



Graduate Medical Education
Policy Manual

**Academic Year
2019-2020**

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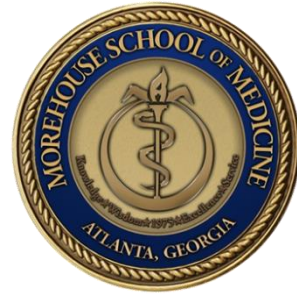
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Preface—Our Vision and Mission

MSM Vision

Leading the creation and advancement of health equity by:

1. Translating discovery into health equity
2. Building bridges between healthcare and health
3. Preparing future health learners and leaders



MSM Mission

We exist to:

- Improve the health and well-being of individuals and communities;
- Increase the diversity of the health professional and scientific workforce;
- Address primary healthcare 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.

“We are on a mission”

Morehouse School of Medicine (MSM) is like no other medical school in the country. We attract students who want to be great doctors, scientists, and healthcare professionals, and who want to make a lasting difference in their communities.

MSM ranks number one in the first-ever study of all United States medical schools in the area of social mission. The ranking came as a result of MSM’s focus on primary care and addressing the needs of underserved communities, a role which the study emphasizes is critical to improving overall healthcare in the United States. Such recognition underscores the vital role that MSM and other historically black academic health centers play in the nation’s healthcare system by addressing head on the issues of diversity, access, and misdistribution.

Put simply, we attract and train the doctors and health professionals America needs most: those who will care for underserved communities; those who will add racial and ethnic diversity to the health professions and scientific workforce; those who will dedicate themselves to eliminating the racial, ethnic, and geographic health inequities that continue to plague the community.

Likewise, our researchers seek to understand not only the biological determinants of illness and health, but also the social determinants: the circumstances in which someone is born, lives, works, and ages. These circumstances can be shaped by diverse forces, but can be just as powerful as physiology, if not more so, when it comes to health and wellness.

Graduate Medical Education (GME)

GME is an integral part of the Morehouse School of Medicine (MSM) medical education continuum. Residency is an essential dimension of the transformation of the medical student 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.

KNOWLEDGE

WISDOM

EXCELLENCE

SERVICE

The Scope of This Manual

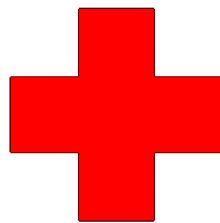
The Graduate Medical Education (GME) Policy Manual is an outline of the basic GME policies, practices, and procedures at Morehouse School of Medicine (“MSM” or “School”). The Policy Manual is intended only as an advisory guide. **The term “resident” in this document refers to both specialty residents and subspecialty fellows.**

This policy manual should not be construed as, and does not constitute, an offer of employment for any specific duration. This policy manual does not constitute an expressed or implied contract of employment for any period of time. Either MSM or an employee may terminate the employment relationship at any time with or without cause and with or without notice.

MSM will attempt to keep the GME Policy Manual and its online version current, but there may be times when a policy will change before this material can be revised online. Therefore, you are strongly urged to contact the GME Office to ensure that you have the latest version of MSM’s policies.

Policy updates will be communicated to the MSM community via e-mail and will be posted on the MSM internet site. MSM may add, revoke, suspend, or modify the policies as necessary at its sole discretion and without prior notice to employees. This right extends to both published and unpublished policies. A copy of the GME Policy Manual may be downloaded from the MSM website.

The MSM Policy Manual supersedes all prior GME Policy Manuals, policies, and employee handbooks of MSM. The effective date of each policy indicates the current policy and practice in effect for the school.



Welcome from the GME Office!



Dear new and continuing residents:

Welcome to the 2019-20 academic year of training! The Graduate Medical Office supports and provides oversight to all its ACGME-accredited residency and fellowship programs. As the Designated Institutional Office (DIO), I am committed to ensuring that our residents and fellows receive quality educational experiences and the necessary resources to successfully complete residency training.

MSM GME provides a very competitive fringe benefit package to residents. Our resident stipend amounts rank over the 75th percentile nationally and includes excellent health coverage. Our programs provide vacation and sick leave benefits that are generous compared to other national training programs.

Resources provided and paid by all Morehouse School of Medicine residency/fellowship programs include:

- Board review preparation for seniors
- Book allowance each year
- iPads or laptops for all new residents/fellows
- Life support certification and recertification
- Marketing collateral—t-shirts, lunchboxes, coffee cups, speakers, etc.
- New paging system
- Resident/fellow travel to conferences
- State temporary medical licenses
- White lab coats

I enjoy teaching and interacting with residents and strive to obtain resident input and feedback on improving our institution and programs. My expectations for MSM GME residents/fellows are that you:

- Dedicate yourself and your hard work to learn and provide top quality care to our patients;
- Contribute to and be part of solutions to improve and innovate our institution; and
- Advocate for the community.

I look forward to working with you all in the upcoming year. Please feel free to contact the GME Office with questions or concerns.

Yolanda Wimberly, MD, MSc

Associate Dean of Graduate Medical Education and Clinical Affairs
ACGME Designated Institutional Official

The GME Office is located on the Grady campus at:

22 Piedmont Ave, SW
Piedmont Hall, Suite 125
Atlanta, GA 30303
404-752-1857

Welcome from the Resident Association

The Morehouse School of Medicine (MSM) Resident Association (RA) is the representative body and voice for MSM residents. The RA works in collaboration with the leadership and administration of MSM Graduate Medical Education (GME) and its educational affiliates to ensure that residents are involved in providing input and feedback regarding decisions pertaining to residency education. The officers of the RA are available to residents as a resource in the informal concern and complaint process.

Membership in the RA is extended to all residents. The structure and purpose of the association are contained in these bylaws. Residents are encouraged to become involved in the Morehouse School of Medicine Resident Association and to use it as a vehicle for communication regarding direct involvement in policy-making, institutional administration, and interdepartmental coordination.

Resident Association Mission

The Morehouse Resident Association's mission is to be the voice of all residents. The RA advocates for MSM residents and strives to contribute to their well-being, the improvement of their learning environment, and to foster a well-balanced residency experience through communal activities.

Bylaws of the Morehouse School of Medicine Resident Association

Recognizing that the rendering of professional service to patients in accordance with the precepts of modern scientific medicine and the maintenance of the efficiency of the individual physician may best be served by coordinated action, the residents who are training at Morehouse School of Medicine do hereby organize themselves into a Resident Association to provide such coordination in conformity with the following bylaws.

ARTICLE I

The name of this organization shall be the "Morehouse School of Medicine Resident Association" (RA).

ARTICLE II

The Morehouse School of Medicine Resident Association shall be composed of physicians who are interns and residents appointed by and currently under contract to Morehouse School of Medicine.

ARTICLE III

OFFICERS, COMMITTEES, AND RESPONSIBILITIES OF MEMBERS-AT-LARGE

Section 1: Officers

- A. The officers of the Morehouse School of Medicine Resident Association shall be the President, the President-Elect, and the Secretary-Treasurer. The President shall call and preside at all meetings and shall be a member ex-officio of all committees. He or she shall represent the Association on the Graduate Medical Education Committee as a voting member. He or she shall have the authority to correspond and communicate resident concerns and to address confidential matters as necessary.

- B. The President-Elect, in the absence of the President, shall assume all his or her duties and shall have all his or her authority. He or she shall represent the Resident Association on the Graduate Medical Education Committee as a voting member. He or she shall have the authority to correspond and communicate resident concerns, and to address confidential matters as necessary.
- C. The Secretary-Treasurer shall keep accurate records of all meetings, call meetings on behalf of the President, and perform such duties as ordinarily pertain to his or her office. The Secretary-Treasurer shall take direction from the President, President-Elect, and the Executive Committee. He or she shall act as Treasurer of the Morehouse School of Medicine Resident Association when necessary.

Voting of Officers:

The President-Elect and Secretary-Treasurer shall be elected annually during the orientation of returning residents by all current residents in good standing from all Morehouse School of Medicine Residency Programs. The previous year's President-Elect shall serve as the President of the Executive Committee thus serving a second year of his or her term.

Section 2: Committees

- A. **Resident Association Executive Committee**—The Morehouse School of Medicine Resident Association shall have an Executive Committee. The membership of the Executive Committee shall consist of the President, President-Elect, and Secretary-Treasurer.
- B. **Resident Association Council**—The Morehouse School of Medicine Resident Association shall have a Council. The membership of the RA Council shall consist of at least two (2) members-at-large representing each residency program: Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Preventative Medicine, Psychiatry, and Surgery.
- C. **Members-at-Large**—These members must be peer-selected on an annual basis with one resident designated as the RA voting representative of the Executive Committee, therefore ensuring one vote per program.
- D. **Ex-Officio Members**—The President, President-Elect, and Secretary-Treasurer of the Resident Association shall be ex-officio members of the RA Council.
- E. **Standing and Special Committees of the Resident Association**—All committee representatives shall be appointed by the President. Standing committees shall be appointed for one year. Special committees shall retain their appointments until discharged by the President. Committees shall be reconstituted annually. Appointed representatives to committees are responsible for providing a brief written summary to the RA Officers within seven (7) days of attending a committee meeting.

Standing Committees:

Representatives from the Resident Association membership shall be appointed by the President to sit as members on the following committees as requested by MSM and hospital affiliates and as deemed necessary by the Resident Association:

- Grady Memorial Hospital (GMH) Patient Safety and Quality Improvement Committees as requested by GMH and GME leadership
- GMEC Patient Safety and Quality Improvement Subcommittee
- GME special annual committees requesting a resident representative that include but are not limited to:
 - Graduation
 - Recruitment
 - New Resident Onboarding
 - Resident Orientation
 - Special Reviews of Programs

The RA President-Elect and Secretary shall keep an annual committee list of resident appointments.

Section 3: Responsibilities of Members-at-Large (MaL)

Members-at-large are responsible for representing the residents of their program and communicating information from the RA council meetings. Additional responsibilities of a MaL are to attend quarterly RA Council meetings and participate as a member on at least one institution/hospital committee as requested/appointed by the RA President.

**ARTICLE IV
MEETINGS**

Section 1: Regular Meetings—RA Council

Regular meetings of the RA Council shall be held at least quarterly, with the exception of July, or at the discretion of the President of the RA. All members-at-large will be notified at least one month in advance. All meetings shall be open to any member of the Resident Association unless otherwise specified.

Section 2: Special Meetings—Executive Committee

- A. Special meetings of the Executive Committee or of the Resident Association Council may be called at any time by the President of the Resident Association.
- B. The Director of Graduate Medical Education shall be invited to regular Executive Committee and RA Council meetings in an advisory capacity and shall be excused from such meetings, if necessary, when residents choose to discuss confidential RA matters.

Section 3: Quorum

Any five members of the RA Council present at any given meeting shall constitute a quorum. All officers must be present at Executive Committee meetings for a quorum.

Section 4: Meeting Agendas

- A. The agenda at any regular RA Council meeting shall be:
 - 1. Call to order
 - 2. Reading of the minutes of the last regular and all special meetings
 - 3. Unfinished business
 - 4. Communications
 - 5. Reports, as indicated, from representatives of standing and special committees
 - 6. New business
 - 7. Adjournment
- B. The agenda at special (Executive Committee) meetings shall be:
 - 1. Reading of the notice calling the meeting
 - 2. Discussion of the business for which the meeting was called

ARTICLE V AMENDMENTS

Amendments to these bylaws shall be proposed by resolution at a regular meeting of the Executive Committee. Proposed amendments shall be voted on at a scheduled meeting of the Resident Association Council and shall require two-thirds majority of those present and voting for adoption. A copy of the resolution shall be transmitted in writing to all members of the Resident Association 30 days prior to such a meeting.

ARTICLE VI ADOPTION

These bylaws will be voted on and must be approved by majority vote of all active residents who are in good standing with their programs.

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General Information for Faculty Members

The Graduate Medical Education Committee (GMEC) highly values the contributions of our faculty members. The GMEC agrees, supports, and adheres to the ACGME requirements and standards as related to faculty members as follows (reference: ACGME Common Program Requirements July 1, 2019):

“Faculty members are a foundational element of graduate medical education—faculty members teach residents/fellows how to care for patients. Faculty members provide an important bridge allowing residents/fellows to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach.

“By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population. Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents/fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the wellbeing of the residents, fellows and themselves.”

Per Section II.B. of the ACGME Common Program Requirements:

At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents/fellows at that location.

Responsibilities of Faculty Members

Faculty members must:

1. Be role models of professionalism.
2. Demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care.
3. Demonstrate a strong interest in the education of residents/fellows.
4. Devote sufficient time to the educational program to fulfil their supervisory and teaching responsibilities.
5. Administer and maintain an educational environment conducive to educating residents/fellows.
6. Regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
7. Pursue faculty development designed to enhance their skills at least annually:
 - a. As educators;
 - b. In quality improvement and patient safety;
 - c. In fostering their own and their residents’/fellows’ well-being; and
 - d. In patient care based on their practice-based learning and improvement efforts.

Faculty Qualifications

Faculty members must:

- Have appropriate qualifications in their field and hold appropriate institutional appointments;
- Have current certification by the American Board of the specific specialty or the American Osteopathic Board of the specific specialty, or possess qualifications judged acceptable to the Review Committee; and
- Possess current medical licensure and appropriate medical staff appointment.

Core Faculty members must:

- Be designated by the program director;
- Have a significant role in the education and supervision of residents/fellows;
- Devote a significant portion of their entire effort to resident education and/or administration;
- Teach, evaluate, and provide formative feedback to residents/fellows as a component of their activities; and
- Complete the annual ACGME Faculty Survey.

Any non-physician faculty members who participate in residency/fellowship program education must be approved by the program director.

ACGME Specialty Review Committees:

- May further specify additional physician and non-physician faculty member qualifications;
- Must specify the minimum number of core faculty and/or the core faculty to resident/fellow ratio; and
- May specify requirements specific to associate program director(s).

General Information for Residents

Access to Information

- Each resident shall be provided with the right to access MSM and affiliate policies, procedures, medical staff bylaws, quality assurance requirements, and personal educational information.
- Each resident shall have access to the internet and information retrieval sites through residency program computers, limited access from home computers (upon request), or from the MSM library system.
- Residents are briefed and tested regarding their responsibility to maintain patient confidentiality as guided by HIPAA regulations established in April 2003 and by MSM compliance requirements.

Compensation

- Morehouse School of Medicine (MSM) compensates residents directly. The Graduate Medical Education Committee (GMEC) annually develops and recommends annual stipend (salary) amounts for each PGY level.
- The stipend scale allows residents to receive an increase in compensation for each graduated education level.
- An individual assigned as a chief resident will receive a higher stipend amount for his or her administrative duties.

Eligibility for Specialty Board Examination

Each resident should become familiar with the requirements of her or his specialty board as listed on the American Board of Medical Specialties (ABMS) website or on the individual specialty website. The resident's program administration representative can assist in finding this information.

E-mail Requirement

All residents are required to utilize Morehouse School of Medicine e-mail addresses for all business and educational e-mail communication. MSM e-mail addresses are provided/assigned at the beginning of residency training.

Exposures to Blood, Body Fluids, and Biohazardous Materials

- Workers' Compensation Insurance provides compensation and/or medical care for workers who are injured or become ill as a direct result of their job. Coverage begins on the resident's first day of employment.
- In addition to contacting required person(s) at the hospital/site, residents must also contact Ms. Arlene Godfrey, MSM Human Resources, Employee Relations, Clinical Services at (404) 752-1964 and agodfrey@msm.edu for all work-related injuries and/or exposures including: blood, body fluids, needle sticks, and biohazardous exposures.
- Prior to evaluation and/or treatment, residents MUST be assigned a Workers' Compensation number and choose from an MSM Panel of Healthcare Providers. For additional information, refer to MSM's Workers' Compensation Policy (HR 6.03).


Fringe Benefits and Resident/Fellow Resources

- **Benefits:** In addition to salary, Morehouse School of Medicine offers residents and their eligible dependents health insurance benefits. Residents are also provided disability insurance benefits, confidential counseling and psychological services, vacation, parental, sick or other leave with coverage starting the first recognized day of the training program. These offerings are uniform for all residents and administered by MSM Human Resources in accordance with the vendor programs and/or policies in force at the time of this agreement. Detailed information on fringe benefits for residents can be provided by the MSM Human Resources Department.
- **Counseling:** Short term counseling is available from MSM Counseling Services, Shawn Garrison, Ph.D. at (404) 752-1789, or sgarrison@msm.edu.
- **Cigna Employee Assistance Program (EAP), CARE 24/7/365:** This benefit is available for residents as a self-referral or for family assistance. Residents are briefed on these programs by HR during in-coming orientation. Residents are briefed annually on the Drug Awareness Program, resident impairment issues, and family counseling. More information regarding these programs is available in the Human Resources Department at (404) 752-1600, or Cigna EAP directly at (877) 622-4327, online at www.CignaBehavioral.com and log in using employer ID: MSM.
- **Equipment:** iPads and/or laptops must be returned by residents who do not complete their program.
- **Laboratory (White) Coats:** Clinical laboratory coats are provided to residents free of charge but are subject to the requirements of MSM and the rules of the affiliates.
- **Leave:** As addressed in the resident/fellow leave policy, residents/fellows are cautioned that to fulfill the program requirements and that of the specialty certification board, it may be necessary for the resident to spend additional time in the program to make up for time lost when utilizing the various leave options.
 - **Resident/Fellow Vacation Leave:** Residents are allotted 15 days compensated leave per academic year (from July through June). Vacation leave is not accrued from year to year. Each **residency** program is responsible for the administration of residents' leave to include scheduling, tracking, approving, and reporting leave to the department, GME, and the MSM-Human Resources Department. Vacation blocks shall be designed within the structure of the residency program schedules.
 - **Resident/Fellow Sick Leave:** Compensated sick leave is 15 days per year. This time can be taken for illness, injury, and medical appointments for the resident or for the care of an immediate family member. Sick leave is not accrued from year to year. A **combination** of sick leave and vacation leave may be used to care for oneself or an immediate family member. When these two leave categories are exhausted, any additional leave will be uncompensated (residents should also refer to the program-specific Resident Leave Policy).
 - **Family and Medical Leave Act (FMLA):** All residents and fellows should contact Marla Thompson in the Human Resources Department (HRD) and the Office of Disability Services and Leave Management ods@msm.edu at (404) 752-1871 for guidance and questions about FMLA. The program requirements and the specifications of the program specialty board apply to the time required to make up absences.

- **Leave of Absence Without Pay (LWOP):** When possible, requests for leaves of absence without pay shall be submitted by residents in writing to the residency program director for disposition far in advance of any planned leave. All requests shall identify the reason for the leave and its duration. Residents/fellows should discuss with the program director the impact of the leave on a possible delay in program completion. The MSM-Human Resources Department shall determine the feasibility and all applicable criteria prior to a resident/fellow being granted LWOP and shall advise both the resident and the residency/fellowship program regarding details and procedures.
- **Other Leave Types:** All leave types are explained in detail in the Morehouse School of Medicine Human Resource Policy Manual and made available by contacting Marla Thompson at (404) 752-1871.
- **Library Services and Multimedia Services:** These services are available at Morehouse School of Medicine to include electronic media search access. Inpatient facilities have libraries available and vary in the content and services available. Ambulatory care facilities have limited libraries. All residents/fellows have on-line search access capability through the MSM network.
- **Nepotism Policy (See MSM Human Resources Policy 2.04):** MSM permits the employment and/or enrollment for academic purposes of qualified relatives of employees as long as such employment or academic pursuit does not, in the opinion of the school, create actual conflicts of interest. The MSM Human Resources Nepotism policy states: “no direct reporting or supervisor-to-subordinate relationship may exist between individuals who are related by blood or marriage, or who reside in the same household.”

For academic purposes, no direct teaching or instructor-to-resident/fellow or instructor-to-student relationship can exist. No employee is permitted to work within “the chain of command” when one relative’s work responsibilities, salary, hours, career progress, benefits, or other terms and conditions of employment could be influenced by the other relative.” Additionally, “each employee, student, or resident/fellow has a responsibility to keep his/her supervisor, the appropriate Associate Dean or Residency/Fellowship Program Director and Human Resources informed of changes relevant to this policy.”
- **Office of Disability Services:** For information regarding disabilities, contact Marla Thompson at (404) 756-1871, ods@msm.edu.
- **Parking Facilities:** Parking is available at each clinical affiliate and may require payment of a reasonable fee.

**Graduate Medical Education Committee (GMEC)
Policies, Procedures, Processes, and Program Templates**

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-01
		EFFECTIVE DATE	06/01/2017
		PAGE(S)	10
	SUBJECT ADVERSE ACADEMIC DECISIONS AND DUE PROCESS POLICY	SUPERSEDES	05/01/2015 06/01/2014 04/01/2011 04/01/2013

Adverse Academic Decisions and Due Process Policy

I. PURPOSE:

- 1.1. Morehouse School of Medicine (MSM) shall provide residents and fellows with an educational environment that MSM believes is fair and balanced.
- 1.2. This policy outlines the procedures which govern adverse academic decisions and due process procedures relating to residents and fellows during their appointment periods at Morehouse School of Medicine regardless of when the resident or fellow matriculated.
- 1.3. Actions addressed within this policy shall be based on an evaluation and review system tailored to the specialty in which the resident/fellow is matriculating.

II. SCOPE:

- 2.1. All MSM administrators, faculty, staff, residents, fellows and administrators at participating affiliates shall comply with this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.
- 2.2. Residents and fellows shall be given a copy of this Adverse Academic Decisions and Due Process policy at the beginning of their training.

III. DEFINITIONS:

3.1. Academic Deficiency

- 3.1.1. A resident/fellow's academic performance is deemed deficient if performance **does not meet/does not satisfy** the program and/or specialty standards.
- 3.1.2. Evidence of academic deficiency for a resident/fellow can include, but is not limited to:
 - 3.1.2.1. Having an insufficient fund of medical knowledge
 - 3.1.2.2. Inability to use medical knowledge effectively
 - 3.1.2.3. Lack of technical skills based on the resident/fellow's level of training
 - 3.1.2.4. Lack of professionalism, including timely completion of administrative functions such as medical records, duty hours, and case logging
 - 3.1.2.5. Unsatisfactory written evaluation(s)
 - 3.1.2.6. Failure to perform assigned duties
 - 3.1.2.7. Unsatisfactory performance based on program faculty's observation
 - 3.1.2.8. Any other deficiency that affects the resident/fellow's academic performance

3.2. Opportunity to Cure occurs when a resident/fellow is provided the opportunity to correct an academic deficiency and corrects the academic deficiency to the satisfaction of the faculty, program director, department chairperson, and Clinical Competency Committee of the program in which the resident is enrolled.

3.3. Day—a calendar business day 8:30 am–5:00 pm, Monday-Friday; weekends and MSM-recognized holidays excluded

3.4. Corrective Action

3.4.1. Written formal action taken to address a resident/fellow's academic, professional, and/or behavioral deficiencies and any misconduct

3.4.2. Typically, "corrective action" includes/may include probation which can result in disciplinary action such as suspension, non-promotion, non-renewal of residency/fellowship appointment agreement, dismissal, or termination pursuant to the due process guidelines outlined in this policy or in other appropriate MSM policies.

3.4.3. Corrective action does not include a written or verbal notice of academic deficiency.

3.5. Disciplinary Action—suspension, non-promotion, non-renewal of residency/fellowship appointment agreement

3.6. Dismissal—the immediate and permanent removal of the resident from the educational program for failing to maintain academic and/or other professional standards required to progress in or complete the program. This includes conduct described in section 4.2 of this policy.

3.7. Due Process

3.7.1. For matters involving academic deficiency(ies) in resident/fellow performance, due process involves:

3.7.1.1. Providing notice to the resident of the deficient performance issue(s);

3.7.1.2. Offering the resident/fellow a reasonable opportunity to cure the academic deficiency; and

3.7.1.3. Engaging in a reasonable decision-making process to determine the appropriate course of action to take regarding whether to impose corrective action.

3.8. GME—Graduate Medical Education

3.9. GME Office—Graduate Medical Education Office of Morehouse School of Medicine

3.10. Mail—to place a notice or other document in the United States mail or other courier or delivery service

3.10.1. Notices mailed via first class mail, postage prepaid, unless returned to sender by the United States Postal Service or other courier or delivery service, are presumed to have been received three (3) days after mailing.

3.10.2. Unless otherwise indicated, it is not necessary in order to comply with the notice requirements in this policy to hand-deliver the notice or use certified or registered mail. However, such methods of delivery, when documented, will verify actual notice. It is the resident's responsibility to ensure that his or her program and the GME office possess the resident/fellow's most current mailing address.

3.10.3. E-mail Notification—Morehouse School of Medicine e-mail addresses (@msm.edu) are the official e-mail communication for all employees including residents/fellows. E-mailing information to the resident's official MSM e-mail address is sufficient to meet MSM's notification and mail obligations except where otherwise indicated. Residents/fellows are responsible for ensuring that they check and are receiving e-mail communication.

3.11. Meeting

3.11.1. The appeals process outlined in this policy provides a resident an opportunity to present evidence and arguments related to why he or she believes the decision by the program director, department chairperson, or Clinical Competency Committee to take action for non-renewal or dismissal is unwarranted.

3.11.2. It is also the opportunity for the program director, department chairperson, or Clinical Competency Committee to provide information supporting its decision(s) regarding the resident.

3.12. Misconduct

3.12.1. Misconduct involves violations of standards, policies, laws, and regulations that affect professional and ethical standards of a physician in training.

3.12.2. These violations constitute a breach of the MSM Resident Training Agreement.

3.13. Non-Renewal of Appointment—if the residency program determines that a resident's performance is not meeting the academic or professional standards of MSM, the program, the ACGME program requirements, the GME requirements, or the specialty board requirements, the resident will not be reappointed for the next academic year.

3.13.1. Reappointment in a residency/fellowship program is not automatic.

3.13.2. The program may decide to not reappoint a resident/fellow, at its sole discretion.

3.14. Non-Promotion

3.14.1. Resident/fellow annual appointments are for a maximum of 12 months, year to year.

3.14.2. A delay in being promoted to the next level is an academic action used in limited situations. These limited situations include, but are not limited to, instances where a resident has an overall unsatisfactory performance during the academic year or fails to meet any promotion criteria as outlined by the program.

3.15. Notice of Deficiency—the residency/fellowship program director may issue a written warning to the resident to give notice that academic deficiencies exist that are not yet severe enough to require a formal corrective action plan or disciplinary action, but that do require the resident to take immediate action to cure the academic deficiency. It is at the program director's discretion as to whether a written remediation will be required.

3.16. CCC—Clinical Competency Committee reviews all resident/fellow evaluations at least semi-annually; prepares and ensures the reporting of Milestones evaluations of each resident semi-annually to ACGME; and advises the program director regarding resident progress, including promotion, remediation, or dismissal.

3.17. Probation—a residency/fellowship program may use corrective action when a resident/fellow's violations include but are not limited to:

3.17.1. Providing inappropriate patient care;

3.17.2. Lacking professionalism in the education and work environment;

3.17.3. Failure to cure notice of academic deficiency or other corrective action;

3.17.4. Negatively impacting healthcare team functioning; or

3.17.5. Causing residency/fellowship program dysfunction.

3.18. Remediation

3.18.1. Remediation cannot be used as a stand-alone action and must be used as a tool to correct a Notice of Academic Deficiency or probation and assists in strengthening resident performance when the normal course of faculty feedback and advisement is not resulting in a resident's improved performance.

3.18.2. Remediation allows the resident/fellow to correct an academic deficiency(ies) that would adversely affect the resident/fellow's progress in the program.

3.19. Suspension

3.19.1. Suspension is the act of temporarily removing a resident from all program activities for a period of time because the resident/fellow's performance or conduct does not appear to provide delivery of quality patient care or is not consistent with the best interest of the patients or other medical staff.

3.19.2. While a faculty member, program director, chairperson, clinical coordinator, or administrative director, or other professional staff of an affiliate may remove a resident from clinical responsibility or program activities, only the program director makes the determination to suspend the resident and the length (e.g.: days) of the resident/fellow's suspension.

3.19.3. Depending on circumstances, a resident/fellow may not be paid while on suspension. The program director determines whether a resident will be paid or not paid.

3.20. Reportable Adverse Actions—probation, suspension, non-renewal, and dismissal may be reportable actions by the program/MSM for state licensing, training verifications, and hospital/insurance credentialing depending upon the state and entity.

IV. POLICY:

4.1. When a resident/fellow fails to achieve the standards set forth by the program, decisions must be made about notice of academic deficiency, probation, suspension, non-promotion, non-renewal of residency appointment agreement, and in some cases, dismissal. MSM is not required to impose progressive corrective action but may determine the appropriate course of action to take regarding its residents/fellows depending on the unique circumstances of a given issue.

4.2. Residents/fellows engaging in conduct violating the policies, rules, bylaws, or regulations of MSM or its educational affiliates, or local, state, and federal laws regarding the practice of medicine and the standards for a physician in training may, depending on the nature of the offense, be dismissed.

4.2.1. Such misconduct will be considered a breach of the Resident/fellow Appointment Agreement or Reappointment Agreement.

4.2.2. In such instances, the Graduate Medical Education Office and Human Resources Department may be involved in the process of evaluating the violation.

4.3. A resident who exhibits unethical or other serious behaviors that do not conform to achieving the skills required for the practice of medicine may be summarily dismissed.

V. PROCEDURES:

- 5.1.** If any clinical supervisor deems a resident/fellow's academic or professional performance to be less than satisfactory, the residency/fellowship program director will require the resident to take actions to cure the deficiencies.

5.2. Notice of Academic Deficiency

- 5.2.1.** The residency/fellowship program director may issue a Notice of Academic Deficiency to a resident to give notice that academic deficiencies exist that are not yet severe enough to require corrective action, disciplinary action, or other adverse actions but that do require the resident/fellow to take immediate action to cure the academic deficiency.
- 5.2.2.** This notice may be concerning both progress in the program and the quality of performance.
- 5.2.3.** Residents/fellows will be provided reasonable opportunity to cure the deficiency(ies) with the expectation that the resident/fellow's academic performance will be improved and consistently maintained.
- 5.2.4.** It is the responsibility of the resident/fellow, using necessary resources, including advisor, faculty, PDs, chairperson, etc., to cure the deficiency(ies).
- 5.2.5.** The residency/fellowship program director will notify the GME director in writing of all notices of deficiency(ies) within five (5) calendar days of the program director's decision.

5.3. Probation

- 5.3.1.** A residency/fellowship program may use this corrective action when a resident/fellow's actions are associated with:
- 5.3.1.1.** Providing inappropriate patient care;
 - 5.3.1.2.** Lacking professionalism in the education and work environments;
 - 5.3.1.3.** Negatively impacting healthcare team functioning; or
 - 5.3.1.4.** Failure to comply with MSM, GME, and/or program standards, policies, and guidelines.
 - 5.3.1.5.** Causing residency/fellowship program dysfunction.
- 5.3.2.** Probation can be used as an option when a resident/fellow fails to cure a notice of academic deficiency or other corrective action.
- 5.3.3.** The program director must notify and consult with the GME DIO and/or director before issuing a probation letter to a resident.
- 5.3.3.1.** A probation letter must be organized by ACGME core competencies and detail the violations and academic deficiencies.
 - 5.3.3.2.** A probationary period must have a definite beginning and ending date and be designed to specifically require a resident/fellow to correct identified deficiencies through remediation.

- 5.3.3.3.** The length of the probationary period will depend on the nature of the particular infraction and be determined by the program director. However, the program director should set a timed expectation of when improvement should be attained. The duration will allow the resident/fellow reasonable time to correct the violations and deficiencies.
- 5.3.3.4.** A probation period cannot exceed six (6) months in duration and residents cannot be placed on probation for the same infraction/violation for longer than 12 consecutive months (i.e.: maximum of two (2) probationary periods).
- 5.3.4.** Probation decisions shall not be subject to the formal appeals process.
- 5.3.5.** While on probation, a resident/fellow is not in good standing.
- 5.3.6.** Remediation must be used as a tool for probation. Developing a viable remediation plan consists of the following actions:
 - 5.3.6.1.** The resident/fellow must be informed that the remediation is not a punishment, but a positive step and an opportunity to improve performance by resolving the deficiency.
 - 5.3.6.2.** The resident/fellow may be required to make up time in the residency/fellowship if the remediation cannot be incorporated into normal activities and completed during the current residency year.
 - 5.3.6.3.** The resident/fellow must prepare a written remediation plan, with the express approval of the program director as to form and implementation. The program director may require the participation of the resident/fellow's advisor in this process.
 - 5.3.6.3.1.** The plan shall clearly identify deficiencies and expectations for reversing the deficiencies, organized by ACGME core competencies.
 - 5.3.6.3.2.** It is the responsibility of the resident to take actions to meet all standards, and to take the initiative to make improvements as necessary.
- 5.3.7.** All residents placed on probation are required to meet with the Director for Graduate Medical Education.
- 5.3.8.** If the deficiency(ies) persist during the probationary period and are not cured, the residency program director may initiate further corrective or disciplinary action including but not limited to continuation of probation with or without non-promotion, non-renewal of residency/fellowship appointment agreement, or dismissal.
- 5.3.9.** The program director must notify and consult with the GME DIO and/or director before initiating further corrective or disciplinary action.
 - 5.3.9.1.** If the reasons for non-promotion, non-renewal of appointment, or dismissal occur within the last four (4) months of the resident/fellow's appointment year, the program will provide the resident/fellow reasonable notice of the reasons for the decision as circumstances reasonably allow.
 - 5.3.9.2.** The decision of the program director will be communicated to the resident/fellow and to the Office of Graduate Medical Education.
 - 5.3.9.3.** The residency/fellowship program director will notify the resident/fellow in writing of non-promotion, non-renewal of appointment, or dismissal decisions.

5.4. Suspension

- 5.4.1.** Suspension shall be used as an immediate disciplinary action because of a resident/fellow's misconduct. Suspension is typically mandated when it is in the best interest of the patients [patient care] or professional medical staff that the resident/fellow be removed from the workplace.
- 5.4.2.** A resident/fellow may be placed on paid or unpaid suspension at any time for certain violations in the workplace.
- 5.4.3.** A resident may be removed from clinical responsibility or program activities by a faculty member, program director, department chairperson, clinical coordinator, or administrative director of an affiliate. At his or her sole discretion, that individual can remove the resident/fellow if he or she determines that one of the following types of circumstances exist:
 - 5.4.3.1.** The resident/fellow poses a direct detriment to patient welfare.
 - 5.4.3.2.** Concerns arise that the immediate presence of the resident/fellow is causing dysfunction to the residency program, its affiliates, or other staff members.
 - 5.4.3.3.** Other extraordinary circumstances arise that would warrant immediate removal from the educational environment.
- 5.4.4.** All acts of removal from clinical responsibility or program activities shall be documented by the initiating supervisor or administrator and submitted to the program director in writing within 48 hours of the incident/occurrence, explaining the reason for the resident/fellow's removal and the potential for harm.
- 5.4.5.** After receiving written documentation of the incident/occurrence, the program director has up to five (5) days to determine if a resident/fellow will be suspended.
- 5.4.6.** Only the program director has authority to suspend a resident/fellow from the program and decide the length of time of the suspension, regardless of individual hospital or affiliate policies and definitions of suspension.
- 5.4.7.** The program director must notify and consult with the GME DIO and/or director before suspending a resident/fellow.
- 5.4.8.** After a period of suspension is served, further corrective or disciplinary action is required.
 - 5.4.8.1.** The program director shall review the situation and determine what further disciplinary action is required.
 - 5.4.8.2.** Possible actions to be taken by the program director regarding a suspended resident/fellow may be to:
 - 5.4.8.2.1.** Return the resident/fellow to normal duty with a Notice of Academic Deficiency;
 - 5.4.8.2.2.** Place the resident/fellow on probation; or
 - 5.4.8.2.3.** Initiate the resident/fellows' dismissal from the program.

5.5. Failure to Cure Academic Deficiency—if a resident/fellow fails to cure academic deficiencies through an approved corrective action, formal corrective action plan (remediation), probation, or other forms of academic support, the program director may take an action, including but not limited to, one or more of the following actions:

- 5.5.1. Probation/continued probation
- 5.5.2. Non-promotion to the next PGY level
- 5.5.3. Repeat of a rotation or other education block module
- 5.5.4. Non-renewal of residency/fellowship appointment agreement
- 5.5.5. Dismissal from the residency/fellowship program

5.6. The resident/fellow shall have the right to appeal only the following disciplinary actions:

- 5.6.1. Dismissal or termination from the residency/fellowship program
- 5.6.2. Non-renewal of the resident/fellow's appointment

5.7. Appeal Procedures—Program and Department

5.7.1. All notices of dismissal from the residency/fellowship program or a non-renewal of the resident/fellow's appointment shall be delivered to the resident/fellow's home address by priority mail and e-mail. A copy may also be given to the resident/fellow on site, at the program's sole discretion.

5.7.2. If the resident intends to appeal the decision, he or she should communicate intent to do so in writing to the program director within seven (7) days upon receipt of the letter that identifies the decision.

5.7.3. The program director will notify the department chairperson who then convenes the departmental appeal committee.

5.7.3.1. The Departmental Appeal Committee shall consist of a minimum of three (3) faculty members and one (1) administrative person (usually the residency/fellowship program manager) who functions as a facilitator and manages scheduling, communication, and administrative functions of the committee. The Committee will select one of the three faculty members as lead to complete the written recommendation on behalf of the committee.

5.7.3.2. A Departmental Appeal Committee will meet to review the resident/fellow's training documents and hear directly from the resident/fellow and program director regarding the matter.

5.7.3.3. The Appeal Committee will notify the resident/fellow and program director of the meeting date, time, place, and committee members' names and titles.

5.7.3.4. The program director must submit a written summary letter and timeline of events for the committee to review at least 24 hours before the scheduled meeting.

5.7.3.5. The resident may submit written documentation to the committee to review and must do so at least 24 hours before the scheduled meeting.

5.7.3.6. The resident/fellow may bring an advocate, such as a faculty member, staff member, or other resident.

5.7.3.7. Legal counsel is not permitted to attend the appeal because the process is an academic appeal.

5.7.3.8. Appeal meetings may not be recorded.

5.7.3.9. The Department Appeal Committee reserves the right to determine the manner in which the meetings with the resident/fellow and program director will be conducted.

5.7.4. The Departmental Appeal Committee will present its written recommendation to the program director within seven (7) days of the end of the appeal meeting. The program director will then forward the resident's training documents, all information concerning the dismissal/termination/nonrenewal, written appeal recommendation, and any other pertinent information to the chairperson.

5.7.5. The department chairperson will review all materials and make the final departmental decision within seven (7) days of receipt of materials.

5.7.6. The department chairperson will communicate the final written departmental decision to the program director.

5.7.7. The program director will then communicate the decision by written letter to the resident/fellow via mail and e-mail. This should occur within ten (10) days of the final decision.

5.8. Appeal to the Dean

5.8.1. The resident/fellow may appeal the decision of the department chair.

5.8.2. If the resident/fellow is unsuccessful in his or her appeal to the chairperson, he or she may submit a written request to the dean for a review of due process involved in the program's decision of dismissal/termination/non-renewal of appointment.

5.8.3. A request for appeal to the dean must be submitted in writing within seven (7) days of the notification of the final departmental decision.

5.8.4. The appeal must be submitted to both the dean and the program director.

5.8.5. The dean shall instruct the GME office to convene an Institutional Appeal Committee to review the case and provide an advisory opinion as to whether the residency/fellowship program afforded the resident/fellow due process in its decision to dismiss or to not renew the resident's appointment. This review is that of program protocol and documentation in the case. MSM's Designated Institutional Officer, or his or her designee, shall chair the institutional appeal committee.

5.8.5.1. The Institutional Appeal Committee shall consist of the DIO, two (2) faculty members, and one (1) administrative person, usually the GME Director, who functions as a facilitator and manages scheduling, communication, and administrative functions of the committee.

5.8.5.2. The Institutional Appeal Committee will meet to review the resident/fellow's training documents and hear directly from the resident/fellow and program director regarding the matter.


5.8.5.3. The Institutional Appeal Committee will notify the resident/fellow and program director of the meeting date, time, place, and committee members' names and titles.

- 5.8.5.4.** The program director shall provide the training documents and record of the departmental appeal proceedings.

The program director must also provide a written summary letter and timeline of events for the committee to review at least 24 hours before the scheduled meeting.
- 5.8.5.5.** The Institutional Appeal Committee shall give the resident/fellow an opportunity to present written and/or verbal evidence to dispute the allegations that led to the disciplinary action.

The resident/fellow may submit written documentation to the committee to review and must do so at least 24 hours before the scheduled meeting.
- 5.8.5.6.** The resident/fellow may bring an advocate, such as a faculty member, staff member, or other resident/fellow.
- 5.8.5.7.** Legal counsel is not permitted to attend the appeal because the process is an academic appeal.
- 5.8.5.8.** Recording of meeting(s) and/or proceedings is prohibited.
- 5.8.6.** The institutional appeals committee chair will submit a written report of the findings to the dean who will make the final determination regarding the status of the resident/fellow.
- 5.8.7.** The final written determination by the dean may be:

 - 5.8.7.1.** That the resident/fellow is returned to the residency/fellowship program without penalty.
 - 5.8.7.2.** Recommendation for dismissal, termination, or non-renewal of appointment stands.
 - 5.8.7.3.** Other as deemed appropriate by the dean.
- 5.8.8.** If a recommendation for dismissal/termination/non-renewal is confirmed, the resident/fellow is removed from the payroll effective the day of the dean's decision.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-02
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	04
	SUBJECT ANNUAL INSTITUTION AND PROGRAM REVIEW POLICY	SUPERSEDES	06/01/2014

Annual Institution and Program Review Policy

I. PURPOSE:

The purpose of this policy is to provide guidelines for Accreditation Council of Graduate Medical Education (ACGME) Next Accreditation System (NAS) required Graduate Medical Education Committee (GMEC) oversight of Institutional- and Program-level annual review procedures and processes effective July 1, 2014 with minor revisions effective July 1, 2019.

II. SCOPE:

- 2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, fellows and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.
- 2.2. All ACGME programs must conduct and implement program-level procedures and processes for annual program evaluation and review.

III. GLOSSARY OF ANNUAL REVIEW TERMS:

- 3.1. Graduate Medical Education Committee (GMEC)—ACGME required advisory committee with oversight of institution and program accreditation. Membership includes program directors, assistant program directors, program managers, residents/fellows, MSM and affiliate representatives from human resources, legal, patient safety and quality improvement, the DIO, and GME office staff.
- 3.2. Annual Institutional Review (AIR) - ACGME required process to review and assess performance indicators, quality improvement goals and metrics, monitoring procedures and action plans.
- 3.3. Annual Program Review (APR) – GMEC and GME required process to ensure program maintenance of ACGME accreditation.
- 3.4. Special Review (SR)—ACGME process to identify and assist underperforming programs to improve.
- 3.5. Self-Study Visit (SSV)—Replaces ACGME site visits and will eventually occur every 10 years as long as programs and institutions demonstrate substantial compliance with ACGME requirements and performance indicators.
- 3.6. Annual Program Evaluation (APE) – written documentation that programs, through their PECs are documenting formal, systematic evaluation of the curriculum annual per ACGME requirements.

IV. ANNUAL INSTITUTION AND PROGRAM REVIEW POLICIES AND PROCEDURES:

Responsibilities of the GMEC include effective oversight of the ACGME accreditation status of the sponsoring institution and its ACGME-accredited programs.

4.1. Oversight of the sponsoring institution's accreditation through an Annual Institutional Review (AIR)

4.1.1. The GMEC must identify institutional performance indicators for the AIR to include at a minimum:

- The most recent ACGME institutional letter of notification
- Results of ACGME surveys of residents/fellows and core faculty members
- Each of its ACGME-accredited programs' ACGME accreditation information, including accreditation statuses and citations

4.1.2. The DIO must annually submit a written executive summary of the AIR to the Sponsoring Institution's governing body. The written executive summary must include:

4.1.2.1. A summary of the institutional performance on indicators for the AIR

4.1.2.2. Action plans and performance monitoring procedures resulting from the AIR

4.2. Oversight of the residency programs' accreditation through an Annual Program Review Process (APR) that includes review of:

- The quality of the GME learning and working environment within the sponsoring institution, its ACGME-accredited programs, and its participating sites
- The quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty-specific Program Requirements
- Programs' annual evaluation and improvement activities

4.3. Programs must have a program-level APE policy and process and must complete the GME APE report template for submission of GMEC review and approval.

4.4. Programs must track and monitor required data and information to accurately complete the ACGME Annual Accreditation Data System (ADS) update including:

- Changes in program and participating sites
- Progress of addressing any citations
- Educational environment—curriculum, duty hours, supervision, etc.
- Faculty and resident scholarly activity
- Faculty development activities
- Resident and faculty participation in Patient Safety and Quality Improvement activities

4.5. Programs must annually review and monitor their compliance with the following program performance indicators:

- ACGME resident and faculty survey results
- Program Board pass rates
- Semi-annual resident evaluation—Milestone-based evaluation reporting
- Clinical experience—case/patient/procedure logs

4.6. The GME DIO and director will complete annual scorecards for each program based on assessment of the data above, metrics, and information.

4.7. The annual program scorecards create the Institutional Dashboard for monitoring programs' compliance with APR requirements.

4.8. Oversight of underperforming programs through a Special Review process.

4.8.1. Special Review Criteria: A program will be placed on a special review for non-compliance in three (3) of the five (5) areas as follows:

- ACGME letters of warning, concern, complaint, and/or focused or full site visit announcements
- Underperformance in five (5) or more of 18 of the Annual GME Program Scorecard Metrics, including the ACGME program performance indicators as follows:
 - Annual ADS updates
 - APE Report
 - GMEC/GME program compliance
 - Accreditation status
 - Citations/progress reports
 - Match fill rate
 - Program policies
 - ITE results
 - Resident PSQI involvement
 - Faculty PSQI involvement
 - Resident scholarly activities
 - Faculty scholarly activities
 - Case/procedure/patient logs
 - Semi-annual resident evaluation
 - Faculty evaluation of residents
 - Duty Hour monitoring and oversight
 - Milestone data/reporting
 - Faculty development
- Failure to comply with ACGME Common and Specialty Specific program requirements not stated/listed in this policy
- Noncompliance with Specialty Board Pass Rates
- Noncompliance with ACGME Resident Survey in two (2) or more of the seven (7) content areas below the national compliance rate:
 - Duty Hours
 - Faculty
 - Evaluation
 - Educational content
 - Resources
 - Patient safety/teamwork
 - Overall evaluation of program

4.8.2. Special Review Protocol

4.8.2.1. The GME Office will schedule a special review of a program. Separate meetings with program stakeholders will include:

- Residents/fellows
- Core faculty
- Program leadership—the department chairperson, program director, associate program director(s), and program manager

The number of faculty and residents that need to attend will be determined by the GME Office based on the size of the program.

4.8.2.2. Members of the special review committee will include the MSM Dean (as necessary), Designated Institutional Official, Director of GME, a program director and program manager from another program, and a member of the Resident Association that is not in the program being reviewed.

4.8.2.3. Program Performance Indicator and metrics data utilized during a special review include:

- Most current annual program scorecard
- ACGME resident and faculty survey results
- ADS summary report
- Board exam pass rates
- Annual program evaluation reports
- Special review faculty and resident questionnaires
- Program policies, resident training files, program compliance reports from New Innovations
- Any additional information deemed pertinent by the Review Committee

4.8.3. Special Review Report, Institutional Decisions, and GMEC Monitoring

4.8.3.1. A special review report that describes the quality improvement goals, the corrective actions, institutional decisions, and the process for GMEC monitoring of outcomes will be completed by the GME Office and presented to the GMEC for review and approval.

4.8.3.2. Institutional decisions and action regarding Special Review status of a program: The program director of a special review program must provide semiannual written and verbal progress reports to the GMEC demonstrating improvement per recommendations and deadlines detailed in the special review report.


4.8.3.3. Period of time for Special Review status

4.8.3.3.1. Programs on Special Review status will have a maximum of two (2) years to improve in the criteria stated and be removed from special review status.

4.8.3.3.2. The period of time starts when the special report is presented to the GMEC.

4.8.3.3.3. If a program is on Special Review status for more than two (2) years, the GMEC will appoint a subcommittee that consists of a program director, Director of GME, and a program manager to conduct a thorough review of the program, provide recommendations, and present those recommendations to the dean and chair of the department on Special Review.

4.8.3.3.4. The dean, DIO, and chair will meet to discuss the GMEC recommendations.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-03
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	03
	SUBJECT CONCERN AND COMPLAINT POLICY FOR RESIDENTS AND FELLOWS	SUPERSEDES	08/14/2018 06/01/2014

Concern and Complaint Policy for Residents and Fellows

I. PURPOSE:

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

Note: For purposes of this policy, a concern or complaint involve issues relating to personnel, patient care, and matters related to the program or hospital training environment.

II. SCOPE:

- 2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, fellows and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.
- 2.2. Programs must use the Program Concern and Complaint Process Template that follows this policy to create their program level policy and procedure which must be included in the program's policy manual to comply with ACGME requirements.

III. CONCERN AND COMPLAINT POLICY:

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

IV. CONCERN AND COMPLAINT PROCEDURE:

- 4.1. If the resident is not satisfied with the program-level resolution, the individual should discuss the matter with the department chair or service chief of a specific hospital. If no solution is achieved, the resident may seek assistance from the Graduate Medical Education (GME) Designated Institutional Official (DIO). If the complaint is to formally notify the institution of an incident involving harassment or discrimination, see the Morehouse School of Medicine Non-Discrimination, Anti-Harassment, and Retaliation Policy for procedures to be followed.

- 4.2.** If for any reason the resident does not want to discuss concerns or complaints with the program director, associate program director, department chair, or service chief, the following resources are available:
- 4.2.1.** For issues involving program concerns, training matters, or work environment, residents can contact the Graduate Medical Education Assistant Dean and Director at (404) 752-1011 or tsamuels@msm.edu.
- 4.2.2.** For problems involving interpersonal issues, the resident/fellow may be more comfortable discussing confidential informal issues apart and separate from the resident/fellow's parent department with the Resident Association President or President Elect.
- 4.2.2.1.** Any resident or fellow may directly raise a concern to the Resident Association Forum.
- 4.2.2.2.** Resident Association Forums and meetings may be conducted without the DIO, faculty members, or other administrators present.
- 4.2.2.3.** Residents and fellows have the option to present concerns that arise from discussions at Resident Association Forums to the DIO and GMEC.
- 4.2.3.** Residents can provide anonymous feedback, concerns, and complaints to any department at Morehouse School of Medicine by completing the GME Feedback form <http://www.msm.edu/Education/GME/feedbackform.php>.
- 4.2.3.1.** Comments are anonymous and cannot be traced back to individuals.
- 4.2.3.2.** Personal follow-up regarding how feedback, concerns, or complaints have been addressed by departments and/or GME will be provided only if the resident elects to include his or her name and contact information in the comments field.
- 4.2.4.** MSM Office of Compliance and Corporate Integrity
<http://www.msm.edu/Administration/Compliance/index.php>.
- 4.2.4.1.** The MSM Compliance Hotline 1 (855) 279-7520 is an anonymous and confidential mechanism for reporting unethical, noncompliant, and/or illegal activity.
- 4.2.4.2.** Call the Compliance Hotline or email www.msm.ethicspoint.com to report any concern that could threaten or create a loss to the MSM community including:
- Harassment—sexual, racial, disability, religious, retaliation
 - Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical, and waste management safety issues
 - Other reporting purposes:
 - Misuse of resources, time, or property assets
 - Accounting, audit, and internal control matters
 - Falsification of records
 - Theft, bribes, and kickbacks

Refer to the current version of the MSM [GME Policy Manual](#) for detailed information regarding the Adverse Academic Decisions and Due Process Policy.

MSM GME Concern/Complaint Program Policy Manual Template

PROGRAM CONCERN AND COMPLAINT PROCESS

Program Name _____

Concern and Complaint Process—for Residents and Fellows

To ensure that residents and fellows can raise concerns and complaints and to provide feedback without intimidation or retaliation, in an appropriate confidential manner, the following options and resources are available and communicated to residents, fellows, and faculty members annually.

Step One

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

Step Two


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

Step Three

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

- For issues involving program concerns, training matters, or work environment, residents can contact the Graduate Medical Education Director at (404) 752-1011 or tsamuels@msm.edu.
- For problems involving interpersonal issues, a comfortable option may be to discuss with the Resident Association President or President Elect confidential informal issues apart and separate from the resident's parent department.

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-04
		EFFECTIVE DATE	06/01/2019
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	SUBJECT EDUCATIONAL PROGRAM REQUIREMENTS	SUPERSEDES	

Educational Program Requirements

I. PURPOSE:

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

II. SCOPE:

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

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

III. ACGME Competencies

- 3.1. The term "resident" refers to both specialty residents and subspecialty fellows. After the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms "resident" and "fellow" will be used respectively.
- 3.2. In compliance with ACGME Common Program Requirements IV.B., "The program(s) must integrate the following ACGME Competencies into the curriculum (Core)":

3.2.1. Professionalism (IV.B.1.a)

3.2.1.1. Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.

3.2.1.2. Residents must demonstrate competence in:

- Compassion, integrity, and respect for others;
- Responsiveness to patient needs that supersedes self-interest;
- Respect for patient privacy and autonomy;
- Accountability to patients, society, and the profession;
- Respect and responsiveness to diverse patient populations, including, but not limited to, diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation.
- Ability to:
 - Recognize and develop a plan for one's own personal and professional well-being; and
 - Appropriately disclose and address conflict or duality of interest.

3.2.2. Patient Care and Procedural Skills (IV.B.1.b)

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

3.2.2.2. Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

3.2.3. Medical Knowledge (IV.B.1.c)

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

3.2.4. Practice-based Learning and Improvement (IV.B.1.d)

3.2.4.1. Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

3.2.4.2. Residents must demonstrate competence in:

- 3.2.4.2.1.** Identifying strengths, deficiencies, and limits in one's knowledge and expertise;
- 3.2.4.2.2.** Setting learning and improvement goals;
- 3.2.4.2.3.** Identifying and performing appropriate learning activities;
- 3.2.4.2.4.** Systematically analyzing practice, using quality improvement methods and implementing changes with the goal of practice improvement;
- 3.2.4.2.5.** Incorporating feedback and formative evaluation feedback into daily practice;
- 3.2.4.2.6.** Locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and,
- 3.2.4.2.7.** Using information technology to optimize learning.

3.2.5. Interpersonal and Communication Skills (IV.B.1.e)

3.2.5.1. Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

3.2.5.2. Residents must demonstrate competence in:

3.2.5.2.1. Communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

3.2.5.2.2. Communicating effectively with physicians, other health professionals, and health-related agencies;

3.2.5.2.3. Working effectively as a member or leader of a healthcare team or other professional group;

3.2.5.2.4. Educating patients, families, students, residents, and other health professionals;

3.2.5.2.5. Acting in a consultative role to other physicians and health professionals; and

3.2.5.2.6. Maintaining comprehensive, timely, and legible medical records, if applicable.

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

3.2.6. Systems-based Practice (IV.B.1.f)

3.2.6.1. Residents must demonstrate an awareness of and responsiveness to the larger context and system of healthcare, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal healthcare.

3.2.6.2. Residents must demonstrate competence in:

3.2.6.2.1. Working effectively in various healthcare delivery settings and systems relevant to their clinical specialty;

3.2.6.2.2. Coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty;

3.2.6.2.3. Advocating for quality patient care and optimal patient care systems;

3.2.6.2.4. Working in interprofessional teams to enhance patient safety and improve patient care quality;

3.2.6.2.5. Participating in identifying system errors and implementing potential systems solutions;

3.2.6.2.6. Incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; and

3.2.6.2.7. Understanding healthcare finances and the impact those finances have on individual patients' health decisions.

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

IV. Curriculum Organization and Resident Experiences

MSM GME programs must:

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

V. Scholarship

- 5.1.** Program responsibilities include:

- 5.1.1.** Demonstrate evidence of scholarly activities consistent with its mission(s) and aims;
- 5.1.2.** Allocate adequate resources, in partnership with its Sponsoring Institution, to facilitate resident and faculty involvement in scholarly activities;
- 5.1.3.** Advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.

- 5.2.** Programs must demonstrate faculty scholarly activity accomplishments, for both core and non-core faculty, in at least three of the following domains:

- 5.2.1.** Research in basic science, education, translational science, patient care, or population health;
- 5.2.2.** Peer-reviewed grants;
- 5.2.3.** Quality improvement and/or patient safety initiatives;
- 5.2.4.** Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports;
- 5.2.5.** Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials;
- 5.2.6.** Contribution to professional committees, educational organizations, or editorial boards;
- 5.2.7.** Innovations in education.

- 5.3.** All MSM GME programs must demonstrate dissemination of scholarly activity within and external to the program by the following methods:


- 5.3.1.** Faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor;
- 5.3.2.** Peer-reviewed publication.

- 5.4. Resident/Fellow Scholarly Activity—residents and fellows must participate in scholarship activity.
- 5.5. The GME DIO and GMEC will provide oversight of programs' compliance with required educational components during the annual institutional and program review process and procedures.

VI. Documentation

All MSM GME residency and fellowship programs are required to:

- 6.1. Track and document scholarly activity data annually, for residents, fellows, and all core and non-core faculty involved in teaching, advising, and supervising as part of the Annual Program Evaluation (APE) process.
- 6.2. Document and implement program-level scholarly requirements and guidelines that are distributed and reviewed with the residents, fellows, and faculty members on an annual basis.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-05
		EFFECTIVE DATE	06/01/2014
		PAGE(S)	06
	<u>SUBJECT</u> DISASTER PREPAREDNESS AND RESIDENCY POLICY	SUPERSEDES	04/01/2011

Disaster Preparedness and Residency Policy

I. **PURPOSE:**

The purpose of this policy is to provide guidelines for communication with and assignment/allocation of resident physician manpower in the event of disaster, and the policy and procedures for addressing administrative support for Morehouse School of Medicine (MSM) Graduate Medical Education (GME) programs and residents in the event of a disaster or interruption in normal patient care. It also provides guidelines for communication with residents and program leadership whereby to assist in reconstituting and restructuring educational experiences as quickly as possible after a disaster, or determining need for transfer or closure in the event of being unable to reconstitute normal program activity.

II. **SCOPE:**

- 2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.
- 2.2. This policy is in addition to any emergency preparedness plans established by MSM and its affiliate institutions. Residents are also subject to the inclement weather policies of the medical school and affiliate institutions.

III. **GLOSSARY OF DISASTER TERMS:**

- 3.1. A disaster is defined within this policy as an event or set of events causing significant alteration of the residency experience at one or more residency programs.
- 3.2. This policy and procedures document acknowledges that there are multiple strata or types of disaster:
 - Acute disaster with little or no warning (e.g.: tornado or bombing)
 - Intermediate disaster with some lead time or warning (e.g.: flooding or ice)
 - Insidious disruption or disaster (e.g.: avian flu)
- 3.3. This document addresses disaster or disruption in the broadest terms.

IV. DISASTER POLICIES AND PROCEDURES:

4.1. A Resident's Duties in Disasters

- 4.1.1.** In the case of anticipated disasters, residents are expected to follow the rules in effect for the training site to which they are assigned at the time. In the immediate aftermath, the resident is expected to attend to personal and family safety and then render humanitarian assistance where possible. In the case of anticipated disasters, residents who are not "essential employees" and are not included in one of the clinical site's emergency staffing plans should secure their property and evacuate, should the order come.
- 4.1.2.** If there is any question about a resident status, he or she should contact the program director before the pending disaster.
 - 4.1.2.1.** Residents who are displaced out of town will contact their program directors as soon as communications are available.
 - 4.1.2.2.** During and/or immediately after a disaster (natural or man-made), residents will be allowed and encouraged to continue their roles where possible and to participate in disaster recovery efforts.

4.2. Manpower/Resource Allocation during Disaster Response and Recovery

- 4.2.1.** All residency programs at MSM are required to develop and maintain a disaster recovery plan.
 - 4.2.1.1.** These plans should include, but are not limited to, designated response teams of appropriate faculty, staff, and residents, pursuant to departmental, MSM, and affiliated hospital policies.
 - 4.2.1.2.** These response team listings should be reviewed on a regular basis, and the expectations of those members should be relayed to all involved.
- 4.2.2.** As determined to be necessary by the program director and/or chief medical officer at the affiliated institutions (and/or MSM leadership), physician staff reassignment or redistribution to other areas of need will be made. This shall supersede departmental team plans for manpower management.
 - 4.2.2.1.** Information on the location, status, and accessibility and availability of residents during disaster response and recovery is derived from the Designated Institutional Official (DIO) and/or Associate Dean for Clinical Affairs or their designees in communication with program directors and/or program chief residents.
 - 4.2.2.2.** The DIO and Associate Dean for Clinical Affairs will then communicate with the chief medical officers of affiliated institutions as necessary to provide updated information throughout the disaster recovery and response period.
- 4.2.3.** Due to the unique nature of the Grady Health System, it is intended that its supporting academic institutions strive to provide support, such as resident placement, in concert with Grady Health System and Emory University School of Medicine in times of disaster or in the case of other events resulting in the interruption of patient care. The MSM DIO will maintain contact with Grady Medical Affairs and Emory GME officials, the DIO, and other administrative personnel from other area academic institutions to determine the scope and impact of the disaster on each institution's residency programs.

4.3. Communication

4.3.1. The Graduate Medical Education office and/or all residency programs shall maintain current contact information for all resident physicians. The collected information must include at minimum:

- Address
- Pager number
- All available phone numbers (home, cell, etc.)
- Primary and alternate e-mail addresses
- Emergency contact information

4.3.2. This information will be updated at least annually before July 1 and within five (5) business days of a change in order to maintain optimal accuracy and completeness. Along with any internal database documents, this information shall be maintained in the New Innovations Residency Management Suite.

4.3.3. The GME office shall share information with MSM-Human Resources, MSM Public Safety, and affiliate administration as appropriate.

4.3.4. All residents must participate in the MSM Mass Alert System (MSM ALERT). Their contact information must be updated at least annually before July 1, and as appropriate, the resident must maintain optimal accuracy and completeness (requirements attached).

4.3.5. All GME programs must submit departmental phone trees and updates to disaster plans to the GME office by July 31 of each year.

4.4. Legal and Medical-Legal Aspects of Disaster Response Activity

It is preferred that, whenever and wherever possible, notwithstanding other capacities in which they may serve, residents also act within their MSM function when they participate in disaster recovery efforts. While acting within their MSM function, residents will maintain their personal immunity to civil actions under the federal and state tort claims acts, as well as their coverage for medical liability under their MSM policy.

4.5. Payroll

4.5.1. Residents are encouraged to be paid through electronic deposit, which process is performed off-site. Using this method, no compensation interruption is anticipated.

4.5.2. Residents are encouraged to execute personal banking with an institution that has (at least) regional offices available.

4.6. Administrative Information Redundancy and Recovery

4.6.1. All hardcopy records maintained in the GME office will also be maintained electronically. All hardcopy residency files will be scanned as processing is completed and maintained electronically as backup to the hardcopy files.

4.6.2. In addition, all GME programs are responsible for maintaining sufficient protection and redundancy for their program information and resident educational records. At minimum, all programs will maintain the following documentation on NI Residency Management Suite:

- Electronic files of resident evaluations
- Certification letters

- Procedure log summaries
- Immunization records
- Promotion/graduation certificates

4.7. ACGME Disaster Policy and Procedures

- 4.7.1.** Upon declaration of a disaster by the ACGME Chief Executive Officer, the ACGME will provide information on its website and periodically update information relating to the event, including phone numbers and e-mail addresses for emergency and other communication with the ACGME from disaster-affected institutions and residency programs.
- 4.7.2.** The Designated Institutional Official (DIO) of MSM will contact the ACGME Institutional Review Committee Executive Director with information and/or requests for information.
- 4.7.2.1.** Program directors should call or e-mail the appropriate Review Committee Executive Director with information and/or requests for information.
- 4.7.2.2.** They should also communicate with site directors/supervisors at affiliate institutions regarding resident status and then communicate pertinent information to the DIO.
- 4.7.3.** Residents who are out of communication with MSM-GME and their programs should call or e-mail the appropriate Review Committee Executive Director with information and/or requests for information. On its website, the ACGME will provide instructions for changing resident e-mail information on WebAds.
- 4.7.4.** In addition to the resources listed in this document, residents are directed to the Accreditation Council for Graduate Medical Education (ACGME) website (www.acgme.org) for important announcements and guidance.

4.8. Communication with the ACGME

- 4.8.1.** The MSM-DIO or named designee will be responsible for all communication between MSM and the ACGME during a disaster situation and subsequent recovery phase.
- 4.8.2.** Within ten (10) days after the declaration of a disaster, the DIO will contact the ACGME Institutional Review Committee to discuss particular concerns and possible leaves of absence or return-to-work dates to establish for all affected programs should there be a need for:
- Program reconfigurations to the ACGME
 - Residency transfer decisions
- 4.8.3.** The due dates for submission will be no later than 30 days post disaster, unless other due dates are approved by the ACGME. If within ten (10) days following a disaster the ACGME has not received communication from the DIO, the ACGME will initiate communication to determine the severity of the disaster, its impact on residency training, and plans for continuation of educational activities.
- 4.8.4.** The DIO, in conjunction with the Associate Dean for Clinical Affairs (or their designees) and program directors, will monitor:
- The progress of patient care activities returning to normal status
 - The functional status of all training programs to fulfill their educational mission both during a disaster and the recovery phase

4.8.5. These individuals will work with the ACGME and the respective RRCs to determine if the impacted sponsoring institution and/or its programs:

- Are able to maintain functionality and integrity
- Require a temporary transfer of residents to alternate training sites until the home program is reinstated
- Require a permanent transfer of residents

4.8.6. If more than one location is available for the temporary or permanent transfer of a particular physician, the preferences of the resident must be taken into consideration by the home sponsoring institution. Residency program directors must make the keep/transfer decision timely so that all affected residents maximize the likelihood of completing their training in a timely fashion.

4.9. Resident Transfer

4.9.1. Institutions offering to accept temporary or permanent transfer from MSM residency programs affected by a disaster must complete the transfer form on the ACGME website.

4.9.1.1. Upon request, the ACGME will supply information from the form to affected residency programs and residents.

4.9.1.2. Subject to authorization by an offering institution, the AGCME will post information from the form on its website.


4.9.1.3. The ACGME will expedite the processing of requests for increases in resident complement from non-disaster-affected programs to accommodate resident transfers from disaster-affected programs. The Residency Review Committee will expeditiously review applications and make and communicate decisions as quickly as possible.

4.9.2. The ACGME will establish a fast track process for reviewing (and approving or denying) submissions by programs related to program changes to address disaster effects, including, without limitation:

- Addition or deletion of a participating site
- Change in the format of the educational program
- Change in the approved resident complement

4.9.3. At the outset of a temporary resident transfer, a program must inform each transferred resident of the minimum duration and the estimated actual duration of his or her temporary transfer and continue to keep each resident informed of such durations. If and when a residency program decides that a temporary transfer will continue to or through the end of a training year, the residency program must so inform each such transferred resident.

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-06
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	07
	<u>SUBJECT</u> EVALUATION OF RESIDENTS, FELLOWS, FACULTY, AND PROGRAMS POLICY	SUPERSEDES	06/01/2018 06/01/2014 04/01/2011

Evaluation of Residents, Fellows, Faculty, and Programs Policy

I. **PURPOSE:**

- 1.1. The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory under the heading, “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition).
- 1.2. This policy also ensures that MSM GME residents, fellows, faculty, and training programs are evaluated as required in the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common, and Specialty/Subspecialty-Specific Program Requirements.

II. **SCOPE:**

- 2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, fellows, and accredited affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.
- 2.2. All MSM residency and fellowship programs must:
 - 2.2.1. Have a program-level evaluation policy and procedures for assessment and evaluation of residents, fellows, faculty, and program that are compliant with ACGME Common and Specialty-Specific Requirements.
 - 2.2.2. Employ the New Innovations System for all required evaluation components.
- 2.3. The GME Office will monitor all evaluation components, set-up, and completion rates, and will provide programs with a minimum of quarterly delinquent and compliance reports.

III. **FACULTY EVALUATION AND FEEDBACK OF RESIDENTS AND FELLOWS:**

- 3.1. Faculty members must directly observe, evaluate, and provide frequent feedback on resident/fellow performance during each rotation or similar educational assignment.
- 3.2. Evaluation must be documented at the completion of the assignment.
 - 3.2.1. For block rotations of more than three (3) months in duration, evaluation must be documented at least every three (3) months.
 - 3.2.2. Continuity clinic and other longitudinal experiences, in the context of other clinical responsibilities, must be evaluated at least every three (3) months and at the completion of the experience.

3.3. Clinical Competency Committee (CCC)

- 3.3.1.** A Clinical Competency Committee must be appointed by the program director.
- 3.3.2.** At a minimum, the Clinical Competency Committee must include three (3) members of the program faculty, at least one of whom is a core faculty member.
- 3.3.3.** Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents and/or fellows.
- 3.3.4.** The Clinical Competency Committee must:
 - 3.3.4.1.** Review all resident/fellow evaluations at least semi-annually;
 - 3.3.4.2.** Determine each resident/fellow's progress on achievement of the specialty-specific Milestones;
 - 3.3.4.3.** Meet prior to the resident/fellow's semi-annual evaluations and advise the program director regarding each resident's/fellow's progress.

IV. RESIDENT/FELLOW ASSESSMENT AND EVALUATION:

- 4.1.** Evaluation concerning performance and progression in the residency/fellowship program shall be provided to the resident throughout the duration of the program. Assessments and evaluations will measure performance against curricular standards.
- 4.2.** A primary activity within a residency/fellowship program is to identify deficiencies in a resident/fellow's academic performance.
 - 4.2.1.** This requires ongoing monitoring for early detection, before serious problems arise.
 - 4.2.2.** The purpose of this requirement is to provide the resident/fellow with notice of deficiencies and the opportunity to cure.
- 4.3.** The resident will be provided with a variety of supervisors, including clinical supervisors, resident trainers, and faculty advisors, with whom to discuss professional and personal concerns.
- 4.4.** In addition to personal discussions, the resident/fellow will receive routine verbal feedback and periodic written evaluations on his or her performance and progress in the program. These measurements should highlight both positive performance and deficiencies.
- 4.5.** The resident/fellow must have the opportunity to review evaluations with supervisors and to attach a written response, preferably in the form of reflection and planning for improvement.
- 4.6.** At the end of each rotation, the resident will have an ACGME, competency-based, global assessment of performance for the period of assignment.
 - 4.6.1.** The faculty must evaluate resident/fellow performance in a timely manner during each rotation or similar educational assignment and document this evaluation within 14 days of completion of the rotation or assignment.
 - 4.6.2.** Evaluations must be immediately available for review by the resident. Resident/fellow notification of completed evaluations should be set up in New Innovations by requiring that residents/fellows sign off electronically on the evaluation.

- 4.7.** In addition to the global assessment evaluation by faculty members, multisource methods and evaluators will be used to provide an overall assessment of the resident's competence and professionalism.
- 4.8.** The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones.
- 4.8.1.** This performance evaluation must use multiple methods and evaluators including:
- Narrative evaluations by faculty members and non-faculty evaluators
 - Evaluations from other professional staff members
 - Clinical competency examinations
 - In-service examinations
 - Oral examinations
 - Medical record reviews
 - Peer evaluations
 - Resident self-assessments
 - Patient satisfaction surveys
 - Direct observation evaluation
- 4.8.2.** This information must be provided to the CCC for its synthesis of progressive resident/fellow performance and improvement toward unsupervised practice.
- 4.9.** Non-cognitive skills and behaviors are observed and measured as an integral part of the evaluation process. Professionalism must be demonstrated, including the possession of a positive attitude and behavior along with moral and ethical qualities that can be objectively measured in an academic/clinical environment.
- 4.10.** A resident/fellow will be assigned supervisory and teaching responsibilities for medical students and junior residents as they progress through the program.
- 4.11.** Residents/fellows will be evaluated on both clinical and didactic performance by faculty, other residents/fellows, and medical students.
- 4.12.** Semi-Annual Evaluation
- 4.12.1.** At least twice in each Post-Graduate Year, the residency/fellowship director, or their designee, with input from the Clinical Competency Committee, must:
- 4.12.1.1.** Meet with each resident and fellow to review his or her documented semi-annual evaluation of performance.
- 4.12.1.1.1.** This must include progress along the specialty-specific Milestones.
- 4.12.1.1.2.** The resident or fellow must be provided a copy of the evaluation.
- 4.12.1.2.** Assist residents/fellows in developing individualized learning plans to capitalize on their strengths and to identify areas for growth; and
- 4.12.1.3.** Develop plans for residents/fellows failing to progress, following institutional policies and procedures.

4.13. Resident/Fellow Progression Evaluation

4.13.1. At least annually, each resident/fellow must be given a summative evaluation that includes her or his readiness to progress to the next year of the program.

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

4.14. Final Evaluation

4.14.1. At the end of a residency or fellowship, upon completion of the program, the program director must provide a final evaluation for each resident/fellow.

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

4.14.3. The final evaluation must:

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

4.14.3.2. Verify that the resident or fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice;

4.14.3.3. Consider recommendations from the CCC;

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

V. FACULTY EVALUATION:

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

5.2. The program director must establish and use a process to evaluate each faculty member's performance as it relates to the educational program.

5.2.1. This evaluation must occur at least annually.

5.2.2. The evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.

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

5.3. These faculty evaluations must be aggregated, made anonymous, and provided to faculty members annually in a summary report.

5.3.1. This summary may be released as necessary, with program director review and approval in instances where evaluations are required for faculty promotions.

5.3.2. Programs must not allow faculty members to view individual evaluations by residents or fellows.

- 5.4. In order to maintain confidentiality of faculty performance evaluations, small programs with four (4) or fewer residents/fellows may use the following modification of evaluation submissions:
- Generalized and grouped residents' comments to avoid identifying specific resident feedback
 - Aggregate faculty performance evaluations across multiple academic years
- 5.5. Program directors must maintain continuous and ongoing monitoring of faculty performance. This may include:
- Automated alerts regarding low evaluation scores on end-of-rotation evaluations by residents,
 - Regular surveillance of end-of-rotation evaluations,
 - Regular verbal communication with residents regarding their experiences.
- 5.6. The program director should notify the appropriate department chair(s) when a faculty member receives unsatisfactory evaluation scores.
- 5.7. Faculty performance must be reviewed and discussed during the annual faculty evaluation review process conducted by the chair or division.
- 5.8. Faculty members must receive feedback on their evaluations at least annually.
- 5.9. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.

VI. PROGRAM EVALUATION AND IMPROVEMENT:

- 6.1. Program directors must appoint the Program Evaluation Committee (PEC) to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.
- 6.2. The PEC must be composed of at least two (2) faculty members, at least one of whom is a core faculty member, and should include at least one resident/fellow.
- 6.3. PEC responsibilities must include:
- 6.3.1. Advising the program director, through program oversight;
 - 6.3.2. Reviewing the program's self-determined goals and its progress toward meeting them;
 - 6.3.3. Guiding ongoing program improvement, including development of new goals, based upon outcomes; and
 - 6.3.4. Reviewing the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.

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

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

6.5. The PEC must evaluate the program's mission and aims, strengths, areas for improvement, and threats. The annual review, including the action plan, must:

6.5.1. Be distributed to and discussed with the members of the teaching faculty and the residents/fellows;

6.5.2. Be submitted to the DIO.

6.6. The program must complete a Self-Study prior to its 10-year accreditation site visit, a summary of which must be submitted to the DIO.

VII. ACGME Board Pass Rate Requirements

7.1. These requirements fulfill compliance with Section V.C.3.a-f. of common program requirements.


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

7.3. Specialties pass rates

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

7.3.2. For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six (6) years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

- 7.3.3.** For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three (3) years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.
- 7.3.4.** For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six (6) years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.
- 7.3.5.** For each of the exams referenced above, any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.
- 7.4.** Programs must report board certification status in ADS annually for the cohort of board-eligible residents that graduated seven (7) years earlier.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-07
		EFFECTIVE DATE	06/01/2014
		PAGE(S)	04
	<u>SUBJECT</u> GRADUATE MEDICAL EDUCATION COMMITTEE PURPOSE AND STRUCTURE POLICY	SUPERSEDES	04/01/2011

Graduate Medical Education Committee Purpose and Structure Policy

I. **PURPOSE:**

This purpose of this policy is to establish the purpose and structure of the Morehouse School of Medicine (MSM) Graduate Medical Education Committee (GMEC) per the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements effective July 1, 2018.

II. **GMEC MEMBERSHIP:**

- 2.1. The GMEC is comprised of members representing all key areas of the institution:
 - Associate Dean and Designated Institutional Official (DIO) who is the chair of the GMEC
 - Program directors and program managers representing each residency and fellowship program
 - Three (3) total resident representatives of the Resident Association (RA);
 - A Grady/MSM Patient Safety/Quality Improvement officer
 - GME director and office staff
 - Representatives from the MSM office of the president, office of medical education, office of student affairs, human resources, compliance, library, finance, marketing and communications, and information services and technology.
- 2.2. Representatives from major affiliates (Grady, VAMC and CHOA) are invited to attend at least one (1) GMEC meeting and the annual GMEC Retreat to share institutional/hospital information and updates.
- 2.3. The following voting members of the GMEC are designated one vote for a total of 15 voting members:
 - DIO/chair
 - All ten (10) program directors
 - One (1) representative from the Resident Association
 - One (1) PSQI officer
 - One (1) representative from Human Resources
 - One (1) representative from the Office of the President
 - One (1) representative from Student Affairs
 - One (1) program manager chair

2.4. MSM GMEC adheres to the ACGME institutional requirements for GMEC subcommittees (SC):

- 2.4.1.** Each sub-committee that addresses required GMEC responsibilities must include a peer-selected resident/fellow.
- 2.4.2.** The Resident Association fulfills this requirement for subcommittees with either RA leadership serving on subcommittees and/or resident leadership selecting other residents.
- 2.4.3.** Subcommittee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC.
- 2.4.4.** All GMEC members are required to participate on at least one subcommittee as needed.
- 2.4.5.** Each subcommittee has a chair who provides verbal and/or written information to the GMEC on behalf of the subcommittee

2.5. GMEC Subcommittee List:

- Patient Safety/Quality Improvement
- Faculty Development
- Resident Wellness
- GME Office/GMEC Event and Activities
 - Chief Resident Leadership Academy
 - Graduation
 - Compact
 - Orientation
 - Research Day
 - Other


III. GMEC Meetings and Attendance:

- 3.1.** The GMEC meets eleven (11) months of each year.
 - 3.1.1.** There is no meeting during the month of July.
 - 3.1.2.** GMEC meetings occur on the first Tuesday of the month from August - June, from 3:30pm - 5:00 pm.
 - 3.1.3.** Attendees at each meeting of the GMEC includes at least one resident/fellow member from the MSM Resident Association.
- 3.2.** These meetings are designed to allow for the exchange of ideas, problem-solving, engagement among members, and updates on future planning initiatives. They are vital, and the expectation is that all will be in attendance unless an emergency requires otherwise.
- 3.3.** The GME Office on behalf of the GMEC maintains meeting agendas and minutes that document execution of all required GMEC functions and responsibilities.
- 3.4.** The GME Office is also responsible for planning and hosting the annual GMEC retreat.

IV. GMEC Responsibilities and Oversight:

- 4.1.** The GMEC is charged with the following responsibilities and oversight:
- 4.1.1.** The ACGME accreditation status of the sponsoring institution and each of its ACGME-accredited programs;
 - 4.1.2.** The quality of the GME learning and working environment within the sponsoring institution, each of its ACGME accredited programs, and its participating sites;
 - 4.1.3.** The quality of educational experiences in each ACGME accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Institutional Requirements; Common and Specialty /Subspecialty-specific Program Requirements;
 - 4.1.4.** The ACGME-accredited program(s)' annual program evaluations and self-studies; and
 - 4.1.5.** All processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the sponsoring institution.
 - 4.1.6.** The provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided.
- 4.2.** GMEC must review and approve the following items:
- Institutional GME policies and procedures
 - Annual recommendations to the sponsoring institution's administration regarding resident/fellow stipends and benefits
 - Applications for ACGME accreditation of new programs
 - Requests for permanent changes in resident/fellow complement
 - Major changes in each of its ACGME-accredited programs' structure or duration of education
 - Additions and deletions of each of its ACGME-accredited programs' participating sites
 - Appointment of new program directors
 - Progress reports requested by a review committee
 - Responses to Clinical Learning Environment Review (CLER) reports
 - Requests for exceptions to clinical and educational work hour requirements
 - Voluntary withdrawal of ACGME program accreditation
 - Requests for appeal of an adverse action by a review committee; and
 - Appeal presentations to an ACGME Appeals Panel.
- 4.3.** The GMEC must demonstrate effective oversight of the sponsoring institution's accreditation through an Annual Institutional Review (AIR). See the GME/GMEC Annual Institution and Program Review Policy.
- 4.4.** The GMEC must identify institutional performance indicators for the AIR, to include at a minimum:
- The most recent ACGME institutional letter of notification
 - Results of ACGME surveys of residents/fellows and core faculty members
 - Each of its ACGME-accredited programs' ACGME accreditation information, including accreditation statuses and citations

- 4.5.** The DIO must annually submit a written executive summary of the AIR to the Sponsoring Institution's governing body. The written executive summary must include:
- Summary of institutional performance on indicators for the AIR and
 - Action plans and performance monitoring procedures resulting from the AIR
- 4.6.** The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process.
- 4.6.1.** The Special Review process must include a protocol that:
- Establishes criteria for identifying underperformance and
 - Results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-08
		EFFECTIVE DATE	06/01/2014
		PAGE(S)	05
	<u>SUBJECT</u> NIGHT FLOAT POLICY	SUPERSEDES	04/01/2011

Night Float Policy

I. **PURPOSE:**

Management of hospitalized patients remains essential for the practice of medicine. The night float allows residents to refine history and physical examination skills, develop experience in the selection of diagnostic tests, and learn the management of a wide variety of diseases.

II. **BACKGROUND:**

- 2.1. Night float provides exposure to common medical problems of hospitalized patients and allows residents the opportunities to develop discharge care plans. Additionally, residents encounter uncommon medical conditions and have the opportunity to interact with subspecialists while managing patients with complex conditions.
- 2.2. Night float is designed to give PGY-1 residents more experience in initial evaluation and management of patients as well as experience in managing patients overnight in the hospital. There is a strong focus on effective hand-offs, teamwork, and shared responsibility for patient care.
- 2.3. In addition, there is increased autonomy for PGY-2 and PGY-3 learners, and therefore a need for the refinement of skills in practice-based learning and improvement.

III. **SCOPE:**

This policy applies to all MSM physicians who are teachers or learners in a clinical environment and who have responsibility for patient care in that environment.

IV. **POLICY:**

- 4.1. Night float must occur within the context of the 80-hour and 1-day-off-in-7 requirements. The maximum number of consecutive weeks of night float and maximum number of months of night float per year may be further specified by the Specialty Review Committee.
- 4.2. Night float must be an educational experience for all residents. It must have its own competency-based curriculum and evaluation system.
- 4.3. A *Sample Curriculum for Night Float* is attached to this policy as Appendix A.

V. HOW LEARNING OBJECTIVES ARE MET:

Learning objectives are met by including the following elements:

- Direct patient care on the inpatient wards, both admitting to and covering medicine teams at night
- Interaction with consultants and support staff
- Participation in morning report
- Participation in daily night float rounds, typically at the bedside with the accepting Attending physician and team
- Literature searches to answer clinical questions that arise on rounds or during patient care; review of these literature searches
- Interaction with the interdisciplinary healthcare team
- Chart stimulated recall exercise (at least one per night float rotation)

VI. REQUIRED READING/RESOURCES:

- 6.1. Specific readings will be assigned by supervising clinical faculty members and fellows.
- 6.2. In addition, it is expected that residents read articles that are relevant to the patients they see, including articles generated through literature searches and distributed at morning report or at rounds.
- 6.3. Residents should become familiar with national and hospital guidelines for care of common medical disease states.

VII. EVALUATION:

- 7.1. Supervising Attendings will evaluate residents.
 - 7.1.1. These evaluations must be discussed in person with the residents.
 - 7.1.2. There should be regular informative feedback from supervising Attendings regarding performance.
- 7.2. Residents will log their performed procedures. The Attendings or other supervising physicians shall document satisfactory performance through the electronic procedure logger.
- 7.3. Resident peers (interns and residents) shall evaluate each other using the resident peer evaluation.

APPENDIX A

SAMPLE NIGHT FLOAT CURRICULUM

Learning Objectives:

At the end of the rotation, residents will be expected to become more proficient in:

1. Patient Care:

- **History taking:** Residents at all levels of training will collect a thorough history by soliciting patient information and by consulting other sources of primary data in a logical and organized fashion.
 - History taking will be hypothesis driven.
 - Interviewing will adapt to the time available, use appropriate nonverbal techniques, and demonstrate consideration for the patient.
 - The resident will inquire about the emotional aspects of the patient's experience while demonstrating flexibility based on patient need.
- **Physical Examination:** Residents at all levels of training will perform a comprehensive physical exam, describing the physiological and anatomical basis for normal and abnormal findings.
- **Charting:** Residents at all levels of training will record data in a legible, thorough, systematic manner. Upper level residents will communicate clinical information in succinct resident admit notes, focusing on the communication of assessment and plan, and the thought process behind both.

2. Procedures:

- PGY-1 residents will demonstrate knowledge of:
 - Procedural indications
 - Contraindications
 - Necessary equipment
 - Specimen handling
 - Patient after-care
 - Risk and discomfort minimization
- PGY-1 residents will participate in informed consent and assist patients with decision making. They will correctly identify the meaning of test results.
- PGY-2 and PGY-3 residents will demonstrate extensive knowledge and facility in the performance of procedures while minimizing risk and discomfort to patients. They will assist their junior peers in skill acquisition.

3. Medical Decision Making, Clinical Judgment, and Management Plans:

All residents will demonstrate improving their skill in assimilating information that they have gathered from the history and physical exam.

- PGY-2 residents will:
 - Regularly integrate medical facts and clinical data while weighing alternatives and keeping patient preference in mind.
 - Regularly incorporate consideration of risks and benefits when considering testing and therapies.
 - Present up-to-date scientific evidence to support their hypotheses.
 - Consistently monitor and follow up with patients appropriately.
 - Develop plans to avoid or delay known treatment complications and be able to identify when illness has reached a point where treatment no longer contributes to improved quality of life.
- PGY-3 residents will demonstrate all the skills listed above for PGY-2 residents and in addition, will:
 - Demonstrate appropriate reasoning in ambiguous situations while continuing to seek clarity
 - Not overly rely on tests and procedures
 - Continuously revise assessments in the face of new data

4. Medical Knowledge:

- PGY-1 residents will demonstrate knowledge of common disease states encountered while admitting to the inpatient services. They will also demonstrate an ability to acquire new knowledge based on the patient problems encountered nightly.
- PGY-1 residents will demonstrate knowledge of the differential diagnosis, appropriate evaluation and management of common night-time issues encountered on inpatient medicine services, including shortness of breath, chest pain, disorientation, fever, and acute renal failure.
- PGY-2 residents will demonstrate a progression in knowledge and analytical thinking in order to develop well-formulated differential diagnoses for multi-problem patients.
- PGY-3 residents will demonstrate the skills listed above for PGY-1 and PGY-2 residents and will also demonstrate appropriate habits to stay current with new medical knowledge and will exhibit knowledge of effective teaching methods.

5. Practice-Based Learning and Improvement:

- PGY-2 and PGY-3 residents will be able to investigate and evaluate their own inpatient care practices and identify areas for improvement. They will demonstrate critical evaluation of their individual medical decisions through documentation of chart reviews on selected patients followed for diagnostic and therapeutic learning points after initial admission by the night float resident.

- PGY-2 and PGY-3 residents will also demonstrate the ability to formulate well-designed clinical questions, initiate electronic literature searches, and critically appraise search results for validity and usefulness in accessing best evidence for clinical decisions. They will regularly demonstrate knowledge of the impact of study design on validity or applicability to individual patients.
- PGY-2 and PGY-3 residents will also demonstrate the ability to teach resident colleagues during morning report with appropriate preparation and research for assigned topics.

6. Interpersonal and Communication Skills:

- PGY-1 residents will demonstrate an ability to communicate pertinent clinical information regarding a patient's history, physical examination, evaluation and management plan both in writing and orally to accepting medicine teams. They will also demonstrate effective communication styles with families, patients, and hospital staff.
- PGY-2 residents will exhibit team leadership skills through effective communication as manager of a team. PGY-2 residents are expected to assist junior peers, medical students, and other hospital personnel to form professional relationships with support staff. Residents will respond to feedback in an appropriate manner and make necessary behavioral changes. PGY-2 residents will be able to communicate with patients concerning end-of-life decisions.
- PGY-3 residents should additionally be able to successfully negotiate nearly all "difficult" patient encounters with minimal direction. Third year residents should function as team leaders with decreasing reliance upon attending physicians.


7. Professionalism:

All residents will demonstrate integrity, accountability, respect, compassion, patient advocacy, and dedication to patient care that supersedes self-interest. Residents will demonstrate a commitment to excellence and continuous professional development. Residents will demonstrate a commitment to ethical principles pertaining to the provision or withholding of clinical care, confidentiality of patient information, and informed consent. Residents are expected to show sensitivity and responsiveness to patients' culture, age, gender, and disabilities. Residents will be punctual and prepared for teaching sessions.

8. Systems-Based Practice:

- PGY-2 residents will consistently understand and adopt available clinical practice guidelines and recognize the limitations of these guidelines. They will work with patient care managers, discharge coordinators, and social workers to coordinate and improve patient care and outcomes.
- PGY-3 residents, in addition, will enlist social and other out-of-hospital resources to assist patients with therapeutic plans and know how these activities can affect the hospital system performance. PGY-3 residents are expected to model cost-effective therapy.

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		EFFECTIVE DATE	06/01/2014
		PAGE(S)	04
	<u>SUBJECT</u> PATIENT HAND-OFF POLICY—TRANSITIONS OF CARE POLICY	SUPERSEDES	04/01/2011

Patient Hand-off—Transitions of Care Policy

I. **PURPOSE:**

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

II. **BACKGROUND:**

- 2.1. In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. Hand-off refers to the orderly transmittal of information, face-to-face, that occurs when transitions in the care of the patient are occurring.
- 2.2. Proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during that shift. In summary, the primary objective of a hand-off is to provide complete and accurate information about a patient's clinical status, including current condition and recent and anticipated treatment. The information communicated during a hand-off must be complete and accurate to ensure safe and effective continuity of care.

III. **SCOPE:**

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

IV. **POLICY:**

- 4.1. **Transitions of Care**—The Sponsoring Institution must facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care and in partnership with its ACGME-accredited program(s), ensure and monitor effective structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites.
- 4.2. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.
- 4.3. Programs and clinical sites must maintain and communicate schedules of Attending physicians and residents currently responsible for care.
- 4.4. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in ACGME Common Program Requirement VI.C.2 (Resident Well-Being), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.

- 4.5. Programs must ensure that residents are competent in communicating with team members in the hand-off process.
- 4.6. Programs in partnership with their sponsoring institutions must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety.
 - 4.6.1. Hand-offs must follow a standardized approach and include the opportunity to ask and respond to questions.
 - 4.6.2. A hand-off is a verbal and/or written communication which provides information to facilitate continuity of care. A hand-off or “report” occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:
 - Move to a new unit
 - Transport to or from a different area of the hospital for care. e.g.: diagnostic/treatment area
 - Assignment to a different physician temporarily, e.g.: overnight/ weekend coverage or longer (e.g.: rotation change)
 - Discharge to another institution or facility
 - 4.6.3. Each of the situations above requires a structured hand-off with appropriate communication.

V. CHARACTERISTICS OF A HIGH-QUALITY HAND-OFF:

- 5.1. Hand-offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.
- 5.2. Hand-offs include up-to-date information regarding the patient’s care, treatment and services, condition, and any recent or anticipated changes.
- 5.3. Interruptions during hand-offs should be limited in order to minimize the possibility that information would fail to be conveyed or would be forgotten.
- 5.4. Hand-offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.

VI. HAND-OFF PROCEDURES:

- 6.1. Hand-off procedures will be conducted in conjunction with (not be limited to) the following physician events:
 - Shift changes
 - Meal breaks
 - Rest breaks
 - Changes in on-call status
 - Contacting another physician when there is a change in the patient’s condition
 - Transfer of patient from one care setting to another
- 6.2. Hand-off procedures and information transfer forms and guidelines for physicians are developed and implemented by each service according to the needs of that service. The hand-off forms or guidelines may be in either paper or electronic format and must include clinical information agreed upon by physicians on that service, as being integral to the provision of safe and effective patient care for that patient population.

- 6.3. Each service will develop and implement a hand-off process that is in keeping with the shift or rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.
- 6.4. Each service hand-off process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.
- 6.5. Each hand-off process must be conducted discreetly and free of interruptions to ensure a proper transfer.
- 6.6. Each hand-off process must include at minimum a senior resident or Attending physician.
- 6.7. A resident physician must not leave the hospital until a face-to-face hand-off has occurred with the Attending physician or senior resident coming onto the service. Telephonic hand-off is not acceptable.

VII. STRUCTURED HAND-OFF:

- 7.1. Within each service, hand-offs will be conducted in a consistent manner, using a standardized hand-off form or structured guideline.
- 7.2. Hand-offs, whether verbal or written, should include, at minimum, specific information listed below (as applicable):
 - Patient name, location, age/date of birth
 - Patient diagnosis/problems, impression
 - Important prior medical history
 - DNR status and advance directives
 - Identified allergies
 - Medications, fluids, diet
 - Important current labs, vitals, cultures
 - Past and planned significant procedures
 - Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
 - Plan for the next 24+ hours
 - Pending tests and studies which require follow up
 - Important items planned between now and discharge

VIII. FORMATTED PROCEDURE:

- 8.1. A receiving physician shall:
 - 8.1.1. Thoroughly review a written hand-off form or receive a verbal hand-off and take notes.
 - 8.1.2. Resolve any unclear issues with the transferring physician prior to acceptance of a patient.

- 8.2. In addition, the SBAR can be used to deliver or receive the information:
- **Situation:** What is the problem?
 - **Background:** Pertinent information to problem at hand
 - **Assessment:** Clinical staff's assessment
 - **Recommendation:** What do you want done and/or think needs to be done?
- 8.3. The following document is a suggested format for programs to document information with a sign-out process.

A SAMPLE FORMAT

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

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

1. Interactive communications allowed for the opportunity for questioning between the giver and receiver about patient information.
2. Up-to-date information regarding the patient's care, treatment and services, condition, and any recent or anticipated changes was communicated.
3. A process for verification of the received information, including repeat-back or read-back, as appropriate, was used.
4. An opportunity was given for the receiver of the hand-off information to review relevant patient historical information, which may include previous care, and/or treatment and services.
5. Interruptions during hand-offs were limited in order to minimize the possibility that information would fail to be conveyed, not be heard, or forgotten.


Receiving Resident's Name and Signature

Date/Time

Departing Resident's Name and Signature

Date/Time

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-10
		EFFECTIVE DATE	06/01/2014
		PAGE(S)	06
	SUBJECT PROFESSIONALISM POLICY	SUPERSEDES	N/A

Professionalism Policy

(Resident Code of Conduct, Dress Code, and Social Media Guidelines)

I. PURPOSE:

- 1.1. Residents are responsible for fulfilling all obligations that the GME Office, hospitals, and residency programs deem necessary for them to begin and continue duties as a resident, including but not limited to:
 - 1.1.1. Attending orientations, receiving appropriate testing and follow-up, if necessary, for communicable diseases, fittings for appropriate safety equipment, necessary training and badging procedures (all of which may be prior to appointment start date)
 - 1.1.2. Completing required GME, hospital and program administrative functions in a timely fashion and before deadlines such as medical records, mandatory on-line training modules, and surveys or other communications
- 1.2. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff.
- 1.3. All GME program directors and faculty are responsible for educating, monitoring, and providing exemplary examples of professionalism to residents.
- 1.4. Refer to the GME [CONCERN AND COMPLAINT PROCEDURE](#): regarding confidential professionalism reporting systems and resources.

II. SCOPE:

- 2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.
- 2.2. Each program must have a program-level professionalism policy which describes how the program provides professionalism education to residents. The program director will ensure that all program policies relating to professionalism are distributed to residents and faculty. A copy of the program policy on professionalism must be included in the official program manual and provided to each resident upon matriculation into the program.

III. POLICY:

- 3.1. **Professionalism**—Residents and faculty members must demonstrate an understanding of their personal role in the:
 - 3.1.1. Provision of patient- and family-centered care
 - 3.1.2. Safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events

3.1.3. Assurance of their fitness for work, including:

- 3.1.3.1.** Management of their time before, during, and after clinical assignments; and
- 3.1.3.2.** Recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team

3.1.4. Commitment to lifelong learning

3.1.5. Monitoring of their patient care performance improvement indicators; and

3.1.6. Accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data

3.2. Professionalism—Code of Conduct

Residents are responsible for demonstrating and abiding by the following professionalism principles and guidelines.

3.2.1. Physicians must develop habits of conduct that are perceived by patients and peers as signs of trust. Every physician must demonstrate sensitivity, compassion, integrity, respect, and professionalism, and must maintain patient confidentiality and privacy.

3.2.2. A patient's dignity and respect must always be maintained.

3.2.3. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

3.2.4. Residents are responsible for completing hospital, program, and GME educational and administrative assignments by given deadlines that include:

- Timely completion of evaluations and program documentation;
- Logging of duty hours, cases, procedures, and experiences; and
- Promptly arriving for educational, administrative, and service activities.

3.2.5. A medical professional consistently demonstrates respect for patients by his or her performance, behavior, attitude, and appearance.

3.2.6. Commitment to carrying out professional responsibilities and an adherence to ethical principles are reflected in the following expected behaviors:

- Respect patient privacy and confidentiality.
- Knock on the door before entering a patient's room.
- Appropriately drape a patient during an examination.
- Do not discuss patient information in public areas, including elevators and cafeterias.
- Keep noise levels low, especially when patients are sleeping.

3.2.7. Respect patients' autonomy and the right of a patient and a family to be involved in care decisions.

3.2.7.1. Introduce oneself to the patient and his or her family members and explain their role in the patient's care.

3.2.7.2. Wear name tags that clearly identify names and roles.

- 3.2.7.3.** Take time to ensure patient and family understanding and informed consent of medical decisions and progress.
- 3.2.8.** Respect the sanctity of the healing relationship.
 - 3.2.8.1.** Exhibit compassion, integrity, and respect for others.
 - 3.2.8.2.** Ensure continuity of care when a patient is discharged from a hospital by documenting who will provide that care and informing the patient of how that caregiver can be reached.
 - 3.2.8.3.** Respond promptly to phone messages, pages, e-mail, and other correspondence.
 - 3.2.8.4.** Provide reliable coverage through colleagues when not available.
 - 3.2.8.5.** Maintain and promote physician/patient boundaries.
- 3.2.9.** Respect individual patient concerns and perceptions.
 - 3.2.9.1.** Comply with accepted standards of dress as defined by each hospital.
 - 3.2.9.2.** Arrive promptly for patient appointments.
 - 3.2.9.3.** Remain sensitive and responsive to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
- 3.2.10.** Respect the systems in place to improve quality and safety of patient care.
 - 3.2.10.1.** Complete all mandated on-line tutorials and public health measures (e.g.: TB skin testing) within designated timeframe.
 - 3.2.10.2.** Report all adverse events within a timely fashion.
 - 3.2.10.3.** Improve systems and quality of care through critical self-examination of care patterns.
- 3.2.11.** A professional consistently demonstrates respect for peers and co-workers.
 - 3.2.11.1.** Respect for colleagues is demonstrated by maintaining effective communication.
 - 3.2.11.2.** Inform primary care providers of patient's admission, the hospital content and discharge plans.
 - 3.2.11.3.** Provide consulting physicians all data needed to provide a consultation.
 - 3.2.11.4.** Maintain legible and up-to-date medical records, including dictating discharge summaries within approved hospital guidelines.
 - 3.2.11.5.** Inform all members of the care team, including non-physician professionals, of patient plans and progress.
 - 3.2.11.6.** Provide continued verbal and written communication to referring physicians.
 - 3.2.11.7.** Understand a referring physician's needs and concerns about his or her patients.

3.2.11.8. Provide all appropriate supervision needed for those one is supervising, by informing and involving supervising faculty of any changes in patient status, and by providing informed and safe handoffs to colleagues who provide patient coverage.

3.2.11.9. Acknowledge, promote, and maintain the dignity and respect of all healthcare providers.

3.2.12. Respect for diversity of opinion, gender, and ethnicity in the workplace.

3.2.12.1. Maintain a work environment that is free of harassment of any sort.

3.2.12.2. Incorporate the opinions of all health professionals involved in the care of a patient.

3.2.12.3. Encourage team-based care.

3.2.12.4. In addition, professionals are held accountable to specialty-specific board and/or society codes of medical professionalism.

3.3. Professionalism—Dress Code

Residents must adhere to the following code elements to reflect a professional appearance in the clinical work environment; residents are also held accountable to relevant individual hospital/site and MSM institution policies.

3.3.1. Identification: Unaltered ID badges must be worn and remain visible at all times. If the badge is displayed on lanyard, it should be a break-away variety.

3.3.2. White Coats: A long white coat that specifies the physician's name and department should be worn.

3.3.3. Personal Hygiene:

3.3.3.1. Hair must be kept clean and well groomed. Hair color or style may not be extreme. Long hair must be contained as so to not drape or fall into work area.

3.3.3.2. Facial hair must be neat, clean, and well-trimmed.

3.3.3.3. Fingernails must be kept clean and of appropriate length.

3.3.3.4. Scent of fragrance or tobacco should be limited/minimized.

3.3.4. Shoes/footwear: Must be clean, in good repair, and of a professional style appropriate to work performed. No open-toed shoes may be worn. Shoes must have fully enclosed heels or secured with a heel strap for safety purposes.

3.3.5. Jewelry: Must not interfere with job performance or safety.

3.3.6. Inappropriate/not permitted: Pins, buttons, jewelry, emblems, or insignia bearing a political, controversial, inflammatory, or provocative message may not be worn.

3.3.7. Tattoos: Every effort must be made to cover visible tattoos.

3.3.8. Clothing: Must reflect a professional image, including: dress-type pants and collared shirts; skirt and dress length must be appropriate; clothing should cover back, shoulders, and midriff; modest neckline (no cleavage).

3.3.9. Scrubs: Residents may wear scrubs in any clinical situation where appropriate. When not in a work area, a white coat should be worn over scrubs.


3.4. Professionalism: Social Media Guidelines

- 3.4.1. Because social media blurs the line between personal voice and institutional voice, these guidelines were created to clarify how best to protect personal and professional reputations when participating.
- 3.4.2. In both professional and institutional roles, employees need to adopt a common sense approach and follow the same behavioral standards as they would in real life, and are responsible for anything they post to social media sites either professionally or personally.
- 3.4.3. For these purposes, “social media” includes but is not limited to social networking sites, collaborative projects such as wikis, blogs, and microblogs, content communities, and virtual communities.
- 3.4.4. Best practices for all social media sites, including personal sites follow:
 - 3.4.4.1. **Think before posting**—There is no such thing as privacy in the social media world. Before you publish a post, consider how it would reflect on you, your department/unit, and on the institution.

Search engine databases store posts years after they were published, so posts could be found even if they were deleted; and comments may be forwarded or copied.
 - 3.4.4.2. **Be accurate**—Verify your information for accuracy, spelling, and grammatical errors before posting. If an error or omission ends up being posted, post a correction as quickly as possible.
 - 3.4.4.3. **Be respectful**—The goal of social media is to engage your audience in conversation. At times, that comes in the form of opposing ideas. Consider how to respond or disengage in a way that will not alienate, harm, or provoke.
 - 3.4.4.4. **Remember your audience**—Though you may have a target audience, be aware that anything posted on your social media account is also available to the public at large, including prospective students, current students, staff, faculty, and peers.
 - 3.4.4.5. **Be a valuable member**—Contribute valuable insights in your posts and comments. Self-promoting behavior is viewed negatively and can lead to you being banned from a website or group you are trying to participate in.
 - 3.4.4.6. **Ensure your accounts’ security**—A compromised account is an open door for malicious entities to post inappropriate or even illegal material as though it were from you. If you administer a hospital/school/college/department/unit social media account, be sure to use a different password than for your personal accounts. Follow best practices in selecting and protecting your university account passwords.

3.4.5. Guidelines for all social media sites, including personal sites

- 3.4.5.1. Protect confidential and proprietary information**—Do not post confidential information about MSM, students, faculty, staff, patients, or alumni; nor should you post information that is proprietary to an entity other than yourself.
- 3.4.5.2.** Employees must follow all applicable Federal privacy requirements for written and visual content, such as FERPA and HIPAA. Failure to do so comes at the risk of disciplinary action and/or termination.
- 3.4.5.3. Respect copyright and fair use**—When posting, be aware of the copyright and intellectual property rights of others and of the university. Refer to MSM system policies on copyright and intellectual property for more information/guidance.
- 3.4.5.4. Do not imply MSM endorsement**—The logo, word mark, iconography, or other imagery shall not be used on personal social media channels. Similarly, the MSM name shall not be used to promote a product, cause, or political party/candidate.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-11
		EFFECTIVE DATE	04/01/2011
		PAGE(S)	01
	<u>SUBJECT</u> PROFESSIONAL LIABILITY COVERAGE LETTER OF UNDERSTANDING	SUPERSEDES	N/A

Professional Liability Coverage Letter of Understanding

This letter shall be completed upon appointment to a MSM Residency program and at the time a resident enters into moonlighting activities.

This is to certify that I, _____, am a resident physician at Morehouse School of Medicine. As a resident in training, I understand that all professional activities that are sanctioned by Morehouse School of Medicine and related to, or are a part of, the Residency Education Program are covered by the following professional liability coverage:

- \$1 million per/occurrence and; \$3 million annual aggregate; and
- Tail coverage for all incidents that occur during my tenure as a resident in accordance with the above.

In addition, I understand that the above professional liability insurance coverage does not apply to professional activities in which I become involved outside of the residency program, and that upon written approval by the residency program director to moonlight, I am personally responsible for securing adequate coverage for these outside activities from the respective institutions or through my own resources.

Check appropriate box: Resident Agreement ☐ Moonlighting Request ☐

Signed: _____ Date: _____

Social Security Number: _____


Home Address: _____

City: _____ State: _____

Zip Code: _____

Return Signed Original to Office of Graduate Medical Education

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-12
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	12
	<u>SUBJECT</u> RESIDENT AND FELLOW ELIGIBILITY, SELECTION, AND APPOINTMENT POLICY	SUPERSEDES	05/01/2015 06/01/2014 04/02/2013 03/01/2011 10/01/1992

Resident and Fellow Eligibility, Selection, and Appointment Policy

I. PURPOSE:

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

II. SCOPE:

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

III. POLICY:

- 3.1. This policy is bound by the parameters of residency and fellowship education and complies with MSM Human Resources policies.
- 3.2. Applicants to Morehouse School of Medicine (MSM) residency and fellowship programs must be academically qualified to enter into a program.
- 3.3. The institution shall participate in the National Resident Matching Program (NRMP).
 - 3.3.1. All MSM Post-Graduate Year One (PGY-1) resident positions shall be made available for application by all students graduating from United States and Canadian accredited medical schools as determined by the NRMP.
 - 3.3.2. Other applicants eligible to enter the “match,” including International Medical School Graduates (IMGs), may also apply.
- 3.4. MSM residency and fellowship programs will select from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they have applied.
- 3.5. Aptitude, academic credentials, the ability to communicate effectively, personal characteristics such as motivation and integrity, and the ability to function within parameters expected of a practitioner in the specialty shall be considered in the selection process.

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

3.6.1. Introduction

- 3.6.1.1.** Medicine is an intellectually, physically, and psychologically demanding profession. All phases of medical education require knowledge, attitudes, skills and behaviors necessary for the practice of medicine and throughout a professional career.
- 3.6.1.2.** Those abilities that residents/fellows must possess to practice safely are reflected in the technical standards that follow. These technical standards/essential functions are to be understood as requirements for training in all Morehouse School of Medicine residencies and are not to be construed as competencies for practice in any given specialty.
- 3.6.1.3.** Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.
- 3.6.1.4.** Residents and fellows in Graduate Medical Education programs must be able to meet these minimum standards with or without reasonable accommodation.

3.6.2. Standards—Observation

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

3.6.3. Standards—Communication

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

3.6.4. Standards—Motor

- 3.6.4.1.** Residents/fellows must possess sufficient motor function to elicit information from the patient examination by palpation, auscultation, tapping, and other diagnostic maneuvers.
- 3.6.4.2.** Residents/fellows must also be able to execute motor movements reasonably required for routine and emergency care and treatment of patients.

3.6.5. Standards—Intellectual: Conceptual, Integrative, and Quantitative Abilities

- 3.6.5.1.** Residents/fellows must be able to measure, calculate, reason, analyze, integrate, and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions which are critical skills demanded of physicians.
- 3.6.5.2.** In addition, residents/fellows must be able to comprehend three-dimensional

relationships and to understand spatial relationships of structures.

3.6.6. Standards—Behavioral and Social Attributes

3.6.6.1. Residents/fellows must possess the psychological ability required for the full utilization of their intellectual abilities for:

3.6.6.1.1. The exercise of good judgment;

3.6.6.1.2. The prompt completion of all responsibilities inherent to diagnosis and care of patients; and

3.6.6.1.3. The development of mature, sensitive, and effective relationships with patients, colleagues, and other healthcare providers.

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

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

3.6.6.4. Residents/fellows must be able to work effectively and collaboratively as team members.

3.6.6.5. Residents/fellows must demonstrate ethical behavior consistent with professional values and standards, as a component of their education and training.

3.6.7. Standards—Reasonable Accommodation

3.6.7.1. A reasonable accommodation is designed to assist an employee in the performance of the essential functions of his or her job and an applicant in fulfilling MSM's application requirements.

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

3.6.7.3. Accommodations are made on a case-by-case basis.

3.6.7.4. MSM will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in a given situation. Complete information is found on the MSM Human Resources Office of Disability Services web page at <https://www.msm.edu/Administration/HumanResources/disabilityservices/index.php>.

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

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

IV. Title IX Compliance:

- 4.1. The residency education environment shall be free of undue harassment, confrontation, and coercion because of one's gender, cultural and religious beliefs, other individual traits, and status or standing.
- 4.2. Therefore, in compliance with the Title IX of the Education Amendments of 1972, Morehouse School of Medicine (MSM) does not discriminate on the basis of sex in its education programs and activities and is required under Title IX and the implementing regulations not to discriminate in such a manner. Prohibited sex discrimination covers sexual misconduct including, but not limited to, sexual harassment and sexual violence, and extends to employment in and admission to such programs and activities.
- 4.3. It is the policy of MSM that discrimination against any person or group of persons on the basis of race, color, national origin, religion, gender, sexual orientation, marital status, ancestry, genetic information, age, disability, veteran or military status, or any other legally protected characteristic is specifically prohibited. This is in compliance with federal law, including Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act (and ADAAA amendments).
- 4.4. MSM prohibits retaliation against members of the MSM community who raise concerns about or report incidents of discrimination based on legally protected characteristics.
- 4.5. Marla Thompson, Title IX Coordinator, has been designated to handle inquiries about and reports made under MSM's Sex/Gender Nondiscrimination and Sexual Harassment policy.

Direct dial (404) 752-1871 Fax (404) 752-1639 E-mail: mthompson@msm.edu

Morehouse School of Medicine

720 Westview Drive, SW Harris Building, Atlanta, GA 30310

Contact MSM's Human Resources Office for the current policy

V. RESIDENT AND FELLOW ELIGIBILITY CRITERIA:

- 5.1. Sponsoring Institutions are required to have written policies and procedures for resident/fellow recruitment and must monitor each of its ACGME accredited programs for compliance.
- 5.2. The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) Institutional Requirements, Section IV.A. Institutional GME Policies and Procedures—Resident/Fellow Recruitment, and the ACGME Common Program Requirements—Resident/Fellow Appointments/Eligibility/Transfers—Section III.A-C.
- 5.3. Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:
 - 5.3.1. Graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or
 - 5.3.2. Graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA).

- 5.3.3.** Graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:
- 5.3.3.1.** Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment;
 - 5.3.3.2.** Holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty or subspecialty program; or
 - 5.3.3.3.** Has graduated from a medical school outside the United States and has completed a Fifth Pathway program provided by an LCME-accredited medical school.
- 5.4.** An applicant invited to interview for a resident or fellow position must be informed in writing or by electronic means of the most current terms, conditions, and benefits of appointment to the ACGME-accredited program. Information must include:
- Financial support
 - Vacations
 - Parental, sick, and other leaves of absence
 - Professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents
- 5.5.** Each resident or fellow in MSM 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.
- 5.6.** All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in:
- ACGME-accredited residency programs;
 - AOA-approved residency programs;
 - Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada; or
 - Residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.
- 5.7.** Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.
- 5.8.** A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.
- 5.9.** For resident eligibility exceptions granted by ACGME specialty review committees, see specialty-specific requirements.

VI. FELLOW APPOINTMENTS ELIGIBILITY CRITERIA

6.1. Each ACGME Review Committee will choose one of the following: (please review the program requirements for the specialty-specific eligibility criteria)

6.1.1. Option 1: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in:

- An ACGME-accredited residency program;
- An AOA-approved residency program;
- A program with ACGME International (ACGME-I) Advanced Specialty Accreditation;
- A Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)- accredited residency program located in Canada.

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

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

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

6.3. For fellow eligibility exceptions granted by ACGME specialty review committees, see subspecialty-specific requirements.

VII. GMEC and ACGME Program Positions and Appointment Approval

7.1. Program directors must not appoint more residents or fellows than approved by the ACGME Review Committee.

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

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

7.3. All complement increases must be approved by the GMEC and the ACGME Review Committee.

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

VIII. Resident/Fellow Transfers

- 8.1. Upon matriculation, the program must obtain verification of previous educational experiences and a summative competency-based performance evaluation, signed by the previous program director prior to acceptance of a transferring resident/fellow, and the candidate's Milestones evaluations.
- 8.2. Residents are considered transfer residents under several conditions including moving from one program to another within the same or different sponsoring institution and when entering a PGY-2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the match (e.g.: accepted to both programs right out of medical school).
- 8.3. Before accepting a transfer resident, the program director of the "receiving program" must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current program director.
- 8.4. The term "transfer resident" and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.
 - 8.4.1. MSM residency programs, however, shall identify all residents who would begin the residency program and would have to continue beyond the "Initial Residency Period."
 - 8.4.2. **Note:** The initial residency period is the length of time required to complete a general residency program (e.g.: Internal Medicine: 3 years; Psychiatry: 4 years).

IX. ADDITIONAL ELIGIBILITY REQUIREMENTS:

For any applicant to be eligible for appointment to an MSM residency/fellowship program, the following requirements must be met in addition to the eligibility criteria stated above

- 9.1. All MSM residency and fellowship programs shall participate in the National Resident Matching Program (NRMP) for PGY-1 level resident and fellowship positions.
 - 9.1.1. All parties participating in the match shall contractually be subject to the rules of the NRMP.
 - 9.1.2. This includes MSM, its residency/fellowship programs, and applicants.
 - 9.1.3. Match violations will not be tolerated.
- 9.2. All applicants to MSM residency and fellowship programs must apply through the Electronic Residency Application Service (ERAS).
 - 9.2.1. This service shall be used to screen needed information on all applicants.
 - 9.2.2. All applicants shall request that three (3) letters of professional and/or academic references, current as of at least 18 months, be sent to the residency program administration via ERAS.
- 9.3. Programs may establish additional selection criteria (e.g.: determine specific minimum scores for the USMLE). Specific criteria must be published for applicants to review as part of the required program-level policy on eligibility and selection.
- 9.4. Residency program directors and their residency committees shall have program standards and criteria to review MSM residency program applications in order to ensure equal access to the program. Eligible resident/fellow applicants shall be selected and appointed only according to ACGME, NRMP, and MSM's requirements and policies.
- 9.5. Applicants from United States- or Canadian-accredited medical schools shall request that an

- original copy of a letter of recommendation or verification from the dean of the medical school be sent to the program administration via ERAS.
- 9.6.** Selectees from a United States LCME- or AOA-accredited medical school shall provide proof of graduation or pending “on-time” graduation. They shall request that official transcripts, diplomas, or “on-time” letters be sent to the program via ERAS.
- 9.7.** Selectees must provide official proof of passing both USMLE Step 1 and USMLE Step 2 (CK and CS) before they are eligible to begin their appointment in MSM residency programs.
- 9.8.** The State of Georgia and MSM consider any time spent in a residency program as time that must be declared by the applicant when applying for a Temporary Resident Postgraduate Training Permit.
- 9.8.1.** This time is applicable whether the applicant completed the period of residency or not.
- 9.8.2.** A letter of explanation/verification is required of the applicant and the past residency program director.
- 9.9.** Applicants who have not graduated from a United States- or Canadian-accredited medical school shall request certification of completion (by seal) by an official of the medical school. If the medical school is not in the United States, such official letters shall be in English and/or have a certified or notarized English translation of the content.
- 9.10.** A current (stamped indefinite) certificate from the Educational Commission on Foreign Medical School Graduates (ECFMG) must also be submitted with ERAS documents.
- 9.10.1.** Initial ECFMG Certificates should not be pending when applicants are reporting to a residency program.
- 9.10.2.** Failure to obtain an ECFMG Certificate by the start date of the resident appointment will void both NRMP and MSM resident/fellow agreements.
- 9.11.** Program directors must ensure that IMG/FMG candidates are eligible for J-1 Visa sponsorship before ranking these candidates in NRMP.
- 9.12.** All selectees shall complete an MSM Non-Faculty Employment Application. The Human Resources Department is available for assistance.
- 9.13.** Upon selection, all academic and employment documents referenced within this section and other documents requested by the residency program must be presented to the program administrator in their original form.
- 9.13.1.** As a part of credentials authentication, documents shall be screened for authenticity and must be void of alterations.
- 9.13.2.** Program administrators shall screen for signatures, seals, notarization, and other official stamps as being original.
- 9.14.** An applicant invited to interview for a resident or fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment. Information that is provided must include:
- Financial support
 - Vacations
 - Parental, sick, and other leaves of absence
 - Professional liability, hospitalization, health, disability, and other insurance accessible to residents/fellows and their eligible dependents

- 9.15. Personal interviews of applicants shall be conducted by at least two (2) faculty members assigned to the program.
 - 9.15.1. These interviews should be documented for the residency program files and be retained for the period determined by MSM management policies.
 - 9.15.2. These interviews also become a permanent part of a selected applicant's file.
- 9.16. If telephone interviews are performed, the same standards and documentation criteria must be used to record the interview.
- 9.17. In MSM programs, the applicant's credentials and the faculty interview summary are formally presented to the Residency Program Advisory Committee (RAC) or equivalent.
- 9.18. A faculty consensus is formed on the selections for entry into the NRMP Rank Order Listing or for departmental selection for those positions not placed in the match (i.e.: PGY-2).
- 9.19. Final disposition for applicant selection and ranking is done by the residency program director and/or department chairperson.

X. NON-IMMIGRANT APPLICANTS TO RESIDENCY PROGRAMS:

- 10.1. MSM supports the AAMC recommendation that the J-1 Visa is the more appropriate visa for non-immigrant International Medical School Graduates (IMGs) seeking resident positions in MSM-sponsored programs (Reference: AAMC Legislative and Regulatory Update, October 15, 1993).
- 10.2. All IMGs shall provide a current (stamped indefinite) certificate of proof of meeting the Educational Commission for Foreign Medical Graduates (ECFMG) requirements for clinical proficiency.
- 10.3. The Exchange Visitor Program is administered by the United States Department of State.
 - 10.3.1. The ECFMG is the sponsoring institution for alien physicians in GME programs under the Exchange Visitor Program.
 - 10.3.2. Applicants may be considered for selection by the residency/fellowship program based on their academic qualifications and eligibility for sponsorship by the ECFMG.
 - 10.3.3. The MSM Human Resource (HR) and GME offices are the school liaisons for processing applications for ECFMG sponsorship of non-immigrants for J-1 status.
- 10.4. Applicants seeking residency positions that have other non-immigrant status such as Transitional Employment Authorization Documents, Asylum status, etc., may need to seek legal counsel to effect entry into a residency program. This review will be coordinated through the MSM HR and GME offices along with the MSM-International Programs office for final determination.
- 10.5. The following visa categories are for international-born or -educated physicians applying to United States Graduate Medical Education programs:
 - 10.5.1. Consular processing of physician visas
 - 10.5.1.1. United States embassies/consulates require face-to-face interviews for all initial visa stamps and in some instances for the renewal of the same visa stamp.
 - 10.5.1.2. It can take several months for a person to receive an appointment at the embassy/consulate to apply for the visa stamp.
 - 10.5.1.3. Embassy/consulate security checks take about one (1) month.

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

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

10.5.2. The J-1 Exchange Visitor Visa

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

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

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

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

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

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

10.5.2.7. A visa is required if the physician is not a United States citizen or permanent resident of the United States.

10.6. Summary of J-1 Visa for IMGs

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

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

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

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

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

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

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

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

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

10.6.10. The visa may be extended only for Board Certification; during this time, the J-1 visitor


cannot work.

- 10.6.11.** The DS-2019 (J-1 application) is renewed yearly with a seven- (7) year limit or length of residency program, whichever comes first.
- 10.6.12.** The J-1 Exchange Visitor may enter the United States 30 days prior to the start of the J-1 Visa and cannot be paid prior to the start date. The J-1 visitor must NOT enter the United States 30 days AFTER the start date listed on form DS-2019.
- 10.6.13.** After the J-1 period ends, the exchange visitor has 30 days to exit the United States and cannot work during this “grace period.”
- 10.6.14.** Moonlighting is not permitted under this visa status.
- 10.6.15.** It is very difficult to process J-1 Visa applications to non-accredited residency/fellowship programs. The ECFMG uses the ACGME’s Green Book for reference of accredited programs and their program duration.
- 10.6.16.** The J-2 visa status is acceptable for Graduate Medical Education training at Morehouse School of Medicine (MSM) but can create problems since the J-2 depends on the J-1 Visa primary holder. The J-2 must have a valid EAD card and must also maintain the EAD card.

XI. RESIDENT APPOINTMENTS:

- 11.1.** Prior to appointment to the program, applicants, must be provided with information that describes the program’s current accreditation status, aims, educational objectives, and structure.
- 11.2.** Morehouse School of Medicine resident appointments shall be for a maximum of 12 months from July to June, year to year.
 - 11.2.1.** At MSM, a “resident appointment” is defined as a non-faculty position granted to an individual based on his or her academic credentials and the meeting of other eligibility criteria as stated in MSM and residency program policies and standards.
 - 11.2.2.** This position is also that of a “physician in training.”
- 11.3.** Resident appointments are managed by the Graduate Medical Education Office on behalf of the Senior Vice President for Academic Affairs and are processed by the Human Resources Department (HRD).
- 11.4.** Residents may enter the residency program at other times during a given Post-Graduate Year (PGY) but must complete all requirements according to the structure of the program.
 - 11.4.1.** This usually means completing the PGY-1 year from the date the resident started.
 - 11.4.2.** There are no provisions for “shared” or “part-time” positions in MSM residency programs.
- 11.5.** A selected applicant must be formally offered a position in the residency program. A written agreement shall be entered into between the applicant and Morehouse School of Medicine (MSM).
 - 11.5.1.** This agreement signed by the residency program director and department chairperson shall constitute a recommendation to the dean for an academic non-faculty appointment.

- 11.5.2.** Approval of the selection shall be by the Director of Graduate Medical Education as the dean's designated approval authority.
- 11.6.** Residents shall not perform any clinical duties until they:
 - 11.6.1.** Are processed through the MSM Human Resources Department and officially become a part of the MSM personnel system; and
 - 11.6.2.** Have obtained a Georgia Temporary Resident Postgraduate Training Permit or possess a permanent physician's license.
- 11.7.** References to support this policy including the Resident Appointment Agreement are available in the GME Office and website at <https://www.msm.edu/Education/GME/index.php>.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-13
		EFFECTIVE DATE	06/01/2014
		PAGE(S)	04
	<u>SUBJECT</u> RESIDENT/FELLOW IMPAIRMENT POLICY	SUPERSEDES	04/02/2013

Resident/Fellow Impairment Policy

I. **PURPOSE:**

Morehouse School of Medicine (“MSM”) understands that an impaired resident can impact patient care. Residents encounter many stressors that are personal or from their clinical/educational environment, which may cause mental and physical impairments or require intervention from substance abuse to reverse issues and illnesses.

To that end, our primary goals are to:

- 1.1. Provide guidance in this policy to prevent or minimize the occurrence of impairment by a resident;
- 1.2. Ensure that the environment is safe for patients, employees, faculty, and residents of MSM; and
- 1.3. Compassionately confront problems of impairment to effect diagnosis, relief from patient care responsibilities if necessary, treatment as indicated, and appropriate rehabilitation.

II. **SCOPE:**

All MSM faculty, residents, and administrators at participating affiliates shall understand and comply with this and all other policies and procedures that govern both Graduate Medical Education (“GME”) programs and resident appointments at MSM.

III. **DEFINITIONS:**

- 3.1. **Impaired Physician:** The American Medical Association (AMA) defines the impaired physician as one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process, or loss of motor skill, or use of drugs including alcohol. This definition includes the impairment of a physician due to a mentally or emotionally disabling state.
 - 3.1.1. An impaired resident physician is one who, because of alcohol or other drugs of abuse, mental disorder, or other medical disorders, is unable to participate within the MSM community with requisite skill and safety.
 - 3.1.2. Signs and symptoms of such impairment could include, but are not limited to, a pattern of the following:
 - Observed negative changes in performance of assigned duties
 - Frequent or unexplained absences and/or tardiness from school responsibilities
 - Frequent or unexplained illnesses or accidents both on and off duty
 - Decreased quality of care or unexplained lack of progression during the training year
 - Significant inability to contend with routine difficulties and take action to

overcome them

- Unusual or inappropriate behavior
- Violations of law, including citations for driving while impaired
- Other psychiatric disturbances or medical illness

3.2. Fatigue Management: Recognition by either a resident or supervisor of a level of resident fatigue that may adversely affect patient safety, and enactment of a solution to mitigate the fatigue.

3.3. Fitness for Duty: Mentally and physically able to effectively perform required duties and promote patient safety.

3.4. Under the Influence: The condition wherein any of the body's sensory, cognitive, or motor functions or capabilities are altered, impaired, diminished, or affected due to alcohol, drugs, or controlled substances. "Under the influence" also means any detectable presence of alcohol or drugs within the body.

IV. POLICY:

It is the policy of MSM to assist an impaired resident physician (as defined above), while maintaining a balance between individual rights and the school's duty to safeguard the public health and effectively discharge its mission. MSM and its residency programs must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

4.1. MSM is committed to providing continuing education and professional assistance to resident physicians when they experience personal stressors that inhibit their progression in a residency program. The residency program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.

4.2. Evaluation and due process will be afforded each affected resident according to MSM's GME Adverse Academic Decisions and Due Process Policy and MSM Human Resources employment policies.

V. CONTINUING EDUCATION:

5.1. MSM's GME conducts an annual policy briefing on the Resident Learning and Work Environment at Incoming and Returning Resident Orientation. This institutional training module is also reinforced annually by the specialty residency program. Discussion and training includes:

- Management of the resident's time before, during, and after clinical assignments;
- Recognition of impairment, including illness and fatigue, in themselves and in their peers;
- Each MSM residency program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his or her patient care duties;
- Education of all program faculty members and residents to recognize the signs of fatigue and sleep deprivation; and
- Education of all faculty members and residents in alertness management and fatigue mitigation processes.

- 5.2. MSM's GME Department provides an annual workshop on Sleep Deprivation and Fatigue during Incoming and Returning Resident Orientation. Training in this area is reinforced by each residency program annually according to its curriculum design.
- 5.3. MSM's GME Department provides an annual Drug Awareness and Drug Free Environment workshop for resident physicians at Incoming and Returning Resident Orientations. This workshop includes discussion of impairment due to substance abuse.

VI. IDENTIFICATION AND REPORTING:

At MSM, changes in ordinary behavior and erratic actions by a resident physician may indicate that he or she is not fit for duty. This may be cause for concern by the resident, by colleagues, supervisors, and administrators. In addition, there can be concern for the safety of patients.

- 6.1. The patient safety concern should be brought to the supervisor's attention immediately.
- 6.2. If a problem is identified, the residency director should be notified for administrative action. According to MSM's Resident Affiliation Agreements, a resident can be immediately removed from duty at the discretion of the supervisor or administrator at a clinical affiliate.
- 6.3. Resident impairment that is associated with the commission of a crime is immediately referred to the Department of Human Resources and General Counsel for disposition.

VII. COUNSELING:

All recommendations for the resident to seek counseling must be with the resident's well-being in mind but must be initiated with the provider or agency by the resident.

- 7.1. Residents cannot be unduly influenced or coerced to seek treatment or other counseling services.
- 7.2. When residents are having severe personal difficulty or exhibit unprofessional behavior that may be caused by a mental or physical impairment, they should immediately be referred to MSM's Office of Disability Services. Some of the problems causing impairment can include sleep deprivation and fatigue, emotional and behavioral problems, substance and drug abuse (including alcohol abuse), marital conflicts, interpersonal discord, family problems, legal problems, and financial problems.

Short term counseling is available from MSM Counseling Services (404) 752-1789.

- 7.3. MSM has an Employee Assistance Program (EAP), CARE 24, available for residents as a self-referral or for family assistance. Residents are briefed on these programs by HR during in-coming orientation. Residents are briefed annually on the Drug Awareness Program, resident impairment issues and family counseling.
 - 7.3.1. More information regarding these programs is available in the Human Resources Department at (404) 752-1600 or directly at (888) 887-4114.
 - 7.3.2. Resident educational programs for impaired physicians will be offered on a case-by-case basis.
- 7.4. A written determination must be made by the provider of care to the resident that a resident is fit to return to duty. This recommendation for a return to duty must be presented to the Office of Disability Services. Any restrictions or accommodations in conjunction with the return to duty must be identified and approved by the Office of Disability Services prior to the resident's return.

- 7.5. Complete information is found on the MSM Human Resources Office of Disability Services web page at

<http://www.msm.edu/Administration/HumanResources/disabilityservices/index.php>

VIII. REMEDATION PROBATION:

When a resident fails to achieve the standards set forth by the program, decisions must be made with regard to notice of deficiency, suspension, remediation, non-promotion, non-renewal of appointment, and in some cases, dismissal.

- 8.1. MSM is not required to progressively discipline residents but may determine the appropriate course of action to take regarding its residents, depending on the unique circumstances of a given issue.
- 8.2. Such misconduct will be considered a breach of the Resident Appointment Agreement or Reappointment Agreement. In such instances, the Office of Graduate Medical Education and the Department of Human Resources may be involved in the process of evaluating the violation.
- 8.3. Residents engaging in conduct violating the policies, rules, bylaws, or regulations of MSM or its educational affiliates, or local, state, and federal laws regarding the practice of medicine and the standards for a physician in training may, depending on the nature of the offense, be dismissed.
- 8.4. In the event of an impaired resident's continuation in the residency program, state requirements may apply to his or her status as a resident physician, including mandatory examination and treatment.


IX. STATE OF GEORGIA REQUIREMENTS:

All MSM Residency Program Directors in the State of Georgia have a mandatory obligation to report troubled or dysfunctional resident physicians according to State of Georgia Medical Board Rule 360-2-.12, Reporting Requirements for Program Directors Responsible for Training Temporary Postgraduate Permit Holders in accordance with Georgia Law.

X. CONFIDENTIALITY:

The identification, counseling, and treatment of an impaired resident are deemed confidential, except as needed to carry out the policies of the Office of Graduate Medical Education or MSM as required by law.

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-14
		EFFECTIVE DATE	07/01/2019
		PAGE(S)	06
	<u>SUBJECT</u> RESIDENT/FELLOW LEARNING AND WORKING ENVIRONMENT POLICY	SUPERSEDES	07/01/2017 06/01/2014 04/01/2011

Resident/Fellow Learning and Working Environment Policy

I. PURPOSE:

- 1.1. Graduate Medical Education (GME) is an integral part of the Morehouse School of Medicine (MSM) medical education program. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients.
- 1.2. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions.
- 1.3. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence.

II. SCOPE:

- 2.1. All MSM administrators, faculty, staff, residents, and administrators at participating training affiliates shall understand and support these and all other policies and procedures that govern both GME programs and resident appointments at MSM.
- 2.2. Each resident will receive a copy of this Resident Learning and Working Environment Policy.

III. POLICY:

- 3.1. Per ACGME Learning and Working Environment requirements, residency education must occur in the context of a learning and working environment that emphasizes the following principles:
 - Excellence in the safety and quality of care rendered to patients by residents today
 - Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
 - Excellence in professionalism through faculty modeling of:
 - The effacement of self-interest in a humanistic environment that supports the professional development of physicians
 - The joy of curiosity, problem-solving, intellectual rigor, and discovery
 - Commitment to the well-being of the students, residents, faculty members, and all members of the healthcare team

3.2. Patient Safety

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

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

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

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

3.2.3. Education on Patient Safety

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

3.2.4. Patient Safety Events

3.2.4.1. 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.

3.2.4.2. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

3.2.4.3. Residents, fellows, faculty members, and other clinical staff members must:

3.2.4.3.1. Know their responsibilities in reporting patient safety events at the clinical site;

3.2.4.3.2. Know how to report patient safety events, including near misses, at the clinical site;

3.2.4.3.3. Be provided with summary information of their institution's patient safety reports

3.2.4.4. Residents must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.

3.2.5. Resident education and experience in disclosure of adverse events

3.2.5.1. Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events.

3.2.5.2. This is an important skill for faculty physicians to model, and for residents to develop and apply.

3.2.5.2.1. All residents must receive training in how to disclose adverse events to patients and families.

3.2.5.2.2. Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.

3.3. Quality Improvement

3.3.1. Education in Quality Improvement is a cohesive model of healthcare which includes quality-related goals, tools, and techniques that are necessary for healthcare professionals to achieve quality improvement goals.

Residents must receive training and experience in quality improvement processes, including an understanding of healthcare disparities.

3.3.2. Quality Metrics refers to access to data which is essential to prioritizing activities for care improvement and for evaluating success of improvement efforts.

Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.

3.3.3. 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.

3.3.3.1. Residents must have the opportunity to participate in inter-professional quality improvement activities.

3.3.3.2. This should include activities aimed at reducing healthcare disparities.

3.4. Clinical Experience and Education (formerly duty hours)

3.4.1. Programs, in partnership with their sponsoring institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

3.4.2. Maximum hours of clinical and educational work per week

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.

3.4.3. Mandatory time free of clinical work and education

3.4.3.1. 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.

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

3.4.3.3. 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.

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

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

3.4.4. Maximum clinical work and education period length

- 3.4.4.1.** Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
- 3.4.4.2.** Up to four (4) hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care and/or resident education.
- 3.4.4.3.** Additional patient care responsibilities must not be assigned to a resident during this time.

3.4.5. Clinical and Educational Work Hour Exceptions

- 3.4.5.1.** In rare circumstances, after handing off all other responsibilities, a resident, on her or his own initiative, may elect to remain or return to the clinical site in the following circumstances:
 - 3.4.5.1.1.** To continue to provide care to a single severely ill or unstable patient;
 - 3.4.5.1.2.** To provide humanistic attention to the needs of a patient or family; or
 - 3.4.5.1.3.** To attend unique educational events.
- 3.4.5.2.** These additional hours of care or education will be counted toward the 80-hour weekly limit.
- 3.4.6.** 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.
 - 3.4.6.1.** 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.
 - 3.4.6.2.** Prior to submitting the request to the review committee, the program director must obtain approval from the sponsoring institution's GMEC and DIO.

3.5. In-House Night Float

- 3.5.1.** Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
- 3.5.2.** The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the review committee.

3.6. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

3.7. At-Home Call

Time spent on patient care activities by residents on at-home call must count towards the 80-hour maximum weekly hour limit.

- 3.7.1.** The frequency of at-home call is not subject to the every-third night limitation, but must satisfy the requirement for one-day-in-seven free of clinical work and education, when averaged over four (4) weeks.
- 3.7.2.** At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- 3.7.3.** Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

3.8. MSM GMEC Clinical Work and Education Oversight Procedure:

It is the goal of the Graduate Medical Education Committee (GMEC) and affiliated hospitals that the institution will have no duty hour violations.

3.8.1. Institutional GMEC Clinical Work and Education Monitoring Process

3.8.2. The Program Annual Review Process

- 3.8.2.1.** The GMEC is responsible for conducting an annual review of all programs.
- 3.8.2.2.** As part of the process, the GME Office will review and document each program's clinical work and education compliance status including review of programs' learning and work environment policies and procedures.
- 3.8.2.3.** The GME Office will monitor, track, and report compliance for all programs to the GMEC on a monthly basis.

3.8.3. ACGME Resident Survey


- 3.8.3.1.** Residents are surveyed by the ACGME every year between January and April.
- 3.8.3.2.** Programs found to be noncompliant with the ACGME duty hours will be required to submit a corrective action plan to GMEC.

3.8.4. Program-Level Oversight and Monitoring for Compliance with clinical work and education requirements

3.8.5. Program Clinical Work and Education Policy

- 3.8.5.1.** All programs must demonstrate compliance with ACGME clinical work and education requirements.
- 3.8.5.2.** Programs must develop and maintain a policy on clinical work and education.

- 3.8.5.3.** Program directors must submit the following items annually into the New Innovations system for GME review:
- 3.8.5.3.1.** The program's schedules reflecting daily work hours and compliance with all clinical work and education requirements
- 3.8.5.3.2.** The program's clinical work and education monitoring policy and process which must:
- Meet the educational objectives and patient care responsibilities of the training program and
 - Comply with specialty-specific program requirements, the Common Program Requirements, the ACGME clinical work and education standards, and the Institutional GME clinical work and education policy
- 3.8.5.3.3.** In addition, the program policy must address:
- How the program monitors duty hours, according to MSM institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements
 - How the program monitors the demands of at-home call and adjusts schedules as necessary to mitigate excessive service demands and/or fatigue, if applicable
 - How the program monitors fatigue, and how the program will adjust schedules as necessary to mitigate excessive service demands and/or fatigue
 - How the program monitors the need for and ensures the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged
 - If the program allows moonlighting; if moonlighting is allowed, the policy must comply with and reference the MSM GME Moonlighting Guidelines
 - If the program allows call trading; if so, document how the program oversees to ensure compliance with clinical work and education requirements
 - Mechanisms used by the program to ensure that residents log their duty hours in New Innovations
- 3.8.5.4.** Program directors must complete weekly/monthly duty hour review periods in the New Innovations system and provide oversight comment(s) for any violation. (See document: Duty Hour Oversight—Program Level for step-by-step instructions.)
- 3.8.5.5.** Follow-up and resolution of identified problems are the responsibility of the program director and the department.
- 3.8.5.6.** An action plan must be created for any violation that includes identifying reasons for the violation(s) and how the program will resolve the issue(s) to prevent future violations.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-15
		EFFECTIVE DATE	TBA
		PAGE(S)	05
	<u>SUBJECT</u> MOONLIGHTING POLICY	SUPERSEDES	TBA

Moonlighting Policy

I. PURPOSE:

The purpose of this moonlighting policy is to ensure that MSM GME programs comply with ACGME requirements.

II. ACGME DEFINITIONS:

- 2.1. Moonlighting: Voluntary, compensated, medically-related work performed beyond a resident's or fellow's clinical experience and education hours and additional to the work required for successful completion of the program.
- 2.2. External moonlighting: Voluntary, compensated, medically-related work performed outside the site where the resident or fellow is in training and at any of its related participating sites.
- 2.3. Internal moonlighting: Voluntary, compensated, medically-related work performed within the site where the resident or fellow is in training or at any of its related participating sites.

III. POLICY:

Moonlighting at MSM must be in accordance with the following guidelines:

- 3.1. PGY-1 residents are not permitted to moonlight.
- 3.2. 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/fellow's fitness for work nor compromise patient safety.
- 3.3. Moonlighting must be approved in writing by the program director and designated institutional official (DIO).
- 3.4. Time spent by residents/fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour Maximum Weekly Hour Limit.
- 3.5. Each resident/fellow requesting entry into such activities shall have a State of Georgia physician's license.
- 3.6. Residents/fellows must complete the Moonlighting Request Form and sign the "Professional Liability Coverage" statement available from the GME office. Examples of these follow this policy.
- 3.7. Professional liability coverage provided by MSM does not cover any clinical activities not assigned to the resident/fellow by the residency/fellowship program.

Moonlighting Policy

- 3.8. Moonlighting activities shall not be credited as being part of the program structure or curriculum.
- 3.9. MSM shall not be responsible for these extracurricular activities. The resident/fellow must secure liability coverage for these outside activities from the respective institutions or through his or her own resources.

IV. MOONLIGHTING CRITERIA:

- 4.1. Resident must be a PGY-2 or higher; PGY-1 residents may not moonlight.
- 4.2. J1-Visa sponsored residents may not moonlight.
- 4.3. A full Georgia Physician's license is required to moonlight.
- 4.4. The resident/fellow must have a "good standing" status in the program.
- 4.5. The resident/fellow must log all internal and external moonlighting hours which count toward the ACGME duty hours.
- 4.6. Moonlighting must occur within the state of Georgia.

Moonlighting Request Form

To be completed by the Resident/Fellow:

Program Name:	Academic Year:
Resident/Fellow Name:	PGY Level:
Georgia Medical License #:	Expiration Date:
Name of Malpractice Carrier:	Malpractice policy #:
Name of Moonlighting Site/Organization:	
Address:	City: Zip Code:
Moonlighting Supervisor Name:	Phone number:
Date Moonlighting Starts:	Date Moonlighting Ends:
Moonlighting Activities:	

Maximum hours per week: Number of weeks:

Check One:

_____ External moonlighting: Voluntary, compensated, medically-related work performed **outside** the site of your training and any of its related participating sites.

_____ Internal moonlighting: Voluntary, compensated, medically-related work performed **within** the site of your training or at any of its related participating sites.

Resident/Fellow Acknowledgement of Moonlighting Policy and Procedures

I _____ attest that I meet and will comply with the moonlighting criteria. I understand that moonlighting activities are not credited toward my current training program requirements. I understand that I cannot moonlight during regular program work hours. I agree to submit another moonlighting approval form if there are any changes in location, activity, hours, supervisor, etc.

I understand that violation of the GME moonlighting policy is a breach of the Resident/Fellow Appointment Agreement and may lead to corrective action. I attest that the moonlighting activity is outside of the course and scope of my approved training program.

I understand that Morehouse School of Medicine assumes no responsibility for my actions as relate to this activity. I will also inform the organization that is employing me and will make no representation which might lead that organization or its patients to believe otherwise. While employed in this activity, I will not use or wear any items which identify me as affiliated with Morehouse School of Medicine, nor will I permit the moonlighting organization to represent me as such.

I give my program director permission to contact this moonlighting employer to obtain moonlighting hours for auditing purposes.

I am not paid by the military or on a J1-visa.

By signing below, I attest and agree to all the above statements:

Resident/Fellow Signature: _____ Date: _____

Moonlighting Policy

To be completed by the Program Director:

I attest that the resident is in good standing and meets all the moonlighting criteria. Moonlighting time does not conflict with the training program schedule. Moonlighting duties/procedures are outside the course and scope of the training program. I agree to monitor this resident for work hour compliance and the effect of this moonlighting activity on overall performance. My approval will be withdrawn if adverse effects are noted.

Approved_____ Not Approved_____

Program Director Signature Date

Associate Dean and Designated Institutional Official (DIO) or Designee:

Approved_____ Not Approved_____

Yolanda Wimberly, MD Date

Professional Liability Coverage – Moonlighting Request

This letter shall be completed upon appointment to a Morehouse School of Medicine Residency Program and at any time a Resident/Fellow enters into moonlighting activities.

This is to certify that I, _____, am a Resident/Fellow Physician at Morehouse School of Medicine. As a Physician in training, I understand that all professional activities that are sanctioned by Morehouse School of Medicine related to or a part of the Residency/Fellowship Education Program, are covered by the following professional liability coverage:

- \$1 million per/occurrence and; \$3 million annual aggregate; and;
- Tail coverage for all incidents that occur during my tenure as a Resident/Fellow in accordance with the above.

In addition, I understand that the above professional liability insurance coverage does not apply to professional activities in which I become involved outside of the MSM Residency/Fellowship Program, and that upon written approval by the residency/fellowship program director to moonlight, I am personally responsible for becoming licensed and securing adequate coverage for these outside activities from the respective institutions or through my own resources.

In addition, all these activities shall be recorded and reported to the residency program director for evaluation and approval.


Resident/Fellow signature: _____ Date: _____

Last Four of Social Security Number: _____

Home Address: _____

Phone Number: _____

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-16
		EFFECTIVE DATE	04/02/2013
		PAGE(S)	04
	<u>SUBJECT</u> RESIDENT/FELLOW LEAVE POLICY	SUPERSEDES	04/01/2011

Resident/Fellow Leave Policy

I. **PURPOSE:**

The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition). MSM residents will be afforded the opportunity to provide for personal and/or family welfare through this defined leave policy.

II. **SCOPE:**

All MSM administrators, faculty, staff, residents, and those administrators at participating training affiliates shall understand and support these and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.

III. **POLICY:**

- 3.1. MSM will provide residents with the opportunity to take personal and family leave as needed during a Post-Graduate Year (PGY).
- 3.2. Leave accounting is the responsibility of the residency program director in coordination with the Office of Graduate Medical Education (GME) and the Human Resources Department.
- 3.3. Federal law, Accreditation Council for Graduate Medical Education (ACGME) “program requirements,” and medical specialty board requirements shall apply as applicable.

IV. **COMPENSATED LEAVE TYPES:**

- 4.1. **Resident Vacation Leave:** Residents are allotted 15 days compensated vacation leave per academic year (from July 1 through June 30).
 - 4.1.1. Vacation leave may not be carried forward from year-to-year (accrued).
 - 4.1.2. Vacation leave shall not be subject to an accumulated “pay out” upon the completion of the program, transfer from the program, or upon a resident’s involuntary termination from the program.
- 4.2. **Sick Leave:** Compensated sick leave is 15 days per year. This time can be taken for illness for the resident or for the care of an immediate family member.
 - 4.2.1. Sick leave is not accrued from year to year.
 - 4.2.2. 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.

- 4.3. Administrative Leave:** Granted at the discretion of the program director, may not exceed ten (10) days per twelve-month period. Residents should be advised that some medical boards count educational leave as time away from training and may require an extension of their training dates.
- 4.4. Holiday Leave:** 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.
- 4.5. Family and Medical Leave:** 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:
- For incapacity due to pregnancy, prenatal medical care, or child birth;
 - To care for the employee's child after birth, or placement for adoption or foster care;
 - To care for the employee's spouse, son, daughter, or parent, who has a serious health condition; or
 - For a serious health condition that makes the employee unable to perform the employee's job.
- 4.5.1.** 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.
- 4.5.2.** 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. Direct all questions about FMLA leave to the Human Resources Department.

V. SHORT TERM DISABILITY:

- 5.1.** Short-term disability (STD) is an MSM employee paid benefit offered to regular full-time employees and part-time employees who are eligible for benefits. The benefits are administered by an insurance carrier, which provides income continuation to employees who are unable to work for up to twenty-six (26) weeks due to a non-work related illness or injury that prevents the performance of normal duties of their position.
- 5.2.** Eligible employees must enroll for the STD program within thirty (30) days of employment. If the employee does not enroll within thirty (30) days of eligibility and would like coverage at a later date, the employee must provide evidence of insurability to gain coverage subject to approval by the insurance carrier.
- 5.3.** There is a required fourteen (14) day benefit elimination period during which an employee must use any available accrued sick and/or vacation leave.
- 5.3.1.** If an employee continues to be determined disabled after the benefit elimination period, the insurance carrier will pay sixty percent (60%) of his or her weekly salary until a decision is made that the employee is no longer disabled, or the employee's claim transitions to Long-Term Disability.
- 5.3.2.** The maximum benefit period for STD is twenty-six (26) weeks.
- 5.3.3.** The benefit period could be shorter as determined by medical documentation submitted. For additional information, refer to MSM's Short Term Disability Policy (HR 6.01).

VI. LEAVE OF ABSENCE WITHOUT PAY:

- 6.1. Leave required beyond available compensated sick and/or vacation leave will be uncompensated Leave without Pay (LWOP).
 - 6.1.1. Requests for LWOP shall be submitted in writing to the Residency Program Director and reviewed by the Human Resources Department for disposition and approval no less than 30 days in advance of the start of any planned leave.
 - 6.1.2. The request shall identify the reason for the leave and the duration.
 - 6.1.3. LWOP, when approved, shall not exceed six (6) months in duration.
- 6.2. MSM's Human Resources Department shall advise both the resident and the residency program director on applicable policies and procedures.
 - 6.2.1. All applicable categories of compensated leave must be exhausted prior to a resident being granted LWOP.
 - 6.2.2. Residents shall consult with the HR Manager for Leave Management prior to taking LWOP.

VII. OTHER LEAVE TYPES:

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.

VIII. RETURN TO DUTY:


- 8.1. 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).
- 8.2. When applicable, the residency program director will record in writing the adjusted date required for completion of the PGY 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.

IX. PROGRAM LEAVE LIMITATIONS:

- 9.1. Leave away from the residency program includes the total of all leave categories taken within an academic year. This includes uncompensated Federal Family and Medical Leave or other Leave without Pay (LWOP).
- 9.2. All leave is subject to the requirements of the individual medical specialty boards and the ACGME-RRC regarding the completion of the program.
 - 9.2.1. It is the responsibility of each residency program director to determine the effect of absence from training for any reason on the individual's educational program and, if necessary, to establish make-up requirements that meet the Board requirements for the specialty.
 - 9.2.2. Residents should review the current certification application eligibility requirements at the specialty board website.

X. PROGRAM-LEVEL LEAVE PROCESSES—MONITORING AND TRACKING:

- 10.1.** All residency programs should have written guidelines for resident leave processes including how to request leave. Guidelines must be consistently applicable to all residents in the program.
- 10.2.** Program Managers are responsible for entering and tracking resident leave in New Innovations and the Kronos systems.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-17
		EFFECTIVE DATE	04/01/2011
		PAGE(S)	03
	<u>SUBJECT</u> RESIDENT/FELLOW PROMOTION POLICY	SUPERSEDES	07/01/2004 10/01/1992

Resident/Fellow Promotion Policy

I. **PURPOSE:**

- 1.1. The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition).
- 1.2. A resident will be prepared to undertake independent medical practice upon the successful completion of a residency program and shall have completed requirements to obtain a physician’s license and prepare for certification by a specialty board.

II. **SCOPE:**

All MSM administrators, faculty, staff, residents, and accredited participating affiliates shall understand and support this policy and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.

III. **POLICY:**

- 3.1. Residency education prepares physicians for independent practice in a medical specialty. A resident is expected to progressively increase his or her level of proficiency in order to advance within a residency program.
- 3.2. MSM’s focus is on the resident’s acquisition and development of pertinent skills and behaviors with the intent of providing a competent practicing physician to the community.
- 3.3. Appointments are made on a yearly basis with the expectation of continuation within the one-year appointment and of reappointment yearly throughout the duration of the residency period.

IV. **RESIDENCY PROGRAM PROMOTION:**

4.1. Program Responsibilities

- 4.1.1. The resident will receive periodic, scheduled, written evaluations of his or her performance, progress, and competence in the program specialty as outlined in the MSM Evaluation Policy.
- 4.1.2. Residents must be familiar with ACGME-RRC and MSM educational requirements to successfully complete the residency program.
 - 4.1.2.1. This should begin on the first day of matriculation.

4.1.2.2. At a minimum, residents must be given the following information by the residency program and/or the GME office:

- A copy of the MSM Graduate Medical Education (GME) General Information Policy
- A Residency Program Handbook (or equivalent) outlining at a minimum:
 - The residency program goals, objectives, and expectations
 - The ACGME Specialty Program Requirements
 - The six general competencies designed within the curriculum of the program
 - Clinical rotations and/or other education modules with specific goals, objectives, and expected outcomes
 - Schedules of assignments to support rotations
 - The educational supervisory hierarchy within the program, rotations, and education affiliates
 - The residency program evaluation system

4.2. Promotion Requirements

4.2.1. In order for a resident to complete an MSM residency education program, he or she must successfully meet the following standards in addition to any program-specific requirements:

4.2.1.1. The resident must exhibit clinical and academic performance and competence consistent with the curricular standards and the level of training undergone.

4.2.1.2. The resident must satisfactorily complete all assigned rotations, as supported by evaluation documentation, in each Post-Graduate Year (PGY).

4.2.1.3. The program director must certify that the resident has fulfilled all criteria, including the program-specific criteria, to move to the next level in the program.


4.2.1.4. The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities that can be objectively measured in an academic and/or clinical environment.

4.2.1.5. The resident must achieve a satisfactory score on the in-service examinations along with other program-specific criteria required in order to advance. ACGME-RRC program requirements provide the outline of standards for advancement.

4.2.2. Upon a resident's successful completion of the criteria listed above, the residency program director will certify the completion by placing the semi-annual evaluations and the promotion documentation into the resident's portfolio indicating that the resident has successfully met the specialty requirements for promotion to the next educational level. If this is a graduating resident, the program director should place the Final Summative Assessment in the resident's portfolio.

4.3. Process and Timeline for Promotional Decisions

- 4.3.1.** Normal promotion decisions are made no later than the fourth month of the appointment. Reappointment agreements are prepared based on the residency Clinical Competency Committee and program director's recommendation for promotion.
- 4.3.2.** When a resident will not be promoted to the next level of training, the program will provide the resident with a written notice of intent no later than four (4) months prior to the end of the resident's current appointment agreement. If the primary reason for non-promotion occurs within the last four (4) months of the appointment agreement period, the program will give as much written notice as circumstances reasonably allow.
- 4.3.3.** If a resident's appointment agreement is not going to be renewed, the residency program must notify the resident in writing no later than four (4) months prior to the end of the resident's current contract. If the decision for non-renewal is made during the last four (4) months of the contract period, the residency program must give the resident as much written notice as possible prior to the end of the appointment agreement expiration.
- 4.3.4.** For more information concerning adverse events, refer to the Adverse Academic Decisions and Due Process Policy.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-18
		EFFECTIVE DATE	06/01/2014
		PAGE(S)	04
	<u>SUBJECT</u> SLEEP DEPRIVATION AND FATIGUE POLICY	SUPERSEDES	04/01/2011 09/07/2009

Sleep Deprivation and Fatigue Policy

I. **PURPOSE:**

The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and training requirements of the Accreditation Council on Graduate Medical Education (ACGME). Resident education and patient care management can be greatly inhibited by resident sleepiness and fatigue.

II. **SCOPE:**

This policy is in direct response to requirements of the ACGME pertaining to fatigue mitigation and is designed to ensure the safety of patients as well as to protect the residents’ learning environment. This policy is in addition to any policy established by MSM and its affiliate institutions regarding sleep deprivation and fatigue.

III. **DEFINITION OF FATIGUE:**

- 3.1. Fatigue is a feeling of weariness, tiredness, or lack of energy. Fatigue can impair a physician’s judgment, attention, and reaction time which can lead to medical errors, thus compromising patient safety.
- 3.2. There are many signs and symptoms that would provide insight to one’s impairment based on sleep deprivation. Clinical signs include:
 - Moodiness
 - Depression
 - Irritability
 - Apathy
 - Impoverished speech
 - Flattened affect
 - Impaired memory
 - Confusion
 - Difficulty focusing on tasks
 - Sedentary nodding off during conferences or while driving
 - Repeatedly checking work and medical errors

IV. POLICY:

- 4.1. Programs must educate all faculty and residents to recognize the signs of fatigue and sleep deprivation and in alertness management and fatigue mitigation processes.
- 4.2. Programs must encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
- 4.3. Each program must ensure continuity of patient care consistent with program resident wellness policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue.
- 4.4. The program's education and processes must be designed to:
 - 4.4.1. Raise faculty and residents' awareness of the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care.
 - 4.4.2. Provide faculty and residents with tools for recognizing when they are at risk.
 - 4.4.3. Identify strategies for faculty and residents to use that will minimize the effects of fatigue (in addition to getting more sleep).
 - 4.4.4. Help identify and manage impaired residents.

V. INDIVIDUAL RESPONSIBILITY:

- 5.1. Resident's Responsibilities in Identifying and Counteracting Fatigue
 - 5.1.1. The resident will be educated on the hazards of sleep deprivation and fatigue in the workplace and in their personal lives (e.g.: motor vehicle accidents).
 - 5.1.2. The resident is expected to adopt habits that will provide him or her with adequate sleep to perform the daily activities required by the program.
 - 5.1.3. If the resident is too fatigued to drive home at the end of a work period, he or she should be encouraged to use another form of transportation (e.g.: taxicab) or take a nap prior to leaving the training site.
- 5.2. Faculty Responsibilities in Identifying and Counteracting Fatigue
 - 5.2.1. Faculty will be educated on the hazards of sleep deprivation and fatigue in the workplace and in the provision of care to patients.
 - 5.2.2. Faculty members will be able to determine if residents are sleep deprived and will make the appropriate recommendations to the resident that will correct this problem.

VI. MSM IMPLEMENTATION:

- 6.1. This policy uses the LIFE Curriculum as the source for recommendations and guidance on the management of sleepiness and fatigue in residents. The LIFE Curriculum was created to educate faculty and residents about the effects by fatigue and other common impairments on performance.

6.2. The policy is designed to:

- 6.2.1.** Identify strategies to assist in the prevention of these conditions;
- 6.2.2.** Provide an early warning system for impairments and ways to effectively manage them;
- 6.2.3.** Access appropriate referral resources;
- 6.2.4.** Identify an impaired resident.

6.3. The Sleep Deprivation and Fatigue Policy is appropriate for all residency programs in that it:

- 6.3.1.** Has a faculty component and a resident component;
- 6.3.2.** Addresses policies to prevent and counteract the negative effects on patient care and learning;
- 6.3.3.** Seeks the expertise of existing faculty to present materials;
- 6.3.4.** Uses modules for role play, case studies that address the adverse effects of inadequate supervision and fatigue.

6.4. The GME office shall sponsor a session during orientation where incoming residents will receive an introduction to Clinical Experience and Education (formerly Duty Hours), sleep deprivation and fatigue, and other impairments.

- 6.4.1.** New residents will continue the discussion on sleep deprivation and fatigue in their residency program.
- 6.4.2.** Each program will revisit the topic periodically throughout the year through role play, videos, and other discussions (many of these materials are available through the LIFE Curriculum).

6.5. Faculty will receive a separate orientation to the LIFE Curriculum modules through a faculty development session conducted by each individual program.

- 6.5.1.** The GME office will periodically survey each program to determine if the core faculty has received the training and over what period of time.
- 6.5.2.** The LIFE Curriculum will suffice for this educational session, however programs are encouraged, where appropriate, to adapt the modules or create new modules that are specific to their specialty.

6.6. It is encouraged that each program revisit the sleep deprivation and fatigue curriculum at least twice during the academic year in addition to preparation for the session that new residents receive during orientation.


VII. COUNSELING:

In the event that a resident is reported as one who appears to be persistently sleep deprived or fatigued during service, the program director and faculty mentor will counsel the resident individually to determine if there are some medical, physical, or psychosocial factors affecting the resident's performance. An appropriate referral will be made based on the findings.

VIII. EVALUATION:

The effectiveness of this policy will be measured by:

- The number of residents who report that they have received the training (ACGME Resident survey);
- The number of residents who comply with the clinical experience and education requirements;
- The assessment by faculty and others of the number of incidents by which a resident can be identified as fatigued during work hours and the number of medical errors attributed to resident fatigue.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-19
		EFFECTIVE DATE	06/01/2017
		PAGE(S)	04
	<u>SUBJECT</u> SUPERVISION AND ACCOUNTABILITY POLICY	SUPERSEDES	06/01/2014 04/01/2011 10/01/1992

Supervision and Accountability Policy

I. **PURPOSE:**

The purpose of this policy is to ensure that the Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) comply with ACGME supervision requirements and that the programs meet the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and the specialty program goals and objectives. The resident physician is expected to progressively increase his or her level of proficiency with the provision of predetermined levels of supervision.

II. **SCOPE:**

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

III. **POLICY:**

- 3.1. Supervision in the setting of graduate medical education has the following goals:
 - 3.1.1. Ensuring the provision of safe and effective care to the individual patient;
 - 3.1.2. Ensuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine;
 - 3.1.3. Establishing a foundation for continued professional growth
- 3.2. Each patient must have an identifiable, appropriately-credentialed, and privileged Attending physician (or licensed independent practitioner) who is responsible and accountable for the patient’s care. This information must be available to residents, faculty members, other members of the healthcare team, and patients.
- 3.3. Residents and faculty members must inform patients of their respective roles in each patient’s care when providing direct patient care.
- 3.4. All residents working in clinical settings must be supervised by a licensed physician. The supervising physician must hold a regular faculty or adjunct faculty appointment from the Morehouse School of Medicine. For clinical rotations occurring outside of Georgia the supervising physician must be approved by the residency program director.

- 3.5. The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.
- 3.5.1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
- 3.5.2. The program director must evaluate each resident's abilities based on specific criteria guided by the Milestones.
- 3.5.3. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and delegate him or her the appropriate level of patient care authority and responsibility. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of the residents.
- 3.5.4. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
- 3.5.5. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty members.
- 3.5.6. Each resident must know the limits of his or her scope of authority, and the circumstances under which he or she is permitted to act with conditional independence. Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available.

IV. LEVELS OF SUPERVISION:

- 4.1. To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classifications of supervision:
- 4.1.1. **Direct Supervision:** The supervising physician is physically present with the resident and patient.
- 4.1.2. **Indirect Supervision with direct supervision immediately available:** The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.
- 4.1.3. **Indirect Supervision with direct supervision available:** The supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.
- 4.1.4. **Oversight:** The supervising physician is available to provide review of procedures and encounters with feedback provided after care is delivered.
- 4.2. Each program must specify in writing the type and level of supervision required for each level of the program.
- 4.2.1. Levels of supervision must be consistent with the Joint Commission regulations for supervision of trainees, "graduated job responsibilities/job descriptions."
- 4.2.2. The required type and level of supervision for residents performing invasive procedures must be clearly delineated.

4.2.3. The Joint Commission Standards for GME Supervision include:

- 4.2.3.1.** “Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff.
- 4.2.3.2.** The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant’s progressive involvement and independence in specific patient care activities.
- 4.2.3.3.** Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner.”

V. SUPERVISION OF PROCEDURAL COMPETENCY:

- 5.1.** Residents shall obtain competence in their field to be able to treat and manage patients in a qualified manner.
- 5.2.** This competence shall be evaluated and documented as to success and qualifications. The following protocol is used for administration of certifying residents’ procedural competency.
 - 5.2.1.** Residents must be instructed and evaluated in procedural techniques by a licensed independent practitioner (LIP) who is certified as competent to independently perform that procedure or who has been credentialed by the medical staff office to perform that procedure.
 - 5.2.2.** The Attending or program director is responsible for assessing procedural competency based on direct observation and/or identifying the number of procedures which must be completed successfully to grant proficiency.
 - 5.2.3.** The program director for each training program will be responsible for maintaining an updated list of residents who have been certified as competent to perform procedures independent of direct supervision. This list must be available to Nursing in order to assist them in developing a physician resource listing.
 - 5.2.4.** The program director must also develop a method for surveillance of continued competency after it is initially granted.
 - 5.2.5.** The ability to obtain and document informed consent is an essential component of procedural competency. The supervising LIP must also supervise and attest to the trainee’s competence in obtaining and documenting informed consent.
 - 5.2.6.** Until a resident trainee is judged competent in obtaining informed consent, he or she may only obtain informed consent while supervised by an individual with credentials in that procedure.

VI. GME PROGRAM SUPERVISION PROCEDURES AND PROCESSES:

- 6.1. Each program will maintain current call schedules with accurate information enabling residents at all times to obtain timely access and support from a supervising faculty member.
- 6.2. Verification of required levels of supervision for invasive procedures will be reviewed as part of the Annual Program Review process. Programs must advise the Associate Dean for GME, in writing, of proposed changes in previously approved levels of supervision for invasive procedures.
- 6.3. The GMEC Committee must approve requests for significant changes in levels of supervision.
- 6.4. The program director will ensure that all program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on supervision must be included in the official Program Manual and provided to each resident upon matriculation into the program.
- 6.5. The GME Office provides a Program Supervision Policy Template and Example for programs to utilize.


VII. CLINICAL RESPONSIBILITIES:

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.

VIII. TEAMWORK:

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in the specialty and larger health system.

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-20
		EFFECTIVE DATE	04/02/2013
		PAGE(S)	02
	<u>SUBJECT</u> USMLE STEP 3 REQUIREMENT POLICY	SUPERSEDES	04/01/2011

USMLE Step 3 Requirement Policy

I. **PURPOSE:**

The purpose of this policy is to ensure that the quality of Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition) and the specialty program goals and objectives. 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. Residents must pass USMLE Step 3 by their 20th month of residency.
 - 3.1.1. Residents must present the official results of their USMLE Step 3 examination to the residency program director before the last working day of the resident's 20th month which is, in a normal appointment cycle, February.
 - 3.1.2. Residents who have not passed Step 3 by the end of the 20th month will not receive a reappointment letter to a residency program at the regular time.
- 3.2. Residents who pass USMLE Step 3 between the 21st and 24th month, will receive a reappointment letter to a residency program at the time of receipt of the results, if this is the sole reason for not receiving an appointment letter.
- 3.3. A resident who passes USMLE Step 3 beyond the outer parameters of this policy (e.g.: passes in the 25th month) shall not be waived to continue in the residency program. However, that resident may reapply to the program subject to review by the Associate Dean for Graduate Medical Education in consultation with the program director and the Director of Graduate Medical Education.
- 3.4. Residents who transfer to MSM at the PGY-1 or PGY-2 level are subject to this policy.
 - 3.4.1. MSM residents who change status after beginning training in a PGY-1 preliminary position in internal medicine or surgery to a categorical position in another MSM program are recognized as a transfer resident.
 - 3.4.2. This policy applies even if the resident remains in internal medicine or surgery (preliminary to categorical).
- 3.5. MSM Residency programs shall not select transfer residents above the PGY-2 level for an MSM appointment if they have not passed USMLE Step 3.

- 3.6.** Residents shall be briefed on this policy in the annual GME Orientation.
- 3.6.1.** Residents who have not passed USMLE Step 3, but are still within the time limits, must sign a Letter of Understanding that they acknowledge the policy.
- 3.6.2.** A copy of the Letter of Understanding is co-signed by the GME Director and shall be placed in the resident's educational file as well as in the Office of Graduate Medical Education file.
- 3.7.** Individual waivers to this policy may be considered by the Associate Dean for Graduate Medical Education under the following circumstances:
- Extended illness or personal leave
 - Personal hardship or extenuating circumstances.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-21
		EFFECTIVE DATE	06/01/2017
		PAGE(S)	02
	<u>SUBJECT</u> WELL-BEING POLICY	SUPERSEDES	

Well-Being Policy

I. **PURPOSE:**

Per ACGME, in the current healthcare 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.

II. **SCOPE:**

Programs, in partnership with their sponsoring institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

III. **POLICY:**

3.1. The responsibility of programs in partnership with their sponsoring institutions must include:

3.1.1. Efforts to enhance the meaning that each resident finds in the experience of being a physician, including:

3.1.1.1. Protecting time with patients

3.1.1.2. Minimizing non-physician obligations

3.1.1.3. Providing administrative support

3.1.1.4. Promoting progressive autonomy and flexibility

3.1.1.5. Enhancing professional relationships

3.1.1.6. Paying attention to scheduling, work intensity, and work compression that impacts resident well-being

3.1.1.7. 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

3.1.2. The opportunity for residents to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

- 3.1.3. Attention to resident and faculty member burnout, depression, and substance abuse
 - 3.1.3.1. 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.
 - 3.1.3.2. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care.
- 3.2. The program, in partnership with its sponsoring institution, must:
 - 3.2.1. Encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;
 - 3.2.2. Provide access to appropriate tools for self-screening; and
 - 3.2.3. Provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.
- 3.3. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies.
 - 3.3.1. Each program must have policies and procedures in place that ensure coverage of patient care if a resident may be unable to perform their patient care responsibilities.
 - 3.3.2. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.

Well-being Resources


1. **Individual Residency and Fellowship Program Directors** – please contact the program director of your training program for any concerns and/or issues with resident and faculty well-being.
2. **Cigna Employee Assistance Program (EAP), CARE 24/7/365:** This benefit is available for residents as a self-referral or for family assistance. Residents are briefed on these programs by HR during in-coming orientation. Residents are briefed annually on the Drug Awareness Program, resident impairment issues, and family counseling. More information regarding these programs is available in the Human Resources Department at (404) 752-1600, or Cigna EAP directly at (877) 622-4327, online at www.CignaBehavioral.com and log in using employer ID: MSM.
3. MSM Office of Counseling Services
National Center for Primary Care, Room 221
720 Westview Drive SW
Atlanta, GA 30310
Office: (404) 752-1778
Fax: (404) 756-5224
Shawn Garrison, Ph.D.
http://www.msm.edu/Current_Students/counselingservices/index.php

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MSM Institutional Policies

**Contact the [MSM Human Resources Department](#)
For the Most Current and Up-to-Date
MSM Institutional Policies
(404) 752-1600
OR**

**Marla Thompson
Title IX Coordinator
Morehouse School of Medicine
720 Westview Drive, SW
Harris Building
Atlanta, GA 30310
Direct Dial: (404) 752-1871
Fax: (404) 752-1639
Email: mthompson@msm.edu**

	MOREHOUSE SCHOOL OF MEDICINE HUMAN RESOURCES POLICIES AND PROCEDURES	POLICY NUMBER	HR 1.04
		EFFECTIVE DATE	03/01/2010
		PAGE(S)	03
	<u>SUBJECT</u> ACCOMMODATION OF DISABILITIES POLICY	SUPERSEDES	09/21/2009

Accommodation of Disabilities Policy

I. PURPOSE:

- 1.1. Morehouse School of Medicine is an equal opportunity employer.
- 1.2. This policy sets forth the school's commitment to compliance with all applicable state and federal laws concerning persons with disabilities, including the Americans with Disabilities Act ("ADA").
- 1.3. MSM will conduct all employment practices in a non-discriminatory manner and will make a reasonable accommodation available to any qualified employee with a disability who requests an accommodation.

II. APPLICABILITY:

This policy applies to all current employees, including student employees, employees seeking promotion, and job applicants.

III. POLICY:

- 3.1. MSM prohibits discrimination and/or harassment of disabled employees and applicants.
 - 3.1.1. An individual is considered to have a disability if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.
 - 3.1.2. A qualified individual with a disability is one who can perform the essential functions of his or her job with or without a reasonable accommodation.
- 3.2. MSM prohibits discrimination and/or harassment against any qualified individual with a disability in its employment practices such as job application procedures, hiring, promotion, discharge, compensation, training, benefits, and other conditions of employment.
- 3.3. Reasonable Accommodation of Disabilities
 - 3.3.1. MSM will make a reasonable accommodation available to any qualified individual with a disability who requests an accommodation.
 - 3.3.2. 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.
 - 3.3.3. Some examples of accommodations include, but are not limited to, the following:
 - Restructuring a job
 - Modifying work schedules
 - Providing interpreters
 - Redesigning work areas and equipment or acquiring new equipment
 - Ensuring facility accessibility to those with physical disabilities

- 3.3.4. Accommodations are made on a case-by-case basis.
- 3.3.5. MSM will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in a given situation.
- 3.3.6. 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.
- 3.3.7. 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.
- 3.3.8. 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.
- 3.3.9. 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. Please see below for information on how to request a reasonable accommodation.

IV. GUIDELINES:

4.1. Procedures for Requesting an Accommodation

- 4.1.1. The Human Resources Department has been designated to coordinate applicant and employee requests for workplace accommodations.
- 4.1.2. A person with a disability may request a reasonable accommodation by contacting the Human Resources Department.
- 4.1.3. If the need for the accommodation is not obvious, a certification of disability from an appropriate healthcare provider, as determined by the school, must accompany the request.
 - 4.1.3.1. In addition, if the initial information provided by an individual's healthcare provider is insufficient to substantiate that the individual has an ADA-qualifying disability and is in need of a reasonable accommodation, the school may require the person requesting the accommodation to provide additional data or be evaluated by a healthcare provider of the school's choice.
 - 4.1.3.2. Employees or applicants requesting a reasonable accommodation are expected to work cooperatively with MSM throughout the accommodation process.
- 4.1.4. All information submitted about a disability will be maintained separately from personnel records and kept confidential in accordance with the ADA, except that:
 - 4.1.4.1. Supervisors and managers may be informed regarding restrictions on the work or duties of qualified individuals with disabilities and necessary accommodations;
 - 4.1.4.2. First aid and safety personnel may be informed, to the extent appropriate, if and when a condition might require emergency treatment;
 - 4.1.4.3. Government officials engaged in enforcing laws such as those administered by the Office of Federal Contract Compliance Programs or the Americans with Disabilities Act may be informed.


- 4.2. Determination of whether an employee is a qualified person with a disability and whether a requested accommodation or any other accommodation is reasonable will be made on a case-by-case basis by the supervisor in consultation with the Human Resources Department after discussion as appropriate with the person requesting the accommodation.

V. INTERNAL GRIEVANCE PROCEDURE:

- 5.1. If you have concerns regarding denial of a reasonable accommodation or the specific accommodation selected by the school, you are encouraged to review the process with the Office of Compliance and Internal Audit.
- 5.2. In the event you disagree with the determination or proposed accommodation or believe you have been discriminated against and/or harassed based on a disability, you should contact the Office of General Counsel.

VI. RETALIATION

- 6.1. MSM takes a very strong stance against retaliation. No employee or applicant will be subject to retaliation for attempting to exercise their rights under this policy.
- 6.2. Those who retaliate against an employee or applicant for making a report of disability discrimination and/or harassment, for attempting to secure a reasonable accommodation or otherwise acting in accordance with this policy will be subject to severe discipline, up to and including termination of employment.
- 6.3. If an employee or applicant believes that he or she has been retaliated against, he or she should immediately request assistance from their supervisor or the Human Resources Department.

	MOREHOUSE SCHOOL OF MEDICINE HUMAN RESOURCES POLICIES AND PROCEDURES	POLICY NUMBER	HR 1.02
		EFFECTIVE DATE	06/22/2009
		PAGE(S)	01
	SUBJECT AFFIRMATIVE ACTION/EQUAL EMPLOYMENT OPPORTUNITY POLICY	SUPERSEDES	N/A

Affirmative Action/Equal Employment Opportunity Policy

I. POLICY:


1.1. Equal Employment Opportunity Statement

- 1.1.1. Morehouse School of Medicine (“MSM” or “school”) is fully committed to a policy of equal opportunity throughout the school, and to this end abides by all applicable federal, state, and local laws pertaining to discrimination and fair employment practices.
- 1.1.2. Accordingly, MSM recruits, hires, trains, promotes, and educates individuals without regard to race, color, citizenship status, national origin, ancestry, gender (sex), sexual orientation, age, religion, creed, disability, marital status, veteran status, political affiliation, genetic information, HIV/AIDS status, or any classification protected by local, state, or federal law.

1.2. Affirmative Action Statement

- 1.2.1. MSM’s affirmative action program is designed to achieve diversity among faculty, administrators, and staff and to treat all appointments and promotions in a manner free from discrimination.
- 1.2.2. At MSM, we seek an inclusive working environment where all talented personnel have an equal opportunity to be recruited, employed, and promoted and to enjoy equally all other terms and conditions of employment.
- 1.2.3. For that reason, along with the principle of nondiscrimination, MSM is mindful of its affirmative action commitment of ensuring that groups specified by the United States Department of Labor (qualified members of minority groups, women, disabled individuals who are otherwise qualified, special disabled veterans, and veterans of the Vietnam era) also have an equal opportunity to be considered for hire, recruitment, promotion, and other terms and conditions of employment.
- 1.2.4. If you have any questions relating to equal opportunity, affirmative action, or if you want the school to pursue a possible violation of the policy, contact MSM’s Human Resources Department at (404) 752-1600 or the Chief Compliance and Internal Audit Officer at (404) 756-8919.

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	MOREHOUSE SCHOOL OF MEDICINE HUMAN RESOURCES POLICIES AND PROCEDURES	POLICY NUMBER	HR 2.04
		EFFECTIVE DATE	03-01-2010
		PAGE(S)	02
	<u>SUBJECT</u> NEPOTISM POLICY	SUPERSEDES	N/A

Nepotism Policy

I. **PURPOSE:**

- 1.1. This policy defines Morehouse School of Medicine's policy regarding the standards for close relatives either working for or obtaining educational instruction at the Morehouse School of Medicine in the same or different departments.
- 1.2. This policy is designed to minimize the occurrence of a conflict of interest in employment decisions and to manage them when they do arise.
- 1.3. This policy applies to all faculty and staff.

II. **POLICY:**


- 2.1. MSM permits the employment and/or enrollment for academic purposes of qualified relatives of employees as long as such employment or academic pursuit does not, in the opinion of the School, create actual conflicts of interest.
- 2.2. For purposes of this policy, "relative" is defined as a spouse, child, parent, sibling, grandparent, grandchild, aunt, uncle, cousin, corresponding in-law, "step" relation, or equivalent, or any person with whom the employee has a close personal relationship such as a domestic partner, romantic partner, or co-habitant.

III. **GUIDELINES:**

MSM will use sound judgment in the placement of related employees in accordance with the following guidelines.

- 3.1. Individuals who are related by blood, marriage, or who reside in the same household are permitted to work or engage in academic pursuits in the same MSM department, provided no direct reporting or supervisor-to-subordinate relationship exists.
 - 3.1.1. For academic purposes, no direct teaching, instructor-to-resident, or instructor-to-student relationship can exist.
 - 3.1.2. That is, no employee is permitted to work within "the chain of command" when one relative's work responsibilities, salary, hours, career progress, benefits or other terms and conditions of employment could be influenced by the other relative.
 - 3.1.3. Similarly, no student is permitted to pursue an educational opportunity within the "chain of command" when one relative's academic duties, grades and responsibilities could be influenced by the other relative.
- 3.2. Related employees may have no influence over the wages, hours, benefits, career progress, and other terms and conditions of the other related staff members, students, or academicians.

- 3.3.** Employees or persons pursuing academic opportunities who marry while employed, or become part of the same household, are treated in accordance with these guidelines. That is, if in the opinion of MSM, a conflict arises as a result of the relationship, one of the employees and/or residents may be transferred at the earliest practicable time.
- 3.4.** Each employee, student, or resident has a responsibility to keep his or her supervisor, the appropriate associate dean or residency program director and the Human Resources Office informed of changes relevant to this policy, such as becoming a domestic partner or relative of another employee through marriage or new supervisory conflicts created by changes in organizational structure.
- 3.5.** Failure to disclose this information to your supervisor, the appropriate associate dean, residency program director, or the Human Resources Office before the decision, or when the information is first learned, may result in disciplinary action up to and including termination or dismissal from one's academic program.
- 3.6.** If the special talents, background, or training of the relative would be in the overall interest of MSM, the department head may request an exception to this policy.
- 3.7.** Exceptions to this policy require the approval of the president, dean, and/or Associate Vice President of Human Resources.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	H.R. 1.00 (Title IX)
		EFFECTIVE DATE	10-1-2014
		PAGE(S)	18
	<u>SUBJECT</u> SEX/GENDER NON-DISCRIMINATION AND SEXUAL HARASSMENT POLICY	SUPERSEDES	9-27-2012 6-22-2009

Sex/Gender Non-Discrimination and Sexual Harassment Policy

I. POLICY:

- 1.1. Morehouse School of Medicine ("MSM" or "School") does not discriminate on the basis of sex in its employment decisions, education programs and education activities as required under Title IX of the Education Amendments of 1972 and in its implementing regulations, and in part under Title VII of the Civil Rights Act of 1964, as well as any other applicable federal and state laws or local ordinances.
- 1.2. This policy covers all employment and admissions decisions affecting any member of the "MSM Community" (as defined below) as they related to conduct prohibited under this policy, including sex/gender discrimination, as well as all types of sexual misconduct, including, but not limited to, sexual harassment and sexual violence.
- 1.3. MSM also prohibits retaliation against members of the MSM Community (as defined below) who raise concerns about or report incidents of sex discrimination and sexual harassment.
- 1.4. Any individual found to have violated this Policy will be subject to disciplinary action up to and including termination for employees, expulsion for students, and non-renewal for resident physicians.
- 1.5. Certain behavior also violates MSM's policy even when it does not constitute a violation of law.
- 1.6. General inquiries about the application of Title IX should be directed to the U.S. Department of Education's Office of Civil Rights or the School's Title IX Coordinator or Deputy Title IX Coordinator:

Marla Thompson
 Title IX Coordinator
 Morehouse School of Medicine
 720 Westview Drive, SW
 Harris Building
 Atlanta, GA 30310
 Direct Dial: (404) 752-1871
 Fax: (404) 752-1639
 Email: mthompson@msm.edu

Valerie Walton

Deputy Title IX Coordinator
Morehouse School of Medicine
720 Westview Drive, SW
Harris Building
Atlanta, GA 30310
Direct Dial: (404) 752-1606
Fax: (404) 752-1639
Email: vjwalton@msm.edu

II. APPLICABILITY:

- 2.1. This Policy applies to all faculty, staff, administration, supervisors, employees, resident physicians, students, applicants, volunteers, patients and visitors to campus, including guests, patrons, independent contractors or clients of MSM (individually "Person(s)"; collectively "the MSM Community").
- 2.2. This Policy prohibits unlawful discrimination, harassment and retaliation on the basis of sex in any employment decision, education program or educational activity, which means all academic, educational, extracurricular, and other programs and operations.
- 2.3. Any MSM Persons designated by MSM to have the authority to address or duty to report alleged gender-based discrimination, sexual harassment and/or retaliation who fails to address or report alleged gender-based discrimination, sexual harassment and/or retaliation of which they know or should have known, may be subjected to sanctions up to and including termination of employment, dismissal or expulsion.

III. DEFINITIONS:

- 3.1. **Complaint** means a Complaint alleging any action, policy, procedure, or practice which would be prohibited by Title IX, such as gender-based discrimination or sexual harassment.
- 3.2. **Complaint Answer** means the written statement of the Respondent regarding the Complaint allegation and possible corrective action.
- 3.3. **Complainant** means an MSM Person who submits a Complaint under this Policy, or an individual or group submitting a Complaint on behalf of an MSM student or employee.
- 3.4. **Consent** means clear, unambiguous, and voluntary agreement between participants to engage in specific sexual activity.
 - 3.4.1. Consent is active, not passive, and is given by clear actions or words.
 - 3.4.2. Consent may not be inferred from silence, passivity, or lack of active resistance alone.
 - 3.4.3. A current or previous dating or sexual relationship is not sufficient to constitute consent, and consent to one form of sexual activity does not imply consent to other forms of sexual activity.
 - 3.4.4. Being intoxicated does not diminish one's responsibility to obtain consent. In some situations, an individual may be deemed incapable of consenting to sexual activity because of circumstances or the behavior of another, or due to their age. Examples of such situations absent of consent include, but are not limited to, incompetence, impairment from alcohol and/or other drugs, fear, unconsciousness, intimidation, coercion, confinement, isolation, or mental or physical impairment.

- 3.5. Corrective Action** means action which is taken by MSM to eliminate or modify any policy, procedure, or practice found to be in violation of Title IX and/or to provide redress to any Complainant injured by the identified violation. Corrective action includes sanctions up to and including, termination of employment, suspension, expulsion, or non-renewal.
- 3.6. Dating Violence** is violence committed by a person:
- 3.6.1.** Who is or has been in a social relationship of a romantic or intimate nature with the victim; and
- 3.6.2.** Where the existence of such a relationship may be determined based on the following factors: (i) the length of the relationship; (ii) the type of relationship; (iii) the frequency of interaction between the persons involved in the relationship.
- 3.7. Discrimination** is adverse treatment of any Person based on that Person's gender, rather than on the basis of his/her individual merit or other lawful considerations. Decisions made with respect to the terms, conditions, or privileges of employment and education including, but not limited to hiring, firing, promoting, disciplining, scheduling, training, or deciding how to compensate an employee, resident, student, or applicant must be made without consideration of an individual's gender.
- 3.8. Domestic Violence (or Family Violence)** is a category of felony or misdemeanor crimes of violence committed by a current or former spouse of the victim, by a person with whom the victim shares a child in common, by a person who is cohabitating with or has cohabitated with the victim as a spouse, by a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction or by any other person against an adult or youth victim who is protected from that person's acts under the domestic or family violence laws of the jurisdiction. Georgia state law specifically defines such violence as the occurrence of a felony or the commission of offenses of battery, simple battery, simple assault, assault, stalking, criminal damage to property, unlawful restraint, or criminal trespass between:
- Past or present spouses;
 - Persons who are parents of the same child;
 - Parents and children;
 - Stepparents and stepchildren;
 - Foster parents and foster children; or
 - Other persons living or formerly living in the same household.
- 3.9. Notice of Outcome** means the written statement of a Title IX Coordinator, Deputy Title IX Coordinator, or other investigator of his/her findings regarding the validity of the complaint and the recommended Corrective Actions to be taken and/or sanctions to be imposed.
- 3.10. Respondent** means a person alleged to be responsible, or who is accused of conduct alleged in the complaint to constitute a Title IX violation. The term may be used to designate persons with direct responsibility for a particular action or those persons with supervisory responsibility for procedures and policies in those areas covered in the complaint (i.e. a department head or chairperson).
- 3.11. Retaliation** is any adverse action taken against an individual because he or she filed a charge of discrimination (including harassment), complained to the School or a government agency about discrimination and/or harassment on the job or in an academic setting, or participated in an employment or student discrimination proceeding (such as an internal investigation or lawsuit), including as a witness.

3.11.1. Retaliation also includes adverse action taken against someone who is associated with the individual opposing the perceived discrimination or harassment, such as a family member.

3.11.2. Examples of retaliation include termination, dismissal, demotion, refusal to promote, or any other adverse action involving a term, condition, or privilege of employment or academic opportunity.

3.12. Sexual harassment is conduct that is sexual in nature, is unwelcome and denies or limits a student's ability to participate in or benefit from a school's education programs, or negatively impacts an individual's work environment at MSM.

3.12.1. It is a form of misconduct that is demeaning to others and undermines the integrity of the employment relationship and learning environment.

3.12.2. Sexual harassment is unlawful and prohibited regardless of whether it is between or among members of the same sex or opposite sex.

3.12.3. Sexual harassment also may consist of inappropriate gender- based comments and gender stereotyping.

3.12.4. Examples of conduct constituting sexual harassment and which create a hostile environment include, but is not limited to:

- Making unwelcome sexual advances, propositions or other sexual or gender-based comments, such as sexual or gender-oriented gestures, sounds, remarks, jokes or comments about a Person's gender, sex, sexuality or sexual experiences;
- Requesting sexual favors, or engaging in other verbal or physical conduct of a sexual nature;
- Verbal abuse of a sexual nature, graphic verbal commentaries about an individual's body, sexually degrading words used to describe an individual, or suggestive or obscene letters, notes, drawings, pictures or invitations;
- Conditioning any aspect of an individual's employment or academic participation on his or her response to sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature;
- Creating an intimidating, hostile or offensive working or academic environment by sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature; and
- Conduct that is criminal in nature, such as rape, sexual assault, domestic violence, dating violence, sexually motivated stalking and other forms of sexual violence.

3.13. Sexual assault is a sexual act against the will and without the consent of the individual (alleged victim).

3.13.1. Falling under the definition of sexual assault is sexual activity such as forced sexual intercourse, sodomy, child molestation, incest, fondling, rape, attempted rape, sexual battery and aggravated sexual battery.

3.13.2. Additionally, Georgia law defines sexual assault as sexual contact that is perpetrated by a person who has supervisory or disciplinary authority over another individual. Sexual assault is a criminal sex offense under Georgia law.

3.14. Stalking occurs when a person follows, places under surveillance or contacts another person (i.e. the victim) at or about any public or private property occupied by the victim other than the residence of the person without the consent of the victim for the purpose of harassing and intimidating the victim.

- 3.14.1.** Harassment and intimidation is a knowing and willful course of conduct directed at a specific person which causes emotional distress by placing such person in reasonable fear for such person's safety or the safety of a member of his or her immediate family, by establishing a pattern of harassing and intimidating behavior, and which serves no legitimate purpose.
- 3.14.2.** Examples of contacting another person include, but are not limited to, communicating in person, by telephone, by mail, by broadcast, by computer or computer network, or by any other electronic device.
- 3.15.** **Title VII**, as referenced in this Policy, means Title VII of the Civil Rights Act of 1964, the Title VII implementing regulations, and any memoranda, directives, guidelines, or subsequent legislation that may be issued or enacted specifically in the context of sex/gender discrimination. Like Title XII, Title VII prohibits, in part, employment discrimination based on sex/gender. All other types of non-gender related prohibited
- 3.16.** **Title VII conduct** is addressed and covered by the School's General Statement of Nondiscrimination and Anti-Harassment Policy.
- 3.17.** **Title IX** means Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681 and 1682), the 1980 implementing regulations (34 C.F.R. Subpart E), and any memoranda, directives, guidelines, or subsequent legislation that may be issued or enacted. Title IX states, in relevant part, that "no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance."
- 3.18.** **Title IX Coordinator**, as referenced in this Policy, means the employee(s) designated to coordinate the School's efforts to comply with and carry out its responsibilities under Title IX and the Title IX implementing regulations.
- 3.18.1.** The Title IX Coordinator (and the Deputy Title IX Coordinator) is responsible for investigating and disposing of all complaints of unlawful sex-based discrimination, sexual harassment and retaliation involving Persons covered under this Policy; monitoring the School's overall implementation of Title IX complaint proceedings; coordinating the School's compliance with Title IX; and determining the corrective action necessary for future prevention of unlawful sex-based discrimination, sexual harassment, and retaliation.
- 3.18.2.** In cases where sex-based employment discrimination is alleged, the Title IX Coordinator (or deputy) will also coordinate the School's efforts to comply with and carry out its responsibilities under Title VII and the Title VII implementing regulations, where the application of Title IX and Title VII overlap.
- 3.19.** **Title IX Investigator**, as referenced in this Policy, means the Title IX Coordinator, Deputy Title IX Coordinator, or their designee, tasked with investigating any complaints made under this Policy, and issuing an Interim Notice of Outcome regarding same.

IV. PROHIBITION AGAINST RETALIATION:

- 4.1. Title IX (and Title VII) expressly prohibits retaliation against anyone who, in good faith, reports what s/he believes is discrimination or harassment, who participates or cooperates in any investigation, or who otherwise opposes unlawful conduct believed to be in violation of this policy.
- 4.2. Retaliation includes intimidation, harassment, threats, or other adverse action or speech against the person who reported the misconduct, the Complainant(s), or witnesses. MSM will not only take steps to prevent retaliation, but it will also take strong corrective action if it occurs.
- 4.3. Anyone who believes he or she has been the victim of retaliation for reporting discrimination or harassment, participating or cooperating in an investigation or otherwise opposing unlawful conduct believed to be in violation of this policy should immediately contact the Title IX Coordinator or the Deputy Title IX Coordinator, who have authority to investigate all such claims.
- 4.4. Any individual found to have retaliated against another individual who engaged in conduct consistent with the protections afforded under this Policy will be in violation of this policy and will be subject to disciplinary action.

V. FALSE ACCUSATIONS:

- 5.1. Anyone who knowingly makes a false accusation of discrimination, harassment, or retaliation will be subject to appropriate sanctions.
- 5.2. Failure to prove a claim of discrimination, harassment, or retaliation does not, in and of itself, constitute proof of a knowing false accusation.

VI. JURISDICTION AND AUTHORITY OF MSM AND THE TITLE IX COORDINATOR:

- 6.1. MSM through the Title IX Coordinator and/or Deputy Title IX Coordinator has jurisdiction to receive, investigate, hear and resolve reports and/or formal complaints brought by MSM faculty, staff, Resident Physicians, students and other members of the MSM Community that involve or invoke Title IX.
- 6.2. The Title IX Coordinator is authorized to enact procedures that include specific instructions for reporting, investigating and resolving incidents and/or Title IX complaints.
- 6.3. There is no time limit to filing a complaint, making a report or commencing an investigation under these procedures.
 - 6.3.1. However, victims are encouraged to report a complaint immediately in order to maximize the School's ability to obtain information, and conduct an adequate, thorough, prompt, and impartial investigation.
 - 6.3.2. Failure to promptly report alleged sex discrimination or sexual violence may result in the loss of relevant information, evidence, and reliable witness testimony, and may impair the School's ability to carry out these procedures.

VII. PROCEDURES A VICTIM SHOULD FOLLOW IMMEDIATELY FOLLOWING THE OCCURRENCE OF SEX DISCRIMINATION OR SEXUAL HARASSMENT:

- 7.1. MSM is acutely aware that a victim of sex discrimination and/or of a sex offense, in particular, may experience physical, mental and emotional trauma as a result of the incident.
- 7.2. Therefore, in order for MSM to conduct a prompt, fair and thorough investigation into the incident and commence appropriate disciplinary proceedings (if the victim so chooses), a victim of sexual violence (e.g., rape, sexual assault, dating violence, domestic violence, stalking) is encouraged to follow these procedures immediately following the occurrence, when possible:
 - 7.2.1. Go to a safe place as soon as possible.
 - 7.2.2. Do not wash, shower, bathe, use the toilet or change clothing.
 - 7.2.3. Preserve any evidence as would be necessary to prove the offense, or in obtaining a protective order, restraining order, and/or no-contact order. Examples of such evidence include:
 - 7.2.3.1. Clothing worn during the incident, including, but not limited to, undergarments;
 - 7.2.3.2. Sheets, bedding, and condoms, if used;
 - 7.2.3.3. A list of witnesses with contact information;
 - 7.2.3.4. Text messages, emails, call history, and social media posts; and
 - 7.2.3.5. Pictures of any injuries.
 - 7.2.4. Call the appropriate law enforcement agency.
 - 7.2.4.1. If the sex offense occurred on campus, contact the Department of Public Safety as soon as possible by (404) 752-1794 or (404) 752-1795.
 - 7.2.4.2. If the attack did not occur on campus, call the law enforcement agency having jurisdiction where the sex offense (i.e. the rape, sexual assault, dating violence, domestic violence, etc.) occurred.
 - 7.2.5. Get medical attention.
 - 7.2.5.1. If called, the Department of Public Safety will assist the victim in calling an EMS, if wanted.
 - 7.2.5.2. You may also take yourself or have someone else take you directly to the medical facility or medical provider of choice.
 - 7.2.5.3. Please ensure that any medical assistance you receive will include collecting any evidence.
 - 7.2.6. Talk to a counselor.
 - 7.2.6.1. The victim may contact MSM Counseling Services at (404) 752-1789 for guidance on medical and counseling services.
 - 7.2.6.2. Employees should consult the Employee Assistance Program at 1-877-622-4327 for guidance on medical and counseling service referrals.
 - 7.2.6.3. The victim also has a right to have an advocate and support person present at the hospital, doctor's office, or urgent care unit for examination.

VIII. OPTIONS FOR REPORTING OR DISCLOSING INCIDENTS OF SEXUAL VIOLENCE:

- 8.1. If a victim of a sex offense, domestic violence, dating violence, sexual assault or stalking or other form of sexual violence is able and feels safe, he or she should clearly explain to the alleged offender that the behavior is objectionable and request that it cease.
- 8.2. Alternatively, if the victim is not able or does not feel safe confronting the alleged offender, or the behavior does not stop, or if the victim believes some adverse employment, academic or educational consequences may result from the discussion, the victim may do one or more of the following:
 - 8.2.1. Report the offense to his/her immediate supervisor or department chairperson, the Title IX Coordinator, or the Deputy Title IX Coordinator.
 - 8.2.2. Notify the Department of Public Safety or other law enforcement authorities;
 - 8.2.3. Request assistance in notifying appropriate law enforcement authorities, which assistance MSM will provide; or
 - 8.2.4. Decline to notify any such authorities.

IX. FILING A COMPLAINT FOR VIOLATIONS OF THE SEX/GENDER NONDISCRIMINATION AND SEXUAL HARASSMENT POLICY:

- 9.1. Any Person, or any individual or group acting on behalf of a Person, seeking to raise concerns with individual or institutional sex-based discrimination, sexual harassment or sexual violence may file a formal complaint with the Title IX Coordinator or the Deputy Title IX Coordinator.
- 9.2. The Title IX Coordinator (or Deputy Title IX Coordinator) must be contacted in order to initiate a complaint.
- 9.3. The complaint should be brought as soon as possible after the most recent incident.
- 9.4. No Person should assume that an official of MSM knows about a particular situation.
- 9.5. The School encourages any individual who feels he or she has been discriminated against or harassed to promptly report the incident to the Title IX Coordinator or the Deputy Title IX Coordinator.
- 9.6. Any person who knows of, or receives a complaint of sex discrimination or sexual harassment should report the information to or file a complaint with the Title IX Coordinator or the Deputy Title IX Coordinator.
- 9.7. Complaints filed with the Title IX Coordinator or the Deputy Title IX Coordinator must be in writing and provide the following information: (i) name and contact information for the complaining Person(s) ("Complainant(s)"); (ii) nature and date of alleged violation; (iii) names and contact information for the Person(s) responsible for the alleged violation (where known) ("Respondent(s)"); (iv) requested relief or corrective action (specification of desired relief shall be the option of the Complainant); and (v) any other background or supplemental information that the Complainant believes to be relevant (e.g., names of other persons affected by the violation, etc.).
- 9.8. Upon receipt of a complaint alleging dating violence, domestic violence, sexual assault, stalking, or sexual violence, the Title IX Coordinator or the Deputy Title IX Coordinator will promptly schedule an individual meeting with the victim to:
 - 9.8.1. Provide him/her a general understanding of these complaint procedures, the prohibition against retaliation, and the investigative process;

- 9.8.2.** Discuss and provide written information regarding forms of support or immediate interventions available to the victim, such as on- and off-campus resources and interim measures;
- 9.8.3.** Discuss and provide written information regarding the victim's options for, and available assistance in, changing any accommodations that may be appropriate and reasonably available concerning the victim's academic, living, transportation and working situations;
- 9.8.4.** Seek to determine if the victim wishes to notify law enforcement authorities, wishes to be assisted in notifying law enforcement authorities, or does not wish to notify law enforcement authorities;
- 9.8.5.** Where applicable, provide information to the victim of his or her rights and the School's responsibilities regarding orders of protection, no contact orders, restraining orders, or similar lawful orders issued by a criminal, civil or tribal court; and
- 9.8.6.** Inform the victim about how MSM will protect his or her confidentiality, including the omission of the victim's identifying information in publicly-available records or in oral and written communications to the accused, to the extent permissible by law.

X. WHEN THE VICTIM REQUESTS CONFIDENTIALITY AND/OR ELECTS NOT TO PROCEED WITH AN INVESTIGATION OR PURSUE FORMAL DISCIPLINARY PROCEEDINGS:

- 10.1.** If the victim does not wish to proceed with an investigation and/or requests that the complaint or report remain confidential, the Title IX Coordinator or the Deputy Title IX Coordinator will inform the victim that the School's ability to respond fully to the incident may be limited because of this desire. The victim should also understand that Title IX prohibits retaliation, and that School officials will not only take steps to prevent retaliation but also take strong responsive action if it occurs.
- 10.2.** The Title IX Coordinator or Deputy Title IX Coordinator will weigh the victim's request(s) for confidentiality and/or wish not to proceed with an investigation against the School's obligation to provide a safe, non-discriminatory environment for all students. Specifically, the Title IX Coordinator or Deputy Title IX Coordinator will consider the following factors:
 - 10.2.1.** The seriousness of the misconduct;
 - 10.2.2.** Whether there have been other complaints of sex discrimination or sexual violence against the accused at the School or any other school or in the nature of prior criminal charges;
 - 10.2.3.** Whether the accused threatened further misconduct or violence against the victim or others;
 - 10.2.4.** Whether the misconduct was committed by multiple perpetrators;
 - 10.2.5.** Whether the misconduct involved use of a weapon;
 - 10.2.6.** The age of the victim;
 - 10.2.7.** Whether the School possesses other means to obtain relevant evidence of the misconduct;

- 10.2.8.** Whether the complaint reveals a pattern of conduct at a particular location or by a particular individual and group of individuals; and
- 10.2.9.** The accused's right to receive information about the allegations if the information is maintained by the University as an "education record" under the Family Educational Rights and Privacy Act (FERPA), if applicable.
- 10.3.** Even if the victim does not wish to file a formal complaint or proceed with an investigation because he or she insists on confidentiality or requests that the complaint not be resolved, Title IX still allows MSM to investigate and take reasonable corrective action in response to the victim's complaint if the Title IX Coordinator or the Deputy Title IX Coordinator determines, subject to the factors listed above, that the School must override the victim's request for confidentiality in order to meet its Title IX obligations. However, these instances will be limited and evaluated on a case-by-case basis. The Title IX Coordinator or Deputy Title IX Coordinator will ultimately inform the victim if the School cannot ensure confidentiality.
- 10.4.** In an instance where the School must disclose a victim's identity to the accused, the Title IX Coordinator or Deputy Title IX Coordinator will inform the victim prior to making the disclosure.

XI. INTERIM AND REMEDIAL MEASURES:

- 11.1.** Regardless of whether a victim of sex discrimination, sexual violence or sexual harassment chooses to report the incident or file a formal complaint, the School shall take one or more of the following remedies, as well as other remedies deemed appropriate for each specific case, while keeping the victim's identity confidential:
 - 11.1.1.** Providing the victim with a campus security escort to ensure that he or she can move safely between buildings on campus;
 - 11.1.2.** Ensuring that the victim and the accused do not attend the same classes, seminars, functions, meetings, etc.;
 - 11.1.3.** Providing counseling services;
 - 11.1.4.** Providing medical services;
 - 11.1.5.** Providing academic support services, such as tutoring (in cases involving students);
 - 11.1.6.** Arranging for the victim to re-take a course or withdraw from a class without penalty, including ensuring that any changes do not adversely affect the victim's academic records;
 - 11.1.7.** Reviewing any disciplinary actions taken against the victim to see if there is a causal connection between the harassment and the misconduct that may have resulted in the victim being disciplined.
- 11.2.** The School also reserves the right to suspend the accused or place him/her on administrative leave pending the investigation of the victim's complaint or disciplinary or criminal proceedings. The interim suspension or leave shall become immediately effective without prior notice whenever there is evidence that the continued presence of the student or employee, respectively, at the School poses a substantial and immediate threat to himself or herself, or to others. A student or employee suspended or placed on administrative leave, respectively, on an interim basis under this policy shall be given a prompt opportunity to appear personally before the Title IX Coordinator or Deputy Title IX Coordinator to discuss the following issues only:

11.2.1. The reliability of the information concerning the Respondent conduct, including the matter of his or her identity; and

11.2.2. Whether the conduct and surrounding circumstances reasonably indicate that the continued presence of the accused on School premises poses a substantial and immediate threat to himself or herself, or to others.

11.3. The School may also consider and take interim remedial measures that affect the broader MSM population, including, but not limited to, offering School-wide counseling and training; developing, updating and disseminating materials on sex discrimination or sexual harassment, developing and implementing new policies and complaint procedures; and conducting internal School investigations to assess the effectiveness of the School's efforts to eliminate sex discrimination or sexual harassment and promote an environment free of sex discrimination and harassment.

11.4. Mediation will not be used to resolve complaints of sexual assault, sexual violence, domestic violence, dating violence, or stalking.

XII. PROCEDURES FOR INVESTIGATING VIOLATIONS OF THE SEX/GENDER NONDISCRIMINATION AND SEXUAL HARASSMENT POLICY:

12.1. Procedure for investigating allegations of co-worker/employee-on-co-worker/employee sexual harassment or sex discrimination

Upon receipt of complaint of any allegation of sex discrimination or sexual harassment between co-workers or employees, the School will promptly investigate, and take prompt, remedial action to remedy any confirmed conduct in violation of this Policy.

12.2. Procedure for investigating allegations of sexual assault, sexual violence, domestic violence, dating violence, stalking or any other Title IX violations not involving co-worker/employee-on-co-worker/employee sexual harassment or sex discrimination:

12.2.1. A Title IX/Discrimination Complaint Form will be prepared by the Title IX Coordinator or the Deputy Title IX Coordinator to facilitate the filing of the complaint. This form can be obtained from the Title IX Coordinator (or deputy).

12.2.2. Within five (5) days of the filing of a Complaint, the Title IX Coordinator or the Deputy Title IX Coordinator will schedule an individual meeting with the accused (i.e. the Respondent) in order to provide him/her with notice of the complaint, of his/her responsibility to submit a written complaint answer within five (5) days after receipt of the complaint notification. The Title IX Coordinator or the Deputy Title IX Coordinator will also provide the Respondent with a general understanding of the procedures for investigating and resolving complaints of sex discrimination and/or sexual harassment, and identify forms of support or immediate interventions available to him/her, if applicable.

12.2.3. The Respondent(s) receiving a copy of a complaint shall, within five (5) days, submit a written complaint answer to the Complainant and the Title IX Coordinator or the Deputy Title IX Coordinator. Such answer shall: (i) confirm or deny each fact alleged in the complaint; (ii) indicate the extent to which the complaint has merit and offer any facts or evidence to disprove the allegations made against him/her; and (iii) indicate acceptance or rejection of any desired redress specified by the Complainant, or outline an alternative proposal for redress.

- 12.2.4.** Within five (5) days after receipt of the Respondent's written complaint answer, the Title IX Coordinator or the Deputy Title IX Coordinator will investigate the allegations. If no complaint answer has been received on the fifth (5th) day after notification of the Respondent, the Title IX Coordinator or the Deputy Title IX Coordinator shall send a "Notice Of Nonresponse" to the Respondent and, if an MSM employee is involved, the employee's immediate supervisor. If no answer has been received within five (5) days after issuance of the "Notice Of Nonresponse," the Title IX Coordinator or the Deputy Title IX Coordinator shall begin the investigation and recommend corrective action without the input of the Respondent. A "Notice Of Nonresponse" shall also be sent to the Complainant.
- 12.2.5.** Pursuing a complaint under these procedures does not affect a victim's ability to pursue a criminal action against the accused through the criminal justice system. A victim of sexual assault, sexual violence, domestic violence, dating violence, stalking, other sex offense, or any other crime recognized by local, state, or federal law may choose to pursue a complaint under these procedures, through the criminal justice system, or both simultaneously.
- 12.2.6.** A victim of sexual assault, sexual violence, domestic violence, dating violence, stalking, or any other Title IX violation may also choose to file a formal complaint with the U.S. Department of Education's Office of Civil Rights.
- 12.3.** Investigations, Findings of Fact and Recommendations for Corrective Action by the Title IX Coordinator or the Deputy Title IX Coordinator
- 12.3.1.** All Complaints of sex discrimination, sexual violence and sexual harassment will be promptly investigated and appropriate interim measures will be taken as expeditiously as possible. MSM reiterates that it reserves the right to investigate and resolve a Complaint or report of sex discrimination and/or sexual harassment regardless of whether the Complainant ultimately desires the School to pursue the complaint.
- 12.3.2.** The amount of time needed to investigate a Complaint will depend in part on the nature of the allegation(s) and the evidence to be investigated (e.g., the number and/or availability of witnesses involved). However, most Complaints will be investigated and resolved within sixty (60) calendar days of the filing of the Complaint, excluding any appeal(s).
- 12.3.3.** The parties to the Complaint will each have an opportunity to be heard by the Title IX Coordinator or Deputy Title IX Coordinator during the investigation, and to present witnesses and other evidence to the Title IX Coordinator or Deputy Title IX Coordinator. The investigation may include conducting interviews of the Complainant, the alleged perpetrator, and any witnesses; reviewing law enforcement investigation documents, if applicable, reviewing student and personnel files; and gathering and examining other relevant documents or evidence.
- 12.3.4.** When investigating an incident, MSM will make reasonable efforts to protect the rights of both the Complainant and the Respondent. MSM will respect the privacy of the Complainant, the Respondent, and the witnesses in a manner consistent with the School's legal obligations to investigate, to take appropriate action, and to comply with any discovery or disclosure obligations required by law.
- 12.3.5.** When investigating a Complaint, MSM will coordinate with any other ongoing School or criminal investigations of the incident.

- 12.3.6.** At reasonable times and various stages until the School's final disposition of the investigation, the Complainant(s) and the Respondent(s) will be informed of the status of the investigation.
- 12.3.7.** Within sixty (60) days of receipt of the complaint filed to commence institutional disciplinary proceedings, the Title IX Coordinator or the Deputy Title IX Coordinator will provide an Interim Notice of Outcome of the investigation or will advise the parties of the additional estimated amount of time needed for the investigation.
- 12.3.8.** In the event the investigation reveals that, by application of the preponderance of evidence standard, it is more likely than not that a Policy Violation (or other inappropriate or unprofessional conduct even if not unlawful), or retaliation occurred, within ten (10) business days following the completion of the investigation, the Title IX Investigator will simultaneously provide the written "Interim Notice of Outcome" to Complainant, Respondent, and appropriate MSM officials for adoption or modification as outlined in Section XIII, below. The Interim Notice of Outcome will include:
- 12.3.8.1.** The determination of whether the Respondent was found responsible or not responsible for the alleged violations;
 - 12.3.8.2.** Where applicable, sanction(s) assigned or remedial measures, the due date(s) of the sanction(s), and any available appeal rights and deadlines;
 - 12.3.8.3.** Any change to the results that occurs prior to the time that such results become final; and
 - 12.3.8.4.** When such results will become final.
- 12.3.9.** Written notice to the appropriate parties relating to discipline, resolutions, and/or final dispositions is deemed to be official correspondence from the School. Disciplinary sanctions imposed may be appealed through the appropriate appeals process depending on the status of the alleged policy violator. MSM will take the appropriate remedial action based on results of the investigation and will follow up as appropriate to ensure that the corrective action is effective.
- 12.3.10.** Complainants are encouraged to report any reoccurrences of conduct that were found to violate this policy or any other related concerns.

XIII. CORRECTIVE ACTION, SANCTIONS, AND NOTICES OF OUTCOME:

Where it is determined that it is more likely than not that the Respondent has committed a violation of this Policy, the following guidelines shall apply:

- 13.1.** For Respondents Classified as Students: Sanctions include one or a combination of the following disciplinary actions:
- 13.1.1. Warning:** Verbal notice that violation of specified regulations and/or continuation or repetition of prohibited conduct may be cause for additional disciplinary action;
 - 13.1.2. Official Reprimand:** A written notice of reprimand for violation of specified regulations, including a warning that continuation or repetition of prohibited conduct may be cause for additional disciplinary action;
 - 13.1.3. Disciplinary Probation:** Exclusion from participation in privileged or extracurricular School-sponsored activities for a specified period of time. Additional restrictions or conditions may also be imposed. Violations of the terms of disciplinary probation, or any other violation of this Code during the period of probation, may result in suspension or expulsion from MSM;

- 13.1.4. Restitution:** Monetary repayment or reimbursement to the School or to an affected party for economic damages resulting from the student's misconduct;
- 13.1.5. Suspension:** Temporary exclusion from MSM premises and other privileges or activities, as set forth in the suspension notice.
- 13.1.6. Expulsion:** Permanent termination of student status, and exclusion from MSM premises, privileges and activities
- 13.1.7. Other Sanctions:** Other sanctions may be imposed instead of, or in addition to, those specified in sections (a) through (f) of this part. For example, community service may also be assigned.
- 13.1.8.** Please note, nothing in the Student Handbook shall prevent the Title IX Investigator from conducting a prompt, fair and thorough investigation into allegations against the Respondent of any Title IX violation, including but not limited to sex discrimination, sexual harassment or sexual violence, or from taking interim measures during the pendency of the investigation, hearing or appeal. In all cases, a preponderance of evidence standard will be applied in determining whether the Respondent is responsible for conduct constituting the Title IX violation.
- 13.1.9.** The Title IX Investigator will submit his/her findings and recommendations for Corrective Actions, and/or sanctions simultaneously to the Complainant, Respondent, and the Associate Dean of Admissions and Student Affairs or his/her designee via an Interim Notice of Outcome. Complainants and Respondents have ten (10) business days from receipt of the Interim Notice of Outcome to file any objections thereto. Objections must be submitted in writing to the Associate Dean of Admissions and Student Affairs or his/her designee.
- 13.1.10.** The Associate Dean of Admissions and Student Affairs or his/her designee shall consider the findings and recommendations of the Title IX Investigator, and any objections filed within ten (10) days of the issuance of the Interim Notice of Outcome by Complainant, Respondent, or any other affected individual, and enter a Final Notice of Outcome within ten (10) business days of receipt of the Interim Notice of Outcome and any objections to same.
- 13.2.** For Respondents Classified as Resident Physicians: Sanctions include one or a combination of the following disciplinary actions:
- 13.2.1. Notice of Deficiency:** The School may issue a written or oral warning to the Resident to give notice that deficiencies exist that are not yet severe enough to require remediation, disciplinary action, or other adverse actions, but that do require the Resident to take immediate corrective action to cure the deficiency;
- 13.2.2. Non-Promotion:** Resident appointments are for a maximum of twelve (12) months, year-to-year. Where a Resident has demonstrated unsatisfactory performance during an academic year or fails a specific rotation required for promotion, the School may elect to delay a Resident's promotion to the next level;
- 13.2.3. Suspension:** The School may elect to suspend a Resident from all program activities for a period of time when it has determined that a Resident's performance or behavior does not appear to be in the best interests of the patients or other medical staff. Depending on the circumstances surrounding the suspension, it may be paid or unpaid;
- 13.2.4. Non-Renewal of Appointment:** The School may elect to not re-appoint a Resident for the next academic year if it determines that a Resident's performance does not meet

the School's academic or professional standards, or the requirements of the Program, the Residency Review Committee Program, GME, or the Specialty Board;

- 13.2.5.** Restitution: Monetary repayment or reimbursement to the School or to an affected party for economic damages resulting from the Resident's misconduct;
- 13.2.6.** Other Sanctions: Other sanctions may be imposed instead of, or in addition to, those specified in sections (a) through (e) of this part. For example, community service or additional training may also be assigned.
- 13.2.7.** Please note, nothing in the Graduate Medical Education ("GME") Policy Manual shall prevent the Title IX Coordinator or Deputy Title IX Coordinator from conducting a prompt, fair and thorough investigation into allegations against the Respondent of any Title IX violation, including but not limited to sex discrimination, sexual harassment or sexual violence, or from taking interim measures during the pendency of the investigation, hearing or appeal. In all cases, a preponderance of evidence standard will be applied in determining whether the Respondent is responsible for conduct constituting the Title IX violation.
- 13.2.8.** The Title IX Investigator will submit his/her findings and recommendations for Corrective Actions, and/or sanctions simultaneously to the Complainant, Respondent, and the Associate Dean of Graduate Medical Education and ACGME Designated Institutional Official or his/her designee via an Interim Notice of Outcome. Complainants and Respondents have ten (10) business days from receipt of the Interim Notice of Outcome to file any objections thereto. Objections must be submitted in writing to the Associate Dean of Graduate Medical Education and ACGME Designated Institutional Official or his/her designee.
- 13.2.9.** The Associate Dean of Graduate Medical Education and ACGME Designated Institutional Official or his/her designee shall consider the findings and recommendations of the Title IX Investigator, and any objections filed within ten (10) days of the issuance of the Interim Notice of Outcome by Complainant, Respondent, or any other affected individual, and enter a Final Notice of Outcome within ten (10) business days of receipt of the Interim Notice of Outcome and any objections to same.
- 13.3.** For Respondents Classified as Faculty: The Respondent shall be subject to the investigation authority of the Title IX Coordinator or Deputy Title IX Coordinator in addition to the procedures outlined in Appendix III of the Faculty Bylaws, and to sanctions up to and including termination.
- 13.3.1.** Nothing in the Faculty Bylaws shall prevent the Title IX Coordinator or Deputy Title IX Coordinator from conducting a prompt, fair and thorough investigation into allegations against the Respondent of any Title IX violation, including, but not limited to, sex discrimination, sexual harassment or sexual violence, or from taking interim measures during the pendency of the investigation, hearing or appeal. In all cases, a preponderance of evidence standard will be applied in determining whether the Respondent is responsible for conduct constituting the Title IX violation.

13.3.2. The Title IX Investigator will submit his/her findings and recommendations for Corrective Actions, and/or sanctions simultaneously to the Complainant, Respondent, and the Vice President and Executive Vice Dean of Research and Academic Administration or his/her designee via an Interim Notice of Outcome. Complainants and Respondents have ten (10) business days from receipt of the Interim Notice of Outcome to file any objections thereto. Objections must be submitted in writing to the Vice President and Executive Vice Dean of Research and Academic Administration or his/her designee.

13.3.3. The Vice President and Executive Vice Dean of Research and Academic Administration or his/her designee shall consider the findings and recommendations of the Title IX Investigator, and any objections filed within ten (10) days of the issuance of the Interim Notice of Outcome by Complainant, Respondent, or any other affected individual, and enter a Final Notice of Outcome within ten (10) business days of receipt of the Interim Notice of Outcome and any objections to same.

13.4. For Respondents Classified as MSM Staff Employees: The Respondent shall be subject to disciplinary action, suspension, and termination as provided in the Discipline and Corrective Action Policy in the HR Policy Manual. Nothing in the HR Policy Manual shall prevent the Title IX Coordinator or Deputy Title IX Coordinator from conducting a prompt, fair and thorough investigation into allegations against the Respondent of any Title IX violation, including but not limited to sex discrimination, sexual harassment or sexual violence, or from taking interim measures during the pendency of the investigation, hearing or appeal. In all cases, a preponderance of evidence standard will be applied in determining whether the Respondent is responsible for conduct constituting the Title IX violation.

13.4.1. The Title IX Investigator will submit his/her findings and recommendations for Corrective Actions, and/or sanctions simultaneously to the Complainant, Respondent, and the Associate Vice President of Human Resources or his/her designee via an Interim Notice of Outcome. Complainants and Respondents have ten (10) business days from receipt of the Interim Notice of Outcome to file any objections thereto. Objections must be submitted in writing to the Associate Vice President of Human Resources or his/her designee.

13.4.2. The Associate Vice President of Human Resources or his/her designee shall consider the findings and recommendations of the Title IX Investigator, and any objections filed within ten (10) days of the issuance of the Interim Notice of Outcome by Complainant, Respondent, or any other affected individual, and enter a Final Notice of Outcome within ten (10) business days of receipt of the Interim Notice of Outcome and any objections to same.

XIV. TITLE IX APPEALS/GRIEVANCE PROCEDURES:

14.1. For purposes of this Policy Section, a "Title IX Grievance" is a complaint concerning any perceived Title IX violation resulting from an MSM policy, practice or procedure. Any member of the MSM Community may file a written Title IX Grievance at any time.

14.2. For purposes of this Policy Section, a "Title IX Appeal" is an appeal by an affected individual to a decision in an Interim or Final Notice of Outcome resulting from a Title IX Complaint Investigation or Hearing.


14.3. First level Appeals/Grievances:

- 14.3.1.** As outlined above, the Title IX Investigator will simultaneously forward the Interim Notice of Outcome to the Complainant, Respondent, and: (i) the Associate Vice President of Human Resources or his/her designee (for Staff decisions or decisions affecting other members of the MSM Community (vendors, visitors, applicants, etc.); (ii) the Vice President and Executive Vice Dean of Research and Academic Administration or his/her designee (for Faculty decisions); (iii) the Associate Dean of Graduate Medical Education and ACGME Designated Institutional Official or his/her designee (for Resident Physician decisions); or (iv) the Associate Dean of Admissions and Student Affairs or his/her designee (for Student decisions). Complainants and Respondents have ten (10) business days from receipt of an Interim Notice of Outcome to object to the findings or recommendations contained therein.
- 14.3.2.** The appropriate designated official will review and consider the Interim Notice of Outcome, as well as any Complainant or Respondent objections to same, and issue a Final Notice of Outcome within the timeframe set forth herein which may adopt, reject, or modify the Interim Notice of Appeal.
- 14.3.3.** For all first level appeals and grievances, the President and Dean will select and designate two (2) independent senior-level members of the MSM Community to monitor and oversee the review process conducted by the appropriate designated official.

14.4. Second Level Appeals/Grievances:

- 14.4.1.** Appeals to the Final Notice of Outcome must be filed within ten (10) business days of receipt with the Chief Compliance Officer and may only be brought on one or more of the following three (3) grounds:
- 14.4.1.1.** To determine whether there was a material deviation from the substantive and procedural protections provided in the complaint proceedings;
- 14.4.1.2.** To determine whether the final decision was based on substantial evidence or information; or
- 14.4.1.3.** To consider new information sufficient to alter the decision or relevant facts not brought out in the investigation or hearing.
- 14.4.2.** All grievances and appeals of Final Notice of Outcome must be submitted in writing, and must include the following information:
- 14.4.2.1.** The name, address, and signature of the Grievant or Appellant;
- 14.4.2.2.** A sufficient description of the issue on appeal (material deviation from substantive/procedural compliant proceedings; failure to base final decision on substantial evidence/information; or new issue or information sufficient to alter the decision) or the allegedly improper policy, practice or procedure resulting in a Title IX violation;
- 14.4.2.3.** The identity of additional witnesses or affected individuals.
- 14.4.2.4.** Attach and/or identify any other documents, facts, or evidence that MSM should consider in reviewing the grievance or appeal.

- 14.4.3.** An appellant is not required to re-submit any documents or information that MSM already has in its possession as a result of its original Title IX investigation.
- 14.4.4.** The Chief Compliance Officer will investigate the appeal, including, but not limited to, review of the grounds for appeal and evidence submitting, seeking the opinion of the Title IX Coordinator's office regarding whether and why the policy, practice, or procedure being grieved or the decision being appealed complies with Title IX, or if not, what, if any, steps should be taken to bring the policy, practice, procedure or decision into compliance with Title IX. The Chief Compliance Officer may also conduct a follow-up conference or hearing with the appellant or other affected individuals or interested parties. The Chief Compliance Officer will, within sixty (60) days of receipt of the appeal, issue a Notice of Appeal Determination either affirming, modifying, or reversing the decision being appealed, or the policy/practice/procedure being grieved. The Notice of Appeal Determination is final and non-appealable.

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	COMPLIANCE
		EFFECTIVE DATE	07/03/2009
		PAGE(S)	12
	<u>SUBJECT</u> INTERACTIONS WITH PHARMACEUTICAL, BIOTECHNOLOGY, MEDICAL DEVICE, AND HOSPITAL AND RESEARCH EQUIPMENT SUPPLY INDUSTRY POLICY	SUPERSEDES	05/01/1997

Interactions with Pharmaceutical, Biotechnology, Medical Device, and Hospital and Research Equipment Supply Industry Policy

I. PURPOSE:

- 1.1. The Morehouse School of Medicine and Morehouse Medical Associates, Inc. ("MSM") is dedicated to improving the health and well-being of individuals and communities; increasing the diversity of the health professional and scientific workforce; and addressing primary healthcare needs through programs in education, research, and service, with emphasis on people of color and the underserved urban and rural populations in Georgia and the nation.
- 1.2. This shared mission requires that faculty, students, trainees, and staff of MSM interact with representatives of the pharmaceutical, biotechnology, medical device, and hospital equipment supply industry ("Industry") in a manner that advances the use of the best available evidence so that medical advancements and new technologies become broadly and appropriately used. While the interaction with Industry can be beneficial, Industry influence can also result in unacceptable conflicts of interest that may lead to increased costs of healthcare, the compromise of patient safety, negative socialization of students and trainees, bias of research results, and diminished confidence and respect among patients, the general public, and regulatory officials.
- 1.3. Because provision of financial support or gifts, even in modest amounts, can exert a subtle but measurable impact on recipients' behavior, MSM has adopted the following policy to govern the interactions between Industry and MSM personnel.
- 1.4. There is a growing body of evidence demonstrating the adverse consequences of interactions between healthcare providers and Industry, including practices such as receipt of small gifts that have traditionally been considered acceptable by professional standards, such as the ethical opinions of the American Medical Association's Council on Medical and Judicial Affairs. While healthcare professionals may not believe that they are personally biased by Industry, retailing by Industry representatives is designed to sell products and advance the interests of Industry's shareholders. This policy has been designed on the basis of the best available literature on conflict of interest and is intended to provide a set of guiding principles that members of the MSM community as well as representatives of Industry can use to ensure that their interactions result in optimal benefit to clinical care, education and research, and maintenance of the public trust.

- 1.5. This policy is designed to affect the behavior and practices of Industry, as much as the behavior of MSM personnel. While partnerships between Industry and physicians may further mutual interests to improve clinical management of diseases and improve patient care, the provision of gifts, food, or other blandishments add nothing to the substance of the exchange and leave both parties subject to questions of integrity and commitment to professional practice responsibilities.
- 1.6. This policy is established to provide guidelines for interactions with Industry representatives for medical staff, faculty, staff, residents, students, and trainees of MSM. Interactions with Industry occur in a variety of contexts, including marketing of new pharmaceutical products, medical devices, and research equipment and supplies on-site, on-site training of newly purchased devices, the development of new devices, educational support of medical students and trainees, and continuing medical education. Faculty and trainees also participate in interactions with Industry off campus and in scholarly publications. Many aspects of these interactions are positive and important for promoting the educational, clinical, and research missions of MSM. However, these interactions must be ethical and cannot create conflicts of interest that could endanger patient safety, data integrity, the integrity of our education and training programs, or the reputation of either a faculty member or the school.

II. SCOPE:

- 2.1. This policy applies to all medical staff, faculty, staff, residents, interns, students, and trainees of MSM.
- 2.2. While this policy addresses many aspects of Industry interaction, it supplements the existing conflict of interest policies of MSM, particularly as they apply to research conflicts of interest:
 - Institutional conflicts of interest
 - Individual conflicts of interest
 - Research conflicts of interest
- 2.3. In all cases where this policy is more restrictive than other MSM conflict of interest policies, this policy shall control.
- 2.4. This policy applies to interactions with all sales, marketing, or other product-oriented personnel of Industry, including those individuals whose purpose is to provide information to clinicians about company products, even though such personnel are not classified in their company as “sales or marketing.”

III. POLICY:

- 3.1. It is the policy of MSM that clinical decision-making, education, and research activities be free from influence created by improper financial relationships with, or gifts provided by, Industry.
- 3.2. For purposes of this policy, “Industry” is defined as all pharmaceutical manufacturers, and biotechnology, medical device, and hospital and research equipment supply Industry entities and their representatives.
- 3.3. In addition, clinicians and their staffs should not be the target of commercial blandishments or inducements—great or small—the costs of which are ultimately borne by our patients and the public at large.

- 3.4. These general principles should guide all potential relationships or interactions between MSM personnel and Industry representatives.
- 3.5. The following specific limitations and guidelines are directed to certain specific types of interactions. For other circumstances, MSM personnel should consult in advance with their deans or department chairs or administrative management to obtain further guidance and clarification.
- 3.6. Charitable gifts provided by Industry in connection with fundraising done by or on behalf of MSM shall be subject to other policies adopted from time to time by MSM or foundations fundraising on their behalf.

IV. SPECIFIC ACTIVITIES:

4.1. Gifts and Provision of Meals

- 4.1.1. MSM personnel are prohibited from accepting or using personal gifts (including food) from representatives of Industry, regardless of the nature or dollar value of the gift. Although personal gifts of nominal value may not violate professional standards or anti-kickback laws, such gifts do not improve the quality of patient care, may subtly influence clinical decisions, and add unnecessary costs to the healthcare system.
- 4.1.2. Gifts from Industry that incorporate a product or company logo on the gift (e.g.: pens, notepads, stethoscopes, journals, textbooks, or office items such as clocks) introduce a commercial, marketing presence that is not appropriate to a non-profit educational and healthcare system.
- 4.1.3. Meals or other hospitality funded directly by Industry may not be offered in any facility owned and operated by MSM, except as outlined in subsection "Support of Continuing Medical Education or Graduate Medical Education" below.
- 4.1.4. MSM personnel may not accept meals or other hospitality funded by Industry, whether on campus or off campus, nor accept complimentary tickets to sporting or other events or other hospitality from Industry. Modest meals provided incidental to attendance at an off-campus event that complies with the provisions of subsection "Industry-Sponsored Meetings or Industry Support for Off-Campus Meetings" below may be accepted.
- 4.1.5. Industry wishing to make charitable contributions to MSM may contact the Office of Institutional Advancement. Such contributions shall be subject to any applicable policies maintained by MSM, and the receiving organizations.

4.2. Consulting Relationships

- 4.2.1. MSM recognizes the obligation to make the special knowledge and intellectual competence of its faculty members available to government, business, labor, and civic organizations, as well as the potential value to the faculty member and MSM. However, consulting arrangements that simply pay MSM personnel a guaranteed amount without any associated duties (such as participation on scientific advisory boards that do not regularly meet and provide scientific advice) shall be considered gifts and are consequently prohibited.
- 4.2.2. In order to avoid gifts disguised as consulting contracts, where MSM personnel have been engaged by Industry to provide consulting services, the consulting contract must provide specific tasks and deliverables, and must be restricted to scientific issues.

- 4.2.3.** The compensation paid must be reasonable and reflect fair market value for the service and time provided, and must be commensurate with the tasks assigned. All such arrangements between individuals or units and outside commercial interests must be reviewed and approved prior to initiation in accordance with appropriate MSM policies.
 - 4.2.4.** For MSM personnel, consulting relationships with Industry may be entered into only with the prior permission of a faculty member's dean, department chair, or administrative management.
 - 4.2.5.** In addition, prior review and written approval from the faculty member's dean is required if consulting relationships with any one company (including the parent and subsidiary companies) will pay the faculty member in excess of \$10,000 in any twelve-month period.
 - 4.2.6.** For employees of MSM who are not faculty, prior written approval of the appropriate supervisor is required for any outside consulting.
 - 4.2.7.** MSM reserves the right to require faculty and employees to request changes in the terms of their consulting agreements to bring those consulting agreements into compliance with MSM policies.
- 4.3. Drug or Device Samples**
- 4.3.1.** The provision by manufacturers of "free" samples of prescription drug or device products is a marketing practice designed to promote the use of these products and to gain access to prescribers to influence their behavior. Studies from the literature quite convincingly demonstrate the effectiveness of this technique to boost sales. At the same time, this practice provides invaluable assistance to some patients to quickly begin a course of treatment or to determine which therapeutic option is most beneficial for that patient. Free samples also have been responsibly incorporated into the evidence-based decision making of some individual and group practices. While societal benefits result from the availability of medications at the point of care, pharmaceutical samples are not preferred because often their prior storage and handling are suspect (temperature/humidity control), accountability is generally low (pilferage, diversion, theft), documentation is usually weak (incomplete logs), patient directions and patient information are not provided and/or are inadequate, and pharmacist review/profiling is left incomplete.
 - 4.3.2.** Therefore, with limited exceptions, sample medications are not permitted in MSM facilities.
 - 4.3.3.** As an alternative, pharmaceutical sales representatives should be encouraged to offer voucher programs which allow patients to get starter supplies of medications through organized distribution channels instead of pharmaceutical samples.

4.3.4. Definitions

- 4.3.4.1. Drug Samples:** Prescription and non-prescription medications which are provided to the sites by pharmaceutical representatives for complimentary distribution to patients as starter doses.
- 4.3.4.2. MSM/MMA Sites:** Applicable to all MSM facilities where care is provided to patients.
- 4.3.4.3. Pharmaceutical Sales Representatives (PSR):** A representative of a pharmaceutical manufacturer who visits the ambulatory care sites for the purpose of soliciting the use of, or providing information about pharmaceutical products. Representatives who visit MSM facilities for the sole purpose of initiating or monitoring research studies are exempt from these guidelines.

4.3.5. Standards

- 4.3.5.1.** Drug samples shall not be made available for use by inpatients.
- 4.3.5.2.** Sample medications are not permitted in MSM facilities except as noted in paragraph "Site Access" below. This includes both patient care and non-patient care areas.
- 4.3.5.3.** Vouchers approved by the MMA Operations Committee ("the Committee") may be distributed by MSM ambulatory care sites in order for patients to receive complimentary starter medications from a pharmacy of their choice. The MMA Operations Committee will determine a formulary of MSM-preferred medications, which then may be available through vouchers. Only vouchers approved by the committee are permitted to be used by MSM clinicians at MSM facilities.
- 4.3.5.4.** Non-approved vouchers may not be distributed by PSRs to MSM ambulatory care sites, nor dispensed by MSM personnel at MSM sites.
- 4.3.5.5.** Under special circumstances in which there is a legitimate clinical need, with the approval noted below, sample medications may be permitted in MSM facilities. Specific requests to have physical samples in a MSM clinic must be made on the Special Cause Sample Request Form, and be approved by the MMA Operations Committee and the MMA Associate Dean for Clinical Affairs.
- 4.3.5.6.** Control of drug samples/vouchers shall be monitored jointly by the Clinical Compliance and Privacy Officer and the MMA Associate Dean for Clinical Affairs.

4.3.6. Procedure Actions

- 4.3.6.1.** Participating pharmaceutical companies may distribute the MMA Operations Committee-approved vouchers to MSM/MMA clinics through their sales representatives. These vouchers are for generic medications or brand drugs that are designated as "preferred" by the committee.
- 4.3.6.2.** PSRs may not distribute non-approved vouchers or coupons within MSM sites, or to MSM clinicians.

- 4.3.6.3.** If a clinic medical director believes there is a clinical need to maintain some physical samples, a request will be made to the MMA Operations Committee, the MMA Associate Dean for Clinical Affairs, and the Clinical Compliance and Privacy Officer using the Special Cause Sample Request Form. If the request is approved, the succeeding steps must be followed:
1. A formulary of approved sample products must be approved for the clinic and samples of only those products are permitted at the site.
 2. The approved products must be reviewed annually by the Associate Dean for Clinical Affairs and the Clinical Compliance and Privacy Officer.
 3. Samples must be stored in a locked secure area that prohibits unauthorized access or that is under constant supervision or surveillance. PSRs are not authorized to have access to drug sample storage areas.
 4. Samples are properly stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and safety, according to manufacturer's specifications and law and regulation.
 5. When samples are received from the manufacturer, they must be recorded on the Sample Drug Log-In Form.
 6. The sample drugs must be inspected monthly by the Associate Dean for Clinical Affairs or designee, and a copy of this review sent to the Clinical Compliance and Privacy Officer.
 7. Samples are organized to allow for easy retrieval, yet segregated to prevent medication errors. Storage areas must be routinely inspected to check for expired and deteriorated sample medications; samples stored in the wrong place; drugs that can no longer be identified by name, strength, and expiration date; and other medications that do not belong in that area.
 8. Samples for prescription drugs are labeled and dispensed according to the same standardized method that MSM uses for non-sample prescription medications.
 9. In the event of a drug recall, the Clinical Compliance and Privacy Officer will notify the clinic. The Associate Dean for Clinical Affairs or designee must review sample inventory and return recalled drugs to the pharmacy.
 10. When dispensing a sample medication to a patient, the physician must select the drug, dose, and quantity of medication to be dispensed. This must be recorded in the patient's medical record. The physician must review the dose-pack and patient label with written instructions prior to the medication being dispensed to the patient.

11. The physician may delegate to a medical assistant or nurse the following steps:

- 1) Complete the Sample Drug Sign-Out Log.
- 2) Complete the Sample Medication Label.
- 3) Document the patient waiver of a child-proof container.
- 4) Obtain final approval from the physician before dispensing.
- 5) Provide patient education regarding the medication.

4.3.6.4. The Clinical Compliance and Privacy Officer will inspect the sample medication storage, log, and dispensing process at least annually. If adherence to this policy is not being met, the privilege of maintaining samples will be revoked.

4.4. Site Access

4.4.1. MSM does not allow use of their facilities or other resources for marketing activities by Industry.

4.4.2. MSM always reserves the right to refuse access to their facilities or to limit activities by Industry representatives consistent with their non-profit mission. However, interaction with representatives of Industry is appropriate as it relates to exchange of scientifically valid information and other data, interactions designed to enhance continuity of care for specific patients or patient populations, as well as training intended to advance healthcare and scientific investigation.

4.4.3. To balance these interests, MSM's Procurement Office will develop a registry to assist in the management of site access by Industry representatives for appropriate purposes.

4.4.4. Sales or marketing representatives of Industry may access MSM facilities only if the company with which they are associated has registered with the MSM Procurement Office, and they have been specifically invited to meet with an individual healthcare provider or a group of healthcare providers for a particular purpose. Individual physicians or groups of physicians or other healthcare professionals may request a presentation by or other information from a particular company through the MSM Procurement Office or other designated institutional official.

4.4.5. Industry representatives should not be permitted in any patient care area unless each of the following exceptions is met:

- The representative is present to provide in-service training on devices and other equipment, including provision of essential guidance on the use of such equipment.
- The presence of the representative is expressly requested and approved in advance by a faculty member.
- The device representative is certified by their employer to provide the requested device training.

4.4.6. Industry representatives should never provide direct patient care services at MSM.

- 4.4.7.** Industry representatives are permitted in non-patient care areas by scheduled appointment only. Therefore, representatives should not be in any MSM facilities without a scheduled appointment with a faculty member or other authorized MSM personnel.
- 4.4.8.** Industry representatives without an appointment as outlined above are not allowed to conduct business in patient care areas (inpatient or outpatient), in practitioners' office areas, or other areas of MSM clinical facilities.
- 4.4.9.** All Industry personnel seeking sales or vendor relationships must work directly with the MSM Procurement Office. While in MSM facilities, all Industry representatives must be identified by name and current company affiliation in a manner determined by such department, as applicable.
- 4.4.10.** All Industry representatives with access to MSM clinical facilities and personnel must comply with institutional requirements for training in ethical standards and organizational policies and procedures.
- 4.5.** Support of Continuing Medical Education or Graduate Medical Education
 - 4.5.1.** Industry support of continuing medical education ("CME/GME") in the health sciences can provide benefit to patients by ensuring that the most current, evidence-based medical information is provided to healthcare practitioners. In order to ensure that potential for bias is minimized and that CME/GME programs are not a guise for marketing, all CME/GME events hosted or sponsored by MSM must comply with the ACCME Standards for Commercial Support of Educational Programs (or other similarly rigorous, applicable standards required by other health professions), whether or not CME/GME credit is awarded for attendance at the event.
 - 4.5.2.** All such agreements for Industry support of CME/GME programs must be negotiated through and executed by the Continuing Medical Education Department and must comply with all policies for such agreements.
 - 4.5.2.1.** Funding may be restricted to a clinical department and must be overseen by the chair of that department.
 - 4.5.2.2.** Funding may not be restricted to a clinical division, a specific program or an individual physician. The CME Committee will oversee Industry sponsorship exceeding established thresholds (see below) to ensure that potential conflicts of interest are appropriately managed.
 - 4.5.3.** Any such educational programs must be open on equal terms to all interested practitioners and may not be limited to attendees selected by the company sponsor(s).
 - 4.5.3.1.** Industry funding for such programming should be used to improve the quality of the education provided and should not be used to support hospitality, such as meals, social activities, etc., except at a modest level.
 - 4.5.3.2.** Industry funding may not be accepted for social events that do not have an educational component. Industry funding may not be accepted to support the costs of internal department meetings or retreats (either on- or off-campus).

- 4.5.4.** Product symposia by MSM exclusively for the education of MSM personnel, MMA patients or the broader community are permissible. Industry products directly related to a MSM educational event may be displayed and discussed as part of the educational event. Industry funding to support these activities is acceptable provided it is processed consistent with this section.
 - 4.5.5.** Industry product fairs are prohibited. Industry representatives are never permitted to display or market any products on any MSM premises, unless they are directly related to an MSM-sponsored education event, as noted above.
 - 4.5.6.** MSM facilities (clinical or non-clinical) may not be rented by or used for Industry funded and/or directed programs, unless there is a CME/GME agreement for Industry support that complies with the policies of the CME Committee. Dedicated marketing and training programs designed solely for sales or marketing personnel supported by Industry are prohibited.
 - 4.5.7.** The Office of Compliance and Internal Audit will review and oversee Industry sponsorship to assess potential conflicts of interest and to propose approaches for management of such potential or actual conflicts of interest. The Office of Compliance and Internal Audit and the Office of General Counsel will review any Industry contribution exceeding \$10,000 in support of CME/GME (fellowship or other support) or general research support in any one fiscal year.
- 4.6. Industry Sponsored Meetings or Industry Support for Off-Campus Meetings**
- 4.6.1.** MSM medical staff, faculty, staff, residents, interns, students, and trainees may participate in or attend Industry-sponsored meetings, or other off-campus meetings where Industry support is provided, so long as:
 - 4.6.1.1.** The activity is designed to promote evidence-based clinical care and/or advance scientific research;
 - 4.6.1.2.** The financial support of Industry is prominently disclosed;
 - 4.6.1.3.** If the MSM representative is an attendee, Industry does not pay attendees' travel and attendance expenses;
 - 4.6.1.4.** Attendees do not receive gifts or other compensation for attendance;
 - 4.6.1.5.** Meals provided are modest (i.e.: the value of which is comparable to the Standard Meal Allowance as specified by the United States Internal Revenue Service) and consistent with the educational or scientific purpose of the event.
 - 4.6.2.** MSM shall not market the event and MSM faculty shall not instruct or encourage participation in or attendance at the event. In addition, if a MSM representative is participating as a speaker:
 - 4.6.2.1.** All lecture content is determined by the MSM speaker and reflects a balanced assessment of the current science and treatment options, and the speaker makes clear that the views expressed are the views of the speaker and not MSM and
 - 4.6.2.2.** Compensation is reasonable and limited to reimbursement of reasonable travel expenses and a modest honorarium not to exceed \$2,500 per event.

4.7. Industry Support for Scholarships or Fellowships or Other Support of Students, Residents, or Trainees

4.7.1. MSM may accept Industry support for scholarships or discretionary funds to support trainee or resident travel or non-research funding support, provided that all of the following conditions are met:

4.7.1.1. Industry support for scholarships and fellowships must comply with all MSM requirements for such funds, including the execution of an approved budget and written gift agreement through the Office of Institutional Advancement, and be maintained in an appropriate restricted account, managed at the school or department as determined by the president, the dean, or his or her designee.

4.7.1.2. Selection of recipients of scholarships or fellowships will be completely within the sole discretion of the school in which the student or trainee is enrolled or, in the case of graduate medical education, the Associate Dean for Graduate Medical Education.

4.7.1.3. Written documentation of the selection process will be maintained.

4.7.1.4. Industry support for other trainee activities, including travel expenses or attendance fees at conferences, must be accompanied by an appropriate written agreement and may be accepted only into a common pool of discretionary funds, which shall be maintained under the direction of the dean or department (as specified in the funding agreement) for the relevant school.

4.7.1.5. Industry may not earmark contributions to fund specific recipients or to support specific expenses.

4.7.1.6. Departments or divisions may apply to use monies from this pool to pay for reasonable travel and tuition expenses for residents, students, or other trainees to attend conferences or training that have legitimate educational merit. Attendees must be selected by the department based upon merit and/or financial need, with documentation of the selection process provided with the request.

4.7.1.7. Approval of particular requests shall be at the discretion of the dean.

4.8. Frequent Speaker Arrangements (Speakers Bureaus) and Ghostwriting

4.8.1. While one of the most common ways for MSM to disseminate new knowledge is through lectures, “speakers bureaus” sponsored by Industry may serve as little more than an extension of the marketing department of the companies that support the programming. Before committing to being a speaker at an Industry-sponsored event, careful consideration should be given to determine whether the event meets the criteria set forth in Section 4.6 of this policy, relating to Industry Sponsored Meetings.

4.8.2. MSM personnel may not participate in, or receive compensation for, talks given through a speakers bureau or similar frequent speaker arrangements if:

4.8.2.1. The events do not meet the criteria of Section 6; or


4.8.2.2. If the content of the lectures given is provided by Industry or is subject to any form of prior approval by either representatives of Industry or event planners contracted by Industry; or

- 4.8.2.3.** The content of the presentation is not based on the best available scientific evidence; or
- 4.8.2.4.** The company selects the individuals who may attend or provides any honorarium or gifts to the attendees.
- 4.8.3.** Under no circumstances may MSM personnel be listed as co-authors on papers ghostwritten by Industry representatives. In addition, MSM personnel should always be responsible for the content of any papers or talks that they give, including the content of slides.
- 4.8.4.** Speaking relationships with company or company event planners are subject to review and approval of the participant's administrator, department chair, or dean as delineated in Section 4.2, Consulting Relationships.
- 4.9.** Other Industry Support for Research
 - 4.9.1.** MSM, through the Office for Sponsored Research Administration, has established policies and contract forms to permit Industry support of research in a manner consistent with the nonprofit mission of MSM.
 - 4.9.2.** True philanthropic gifts from Industry may be accepted through the Office of Institutional Advancement.

V. REPORTING AND ENFORCEMENT

- 5.1.** MSM personnel shall report their outside relationships with Industry using the Industry Conflict of Interest Disclosure Form available at the Office of Compliance and Internal Audit website, at least annually, and more often as needed, to disclose new relationships.
- 5.2.** Alleged violations of this policy within MSM shall be investigated by the Office of Compliance and Internal Audit. Suspected violations of this policy shall be referred to the individual's dean and department chair, or administrative management, who shall determine what actions, if any, shall be taken.
- 5.3.** Violations of this policy by MSM employees may result in the following actions (singly or in any combination), depending on the seriousness of the violation, whether the violation is a first or repeat offense, and whether the violator knowingly violated the policy or attempted to hide the violation:
 - Counseling of the individual involved;
 - Written reprimand, entered into the violator's employment or faculty record;
 - Banning the violator from any further outside engagements for a period of time;
 - Requiring that the violator return any monies received from the improper outside relationship;
 - Requiring the violator to complete additional training on conflict of interest;
 - Removing the violator from supervision of trainees or students;
 - Revoking the violator's MMA hospital privileges;
 - Fines;
 - Termination for cause.
- 5.4.** Any disciplinary action taken hereunder shall follow the established procedures of MSM.

- 5.5.** Industry representatives who violate this policy may be subject to penalties outlined in MSM Procurement Guidelines, or other applicable MSM policies, as well as other actions or sanctions imposed at the discretion of the President of MSM. Such penalties are described in the following guideline. Violation of any of the above procedures by representatives shall result in disciplinary action which may include, but shall not be limited to, the following actions:
- 5.5.1.** First violation: Verbal and written warning to representative; written notification to district manager or representative's supervisor.
 - 5.5.2.** Second violation: Suspension of representative and all other company sales/marketing representatives from MSM for six (6) months.
 - 5.5.3.** Third violation: Suspension of representative and all other sales and marketing representatives of the company from MSM for one (1) year or more. A review of multi-source products obtained from the company will be conducted.
- 5.6.** Representatives found trespassing as defined in this policy will be escorted from the premises and their companies notified as appropriate.

	MOREHOUSE SCHOOL OF MEDICINE HUMAN RESOURCES POLICY AND PROCEDURE	POLICY NUMBER	6.03
		EFFECTIVE DATE	3-26-2014
		PAGE(S)	04
	<u>SUBJECT</u> WORKERS' COMPENSATION POLICY	SUPERSEDES	01/15/2013

Workers' Compensation Policy

I. **PURPOSE:**

The purpose of this policy is to provide employees, residents, and supervisors information concerning employee benefits and instructions for treatment of work-related illnesses, injuries, accidents, and exposures, and for the completion of the required forms.

GME Note: Contact the Human Resources Office for current versions of forms and healthcare providers listed in this policy.

II. **APPLICABILITY:**

All regular full-time and part-time employees and residents are eligible for workers' compensation benefits. Temporary workers and student employees are also eligible to receive workers' compensation benefits. Independent Contractors are not eligible to receive workers' compensation benefits.

III. **GUIDELINES:**

3.1. Employee Responsibilities

- 3.1.1. The employee should immediately provide as much information as possible about his or her injury or illness to the employee's supervisor or departmental designee. This person will assess the situation, assist with arranging proper medical care, and begin the injury reporting process.
- 3.1.2. If the employee requires medical treatment, he or she must follow the procedures outlined below and go to one of the healthcare providers as set forth on the Panel of Healthcare Providers.
- 3.1.3. The employee must complete the Employee's Incident Report Form. After the form is completed, it must be signed and sent to the Human Resources Manager for Disability and Leave Services at the Harris Building, Room H-132.

3.2. Supervisor Responsibilities

- 3.2.1. The supervisor must immediately assess the incident and then assist the employee in seeking appropriate medical care or necessary treatment for any work-related injury. If an injury is a potential life-threatening emergency, the supervisor should call 911.
- 3.2.2. The supervisor must complete the Supervisor's Incident Report Form. After the form is completed, it must be signed and sent to the Human Resources Manager for Disability and Leave Services at the Harris Building, Room H-132.
- 3.2.3. The supervisor must immediately contact the Department of Human Resources if the employee is a temporary employee from a temporary agency. Human Resources will contact the agency to inform the appropriate person of the incident.

3.3. Human Resources Responsibilities

3.3.1. Human Resources will discuss the facts with the employee and the supervisor and determine compensability or non-compensability of each incident.

3.3.2. Human Resources will coordinate efforts for returning an injured employee to work.

IV. PROCEDURES:

4.1. First Steps If an Injury Occurs

The employee's health and safety should be a primary concern at all times. When an incident occurs, these general guidelines should be followed in the event of an incident that causes or almost causes a work injury.

4.1.1. Emergencies: Call 911 whenever appropriate and necessary. If the injury requires immediate medical attention, the employee will go to the nearest emergency room, utilizing an ambulance service when needed. Public Safety should be notified if emergency personnel have been contacted (fire, ambulance, etc.).

4.1.2. Non-Emergencies: An Employee's Incident Report Form should be completed immediately and sent to the Human Resources Disability and Leave Services Manager. A Supervisor's Incident Report Form should also be completed with the assistance of the employee and sent to the Human Resources Disability and Leave Services Manager. Once the Human Resources Disability and Leave Services Manager has determined that the injured employee needs to see a medical provider, the employee must use one of the physicians on our Panel of Healthcare Providers for treatment.

4.1.3. Note: All injuries, whether covered by Workers' Compensation or not must be reported to the employee's supervisor. The guidelines in this document are in addition to any local campus-related injuries, illnesses, and incident reporting. Any person who knowingly makes false claims or statements, or conceals facts in order to receive workers' compensation benefits, may be subject to penalties.

4.2. Reporting the Injury

4.2.1. STEP 1: The employee must notify his or her supervisor (within 24 hours) of the injury. The employee must also report incidents that are minor in nature and incidents that could have caused an injury. This will assist the school in possibly avoiding any further incidents in the future.

4.2.2. STEP 2: With the employee's assistance, the employee's supervisor must complete the Supervisor's Incident Report Form. After this form is completed, it must be submitted to the Human Resources Disability and Leave Services Manager. If needed, the Human Resources Disability and Leave Services Manager will assist the employee or supervisor in completing the form.

4.2.3. STEP 3: The employee must seek prompt medical attention from our Panel of Healthcare Providers. If the incident is an emergency, the employee must seek immediate medical attention from any doctor (or emergency room). When the emergency is over, the employee must get follow-up treatment from a physician on our Panel of Healthcare Providers.

4.2.4. STEP 4: If the injury requires accommodations or modified duty for returning to work, the employee should notify the Human Resources Disability and Leave Services Manager and the employee's supervisor. When follow-up appointments are necessary, the employee should inform his or her supervisor.

4.2.5. STEP 5: The employee must always inform the Human Resources Disability and Leave Services Manager and his or her supervisor when released to return to work full-time with no restrictions.

4.2.6. The Human Resources Disability and Leave Services Manager will notify the School's workers' compensation insurance carrier by completing a report through their reporting system. After this has been completed, a workers' compensation claim number will be generated and forwarded to the employee and the designated healthcare provider. This number will be used to identify the incident and for processing any medical expenses incurred.

4.3. The Claim Process

4.3.1. After the claim has been submitted through our reporting system, the claims representative will investigate the injury and the circumstances surrounding it to determine if the claim is compensable. If it is determined that a claim is not compensable, the claims representative will deny the claim and the employee has the right to challenge this denial.

4.3.2. If the employee is unable to work due to the injury, the claims representative will monitor the situation and work with the Human Resources Disability and Leave Services Manager with regard to the employee returning to work.

4.3.3. IMPORTANT: For questions about payment of bills, reimbursements, lost wage benefits, or other financial matters related to workers' compensation, the employee or any treating physician, hospital, pharmacy, or other medical provider should contact the workers' compensation insurance carrier at:

PMA Insurance Group
P.O. Box 5231
Janesville, WI 53547-5231

4.4. The Weekly Benefit

4.4.1. If an employee is absent from work less than seven (7) calendar days, then he or she will be required to use any accrued sick/vacation time for those days.

4.4.2. Employees who lose at least seven (7) calendar days from work as a result of a work-related injury are entitled to a weekly loss-of-earnings benefit, equivalent to 66-⅔ of the employee's weekly wages up to the maximum as determined by the Georgia Workers' Compensation Act. Employees may elect to use their accrued sick and vacation time in lieu of workers' compensation pay by completing the Election of Salary Form. An employee may not supplement workers' compensation pay with his or her accrued leave.

4.4.3. If the injury causes the employee to miss at least seven (7) calendar days of work, a Georgia Workers' Compensation Wage Statement will be completed by the Human Resources Disability and Leave Services Manager and sent to:

PMA Insurance Group,
1100 Abernathy Road NE,
Bldg. 500 Suite 650,
Atlanta, GA 30328.

V. LEAVE WITHOUT PAY:

- 5.1. The Family and Medical Leave Act (FMLA) or a medical leave of absence is available to employees who have missed work as a result of a work-related injury. While on this type of leave, the employee will not be eligible to accrue paid leave benefits (e.g.: sick, vacation leave.)
- 5.2. Human Resources will consult with the employee's department manager in order to process a Personnel Action Form (PAF) to change the employee's status to Leave Without Pay (LWOP) while the employee is out due to a work-related injury. When the employee is cleared to return to work, the employee is entitled to the same status and rate of pay, including any salary adjustments.
- 5.3. **Note:** If an employee is eligible for FMLA and his or her absence is because of a work-related injury, this time away from work will count against the Employee's FMLA leave entitlement, provided the employee's condition constitutes a Serious Health Condition as defined by the FMLA. For additional information, refer to MSM's FMLA policy (HR 7.05).