies*
  10. OB AMC: *Monday and Thursday\**
  11. July Orientation: *varies*

\*For these rotations, you must go to the hospital to see your patients and write notes before leaving for clinic for 8:30am.

# GRADY MEMORIAL HOSPITAL

## **PARKING**

Grady Hospital, Piedmont Deck.  
Cost: \$21.60 (monthly) via AAA Parking

### **How to Pay for Grady Parking**

Online: NOTE THIS PROCESS TAKES 2-3 business days. The fee covers the month, and usually expires by the 5<sup>th</sup> of the following month.

Go to: [www.aaaparking.com](http://www.aaaparking.com).

Click on 'Customer login'

Click on 'Monthly Accounts'

Account #

.

Password: parking.

ID: LAST 5 digits of white parking card.

In Person: Access parking deck adjacent to the hospital (near Mc Donald's). 3<sup>rd</sup> floor, rear of parking deck (walk straight to the back when you get off elevators, office is located on the left and has shaded windows).

## **GRADY SCRUB CARD**

Perioperative Services

Grady Hospital, 6<sup>th</sup> Floor

Room 6G012

Hours: 7:00 AM – 3:30 PM

Tele #: 404-616-8911

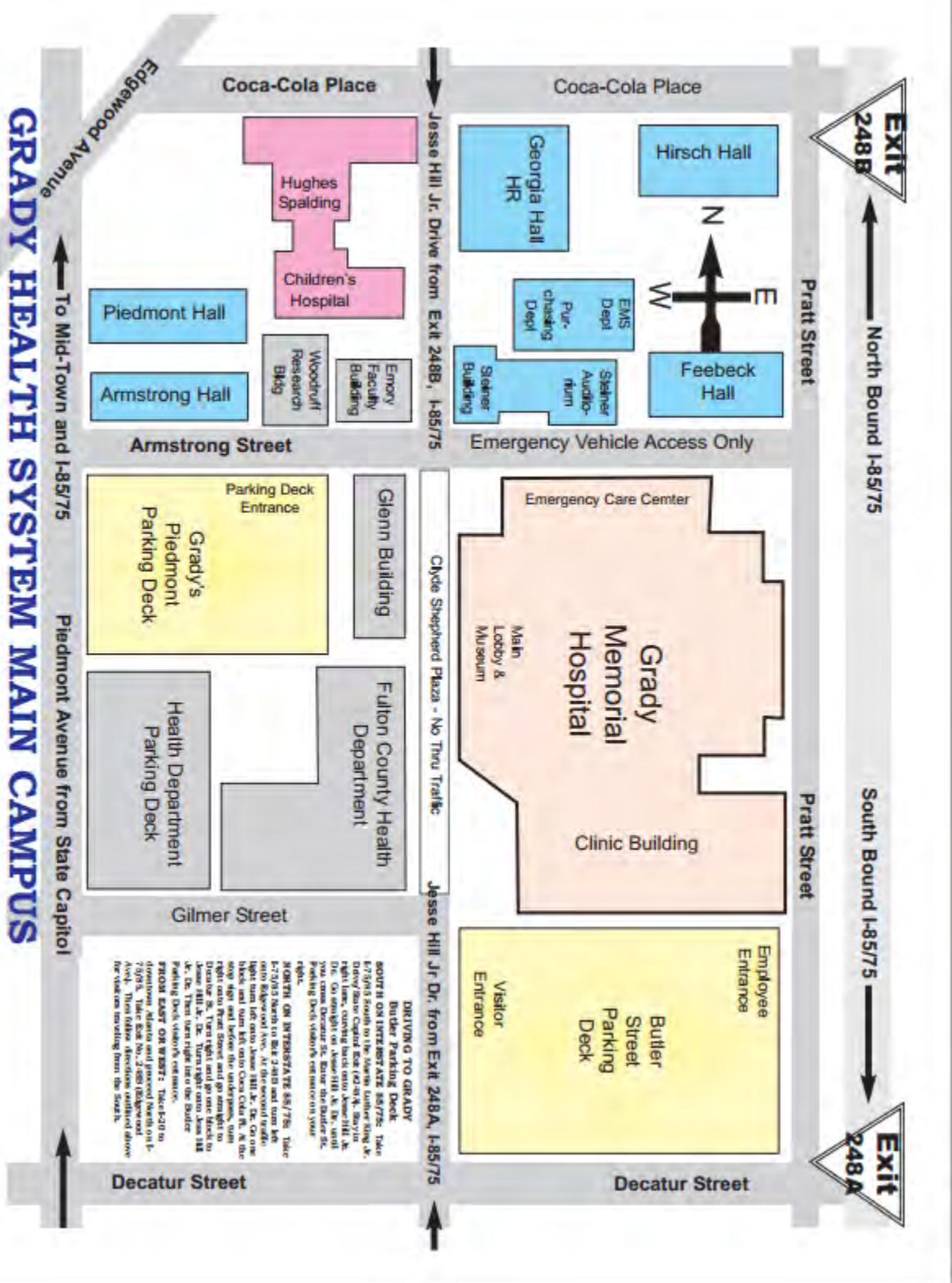
Fill out the form attached below, then scan and email to [dsampson@gmh.edu](mailto:dsampson@gmh.edu) [Denese Sampson]

Max of 2 sets of scrubs allowed to be checked out at a time.

**DO NOT WEAR GREEN GRADY SCRUBS OUTSIDE OF THE HOSPITAL!!!**



## GRADY HEALTH SYSTEM MAIN CAMPUS





## **VETERANS AFFAIRS (VA) ROTATIONS**

Contact Person(s):

### **Initial Point of Contact:**

Ken Ratcliffe

Tele: 404-321-6111, ext: 2720

Fax: 404-728-7668

[Ken.Ratcliffe@va.gov](mailto:Ken.Ratcliffe@va.gov)

***DO NOT CALL HIS CELL PHONE NUMBER! Please contact him via the information given above!***

This is the person you will contact for VA computer codes, passwords, etc. **Please contact him no less than 3-4 weeks before your VA rotation.** Also note that your **VA codes expire after 90 days** of non-use.

### VA Process for Computer Access Codes & ID Badge

- You should have received VA paperwork with instructions sometime after 'match'. At least 3-4 weeks prior to rotation you should:
  - (1) fill out paperwork and fax to Ken Ratcliffe**AND**
  - (2) complete the online privacy and security training course on the VA website**AND**
  - (3) send email to Ken Ratcliffe with the information below:
    - Where you will be rotating [CBOC East Point or Atl VA Main Campus]
    - Height
    - Weight
    - Hair Color
    - Eye Color
    - City/State you were born in
- Once Mr. Ratcliffe has received all of the information above, he will request your computer access codes. Once he receives the codes, he will request an ID Badge on your behalf. Then you will have to follow up with security for when your ID Badge is ready for pick up. **Their phone # is 404-321-6111 ext 17807.**
- You must go to Atlanta VA Main Campus for fingerprinting and to obtain your ID Badge. [Instructions on next page with campus map].
  - Important tidbits
    - Traffic to Decatur is horrible [at any time of the day]
    - You may be asked to return between 5-24hrs after the fingerprinting process for ID
    - Parking on the main campus is horrible [mostly in the middle of the day]
      - Park in 'E' or 'F' parking deck; they are closer to the main bldg.



- Please plan accordingly

## Instructions for Fingerprinting & ID Badges at the Atlanta VA Medical Center

### Where do I get fingerprinted?

Fingerprinting is done in the Fingerprinting and ID badge office on the Ground Floor of the Main Hospital. From the parking deck, enter through the ground level entrance at the back of the hospital. You will see the “A” elevators in front of you when you first walk in. Take a left just past the elevators. Follow this hallway & bear left when the hallway splits. You will see the fingerprinting & ID station offices on the right side of the hallway.

### When can I get fingerprinted?

The badge and ID office is open from 7:00 am – 3:00 pm, Monday-Friday. You may want to call 404-321-6111 ext 17807 or ext 1539 to make sure that an ID badge has been requested for you. You may be asked to return between 5-24hrs after the fingerprinting for ID.

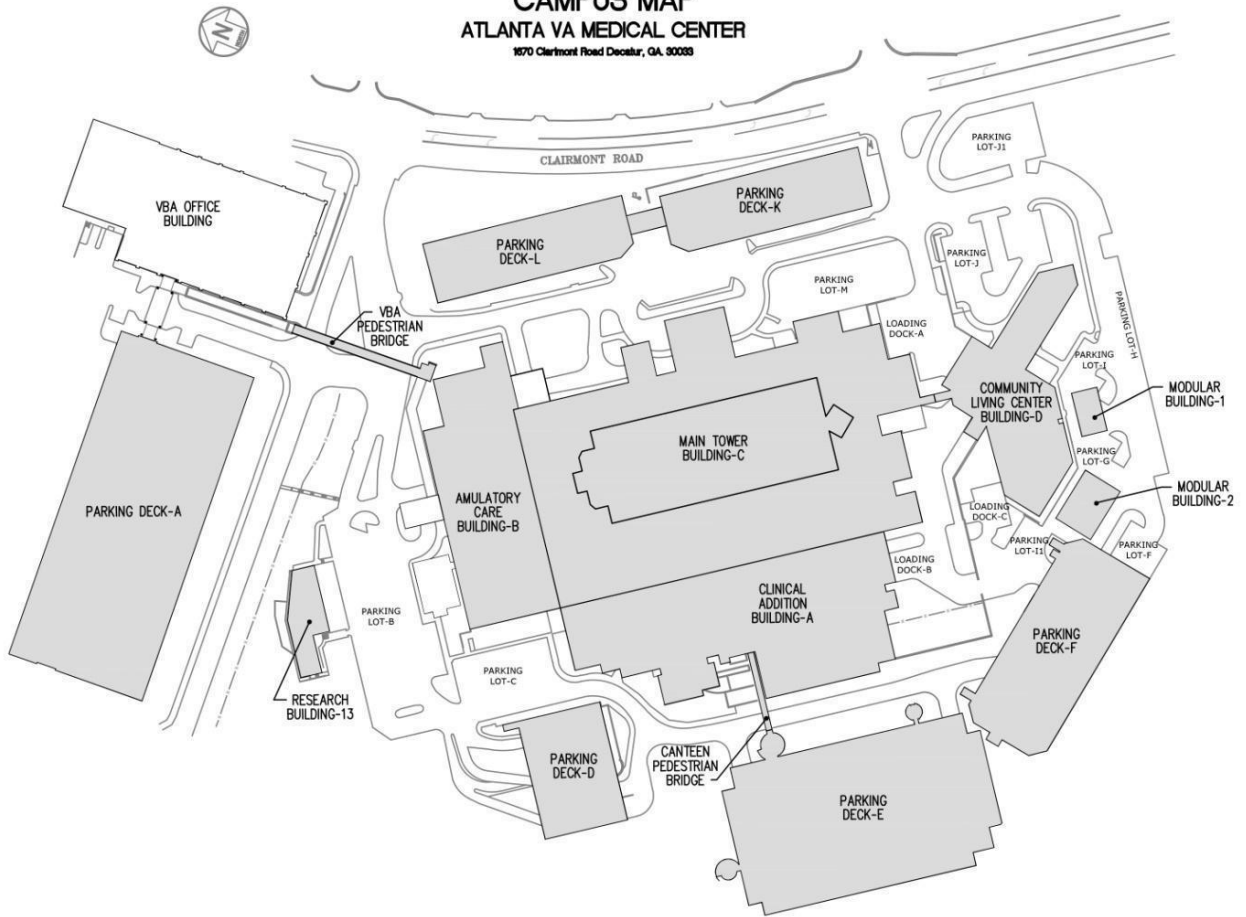
### What do I need to bring?

**Important: You must bring 2 acceptable forms of ID in order to obtain your VA ID badge.**

- The names on both identifications must match exactly (EX: if one ID has a full middle name, then the other must as well, if one ID has a middle initial, then the other must have as well).
- One State or Federal ID must contain a photograph.
- Both IDs must be original documents.
- Both IDs must be currently valid, not expired.

<u>Picture ID From Federal or State Government</u>	<u>Non-Picture ID or Acceptable Picture ID not issued by Fed. or State Government</u>
State-Issued Driver's License State DMV-Issued ID Card U.S. Passport Military ID Card U.S. Coast Guard Merchant Mariner card Foreign Passport with appropriate stamps Permanent Resident Card or Alien Registration Card with a photograph (INS Form I-151/I-551) ID Card issued by federal or state government agencies	School ID with photograph Social Security Card Certified Birth Certificate State Voter Registration Card Native American Tribal Document Certificate of U.S. Citizenship (INS Form N-560 or N-561) Certificate of Naturalization (INS Form N-550 or N-570) Certification of Birth Abroad Issued by the Department of State (Form FS-545 or Form DS-1350) Permanent or Temporary resident card ID Card issued by local government agencies provided it includes the following information: name, date of birth, gender, height, eye color, and address Non-photo ID Card issued by federal or state government agencies provided it includes the following information: name, date of birth, gender, height, eye color, and address Canadian Driver's License U.S. Citizen ID Card (Form I-179)

**CAMPUS MAP**  
**ATLANTA VA MEDICAL CENTER**  
1670 Clairmont Road Decatur, GA 30033



### **VA Neurology Outpatient Rotation**

Atlanta VA Medical Center  
1670 Clairmont Rd, Decatur, GA 30033  
Phone: 404-321-6111

### **Contact Person:**

Charlyn Thomas  
Neurology Rotation Coordinator  
404-321-6111, ext. 5142

### **Evaluator:**

Dr. George Wilmot, MD

**ID Badge:** See VA page

### **Computer Access:**

- If you have never been to the VA, or if it has been more than 90 days since your last log in, you will have to request new access codes. Please contact Dayanda Haynes, ext. 5142, Neurology Coordinator for assistance with obtaining codes two weeks prior to start of rotation. **Ken Ratcliffe is not the point of contact for this rotation.**
- If you were at the VA more than 30 days but less than 90 days ago, you can use your old username, but you will need to call HELP desk at ext. 4357 from on-site (must be on VA campus) to reset your passwords. You must have the following information when calling HELP desk: (1) Campus Site [ex: CBOC East Point or ATL VA main campus], (2) telephone extension # of phone you are using and (3) Room #.

### **Parking:**

- You can park in any open garage (preferable E or F; see campus map on 'VA page'). There is no special pass required. If the garage has a gate on it, you've gone to the wrong lot. Parking is free.

### **Clinic:**

Located on 11<sup>TH</sup> floor (11C). [Take 'C' elevators on Main Floor of VA Hospital to 11<sup>th</sup> floor.]

### **Resident Lounge:**

Room 145, located on Main Floor of VA Hospital. [At 'C' elevators, you will see information desk to your right, take hallway to your left. Lounge is second door on the left. You will see EEG sign hanging above. The room has 3 partitioned cubes with computer/desk setup.]

### **Cafeteria:**

Located on the Main Floor of VA Hospital. [Along the hallway of 'C' elevators, towards exit and bridge to parking deck]

Essential Reading Topics: See reading materials link on New Innovations

- Migraines
- Seizures
- Parkinson's Disease
- MS
- ALS
- Dementia
- Tremors
- EMG/Nerve conduction studies- differentiate between axon and demyelination
- Neuropathy

### Schedule:

- 8am-5pm Ambulatory Clinic.
- In general neurology clinic, you must see at least one New patient and two Return patients. There will also be a medical student, medicine resident, and neurology resident/fellow seeing patients as well.
- When working with Wilmot in the afternoon, you are the only resident.
- You will have occasional inpatient consults in the afternoon. Discuss with Neurology resident/fellow.
- Note Templates: Click 'Templates' tab, click 'Neuro', click 'Neuro (1<sup>st</sup> option)', click 'Neuro Consult'. Name note Neurology Physician Note, identify co-signer.

To search for patients- template on the left- click clinic, then type ATL Neuro in the space, this will populate with a list of neurology attendings, then click on the attending in clinic for that day .e.g Click Clinic, then type ATL neuro, a list of names appear i.e ATL NEURO WINGO, ATL NEURO WILMOT RTN, ATL NEURO WILMOT NEW (RTN- RETURN)

Read the old notes of returning patients to get a comprehensive idea of how to write the notes and manage f/u patients.

Be nice to VA patients and take your time to listen to whatever complaints they have. Some are frustrated that they see different doctors at visits but re-assure them and empathize with them.

### **Monday**

AM: Dr. Fournier, Movement disorder clinic (ALS, Muscular Dystrophy, etc)

PM: Inpatient Consults

### **Tuesday**

AM: Dr. Wilmot, General Neurology Clinic

PM: Dr. Wilmot, General Neurology Clinic

### **Wednesday**

AM: Continuity Clinic at CFHC

PM: FM Didactics

### **Thursday**

AM: Dr. Wilmot/Dr. Evatt, General Neurology Clinic

PM: Dr. Dholakia Clinic

### **Friday**

AM: Inpatient Consults

PM: Inpatient Consults

**Note:** Dr. Wingo's Friday clinic has been moved to Wednesdays am.

## **Emory ECC Grady (Grady ER Rotation)**

### **Contact Person:**

Mr. DeMarlo West

Program Coordinator

[DeMarlo.West@emory.edu](mailto:DeMarlo.West@emory.edu)

She will send you a link for the schedule. You may have a total of 18 - 19 shifts for the month where you may be scheduled to Zone 2. There is currently a great amount of construction so you will be assigned to zone 2 and PES where there is essentially no difference in pts temporarily. However, when in PES you are required to see detention pts and when in Zone 2 you will see pts in an ambulance waiting area. **The shifts are 8 hours each.** Shift change happens at the end of every 8-hour shift, so plan to arrive 10 minutes before your shift. There is no pre-rounding required. The schedules are made 2-3 months in advance. She will ask you in advance what days or weekends you desire off. Please choose the ones you really want. You should have 4 days off for the month; sometimes you may get an extra day. You should also have at least 1 full weekend off, but you have to ask for it. Important tools: Stethoscope, pen light, hammer, lots of pens! In the case of an eye issue you may also need eye

### **Orientation:**

When: There is no in person orientation. When you request for your schedule you will receive a link with instructions for online training, resident agreement form, Emory new-innovations log in, and Grady badge access form (be sure to write ALL EMERGENCY DEPT AREAS under department on form because construction has changed things). On your first day the attending or another resident can also assist with logging into Epic and navigating the ED system.

What: You will be provided with the ER survival booklet via e-mail, that contains important phone numbers, management plans and guidelines for common conditions seen in the ER. You will need to complete an online orientation for ER EPIC **before** the rotation.

**Evaluations:** This rotation online evaluations through New Innovations. After each shift, log into new innovations and request an evaluation from the attending you worked with. We usually need a total of 12 (unless you have vacation during this month, in which case the number of shifts and evaluations needed will be smaller)

**Resident Evals:** Evaluations of yourself that you request from attendings. You must **request** a certain number of evaluations from attendings you work with, after each shift.

It is better to wait until 1-2 hours before shift change (this happens after each 8-hour shift). That way you will have an idea how the attending was to work with and if you performed well during the shift. It is better to request these earlier than later, because shift change can be busy and you or the attending may not have the time. You need a total of 12 completed evaluations at the end to pass the rotation. You can log into the ER website to check your evaluations every 2-3 days.

**Typical Shift:** You need to report to the attending and upper level according to the assigned to your zone. We work in zone 2 and PES (these may change due to construction). PES is really reserved for the behavioral health patients but due to construction, PES is being used for regular ED patients and detention is housing the behavioral health patients. You will be asked to see patients in order of acuity, though patients in the critical care bays are generally seen by the upper level residents.

**Start of shift:** When you log into EPIC- ECC, you must click on sign-in then assign yourself to a patient. Then go assess the patient, start your note and talk to the attending about your plan. Attending will also see the patient once and advise about further plans if needed. Interns are expected to see at least 6-8 patients per shift. You can start seeing other patients before the disposition is ready; you can see 2-3 patients/cases at the same time. According to your disposition plan you may discharge the patient or admit them.

Disposition: The most important aspect of triaging patients in the ER is determining their disposition, i.e. discharge home after some intervention, admit to the CDU for observation, or admit to an inpatient team (Morehouse or Emory). To admit to CDU call extension 43522 directly to sign the patient out. For psychiatry patients your disposition will be to 'Move to PES'. You assess a patient at risk to self or others and place a '1013' forcing them to stay and admitting them. You coordinate with the ER psychiatry staff as to what decision is best, then you call the psychiatry Emory (Morehouse doesn't have psychiatry) team on call to sign out to them before placing the admission order.

Admissions: You will have to talk to the admitting team and sign out a patient when you decide to admit. A patient with an MR number with the last three digits ending in 250 or less is admitted to Morehouse. Those with last 3 of MR number greater than 250 are admitted to Emory. The ER survival guide also has the contact information for these two services.

Consults: You will call the consult according to the last 3 digits of the patient's MR number as above. You can all the operator at 0 for numbers or build a list to keep during the rotation.

Miscellaneous:

- You do get chance to do a lot of procedures like LP, arterial line, Central line, suturing etc. If your patient needs it, you can do it. Even if you've never done it, show enthusiasms for learning procedures and attendings or upper levels are willing to teach.
- ER rounds are conducted after every shift where you get a chance to talk about an interesting case/ teaching point with the rest of the ER team.
- Carry water, snack bars, lunch, energy drinks, dinner pre-packed as you don't have time to go out. Or you can order food to be delivered. You can wear scrubs, comfortable shoes and a white coat is not mandatory.
- You should **stop seeing new patients during the last hour to hour and a half of your shift** and start working on the disposition and notes of your remaining patients in the ER. You cannot leave until you sign out your patients (this means any patient that is still physically on the floor) to an incoming senior ER resident at the end of your shift.

## **Morehouse Pediatrics Inpatient Rotation/Peds Wards**

**LOCATION:** Third floor, Hughes Spalding Children's Hospital, 35 Jesse Hill Jr Dr SE, Atlanta, GA 30303,

**Unit Secretary: 404-785-9840**

### **Contact Person:**

Chief Resident – 1<sup>st</sup> point of contact [Pedschief@msm.edu](mailto:Pedschief@msm.edu)

### **Evaluations:**

Mid month: First attending

Final: Attending present during the last 2 weeks of rotation (this is the most important)

### **CFHC Clinic:**

**During this rotation, you will have one week of clinic at the beginning or end of the month.** After this week, you will not have any other clinic days at CFHC for the month. Please be sure to inform your patients that you will be away for the month. Be sure to take care of labs and f/u with your patients as needed.

### **SCHEDULE:**

The schedule will be found on [www.amion.com](http://www.amion.com). The password is "morehpeds".

Click on the "Call" link and use the blue arrow if necessary to go to the Hughes Spalding schedule for your rotation month.

**EPIC:** PLEASE be sure you can access CHOA - EPIC PRIOR to the start of the rotation. They now use EPIC for documentation and orders on the inpatient service at Hughes Spalding. You should complete your training before so you can have access to CHOA - EPIC on your first day on the floor.

### **PEDS WARDS:**

The day shift begins at 6am with intern signout and night signout is at 7pm. It is important to arrive around 6am to round on your patients and finish your notes prior to the official signout which begins at 8am.

Have the night intern print you an updated sign-out list of all of the patient's on the floor. Your senior will divide the patient's evenly among the interns, or have you divide them among yourselves. Round on each of your patients (review the H&P/progress notes/consults/labs, speak with the nurse/respiratory therapists, get interim history from patient/parent, examine your patients, obtain vitals/check meds etc.).

All of your notes should be done prior to the start of signout at 8am.

The day and the night team have a formal sit-down sign-out, with attending present, using the I-PASS sign-out method (pediatric chief will send you PDF) at 8am in the resident room. Sign-out is typically led by the night intern and may be immediately followed by a didactic lesson. Teaching rounds occur at the bedside at about 9-10 am, you will present your patients at this time.

You will be required to update the signout list with new patients and updates on current patients in epic.

The night shift begins at 7pm. During night you are required to complete what was signed out from the day team as well as update discharge summaries and med rec for potential discharge. You should consult your senior before flagging any orders, discharging any patients or for any concerns while on the floor. When there is an admission from ER, you are responsible for H&P, admission orders, and adding patient to the list. A progress note must be written the following morning if admission occurs before midnight. If admission is after midnight, no progress note has to be written, but the H&P must be complete.

### **Parking:**

Grady Parking Deck. \$21.60/month.

### **ID Badge:**

- Call Gatria [Gay-tree-ah] at 404-785-6800 to ensure that she is available. Her office hours are Mon-Fri, 7:30am-4pm. You can also stop by the security desk in the lobby after hours and or weekends to get badge access
- Go to Security Desk at the Entrance of the hospital and tell the security officer that you are there for your resident badge and he will escort you up to the office on the 2<sup>nd</sup> Floor.
- No paperwork is needed but make sure you have your morehouse badge with you.

#### Computer Access:

- Labs can be viewed in CHOA's Epic. You may have to check Grady epic for results of ECho's . MRI etc (imaging done at grady). You may bring your laptop/tablet to do notes. Progress Note Template included.

#### Physician Break Room:

Located on 2<sup>nd</sup> Floor. Use badge to go thru glass doors. Immediately to the right of the front desk is the resident lounge.

#### Cafe:

Located on the main floor. Walk past elevators and keep straight.

Free food is available in the physician's lounge on the 2<sup>nd</sup> floor. This usually consists of sandwiches, salads, fruit. Ask the other residents where it's located and for the code needed to enter.

#### Essential Reading Topics:

- Asthma
- Sickle Cell
- Croup
- RSV
- Bronchiolitis
- Pneumonia
- Gastroenteritis
- Failure to thrive
- GERD

#### Schedule:

- 12 hr shifts: 7a-7p or 7p-7a. Please note that you will realistically be working 14hr shifts.
- The night team (2 interns) is responsible for H&Ps overnight and discharge planning for the following day.

#### Sign Out

- Night team interns signs out to day team as soon as you arrive (usually at 6a)
- Team sign-out begins at 8am with Rounds immediately after. The night team will be present for sign-out, and will discuss all patients. Night team leaves before Rounds.
- As the day intern, you are responsible for knowing about all your patients and presenting them during rounds with to attending and your upper level
- Notes do not have to be written for patients admitted after midnight, an H&P will suffice, however, you might want to stop by the room and see the patient quickly in case you are asked questions of how the patient is doing since being admitted.
- Ask the Peds intern to share the Morehouse H&P, Progress notes and discharge summary templates with you.

#### SOAP Note

- Vital Signs: include ranges in the past 24 hrs. Include ins/outs in vitals. Ins must be recorded as cc/kg/day, outs (urine output) recorded as cc/kg/hour
- Always include 'General' in physical exam. ex: alert, playful, laughing, smiling, agitated, lethargic, etc.
- Only include new labs.



- For Assessment, say 15 wk old with (name symptoms) likely 2/2 (diagnosis).
- **Plan is listed according to systems (as seen in template)**
- When listing Medication dosages always list #mg/kg

#### Morehouse Peds Didactics

- On Wednesday you will attend Pediatric Didactics from 1-5pm. This may take place at the Piedmont location (walking distance). The Pediatric Intern will assist you with finding out where you need to go.
- On Thursdays you will attend Grand Rounds at 7:30am. On those days the Pediatric Intern has clinic. You should know about all the patients and get a brief sign out before the Intern leaves. You will typically get in earlier on Thursdays.
- You **WILL NOT** attend family medicine didactics on Wednesdays during this rotation, except during your clinic week.

**DRESS CODE:** You may wear scrubs on night or weekend shifts, but are expected to dress professionally on all day shifts Monday through Friday.

#### Nurses:

Pediatric nurses can be a bit intimidating: Do engage your communications skills, listen to them and be patient. Ask your upper levels if you have any questions or doubts. You will also learn a lot from the nurses, so try to be receptive but assertive.

#### Notes:

Be meticulous with your notes, especially discharge instructions and prescriptions. You will need to calculate doses under intense pressure several times during your rotation- keep calm and ask questions if you don't understand- "better safe than sorry". If you get cautioned by nurse/or upper level concerning your prescriptions- run through it with the resident or colleague, do not be flustered but learn from it.

#### **General Notes:**

**This is an extremely busy month, with 14-hour shifts. Take advantage of your downtime. Try not to fall behind on any of your other FM duties. Thankfully, there is no weekly clinic to deal with. Additional articles and Intern expectations available on request.**

**You will have lots of fun and there is a lot to learn about Peds during this month.**

**During inclement weather, be aware you are expected to either sleep in the hospital, or at a location nearby the hospital to ensure you are available to work during your scheduled time.**

# **Pediatrics Emergency Room**

## **Location**

Children's Healthcare of Atlanta (CHOA)  
Emergency Room  
35 Jessie Hill Jr. Drive

## **Contact Person**

Donna Stringfellow, dstring@emory.edu

## **Schedule**

- The schedule is prepared 2-3 months in advance.
- You will receive an email to request vacation time, days you will like off and clinic days. Kindly respond to this in a timely manner.
- Your schedule will be emailed to you by the Emory chiefs or Dr. Naghma Khan, the ED Medical director.
- It is also available on AMION, an online scheduling software
- Scheduling is entered by 4 week blocks, usually starts on a Monday and ends on a Sunday or otherwise on the schedule
- Schedule is located at [www.amion.com](http://www.amion.com) login using the password "emupeds" => click on PES at the top to see your schedule, you can highlight your name for clearer view of our schedule.

**FM Clinic days:** Thursdays

**FM Didactics:** you do not attend FM Wed didactics during this month, when scheduled for a shift. If it is a Wednesday and you are not scheduled for a shift in the Peds ED, then you are to report to didactics. Notify the designated Emory scheduling person of which day of the week your clinic is 2-3 months in advance. It may not be posted yet. So, ask our chiefs and Ms. Stevens for any MSM required dates to tell Emory.

## **Hours:**

- 10 hour shifts, scheduled at
- 7 AM – 5 PM | 9 AM – 7 PM | 11 AM – 9 PM | 5 PM – 3 AM | 7 PM – 5 AM | 9PM – 7 AM
- You will be working with residents from Emory ED, Emory Pediatrics, MSM pediatrics and Emory FM.

## **Didactics:**

- Teaching rounds on Wednesdays, Thursdays and Fridays at 11:30 AM.
- This includes topic presentation and discussion with an ER Fellow or Attending.
- Each resident is asked to pick a topic to present while on the rotation and reserve the day on the black scheduling binder.

## **Orientation:**

- On your first day, arrive 15 minutes early => Charge Nurse and the attending will give you a brief orientation.
- There is a checklist that needs to be signed by both. Be sure to get your badge prior to beginning.
- When you arrive for your shift, always introduce yourself to the attendings, other residents and nurses.
- There is a physician workstation to the left of the nurse' station, write your name and shift on the whiteboard in the station.
- During this rotation, you will be seeing the patients in the ER.
- EPIC CHOA ER: you will be sent an email on directions to complete training online and in person (this lasts 1 hour with a proctor and you must score 90%, or better, to be granted

access). This provides basic navigation of the software. This training is separate from the EPIC Inpatient training

### Workflow

- You sign in when ready to see patients => assign yourself to patients, goal of 1-2 patients at a time/hour.
- Choose according to acuity level first, then according to wait time.
- Acuity levels range from levels 15. Level 1 and 2 need to be seen within 15 – 20 minutes of arrival.
- Choose patient => review chart => evaluate patient => present to attending (total number of attendings vary per shift vary) => start treatment (labs, medications, IV, etc.) => start note/choose next patient => continue to reassess previous patient
- Please note that you are being evaluated on your timely disposition as well as medical knowledge.
- The plan may be to admit the patient, transfer to a higher facility or to discharge.
- You may need to call for various consults. Always consult Hematologist for all sickle cell patients irrespective of disposition
- Try not to take a new patient in the last 1 hour of your shift, instead, use this time to work on the disposition of your patients.
- You can sign out your patients to the other residents coming on shift if your patients are still in the ER at the end of your shift.

### Online Orientation

- You will be forwarded a link for orientation before the rotation starts [www.classes.emory.edu](http://www.classes.emory.edu)
- You will receive your login info via email. The website also has some algorithms and guidelines for the common cases seen
- in the ER which include sickle cell emergencies, exacerbation of asthma, bronchiolitis, AGE (acute gastroenteritis), fever, abscess drainage and suturing lacerations. There is also a neonatal LP video that is required before completion of an LP.

### Procedures

- Aim to do a lot of procedures as you can.
- Log all procedures on a paper and submit to the Peds ER admin staff, Donna Stringfellow, at the end of your rotation.
- The Emory Blackboard website has a template that you need to print to record all your procedures.
- You must have your procedures signed as you get them done by the attending of that day.

### Evaluation

- This is subject to change
- The program manager will request e-evaluations from the attendings at the ED, however you should request and obtain verbal feedback from every attending you work with at the end of your shift.
- Ask Ms. Stevens for assistance in getting an evaluation completed.

### Calling in Sick

- If you need to call in sick, email the Chiefs, admin & your attending ASAP/at least 2 hours before your scheduled start time
- Also call the ED to speak to the attending and notify of your absence. This is to allow time to call in backup. The number to the ED is 404-785-9662.
- To access contact information for the Chief on call, scroll down to the bottom of the daily call schedule screen, and look for the name next to CHIEF. The main pager number is (404) 686-5500.

# **Family Medicine Wards**

## **Location:**

Atlanta Medical Center – South Campus (v9o0AMC-South)  
1170 Cleveland Ave  
East Point, GA 30344

## **Hours:**

=> morning signout: 6 am

=> evening signout: 5 pm

## **Parking/Badge**

- You should have obtained your ID and parking badge during orientation either at AMC-Main campus or South Campus
- For ID/parking badge issues, go the 4<sup>th</sup> floor and locate the conference room at the end of the hallway
- Parking is free at the physician-designated parking area

## **Residents Lounge (2<sup>nd</sup> floor)**

- Get to the North elevators on any floor, once at the second floor, make an immediate right and then left => walk all the way past the double door the end of the hallway to the last two doors to your left and right. The code is 215. You will usually work in the room to your right, signout and presentations will be in the other room.
- There is a male (code: ) and female (code: 125\*) call room available.
- Meals are available for free at AMC-South, preferably at the physician's lounge located on the Ground floor next to the cafeteria. You can also get meals from the cafeteria and sign for

## **Evaluations**

- This according to the 6 ACGME competencies
- You will be evaluated by the Morehouse attendings you work with on the floor, usually 2.
- You will also be evaluated by the chief residents

## **CFHC (Morehouse Healthcare) Clinic Days**

- This varies. You will be assigned to shadow one of the residents on your first clinic day.

## **EHR**

- Cerner, however this will be changing to EpicCare in the future
- You should have received access and training by the health informatics team at AMC, you will be guided on how to create templates for H&Ps, progress notes, etc. to improve workflow. You will receive additional guidance from residents on the floor
- For any Cerner-related questions and concerns at AMC-South, contact Ms. Walgi Gulnaz at (404) 466-4938

## **Team**

- Typically, 2 Family Medicine (FM) residents (both PGY2 or PGY3 or PGY2&PGY3)
- In July, all 6 interns would be on the floor with the two chief residents
- Each intern will then spend one more month on the floor during intern year per your schedule with the other 2 residents for that month

### Patient load

- There are two team of attendings: the Morehouse Faculty and the Eagle's hospitalists group
- Admit all Morehouse patients from the Emergency Room, there is no cap
- Admit 2 Hospitalist patients during the day shift (and 2 during the night shift - for night float)
- Admit 2 patients from the hospitalists before 11 am on Wednesdays
- You could have up to 12 patients admitted by the Hospitalists team
- The Emergency Room is located on the 1<sup>st</sup> floor

### Workflow/Roles and Responsibilities

- Get to the hospital by 5 am to pre-round on your patients, replete labs, start your note and help night float print signout
- Talk to patient's nurse for any overnight events => see all patients assigned to you, either by the chiefs or by yourselves before rounds.
- For patients needing imaging, call radiology, ensure they are on the schedule. You may also have to call lab for delayed results.
- Be familiar with all patients, this will boost your learning experience, knowledge base and help for coverage of larger patient load.
- Preferably have your progress notes done and saved in Cerner before rounds, update after rounds and sign.
- You will be expected to present your patients during rounds using the SOAP format, exude confidence in your assessment and plan, this is the major method for evaluation of your medical knowledge by the attending and chiefs.
- Patients admitted after midnight do not require a progress note, you can do an interval note for updates on care for that day.
- For every admitted patient, add them to the online census on Google Docs
- The Hospitalists would round at their lounge on the 1<sup>st</sup> floor or via phone, Dr. Maduka particularly will round at 7:30am.
- Every Tuesday, a new team of Hospitalists takes over patient care, you will call the team to find out who is the assigned attending to each patient => call and round with them per their preference.
- You will work until 12:00 noon on Wednesdays prior to going to weekly didactics at Buggy Works and return to signout at 5 pm
- Prior to leaving for didactics, tie all loose ends for your patients, inform the Unit Secretary of your departure and provide the name & phone number of the Morehouse attending for cross-coverage
- Learn to put in all orders for your patients, including admission and discharge orders; this is an opportunity for you to be completely familiar with Cerner and to take ownership of your patients and their care.
- For every Morehouse patient, you will need to collect one facesheet and sticker which you will place on a billing sheet and provide to the attending on the first day of the patient's admission.
- You are responsible for discharge summaries of every patient in your care, ensure to have these done within 24 hours of discharge, using the template provided on Google Docs Online.
- Update signout throughout the day and signout patients using the SBAR (Situation, Background, Assessment, Recommendations)

### Admission Process

- The ED will call you, might be the attending: obtain age, date of birth and MRN number
- Review patient's chart and go down to see the patient, your senior resident will also evaluate the patient
- The goal is to see the patient and have admission orders in within 30 minutes of being called.
- At the ED, look for patient's room number in the box next to the secretary => review paper chart and see patient => obtain focused H&P => discuss plan and management with your resident and put in admission orders => update census and signout => complete H&P.

#### Essential Reading Topics:

- COPD
- Asthma
- CHF
- Sepsis
- Shock
- ARDS
- AKI
- CKD
- DKA
- HHS
- Stroke
- Hypertensive Urgencies/Emergencies
- Pneumonia
- Alcohol Withdrawal
- Delirium
- Electrolyte Imbalance
- IV Fluids
- PRN Medications
- VTE Prophylaxis
- ACS
- A-Fib
- EKG
- ABGs
- Pulmonary Embolism
- Mechanical Ventilation
- Vasopressors and Inotropes
- Ventilator Basics
- Syncope
- Hypercalcemia
- Acute Pancreatitis
- GI Bleeding
- Anemia
- Cellulitis
- Meningitis

## **Grady OB/GYN:**

### **Location:**

Grady Hospital  
80 Jesse Hill Jr Drive SE,  
Atlanta, GA 30303  
404-616-1000

Main OB floor: 4J/4K (triage), 4L (labor), 4A (post-partum/high risk antepartum) These areas may change because the floor is under reconstruction and remodeling.

### **Contact Person:**

Morehouse OB Chief Resident Dr Ciara Talbot ([CTalbot@msm.edu](mailto:CTalbot@msm.edu))

### **CHFC Clinic Day:** Thursday

This month you'll be on the rotation with two upper levels (PGY2,3 or 4) and a maybe PGY 1. The intern will help orient you to the labor and delivery floor and how to take care of patients while you're on the rotation. You will mostly be with the intern during the day along with medical students.

Ask fellow FM residents for templates if you are not on service with another intern.

You can wear scrubs during most days, (except Wed for FM didactics). Bring a change of clothing.

Please speak to your fellow second years concerning Wednesday and Thursday protocols.

On Wednesday you are required to round on the patients on 4 A as usual and follow the OB residents to triage patients but make sure you leave at 11:00 am for Family Medicine didactics. (The OB chief is aware that you have to leave for didactics at 11am).

On your Family medicine clinic day (Thursday), you are not required to go to Grady for rounds, you go straight to CFHC.

### **Access:**

Fill out Grady access form. This form must be submitted to Ms. Obi who is in charge of granting access to the Nursery and the Mother/Baby Unit on 4A and 4B. You will not have access to these areas until Ms. Obi signs off. Your badge should grant you access to 4L area.

### **Door codes:**

Morehouse OB residents lounge 4K017 (code 4646)

### **Scrubs:**

You will need to complete the scrub form and submit it on the 6<sup>th</sup> floor. The OB intern will help you find where to go. You can get scrubs on the 4<sup>th</sup> floor or 6<sup>th</sup> floor. Remember you cannot wear green Grady scrubs outside of the hospital areas. You can wear your own scrubs into the hospital and change into green scrubs once you get there.

### **Pre-rounding:**

You will start the day by helping the PGY 1 round on the postpartum patients on 4A and B, usually at 6am. All postpartum patients have to be seen. The upper level may round after you. Your notes should be complete by the time morning report begins at 7am. The OB intern will share notes templates with you. All notes on post partum females must contain the gravity, parity, method of delivery, sex, weight and EBL. They must also contain her preferred method of contraception. These must be reflected in the assessment and plan.

All residents must arrive by 7:00 am for morning lectures and sign-out on M, W, R, F on 5H004 (code 55288) and on Tuesday 4K017 (code 4646).

There's a different attending everyday. You can access the attending schedule via this link:  
<https://app.qgenda.com/link/view?linkKey=03b1292c-b748-4f8a-9f01-653a14d05a8a>

You will also be required to give presentation on the topic of your choice during morning report prior to the end of the rotation. The Chief resident may assign you the topic or you may choose your own topic. OB Didactics are every Friday 12am-5pm, at which time you may be asked to work alongside the attending or midwife, to cover the floor. The best time to procure your deliveries will be during Friday diacritics sessions as you will be the only resident with the midwives or attending. You may also ask to attend these lectures and will be allowed to do so at the discretion of the senior resident. Please inform the team before hand of any requirements you have outside of the rotation that might conflict with these times.

#### Labor and Delivery: 4L

During the daytime you will be working on L&D or Triage. On L&D you will basically write the H&P for patients being admitted, sign consent forms (always do for both vaginal and c-section, and also for blood), following them throughout the labor process and participating in the delivery process. You will also get a chance to go to the OR for any scheduled or emergency C sections. You can also sign up to do circumcisions; it usually depends on the Attending's level of comfort in allowing residents to do the procedure.

#### Triage: 4J/4K

You will also see patients in the 4L "WUCC" - formerly known as the women's urgent care center. The area is essentially triage for all pregnant patients less than 24 weeks EGA or postpartum patients. This is a great chance to improve your skills on pelvic exams, wet preps and triage ultrasound.

You also have to choose two weekend days, Saturday or Sunday this month to do call. You can choose to do day or overnight shift. Day shift: 8am to 8pm. Night shift: 8pm to 8am. It is sometimes nice to take call with your regular floor team, if possible.

#### Discharges

More than likely, you will be writing discharge summaries for patients that you discharge. Check frequently in you epic inbox for any pending discharge summaries. Try to complete you d/c summaries on the same day that you discharge your patient if the service is busy.



## **AMC OB/GYN:**

### **Locations:**

AMC Main: 303 Parkway Dr NE Atlanta, GA 30312, 404-265-4000

Willie J. Freeman Clinic: 1920 John E. Wesley Ave. College Park, GA 30337, 404 765-4146

CFHC Clinic (Buggy Works)

Cascade clinic: 3915 Cascade Road, Suite T-115

**Contact Person:** Dr. Kirstie Cunningham

### **Schedule:**

Mondays all day AMC Main

Tuesdays: PM Clinic CFHC and 6 pm - 9 pm - Cascade clinic

Wednesdays: AM Clinic CFHC

Thursdays all day - WJF

Fridays 8:30 am - 12:00 pm - WJF

1st Saturday of the month - Cascade clinic

This is an outpatient rotation, with deliveries and occasional GYN procedures and consults at AMC Main

### **Morning rounds:**

If there are laboring or post-partum patients, you will round on them each morning at AMC. Try to get there by 6:30 because you have to hand-write notes you are expected to see all of her patients. **L&D is on 7<sup>th</sup> floor** Mother/Baby unit is on 6<sup>th</sup> floor. **If you have badge access issues, please go to the security/badge place on day 1 to get this straightened out.** You will need access to the main physician entrance on the main floor and also to the 6/7<sup>th</sup> floors. Nurses at AMC are way more involved than at Grady, i.e., they do routinely do cervical checks on laboring patients.

**Please, whether your badge gets you in, or you have to press the doorbell to get in on the 6/7<sup>th</sup> floors, head straight to the nurses' station and introduce yourself. They are very territorial.**

Dr. Cunningham is in a group with several other docs, some of whom you'll likely work with. All charts are arranged by color, and this group's chart color is **ORANGE**. Also, there's a big screen at the front desk with room numbers and the attending names. She should have sent you her call schedule so you could see all the other docs she works with: Freeman, Braswell, Simmons, Ford, Sonyika. She usually has one Fri-Sun call a month and possibly one 24hr call. If you live close enough to the hospital, you can take call from home. Just give the nurses your contact information so they can call you (some of them will and others will forget). But you can also call in periodically to check if there are any laboring patients from the call group.

**OR: also on 7<sup>th</sup> floor. Shoe covers and caps are in the hall before you get to the OR.**

**Door Access Codes: (the nurses may not willingly give out these codes)**

Nurse's lounge (this is where you can hang out): 0351\*

Staff bathroom behind nurse's station: 753\*

Supply Room/Scrubs (it is down the hall passed labor room 12): 0351\*

**Lounge:** There's a lounge behind the nurse's station. You can place your belongings in there. But beware, you may be asked to leave the room in the mornings and evenings when nurses are doing sign-out. And, there's nowhere else to hang out.

**Laboring patients:** If they're being induced, you may be asked to stay at AMC so the attending can go to clinic. Unless it's your Tuesday clinic day, then you'll go to clinic as scheduled and go back to AMC afterwards. It's a great idea to stay close to the attending when you are at AMC so a procedure is done, you can see how it's done, and potentially get to participate. **Always let your attending know where you are, if you happen to walk away from a laboring patient.** If you are there and are waiting, send

attending a quick text to let her know where you are. Attending usually goes directly to the patient's room when she arrives, but if you let her know you're there, she may text you. During this month you may also be called to the hospital if any CFHC patients arrive in labor.

C/S: Usually scheduled for 8am. You'll need to get there by 7am or earlier to write the H&P. After the delivery, you will write a delivery and or post op note. Be quick cause you'll still have to make it to clinic on time, by 9am.

**The OR** is down the left hallway parallel to the nurse's station. The gowns, caps, etc are on a cubby on the way there, to the right. **Tips for the OR, learn to suture. Know the anatomy** of the cut, layers of the skin, the parts of the uterus and ovary. What differentiates large from small bowel, the blood supply of the uterus, ovaries (right off the aorta for the ovarian artery).

Mother Baby (6<sup>th</sup> floor): The nurses here are super nice. There's a short Nigerian lady, Ms. Sophia, she super awesome. She'll show you the ropes. Just again, introduce yourself as a FM resident working with the Morehouse attending (Dr. Cunningham).

There's a small cubby area on the left side behind the 6<sup>th</sup> floor nurse's station, where you can write notes. The nurses use this area too. It's nice and private. **You can't eat there!!!**

Attendings also do circumcisions. You should get the consent done, signed and on the chart and tell the nurses to get baby ready. Find out what type of circumcision tool your attending prefers to use, and let the nurses know ahead of time. Our badges do not give access to the nursery, so you'll have to knock.

#### **Notes:**

All hand-written. Always sign your name and spell it out if not clear, then leave your pager number or cell phone number. Find a template that works for you. Different attendings may have different preferences.

**Postpartum**: For SVD, insignificant things include flatus, N/V. Those are only important for CS.

**Newborn**: follow the template for newborn exam. There's some unnecessary stuff on there, but you'll figure it out.

H&P: The forms are located in a cabinet of forms on both 6/7<sup>th</sup> floors.

#### **WJF Clinic:**

WJF: no notes!!! Dr. Cunningham is fine with us writing in the charts. Other attendings prefer for us to wait until after we have presented the patient to them. This is where you **MUST follow the template, strictly!!!**

#### **WJF Template (script)**

" (age) yo (AA)Female, G-P---, EDC dd/mo/yr, by sure/unsure LMP, confirmed by X trimester US, with EGA dd/mo/yr. Pregnancy complicated by XXX. Who presents for follow up OB. Also c/o XXX. She reports a) good fetal movement (y/n), b) contractions (y/n) c) vaginal bleeding (y/n), d)leakage of fluid (y/n), e)vaginal discharge (y/n). BP today: xx/xx, U/A +/- glucose, +/- protein, weight change since last visit: (+/- x lbs), total pregnancy (+/- x lbs). Fundal height: xcm, FHT x's in the RLQ/LLQ. Assessment: 1) IUP at x wks, xdays,. 2) other problems: 3) follow up in x weeks. Labs next visit."

You will get all this info from the chart which will already be in the patient room.

**When you get to WJ, please introduce yourself to the nurses. Her main nurse is Mariam.** If you have a Spanish-speaking patient, you can ask Mariam for help interpreting, if she's not busy. Please always let the nurses know you are there and working with attending, before you do anything else. Also ask them to open the room so you can get a Doppler, keep one in your pocket.

There are a lot of patients to see at WJF, so get there by 9a and ask the nurse **to start bringing patients back as soon as you get there.** Try to move fast and write your presentation down, because you will have to move between patients quickly. Things to read about: cardinal movements of labor, tests of fetal wellbeing (NST, BPP), Naegel's rule, what is a variability on an NST, what is a reactive NST.

ALL THESE PATIENTS COUNT TOWARDS YOUR NUMBERS!!! Always keep a copy of the schedule so you can log patients. **Always write down DOB and ID# as this is needed to log patients.**

**CFHC:** You will help see the attending's patients and present to her. You also write notes on these patients in Practice Partner. It's just like preceptor clinic except the patients don't count towards your numbers.

Note: There is a large panel of patients so it's important to keep up with your notes. In addition, it is important to complete after-visit summaries.

**Discharging patients:**

Prescriptions are usually at the back of the chart. Fill them out on the first postpartum day if not already done. All postpartum patients may resume PNV and may go home with FeSO<sub>4</sub> and Colace if Hgb significantly decreased from admission level. If Hgb < 10, this is severe anemia and if < 9, the attending may give patients the option of receiving an intramuscular form of iron, called Infed. Write the order for 2cc/100mL IM per hip. Write discharge orders to include: nothing per vagina for 6 weeks, precautions for when to seek immediate medical attention: fever, severe abdominal pain, heavy bleeding, and watch for signs of postpartum depression. **ALWAYS** write "may be discharged home **with attending approval**" in the discharge order. The attending must see and approve all discharges. Meaning, patients don't go home until the attending rounds on them or calls the hospital to say they can leave.

**Prescriptions:**

- SVD: Motrin 800mg q6 prn pain
- CS: Tylenol #3 (or Percocet) and Motrin (please ask her to be sure)

**Important AMC Numbers:**

Operator 404-265-4000

L&D 404-265-4724

Mother/Baby Unit:

Interpreter 404-265-3582

Computer program: Cerner

## **Internal Medicine Grady**

**Location:** Grady Hospital

**Contact:** IM chief residents who will direct you to your upper level resident

**Paula Adamson:** [padamson@msm.edu](mailto:padamson@msm.edu)

**CFHC Clinic Day:** Monday (must round on patients and write notes before going to clinic)

**Off Days:** 4 days for the month (but may have more if there are holidays that fall on your clinic day)

**Evaluations:** request from the attending/resident you work with the longest/have a good rapport with

**Teams:** 2 Interns + Upper level who is a PGY 2

If you ever run into any issues or need academic advice on patients or papers, is best to contact the chiefs or your upper level residents, most of them are friendly and used to the family medicine residents

**Lounge:** You mainly spend your time on 5A, 7A or 16<sup>th</sup> floor writing notes, orders, etc. There is also an IM resident room on 9E. You can store your bags here or you can request locker access on 16<sup>th</sup> floor. There is an Emory representative on the 16<sup>th</sup> floor who handles the lockers. For 9E access, you will need to email the IM chief. Ask the chief to email Angela Rogers ([arogers@gmh.edu](mailto:arogers@gmh.edu)) with your ID badge number (the 5-digit code on the white parking badge) to give you access to this room.

**Schedule:** arrive between 6-7am to pre-round. You should arrive in enough time to finish seeing your patients and possibly getting your notes done before signout from the night float at 7.45am.

**Morning Report: daily at 8AM (except holidays and weekends)**

**Location: on the second floor behind the cafeteria.**

Rounds typically start after morning report but it depends on the preference of the attending. After rounds you will carry out the plans for the day which include ordering labs, following up on labs, consults or imaging, procedures, discharging patients. There's usually noon conference every day at 12:00 PM, lunch may or may not be provided. Then be ready to sign out at around 4 PM to the night team on call. You can leave after sign out if you are done for the day. Just be sure to check with your upper level.

**There is Grand Rounds every Wednesday at 12:00pm** in Piedmont Hall. Ask the medicine residents for directions.

### **Call:**

**Q 4-5 days from 7 AM-8 PM.**

There are no rounds on call days; the upper level conducts a phone round with the attending. You admit patients from the ER or there may be transfers from the ICU. After assessing the patient in the ED you will formulate a problem list and do the admission orders with your upper level in EPIC. Then you will do your H&P after completing the orders.

There is a premade order set for admissions in EPIC which allows you to complete the orders very efficiently. Admission orders are usually completed by upper level residents. I will check with upper level resident before doing admission orders.

You and your team can leave if there's nothing pending after 8 PM. Occasionally, the upper level may have a 24 hour call and will leave after rounds the next day.

Post call rounds are usually long as most of the patients will be new.

- Ask your fellow intern or upper level to share the templates for H&P and Progress notes.
- Discharge medications and instructions **print out at the printer on the floor where the patient is located, not on the printer attached to the computer you are working on.**
- You may print your progress notes before rounds so you can have access to labs if needed. Try printing 4 pages on one sheet as it is easier to manage and you save paper too.
- Usually the call days are spent on the 16<sup>th</sup> floor where there is an area with computers. These computers have a different login password. MSM should have established VPN access there now, however, there is also an Emory library login. You will be given your username and password for these computer.

- Elevators: These can be very slow. Get there early enough to have time to wait. Familiarize yourself with the staircases, but be careful, as some of them don't open from the outside.
- If you are new to EPIC and Grady at the start of the rotation, don't be afraid to ask questions about the things you don't know and also you will have orientation to EPIC during your orientation month in July.
- You will always have to follow up on orders that you made with the nurses, labs, X Rays, CT scans etc. Usually the nursing station has a copy of all the important numbers, get a copy for yourself.
- You will spend a lot of time on the phone for consults; follow ups, updates with your attending and upper level.

#### Cross-cover:

The cross-cover is an intern from the on-call team who covers the patients of all the medicine teams from 5pm to 8pm on weekdays and from 11am to 8pm on weekends. All teams will sign-out to the cross-cover intern at 4pm, but most teams are technically present at the hospital until 5pm. You will hold the cross-cover pager until the night float arrives and assumes care of these patients. Sign out usually takes place in the medicine conference room on 7B. The sign outs are printed out from EPIC in SBAR format. You will hold on to all of the sign outs for all the teams and, answer the cross cover pager till the end of your call and sign out to the Night Float team at 8 PM. Arrange your sign outs by writing the name of the team on the sheet, and writing or highlighting any pertinent info on the sign out. Consult your upper level if you are not sure how to handle the pager call.

## **ICU Grady**

**Location:** Grady Hospital, 7<sup>th</sup> floor

**Contact:** IM chief resident who will direct you to your upper level resident

**Paula Adamson:** [padamson@msm.edu](mailto:padamson@msm.edu)

**About the rotation:** You will be working with the Morehouse ICU team comprising of residents from Internal Medicine and rotating residents from Family Medicine, Psychiatry, and OB-GYN.

Patients are admitted from the ER and sometimes transferred from the floors. All the interns will be assigned to 2- 3 patients depending on the number of patients on the floor. Patients are usually admitted to the units 7J and 7K. Rounds usually start at 8 AM. Notes are usually written by the intern and resident covering the night shift and are usually divided in half but the on-coming residents may help out depending on the number of patients. Everyone is expected to know about all the patients assigned to the ICU team. Ask one of the ICU residents to share the ICU notes template with you on EPIC and prior to going on the rotation ask for the room code.

The ICU team is on a 13 month schedule and at the beginning of the month there are orientation classes conducted by the Pharmacy and the Respiratory therapists. Unfortunately this may occur prior to you joining the team so ask them for any notes pertaining to this. There should however be a presentation at some point for you as their team will change while you are on rotation. The classes include orientation about IV antibiotics and vasopressors, sedatives and ventilator management. The ICU team is not required to report for morning report conducted by the medicine team, but may at times be asked to. There is usually an ICU presentation during the month in morning report. Every morning there may be teaching sessions with topic presentation by the ICU residents.

The schedule is usually forwarded 2-3 weeks in advance by the medicine chief. You will need to coordinate with the Internal Medicine Chief Resident who will direct you to the upper level residents on your ICU team.

The call room is located opposite to the door of the 7J North ICU unit. Please contact the IM upper level on your initial day of rotation for access code. Please contact the upper level in the team for the Recommended text: The ICU BOOK is available in electronic format and the link to the free 3<sup>rd</sup> edition is below:

<http://www.rianimazione.info/libri/The%20ICU%20Book-3rd%20ed.pdf>

Please let someone know if you do not have a copy. Good Luck and Enjoy.

## **Surgery at Grady**

### **Location:**

80 Jesse Hill Jr. Dr. SE, Atlanta, GA 30303  
Phone: (404) 616-1000

### **Contact Persons:**

Chief Residents (2016/17):

Carolyn Moore [cmoore@msm.edu](mailto:cmoore@msm.edu)

Cooper Mounzar [cmounzar@msm.edu](mailto:cmounzar@msm.edu)

Please contact 2 weeks prior to the start of your rotation to let them know that you are coming and to get your schedule. They may ask for any preferred off days, you get 4 days per month. If you have any days you would like to have off, please let them know when they ask.

**NOTE:** Wednesday didactics, Tuesday clinics, sick days and post call days DO NOT COUNT AS DAYS OFF.

### **Evaluator:**

Variable: may be the attending you worked most with +/- seniors you worked mostly with (Chief residents, PGY 4 and/or 3s.)

### **ID Badge:**

- An Authorization form has to be sent to Grady Security by the Family Medicine Department (i.e. Ms. Stevens). The fax number to the security office is 404-616-8835. It should include: your name, what floor you need clearance for, length of time you need access. Please call 404-616-8832 if you have any questions.
- Your Grady ID Badge should be visible at all times

### **Computer Access:**

- After you have completed the CBLs, if you do not have an Epic username and password, contact Epic Information Systems at 404-616-3112. You are contacting this person so that they will process an application for Epic username and password. The information that you will need to give them is as follows: Name, Grady ID and a contact number where you can be reached. They already have your email on file, usually they will send an email with the username and password included; as well as, information on how to access Epic via Citrix. There are also two agreements (VPN and Computer Systems Acceptable Use Agreement) that must be completed and signed.
- Your Epic Username and password should grant you access to the computer. When you log into Epic under Department: enter GHS SURG GEN SUR MSM [10100219].
- Under "Shared Patient Lists" on the left hand side of the screen you should have a Block list that will contain all the General Surgery patients on the service, the trauma list and the Vascular list. You will need to ask a resident to share the list with you.
- Access from home: <https://citrixnet.gmh.edu>
- Access to the patient list/updating the patient list: <https://gradynet.gmh.edu> enter in your epic username and password ● Department and Services tab ● Physicians ● MH Surgery Sign-out

**Parking:** In the Piedmont Parking Garage. .

**Clinic:**

- Family Medicine Residents usually do not attend the surgery outpatient clinics unless they are extremely understaffed. Your job is to be on the floor or in the OR.

**Resident Lounge:**

- Located on the 7<sup>th</sup> floor by 7B
- Phone number (404) 616-1474
- Code gets changed often, current code 25874, ask one of the residents for the current code if changed. PLEASE do not give the code out there have been issues with too many outside people having access to the lounge.

**Essential Reading Topics:**

- SBO
- Appendicitis
- GERD
- Direct Hernia vs. Indirect Hernia
- Colonoscopy
- Abscess
- Post-op Fever
- Post op complications
- Wound healing
- Anticoagulation before and after surgery
- Anatomy of the bowel, gallbladder, appendix, including vasculature and nerves

**Schedule:**

- Arrival time varies depending on patient census, average 5am. Ask the upper level you're working with what time they would like to round.
- In general when you are not on call (i.e. not carrying the pagers) you should pre-round on your patients, have your notes completed by 7am. Rounds usually begin at 6am with the senior resident
- When on call your day will start the same, the other interns will sign out their patients to you usually after running their list, you will carry the floor pager, this means that ALL pages about ALL patients on the general surgery floor (only general surgery) will come to you. This pager is also for consults. Therefore make sure you carry your list at all times. You will get pages from other services (medicine, OB-gyn etc) and the ER. You are required to see the ED patients within 30 minutes of the consult. If you have any questions call your senior resident who is on call with you. Call ends at 6PM. Update the sign-out for the night intern who will be coming on. Do not wait till the last minute to update signout as this will delay your going home.
- You will not have to do any nights. Schedule is 6am to 6pm
- Complete the work of the day prior to leaving: this includes putting in orders mentioned by the senior resident on rounds and discharging patients. If you have been mostly responsible for rounding on a patient it will be your responsibility to do the discharge summary. The discharge summary should be completed within 24 hours of discharge from the hospital.
- Every 4<sup>th</sup> night Morehouse is on Trauma call, so you may get more consults for the general teams if trauma is swamped.
- You are welcome and encouraged to go the OR as much as you would like and the schedule permits

**NOTE- Check your Grady Epic at least a week after your Surgery rotation ends for messages in your EPIC inbox for discharge summaries to complete etc. This is very important to avoid having a delinquent record issue with Grady medical records.**



**Monday**

AM: 4am to 6am Pre-round, 6AM Rounds.

PM: Complete the work of the day, go the OR (optional but encouraged)

**Tuesday**

Pre-round and signout to the intern on call after rounds then go to continuity clinic try to be there by 8:30am.

AM/PM: Continuity Clinic

**Wednesday**

AM: 4am to 6am Pre-round, 6am Rounds, 7AM lectures with the surgery residents. Leave by 11am.

PM: FM Didactics

**Thursday**

AM: Pre-round, Rounds

PM: Complete the work of the day, go the OR (optional but encouraged)

**Friday**

AM: Pre-round, Round, 7am Morning Report: M&M

PM: Complete the work of the day, go the OR (optional but encouraged)

**Saturday:** Pre-round, Round, Signout do the work of the day and signout to the intern on call

**Sunday:** Preround, Round, Signout do the work of the day and signout to the intern on call

- You will have a total of 4 random days off in the month
- You must go in and round on your patients every day that is not an off day. This includes weekends and clinic days.
- You will be contacted by a senior resident prior to the start of your rotation with the call schedule. When the schedule is out please review the schedule to make sure that you are not on call during a vacation week, after clinic on Tuesday or after didactics on Wednesday. Also make sure that you are not violating your duty hours

**Useful Numbers for Grady**

Operator            0 (404-616-1000)

ER

Red zone           56435

Blue Zone           56456

**Radiology**

Portables            44001/54002

CT body reading room 56283

CT neuro reading room 57055

MRI reading           56767

CT                    57002

IR                    57006

Nuclear            54602

US                    54519

**Labs**

Chem.                54835

Heme                 54821

Micro                54847

Blood Bank           54839

**2017-2018 MSM Chief Resident Contact Information**

<b>PGY Level/ Status</b>	<b>Name</b>	<b>E-mail</b>	<b>Program</b>	<b>Pager</b>	<b>Cell</b>
<b>PGY3</b>	<b>Oluwaseun Odewole</b>	oodewole@msm.edu	Family Med.	404-278-0663	404-437-2360
<b>PGY3</b>	<b>Onyinye Iheaku</b>	oiheaku@msm.edu	Family Med.		404-643-9814
<b>Adm. Chief</b>	<b>Paula Adamson</b>	Padamson@msm.edu	Internal Med.		
<b>PGY4</b>	<b>Ciara Talbolt</b>	Ctalbolt@msm.edu	OB/GYN		951-313-0755
<b>PGY3</b>	<b>Sunny Onyeabor</b>	Sonyeabor@msm.edu	PH/PM		
<b>PGY4</b>	<b>Brittany Fowler</b>	Bfowler@msm.edu	Psychiatry		404-324-9427
<b>PGY4</b>	<b>Simran Brar</b>	Sbrar@msm.edu	Psychiatry		404-447-4079
<b>Admin Chief</b>	Keila Simmons		Peds		
<b>PGY5</b>	<b>Carolyn Moore</b>	Cmoore@msm.edu	Surgery	678-557-8078	
<b>PGY5</b>	<b>Cooper Moungar</b>	Cmoungar@msm.edu	Surgery		