

Family Medicine Residency Program Handbook 2019–2020

Policies, Procedures, and Program Requirements



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Preface

Morehouse School of Medicine (MSM) Vision and Mission

MSM Vision

Leading the creation and advancement of health equity by:

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

MSM Mission

We exist to:

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

MSM Graduate Medical Education (GME) Goals and Objectives

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

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

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

The MSM Family Medicine Residency Program

History

The MSM Family Medicine Residency Program is located in metropolitan Atlanta, Georgia, a city which is an economic and cultural center for not only the southeastern United States, but also the world at large. Morehouse School of Medicine opened in September 1975 as part of Morehouse College, with Dr. Hugh Gloster as President and Dr. Louis Sullivan as Dean of the medical school. The Department of Family Medicine, the first clinical department, was established in July 1979. In 1981, the Department started the school's first residency program. The department has been an integral part of the development of the school and is a critical link in the school's educational programs. The residency program serves a significant role in Georgia as a producer of family physicians who practice among underserved populations with more than 60% of its graduates remaining in the state after training. The program is accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Our program aims to be the best and most effective program in the southeast in developing superb family physicians for practice in underserved communities. We offer training in all aspects of family medicine including but not limited to office procedures, community outreach, preventive medicine, and women's health care. In our 38-year history, we have successfully recruited well-qualified graduates of accredited medical schools. To date, there are a total of 177 graduates from our program, many of whom have received recognition at the state and national level for their outstanding contributions. A full complement of the brightest, most competent and compassionate students from around the nation and abroad join our residency training program.

The Morehouse Family Medicine Practice, the Morehouse Healthcare Comprehensive Family Healthcare Center, is a model office that provides a setting that fosters educational excellence, provides research opportunities, and exposes residents to ambulatory office operations. Our faculty is a group of highly trained, dedicated, and enthusiastic teachers who are effective in motivating their learners. They are involved in regular scholarly activities and are committed to maintaining excellence in education.

Mission

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

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

Morehouse Family Medicine Residency is a community-based residency program that is affiliated with Atlanta Medical Center, Atlanta Veterans Affairs, Children's Healthcare of Atlanta, and Grady Memorial Hospital. The residency program director, Riba Kelsey-Harris, MD, is responsible for all resident-related policies and procedures. Overall residency program administration policy development is a shared responsibility of our Program administration and the Program Evaluation. Key administrative and curricular components of the program are developed by assigned faculty or clinical and administrative/support staff with oversight from the program director (PD) and Program Evaluation Committee (PEC).

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

Hospital affiliates include:

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

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

Training Goals

The MSM Family Medicine Residency Program goals are listed below:

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

Program Contact, Administration, Faculty & Clinical Staff Information

Residency Program Location Contact Information

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

Further information in relation can be found on our website at

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

Program Administration and Leadership

Program Director – Dr. Riba Kelsey-Harris

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

Other responsibilities include:

- Oversight of all aspects of the residency program and resident education
- Creating and maintaining the affiliation agreements and alliances with the necessary educational and clinical entities, hospitals, clinics, and individual physicians to provide the highest quality training opportunities in the field of family medicine
- Updating and modifying educational goals and curricula
- Overseeing and approving topics for lectures and instruction as deemed fit by the program and the emerging guidelines of the Residency Review Committee (RRC) and the American Board of Family Medicine
- Directly supervising the program manager, the core family medicine faculty, and staff involved with the residency program implementation
- Working closely with the department's chairperson and other officials at MSM to ensure that the program reflects the mission of the institution as well as the department
- Overseeing the resident selection and promotion process

Associate Program Director – Dr. Walkitria Smith

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

Program Manager – Justina Edwards, MPA, JM

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

Program Assistant – Etinosa Evbuomwan

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

Chief Residents – Drs. Kuna Okong and Hikma Jemal

The chief residents support resident teaching activities such as Grand Rounds, Morning Report, and weekly didactics. The chief residents supervise the development and modification of resident schedules, review vacation requests for feasibility, and arrange back-up coverage for unplanned absences. The chief residents attend faculty meetings of the department and serve as the resident liaisons. The chief residents are elected by the residents by February of the PGY2 year and approved by the faculty. A

resident must be in his/her second year of training and in good standing for the most recent 18 months to be eligible for Chief election.

Resident Advisors

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

Residents are expected to initiate and maintain contact with their advisors from the time of orientation and throughout the duration of their residency training. Advisors are expected to document meetings with their resident advisee. Topics discussed should be noted in New Innovations for inclusion in the resident's file. Residents should meet with their resident advisors at least once every three months.

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

The resident advisor should also review the resident's in-training exams and guide the resident's study plan. The resident advisor also represents the resident in cases of due process. Additionally, the advisor provides information about career paths. The resident advisor should monitor the progress of the advisee's quality improvement and research projects.

Program Faculty and Clinical Staff

Clinical Faculty

Faculty Member Name	Board Certification	Email
Nicole Ash-Mapp, MD	Family Medicine	nashmapp@msm.edu
Dolapo Babalola, MD	Family Medicine	dbabalola@msm.edu
Denise Bell-Carter, MD	Family Medicine	Dbell-carter@msm.edu
Kitty Carter-Wicker, MD	Family Medicine	kcwicker@msm.edu
Christopher Ervin, MD	Emergency Medicine	cervin@msm.edu
Jennifer Fowlkes-Callins, MD	Pediatrics	jfcallins@msm.edu
Anne Gaglioti, MD	Family Medicine	agaglioti@msm.edu
Janice Herbert-Carter, MD	Internal Medicine	jherbertcarter@msm.edu
Riba Kelsey-Harris, MD, MSCR	Family Medicine	rkelsey@msm.edu
Ashley McCann, MD	Family Medicine	amccann@msm.edu
Dominic Mack, MD, MBA	Family Medicine	dmack@msm.edu
Yuan Xiang Meng, MD, PhD, MSCR	Family Medicine	ymeng@msm.edu
Michelle Nichols, MD, MS	Family Medicine	mnichols@msm.edu
Lawrence Powell, MD	Family Medicine	lpowell@msm.edu
Walkitria Smith, MD	Family Medicine	wasmith@msm.edu
Charles Sow, MD, MSCR, CPEHR	Family Medicine	csow@msm.edu
Gregory Strayhorn, MD (retired)	Family Medicine	gstrayhorn@msm.edu
Robert Williams, MD	Obstetrics & Gynecology	rwilliams@msm.edu

Non-Clinical Faculty

Faculty Member Name	Area of Focus	Email
Marietta Collins, PhD	Behavioral and Mental Health	mcollins@msm.edu
Arletha Williams-Livingston, PhD	Community Health	awlivingston@msm.edu

Clinical Staff

Name	Role
Front Office Staff	
Latoyia Douglas	Medical Records, Patient Service Representative
Anita Davis	Front Desk, Patient Service Representative
Natasha Ibarra	Front Desk, Patient Service Representative
Shakena Jenkins	Front Desk, Patient Service Representative
Linda Robinson	Supervisor, Front Office
Nico Smith	Front Desk, Patient Service Representative
Pequitta Clark	HIM Manager
Referral Coordinators	
Stephanie Brooks	Referral Coordinator
Kimberly White	Referral Coordinator
Erica McCray	Care Coordinator
Latonya Sallard-Hill	Care Coordinator
Back Office Clinical Staff	
Barbara Cobb, LPN	LPN
Kimberly Miller-Corneh, LPN	LPN
Michelle Remis, LPN	LPN
Tiffany Copeland, RMA	RMA
Shameka Tramell, CMA	CMA
Tan Sinclair, CMA	CMA
Shanikka Springer, RMA	RMA
Support Staff	
Carmen Coggins, RN	Practice Manager
Alysia Coleman	Administrative Assistant, CCMA
Teyunna Stephens, CMA	Care Coordinator, Clinical IT
Tracee Coleman, RN	Clinical Systems Business Manager

Educational Program Requirements – New Policy effective June 1, 2019

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

The program aims of the Family Medicine Residency are as follows:

Program Aims	
Program Aim 1	<ul style="list-style-type: none">Train residents to become excellent family physicians who care for underserved populations.
Program Aim 2	<ul style="list-style-type: none">Provide training in behavioral medicine and family dynamics to foster the physician's awareness of the importance of the family unit in treating the patient.
Program Aim 3	<ul style="list-style-type: none">Provide physicians training experiences in both inpatient and outpatient care.
Program Aim 4	<ul style="list-style-type: none">Provide residents with basic skills necessary to implement preventive care and to consistently educate patients about health and wellness.

ACGME Competencies – referenced and provided in detail below.

The ACGME Competencies

1. Professionalism

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. Residents must demonstrate competence in:

- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society, and the profession; and
- 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 disclosing and addressing conflict or duality of interest.

2. Patient Care and Procedural Skills

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

3. Medical Knowledge

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

4. Practice-based Learning and Improvement

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

- identifying strengths, deficiencies, and limits in one's knowledge and expertise;
- setting learning and improvement goals;
- identifying and performing appropriate learning activities;
- systematically analyzing practice, using quality improvement methods and implementing changes with the goal of practice improvement;
- incorporating feedback and formative evaluation feedback into daily practice;
- locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and,
- using information technology to optimize learning.

5. Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. Residents must demonstrate competence in:

- communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- communicating effectively with physicians, other health professionals, and health-related agencies;
- working effectively as a member or leader of a healthcare team or other professional group;
- educating patients, families, students, residents, and other health professionals;
- acting in a consultative role to other physicians and health professionals; and
- maintaining comprehensive, timely, and legible medical records, if applicable.

6. Systems-based Practice

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

- working effectively in various healthcare delivery settings and systems relevant to their clinical specialty;
- coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty;
- advocating for quality patient care and optimal patient care systems;
- working in interprofessional teams to enhance patient safety and improve patient care quality; and
- participating in identifying system errors and implementing potential systems solutions.

- Incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; and,
- understanding health care finances and its impact on individual patients' health decisions.

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

Program Elements

Morning Report

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

Conferences/Didactic Sessions

- In accordance with ACGME requirement IV.A.3, the program holds regularly scheduled didactic sessions on Wednesdays from 12:30pm to 5:00pm. These sessions are required for all residents except those rotating on certain rotations or under certain circumstances as outlined below.
- When urgent clinical responsibilities or official residency functions preclude a resident from attending a required conference, the residency program director, the associate residency director or the program manager must be contacted to "excuse" the absence.
- Scheduled vacations, out-of-town rotations, and Continuing Medical Education (CME).
 - Residents on the following rotations (see below).
 - Internal Medicine (Grady Wards)
 - Intensive Care Unit (ICU)
 - Peds ER (only when scheduled to work a shift)
 - Pediatric Wards
- Didactics-Related Expectations:
 - The resident must submit an electronic evaluation of each session attended through New Innovations (NI).
 - While on rotations on which the resident is not required to attend the Family Medicine Wednesday conferences, the resident is expected to attend the regularly scheduled rotation-specific conferences as assigned by the rotation director
 - Family Medicine places high emphasis on the quality of its didactic programs. Our expectation is that residents who are scheduled to speak or present will do so in a professional and timely fashion. In the unfortunate event that a resident foresees that he or she will not be able to present (on vacation, CME, etc.), it is expected that the resident will contact the chief resident and the program assistant to allow ample time to schedule another well-prepared session during the vacated didactic slot.
 - When a resident is scheduled to present (case presentation or journal club), he/she must request an attending physician to be a discussant on the chosen topic. The resident must work with the attending to arrange a mutually agreeable time by which

the presentation will be sent to the attending for review and feedback prior to the presentation.

- When a resident is scheduled to present, he/she is required to send the presentation and well-developed objectives to the program assistant two weeks in advance. Any additional articles that must be provided to the attendees of the didactic session should be sent to the Program Assistant a week in advance of the presentation.
- Attendance sheets are posted below the Residency bulletin board outside of the conference room. Residents are required to sign into every didactic session.

Clinical Rotations

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

Continuity Clinic

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

Scholarly Activity

- The program provides a longitudinal research curriculum that prepares residents to produce quality scholarly activity.
- Residents are required to complete a PSQI “mini-project” during their Practice Management rotation and a larger research project in fulfillment of their PGY3 research requirement.
- Aside from meeting these requirements, the program encourages scholarly activity in the form of letters to the editor, case reports, conference presentations, non-required PSQI projects, and the like to foster an environment of inquiry and establish the habit of contributing to the body of knowledge in our discipline.
- In accordance with IV.B.2. of the ACGME Program Requirements, residents are required to complete two scholarly activities, one of which is a quality improvement (QI) project. A QI project is completed during the PGY1 year as part of the longitudinal practice management experience. The second project is started during the PGY1 year and completed by the PGY3 year under the direction of the Departmental Research Director and the resident’s faculty research mentor.

Benefits

Continuing Medical Education (CME)/Book Allowance

Each year, all PGY-2 and PGY-3 residents receive CME funds for educational purposes. Due to a vigorous schedule, first year residents are not granted continued education conference time. However, first year

residents receive a laptop computer purchased by the residency program. CME funds are allocated according to the following schedule:

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

PGY-2 and PGY-3 residents have the option to take the Board Review Course in either the Spring of their 2nd or the Fall of their 3rd year. Whichever year the Board Review course is not taken, the resident has an allotment of \$750 for CME activities or educational materials. All CME requests must be made by April 15th of the PGY-2 or PGY-3 year. Examples of items that can be purchased with CME funds are medical books related to Family Medicine only, stethoscopes, scrubs, medical software for handheld devices, and CME conferences. CME funds cannot be used for computers, computer equipment, or personal device accessories. The residency office should be consulted prior to confirm eligibility for CME funds. All CME funds must be used in the current fiscal year, no later than April 15th. CME funds do not rollover.

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

Professional Organizations

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

Vacation/Sick/CME Leave

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

Note: If all sick and vacation leave is used, additional leave may not be approved, as the ACGME requires that residents not be away from the program for more than 30 days in any program year. Conference attendance for CME does not count against the 30 days.

Rotation Contact Information

PGY-1 Resident Rotations			
Rotation	Rotation Days	Continuity Clinic Days	Contact Information
IM Wards Grady	Daily – No FM Didactics	Mondays	<p>Dr. Chinedu Ivonye - Site Director civonye@msm.edu</p> <p>IM Grady Chief Residents: Eric Chang – echang@msm.edu Suaka Kagbo-Kue – skagbokue@msm.edu</p>
ICU Grady	As scheduled – No FM Didactics	Mondays	<p>Dr. Chinedu Ivonye - Site Director civonye@msm.edu</p> <p>IM Grady Chief Residents: Eric Chang – echang@msm.edu Suaka Kagbo-Kue – skagbokue@msm.edu</p>
Surgery Grady	Daily	Tuesdays	<p>Dr. Clarence Clark - Site Director cclark@msm.edu</p> <p>Chief Residents: Adatee Okonkwo – aokonkwo@msm.edu Michael Williams – mwilliams@msm.edu</p>
L&D Grady	Daily	Thursdays	<p>Dr. Franklin Geary - Site director fgeary@msm.edu</p> <p>OB Chief Resident: Heather Skanes-Devold – hskanes@msm.edu</p>
OB/Gyn AMC	Tues (AM), Thur (PM), Fri (AM) Mon AM @ CFHC Tues (AM), Thurs (PM), Fri (AM) @ WJF Deliveries @ AMC Main	Tues (PM), Thurs (AM)	<p>Dr. Barbara Simmons Email: bjsimmons@msm.edu</p>
Neuro VA Atlanta VA Medical Center	Mon, Tues, Thur, Fri	Wed (AM)	<p>Dr. William Tyor - Site Director Email: William.Tyor@va.gov Charlyn Thomas - Neurology Rotation Coordinator 404-321-6111, ext. 5142</p>
ECC Grady	As scheduled	Wed (AM)	<p>Dr. James O'Shea - Site Director Rikka English - Program Coordinator rikka.rashi.english@emory.edu</p>

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

CBOC	Mon, Tues, Thurs	Wed (AM), Fri	Dr. Kitefre Oboho kitefre.oboho@va.gov 678-232-6619 VA Fort McPherson 1701 Hardee Ave., SW Atlanta, GA 30310
FM Wards	Daily	Tues (PM) or Thurs (PM)	Various FM Attendings
Geriatrics	Varies (Must have Thurs or Mon AM)	Friday (AM)	
ECC Grady	As scheduled	Wed (AM)	Dr. James O'Shea - Site Director Rikka English - Program Coordinator rikka.rashi.english@emory.edu
Sports Medicine	Schedule to be created based on sports game coverages and Dr. Powell's Morehouse College Clinic sessions	Wed (AM), Mon (PM), Tues (PM)	Attending: Dr. Lawrence Powell lpowell@msm.edu Dr. Ashley McCann amccann@msm.edu
Endocrinology	Tues, Weds, Thurs	Mon, Fri	Dr. Peter Thule - Site Director peter.thule@va.gov
GER- CV VA Geriatrics	Mon-Thur or Tues-Fri	Mon, Fri (Depends on VA schedule)	Dr Bobby Culver Jr- Site Director bobby.culver@va.gov (478) 484-5558 Carl Vinson VA 1826 Veterans Blvd. Dublin, GA 31021
PGY III ROTATIONS			
Rotation	Rotation Days	Clinic Days	Contact Information
Dermatology	Tues/Thurs (all day)	Mon, Wed, Fri (PM)	Dr. Jamie MacKelfresh - VA Site Director jpbower@msm.edu Elise Core-Sanders – PA edsande@emory.edu 250 N. Arcadia Ave 2nd Floor Decatur, GA T: 404-727-3669 or T: 404) 321-6111 ext 6380
ENT	ENT: Tues/Thur all day	Weds AM, Fri (all day)	ENT: Dr. Carrie Flanagan carrie.flanagan@va.gov
Ophthalmology	Ophth: Mon, Tues, Thur (all day)	Weds AM, Fri (all day)	Ophth: Dr. Urken - VA Site Director steven.urken@va.gov 1670 Clairmont Road Atlanta, GA T: (404) 321-6111 ext 7422

Cardiology	Mon, Tues, Thursday and weekend calls as scheduled	Wed (Am), Fri	Dr. Adefisayo Oduwole aoduwole@msm.edu
CBOC	Mon, Tues, Thurs	Wed (AM), Fri	Dr. Kitefre Obobo Kitefre.obobo@va.gov 678-232-6619 VA Fort McPherson 1701 Hardee Ave., SW Atlanta, GA 30310
Urology / Radiology	Tues, Weds, Thurs	Mon, Fri	Radiology Dr. Ronald Mixon Ronald.Mixon@va.gov Office: 404-321-6111 ext. 2360 Urology Dr. Donald Finnerty Email: donald.finnerty@va.gov Office: 404-321-6111 Ext. 6601
MH/HB	Tues, Weds, Thurs AM	Mon, Fri	Dr. Marietta Collins – Rotation Director mcollins@msm.edu
Research / Board Review	Mon/Tues/Fri AM	Mon/Tues PM Thur (all day)	Research: Dr. Yuan-Xiang Meng ymeng@msm.edu Board Review: Dr. Walkitria Smith wasmith@msm.edu
Rheumatology	Tues/Thurs clinics	Mon, Wed (AM), Fri	Dr. Karen Atkinson, Director kvatkin@emory.edu Dr. Ayesha Iqbal aigbal@emory.edu
FM Wards	Daily	Tues (PM) or Thurs (PM)	Various FM Attendings
Elective Rotations			
Rotation	Rotation Days	Clinic Days	Contact Information
Family Planning Grady OB Department	Mon (AM), Tues (PM), Thurs	Mon (PM), Tues (AM), Fri	Attending: Dr. Hedwige Saint-Louis hsaintlouis@msm.edu
Nephrology	Mon, Fri	Tues, Thurs	Dr. Lynn Schlanger lynn.schlanger@va.gov
Pulmonary	Mon, Fri	Tues, Thurs	Dr. RuxSadikot - Site Director ruxana.sadikot2@va.gov

Family Medicine In-Patient Service Guidelines

The Department of Family Medicine is responsible for the design and implementation of the Family Medicine In-Patient Service (FMIS). The Family Medicine In-Patient Service (FMIS) consists of patients who are admitted from the FMP (the CFHC), the Morehouse Healthcare Howell Mill practice, Grady East Point, and JenCare and select patients admitted by the Sound hospitalist group. Resident coverage for the teaching service is provided on a 24-hour-a-day, year-round basis.

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

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

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 how to care for patients. Faculty members provide an important bridge allowing residents 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, 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 well-being of the residents 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 include - 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; and,
7. Pursue faculty development designed to enhance their skills at least annually:
 1. As educators
 2. In quality improvement and patient safety
 3. In fostering their own and their residents’/fellows’ well-being; and
 4. In patient care based on their practice-based learning and improvement efforts

Faculty Qualifications – Faculty members must:

1. have appropriate qualifications in their field and hold appropriate institutional appointments.
2. 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.
3. possess current medical licensure and appropriate medical staff appointment.

Core Faculty members must:

1. be designated by the program director
2. have a significant role in the education and supervision of residents/fellows
3. devote a significant portion of their entire effort to resident education and/or administration
4. as a component of their activities, teach, evaluate, and provide formative feedback to residents/fellows.
5. complete the annual ACGME Faculty Survey.

Any non-physician faculty members who participate in residency 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 -resident/fellows ratio.
- May specify requirements specific to associate program director(s).

Appendix

APPENDIX A: Moonlighting Form

APPENDIX B: Hand-off Form

APPENDIX C: Acknowledgement of Promotion and PGY2-Specific Requirements

APPENDIX D: Acknowledgement of Promotion and PGY3-Specific Requirements

APPENDIX E: Evaluation of Faculty by Residency Program Form

APPENDIX F: Resident Leave Request Form

APPENDIX G: Inpatient Survival Guide

APPENDIX H: A Survival Guide for the Intern



Moonlighting Approval Request form

Moonlighting Criteria

1. PGY 2 or higher (PGY 1 residents may not moonlight)
2. J1-Visa sponsored residents may not moonlight
3. A full Georgia Physician's license is required
4. Resident/Fellow must have "good standing" status in the program
5. Residents/fellows must log all internal and external moonlighting hours which count toward the ACGME duty hours
6. Moonlighting must occur within the state of Georgia

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: _____

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

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

Attending Name _____ Date _____

Resident Name _____ PGY Level _____

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

Format

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

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

Resident is competent to perform handoffs independently ☐Yes ☐No

If no, please provide recommendations for improvement _____

Comments _____

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

Promotion Criteria from PGY-1 to PGY-2

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

Patient Care

Regarding patient care, the intern will:

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

Medical Knowledge

Regarding medical knowledge, the intern will:

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

Practice-Based Learning and Improvement

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

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

Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the intern will:

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

Professionalism

Regarding professionalism, the intern will:

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

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

Systems-Based Practice

Regarding systems-based practice, the intern will:

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

Comments: _____

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

Program Director

Faculty Advisor

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

Resident

Date

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

Patient Care

Regarding patient care, the resident will:

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

Medical Knowledge

Regarding medical knowledge, the resident will:

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

Practice-Based Learning and Improvement

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

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

Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the resident will:

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

Comments: _____

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

Program Director

Faculty Advisor

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

Resident

Date



SEMI-ANNUAL EVALUATION OF FACULTY MEMBER BY RESIDENCY PROGRAM

Faculty Name: _____

Evaluation Period: _____

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

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

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

Comments:

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

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

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

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

PD Signature and date: _____

Faculty Signature and date: _____

Chairperson Signature and date: _____

MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM

RESIDENT LEAVE REQUEST FORM

Leave Information

Resident Name: _____
Resident PGY Level: _____

Current Rotation: _____

Type of Leave Requested:

- | | | | |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Sick | <input type="checkbox"/> Vacation | <input type="checkbox"/> Bereavement | <input type="checkbox"/> Time Off Without Pay |
| <input type="checkbox"/> CME/Administrative | <input type="checkbox"/> Jury Duty | <input type="checkbox"/> Maternity/Paternity | <input type="checkbox"/> Other |

Dates of Absence: From: _____ Return Date: _____

Total Number of Days Requested: _____

Chief Resident Signature: _____ Date: _____

Resident Signature: _____ Date: _____

Program Approval

- ☐ Approved
☐ Rejected

Comments:

Program Manager or Program Director Signature: _____

Date: _____



**Family Medicine Residency Program
Policies and Procedures**

**Academic Year
2019-2020**


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Legends

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

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-01
		EFFECTIVE DATE	06/1/2019
		PAGE(S)	01
	<u>SUBJECT:</u> ADVERSE ACTION AND DUE PROCESS POLICY	SUPERSEDES	1/21/2015

Adverse Action and Due Process Policy

I. BACKGROUND

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

II. PURPOSE


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

III. SCOPE

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

IV. POLICY

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

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-02
		EFFECTIVE DATE	06/1/2019
		PAGE(S)	02
	<u>SUBJECT: PROGRAM CONCERN AND COMPLAINT POLICY</u>	SUPERSEDES	1/21/2019

Program Concern and Complaint Policy-For Residents

I. BACKGROUND

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

II. PURPOSE


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

III. POLICY

- 3.1. The process and resources available for reporting concerns and complaints are detailed below.
- 3.2. This process is reviewed annually with residents and faculty.
- 3.3. Any resident/fellow may directly raise a concern to the Resident Association forum.
- 3.4. Resident Association Forums/Meetings may be conducted without the DIO, faculty members, or other administrators present.
- 3.5. Residents/fellows have the option to present concerns that arise from discussions at Resident Association Forums to the DIO and GMEC.
 - 3.5.1. Discuss the concern or complaint with the chief resident, clinical service director, program manager, associate program director, and/or program director as appropriate.
 - 3.5.2. If the concern or complaint involves the Program Director or Rotation Director and/or cannot be addressed in Step 1, residents have the option of discussing issues with the Department Chair, Dr. Folashade Omole at fomole@msm.edu or (404) 756-1206 or the service chief of a specific hospital as appropriate.
 - 3.5.3. If the resident is not able to resolve the concern or complaint within the Program or Department, the following resources are available:

- 3.5.3.1.** For issues involving program concerns, training matters, or the work environment, residents can contact the Graduate Medical Education Director, Tammy Samuels at tsamuels@msm.edu or (404) 752-1011
- 3.5.3.2.** For problems involving interpersonal issues, the Resident Association President or President-Elect is available to discuss confidential informal issues that arise outside of the Department of Family Medicine (issues within the Department should first be discussed with one of the Family Medicine Chief Residents if comfortable)
- 3.5.3.3.** Any resident may directly raise a concern to the Resident Association Forum.
- 3.5.3.4.** Resident Association Forums/Meetings may be conducted without the DIO, faculty members, or other administrators present.
- 3.5.3.5.** Residents have the option to present concerns that arise from discussions at Resident Association Forums to the DIO and GMEC.
- 3.5.3.6.** Anonymous feedback/concerns/complaints can be provided at any time by completing the online GME Feedback form available at the following website:
<http://www.msm.edu/Education/GME/feedbackform.php>.
 - 3.5.3.6.1.** Comments made on this site are anonymous and cannot be traced back to an individual. However, a resident may elect to provide his/her name and contact information if he/she desires personal follow-up regarding how feedback/concerns/complaints have been addressed by the Departments and/or the GME office.
- 3.5.3.7.** For issues involving compliance, the MSM Compliance Hotline at (855) 279-7520 and on-line reporting portal at <https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html> are available. These are anonymous and confidential mechanisms for reporting unethical, noncompliant, and/or illegal activity and should be used to report any concern that could threaten or create a loss to the MSM community, including the following:
 - Harassment- sexual, racial, disability, religious, retaliation
 - Environmental Health and Safety- biological, laboratory, radiation, laser, occupational chemical, and waste management and safety issues

- Other- misuse of resources, time, or property assets; accounting, audit and internal control matters; falsification of records; theft, bribes, and kickbacks

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-03
		EFFECTIVE DATE	06/1/2019
		PAGE(S)	09
	SUBJECT: ELIGIBILITY, SELECTION, AND APPOINTMENT POLICY	SUPERSEDES	1/21/2015

Eligibility, Selection, and Appointment Policy

I. BACKGROUND

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

II. PURPOSE

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

III. POLICY

3.1. Resident Eligibility

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) Institutional Requirements Section IV.A. Institutional GME Policies and Procedures – Resident/Fellow Recruitment, and the ACGME Common Program Requirements – Resident/Fellow Appointments/Eligibility/Transfers – section III.A-C. Sponsoring Institutions are required to have written policies and procedures for resident/fellow recruitment and must monitor each of its ACGME accredited programs for compliance.

- 3.1.1. Applicants with one of the following qualifications are eligible for appointment to accredited residency programs: graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or, graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA);
- 3.1.2. Graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:
 - 3.1.2.1. holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or,
 - 3.1.2.2. holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty-/subspecialty program; or,

- 3.1.10.** The program director (PD) is responsible for verification of the applicants' credentials. Applicants who do not meet the criteria above cannot be considered for the Residency Program.
- 3.2.** The PD and APDs review applicants and are responsible for selection of applicants for interview.
- 3.3.** The Residency Program shall hold a meeting at the end of the interview season with the faculty members and residents who participated in the interview process to inform the final choice of applicants to be ranked in the NRMP match.
- 3.4.** Resident Selection
 - 3.5.** The program considers J-1 visa. Morehouse School of Medicine does not support or sponsor H-1B Visas for residency or fellowship training programs
 - 3.5.1.** Applicants are selected on the basis of preparedness, ability, aptitude, academic credentials, communications skills, and personal qualities such as motivation and integrity.
 - 3.5.2.** Academic credentials include medical school grades and performance as reflected in documentation received directly from the medical school, and United States Medical Licensing Examination (USMLE) scores.
 - 3.5.3.** Prior graduate medical education training, where applicable, will also be considered.
 - 3.5.4.** Formal educational and/or testing results submitted by the applicant may also be considered. Letters of reference from supervisors, educators, and peers, when appropriate, serve to provide additional information on personal characteristics, and are required and evaluated as well.
 - 3.5.5.** 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.
 - 3.5.6.** 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.
 - 3.5.7.** The selection committee then invites selected candidates for an individual interview which is conducted in person. The interview allows in-person confirmation of information provided in the written application as well as an opportunity to assess communication and other non-cognitive skills.
 - 3.5.8.** An applicant invited to interview for a resident/fellow position will be informed in writing or by electronic means, of the most current terms, conditions, and benefits of appointment to the ACGME-accredited program.
 - 3.5.9.** Information provided to the invited applicant will include financial support; vacations; parental, sick, and other leaves of absence; and professional liability,

hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents.

3.5.10. Confidential evaluations by each applicant interviewer will be collected and reviewed by the selection committee and become part of the application file.

3.5.11. The committee and the PD are responsible for the final ranking of candidates in the National Resident Matching Program. All current fourth year medical students from United States medical schools are required to apply through the NRMP process or other appropriate match processes. MSM participates in the NRMP All In Policy and programs will only review applications through ERAS.

3.5.12. NRMP Match:

3.5.12.1. The NRMP All In Policy requires any program participating in the Main Residency Match to register and attempt to fill all positions through the Main Residency Match or another national matching plan.

3.5.12.2. This includes all positions that may begin at the PGY-1.

3.5.12.3. The NRMP will only consider certain exceptions.

3.5.12.4. Program directors and administrators are required to review the terms and conditions of the applicable Match Participation Agreement for their specialty each year and comply with applicable match policies and the Match Commitment, which addresses violations of NRMP Policy.

3.5.12.5. As noted in the Match Participation Agreement, program directors are prohibited from offering positions to ineligible applicants and must use the Applicant Match History in the Registration, Ranking, and Results (R3SM) System to determine an applicant's eligibility for appointment.

3.5.13. As per the Match Participation Agreement, the following actions constitute a breach of the applicable Match Participation Agreement:

3.5.13.1. A program requesting applicants to reveal ranking preferences;

3.5.13.2. An applicant suggesting or informing a program that placement on a rank order list or acceptance of an offer during the Supplemental Offer and Acceptance Program (SOAP) is contingent upon submission of a verbal or written statement indicating the program's preferences;

3.5.13.3. A program suggesting or informing an applicant that placement on a rank order list or a SOAP preference list is contingent

upon submission of a verbal or written statement indicating the applicant's preference;

- 3.5.13.4.** A program requiring applicants to reveal the names or identities of programs to which they have or may apply; or
- 3.5.13.5.** A program and an applicant in the Matching Program making any verbal or written contract for appointment to a concurrent-year residency or fellowship position prior to the release of the List of Unfilled Programs.
- 3.5.13.6.** All candidates who are interviewed shall be given a copy of the MSM appointment agreement, a copy of this policy, and the program's aims. The program will document that the candidate has received a copy of the appointment agreement by obtaining his/her signature at the time of interview.
- 3.5.13.7.** Appointment: The following procedure is required before any resident can officially be appointed as a resident:
- 3.5.13.8.** Primary verification of all credentials is required.
 - 3.5.13.8.1.** The Residency Program in conjunction with the Office of GME and the Human Resources office will conduct this verification.
 - 3.5.13.8.2.** It is the responsibility of the resident to provide sufficient information to allow these verifications to be conducted.
- 3.5.13.9.** At a minimum, the MSM Family Medicine Residency Program must be able to obtain primary source verification of the following elements:
 - 3.5.13.9.1.** Certification of graduation from any accredited medical school or ECFMG-certified medical institution. This documentation must be submitted directly from the academic institution granting the degree or from ECFMG directly to the residency program.
 - 3.5.13.9.2.** ECFMG Certification must be current certification stamped *indefinite* must be submitted with ERAs documents.
 - 3.5.13.9.3.** Letters of recommendation.
 - 3.5.13.9.4.** Documentation accounting for any lapses between the end of medical school and the present. Large gaps of time exceeding one month that are not verifiable will disqualify candidates for consideration for a GME program.
- 3.5.13.10.** Proper documentation of employment and/or work performed since graduation from medical school. The standard for proper documentation will be imposed by the GME program.
- 3.5.13.11.** Passing a criminal background check.

3.5.13.12. Passing of all six competencies in a summative evaluation from the program director for any resident or fellow completing training or transferring from preliminary training or another institution.

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

3.5.15. Applicants who do not meet the criteria stated above cannot be appointed to any graduate medical educational program at the Morehouse School of Medicine.

3.5.16. Completion of primary source verifications renders an applicant eligible for appointment but does not in and of itself result in automatic appointment. Residents are eligible to proceed through the appointment process.

3.5.17. The official start date is contingent upon the resident completing all required paperwork (demographic/tax form, etc.) clearance by employee health service (resident must submit a complete history and physical form), and appropriate visa, if applicable.

3.5.18. Monitoring: This process has been reviewed by members of the Graduate Medical Educational (GME) Committee and agreed upon as a uniform approach to evaluation and selection of residency applicants ensuring compliance with the eligibility and selection criteria as described above is the responsibility of each program director. Oversight for GME is the responsibility of the designated institutional official (DIO) who monitors program compliance through regular annual program accreditation review and the GMEC who reviews policies and procedures on a regular basis.

IV. TECHNICAL STANDARDS AND ESSENTIAL FUNCTIONS FOR APPOINTMENT AND PROMOTION

4.1. BACKGROUND

4.1.1. Family Medicine is an intellectually, physically, and psychologically demanding profession. All phases of medical education require knowledge, attitudes, skills, and behaviors necessary for the practice of medicine throughout a professional career.

4.1.2. Those abilities that residents must possess to practice safely are reflected in the technical standards that follow.

4.1.3. These technical standards and essential functions are to be understood as requirements for training in all Morehouse School of Medicine residencies and are not to be construed as competencies for practice in any given specialty. Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.

- 4.1.4. Residents in Graduate Medical Education programs must be able to meet these minimum standards, with or without reasonable accommodation.

4.2. STANDARDS

4.2.1. Observation

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

4.2.2. Communication

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

4.2.3. Motor Functioning

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

4.2.4. Intellectual—Conceptual, Integrative, and Quantitative Abilities

- 4.2.4.1. Residents must be able to measure, calculate, reason, analyze, integrate, and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions, which are critical skills demanded of physicians.
- 4.2.4.2. In addition, residents must be able to comprehend three-dimensional relationships and to understand spatial relationships of structures.

4.2.5. Behavioral and Social Attributes

- 4.2.5.1. Residents must possess the psychological ability required for the full utilization of their intellectual abilities, for the exercise of good judgment, for the prompt completion of all

responsibilities inherent to diagnosis and care of patients, and for the development of mature, sensitive, and effective relationships with patients, colleagues, and other healthcare providers.

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

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

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

4.2.6. Accommodations

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

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


4.2.6.3. Accommodations are made on a case-by-case basis. MSM will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in a given situation. An accommodation need not be the most expensive or ideal accommodation, or the specific accommodation requested by the individual, so long as it is reasonable and effective.

4.2.6.4. MSM will not provide a reasonable accommodation if the accommodation would result in undue hardship to MSM or if the employee, even with reasonable accommodation, poses a direct threat to the health or safety of the employee or other persons.

4.2.6.5. Any decision to deny a reasonable accommodation on the basis of cost will be reviewed and approved by the Chief Financial Officer and Senior Vice President for Administration of MSM.

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

- 4.2.6.7.** NOTE: It is important to note that the MSM enrollment of non-eligible residents may be cause for withdrawal of residency program accreditation.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-04
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	08
	SUBJECT: CLINICAL ENVIRONMENT AND EDUCATIONAL WORK HOUR POLICY	SUPERSEDES	06/01/2017

Clinical Environment and Educational Work Hour Policy

I. BACKGROUND

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

II. PURPOSE

- 2.1. The purpose of this process is to outline the program's monitoring and oversight of work hours and document how work hour logging issues and/or violations are addressed by the Program.
- 2.2. Work hours are defined as time spent on all clinical and academic activities related to the residency program, such as patient care (both in-patient and out-patient), administrative duties related to patient care, the provision for transfer of patient care, in-house call activities, and scheduled academic conferences/didactics. Hours spent moonlighting must also be included in the work hour calculation. Work hours do not include reading and academic preparation time spent away from the work site.
- 2.3. The ACGME considers clinical and educational work hour limits to be an important element of its comprehensive approach to promote high quality education, wellness, and safe patient care. Residents must adhere to all work hour requirements as detailed below:

2.3.1. Maximum Hours of Clinical and Educational Work per Week

- 2.3.1.1. Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

2.3.2. Mandatory Time Free of Clinical Work and Education

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

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

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

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

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

2.3.3. Maximum Clinical Work and Education Period Length

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

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

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

2.3.4. Clinical and Educational Work Hour Exceptions

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

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

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

2.3.4.1.3. to attend unique educational events

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

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

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

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

III. PROGRAM WORK HOUR MONITORING AND REPORTING PROCESS

- 3.1.** Reporting of resident work hours is required by the residency accrediting agency, the ACGME/Residency Review Committee, and therefore, are not optional. Daily work hour logging in New Innovations is expected and logging within 5 days is required.
- 3.2.** The following guidelines apply to logging duties:
 - 3.2.1.** Logging should be continuous with no gaps (for example for lunch or travel between clinical sites).
 - 3.2.2.** Conferences should be logged contiguous with other duties with no gaps in between.
 - 3.2.3.** For in-house call, log work type "Call". For back-up call assignments when the resident has to go into the hospital, log work type "Back Up-Called In". NOTE: Back-up residents do not log if they do not go into the hospital.
 - 3.2.4.** If your 24-hour shift is extended work to post-call transitions of patient care or mandatory conferences, avoid a violation by logging the following two work types (1) post-call and (2) conferences for the hours that extend beyond the 24-hour period. NOTE: The post-call period must not exceed 4 hours
 - 3.2.5.** Log appropriate work types for moonlighting, vacation, holiday/day off, or sick days.
 - 3.2.6.** Each resident must enter written justification or cause in the event of a violation.
 - 3.2.6.1.** Justifications apply to violations of 24+ or short break rule.
 - 3.2.6.2.** Causes apply to any violation.
 - 3.2.6.3.** These must be entered in New Innovations as comments in the provided for each flagged violation
- 3.3.** Work hour logging is monitored by the Program Manager who provides a weekly logging status report to the Program Director.

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

IV. ALERTNESS MANAGEMENT & FATIGUE MITIGATION

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

when creating the night float, call, and clinic schedules, the chief residents also assign a backup resident who is available for shift coverage when necessary or to come in to assist with in-hospital work for a resident who is overwhelmed with an unexpected increase in patient volume or acuity.

- 4.2.** A “Safe Ride Home” policy addresses the situation in which a resident is excessively fatigued upon completion of his/her work. The policy is detailed below.

4.2.1. Purpose - To outline a process whereby residents who feel too fatigued to safely drive home after a rotation day can feel encouraged to call a cab for a safe ride home from rotation and back again to retrieve their vehicle or report for work the next day and be reimbursed for the expense.

4.2.2. Process - If a situation arises in which a resident is unable to safely drive home at the end of his/her shift due to extreme fatigue or the late hour, the resident is encouraged to take a nap prior to driving home, if possible based on the physical location and access to a secure location for sleeping. In the absence of sleeping as an option, the resident should contact a local taxi or rideshare company for a safe ride home. The resident may in the absence of the ability to return to the original location to pick up his or her vehicle after appropriate rest obtain a cab ride back to the original destination and submit that receipt for reimbursement. The resident should keep the receipt from the ride and bring it to the program office within 30 days of the ride for reimbursement of 100% of the fare (tip not included). The receipt must be accompanied by a description of the circumstances that caused the fatigue and required the use of the safe drive home. All current MSM reimbursement policies apply.

4.2.3. Responsibility - The program offers this service as a way to encourage a resident who is too fatigued to safely drive home to obtain a cab ride home by offering to reimburse the resident for cost of cab fare plus tip per MSM guidelines. The resident holds the responsibility in knowing when he or she needs to utilize this service. The system is not to be abused and must be utilized when absolutely necessary.

V. PROGRAM CALL POLICY/GUIDELINES

5.1. Night Float/Call Responsibilities:

5.1.1. PGY2 and PGY3 residents are assigned to the night float schedule by the Program Manager.

5.1.2. Night float assignments are based on resident availability and current rotation assignments.

5.1.3. Residents are not eligible for night float during the following rotation: FM Wards, ECC, Urology/Radiology, ENT/Ophthalmology, and Peds at GEP or during any month during which the attending has vacation.

- 5.1.4.** Additionally, night float assignment during the same month that a resident has a vacation is avoided although it may occur in rare instances if there are no other residents available.
- 5.1.5.** Although every effort is made to ensure equitable assignment of night float weeks, the situation occasionally arises when one resident may have more night float sessions than another. In all cases, work hour rules are followed.
- 5.1.6.** During the week of night float, the assigned resident will cover the Family Medicine Inpatient Service at AMC-South from 5:00pm to 6:00am from Sunday to and including Thursday and from 5:00pm Friday to 7:00am Saturday. The resident shall not report to his/her assigned rotation during the night float week.
- 5.1.7.** During the night float shift, the night float resident assumes responsibility for the care of the patients carried by the inpatient team from the time of evening sign-out until morning handoff back to the inpatient team or to the on-call resident on Saturday. Responsibilities include but are not limited to ordering and reviewing lab tests and studies, reviewing notes from consultants, evaluating patients, as needed, responding to calls from nurses and the answering service, and admitting patients to the Morehouse Family Medicine and hospitalist services in accordance with established patient cap agreements.
 - 5.1.7.1.** Admission from the Emergency Department: The Family Medicine attending, or hospitalist will contact the resident when a patient in the Emergency Department needs to be evaluated for admission.
 - 5.1.7.2.** After performing the history and physical, the resident must call the attending on call to discuss the history, physical, assessment, and proposed management for approval in order to finalize the admission orders.
 - 5.1.7.3.** Direct admissions are discouraged in the interest of patient safety. However, if an attending proposes to admit a patient directly, he/she must first discuss the patient with the inpatient attending to determine whether initial evaluation and management in the emergency department is more appropriate.
 - 5.1.7.4.** The night float resident is responsible for evaluating all ICU patient and writing interval notes before midnight.
 - 5.1.7.5.** The night float resident is responsible for writing progress notes on all patients on Saturday morning and for contacting the designated member of the inpatient team to assist with progress notes if there are more than 8 patients on service.

5.1.8. The night float resident will spend the remaining three (3)) weeks of the rotation block with duties divided between his or her rotation and the family medicine continuity clinic.

5.2. Long Call and Short Call

5.2.1. Residents on VA rotations who are not assigned to night float during a given month are eligible to be assigned to one long call and one short call during that month.

5.2.1.1. Long call is defined as a 24-hour call at AMC-South from 7:00 am Saturday morning to 7:00 am Sunday morning.

5.2.1.2. Short call is described as a 12-hour shift on Sunday from 7:00am to 7:00pm.

5.2.1.3. The responsibilities of the long call and short call resident are the same as the resident responsibilities described in the Night Float section above.

5.2.1.4. The long call resident is responsible for writing progress notes on all patient on Sunday morning and for contacting the designated member of the inpatient team to assist with notes if there are more than 8 patients on the service.

5.2.2. In addition to the aforementioned responsibilities, the night float, short call, and long call residents are responsible for receiving, addressing, and documenting all after-hours phone calls from the FMP.

5.2.3. The resident will contact the Family Medicine Inpatient Service (FMIS) attending if he or she needs any assistance or has any questions.

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


VI. UNUSUAL RESIDENT-INITIATED EXTENSIONS – ADDITIONAL DUTY

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

6.2. However, in unusual circumstances, a resident on his/her own initiative may remain at the clinical site beyond the 24-hour period to provide care to a single patient. In these cases, the additional hours must be counted toward the 80 work-hour limit and the following justification for extending work must meet one of the following conditions:

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

- provision of humanistic attention to the needs of a patient or family
 - to attend unique educational events
 - The extended work must not exceed 4 hours
- 6.3.** In each circumstance, the following actions must be taken:
- 6.3.1.** The resident must appropriately hand over the care of all other patients to the team responsible for their continuing care
 - 6.3.2.** The resident must document the reasons for remaining to care for the patient in New Innovations
 - 6.3.3.** The Program Director must review each submission of additional service and track both individual resident and program-wide episodes of additional work.
- 6.4.** This program policy is consistent with Morehouse School of Medicine GME policies 7.2.2 and 7.2.3

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

Leave Policy

I. **BACKGROUND**

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

II. **PURPOSE**

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

III. **POLICIES**

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

3.2.5. The resident must clarify with his/her assigned service whether or not he/she is required to work on a holiday.

3.3. Vacation

3.3.1. Each resident is eligible for 15 days of vacation annually.

3.3.2. Vacation may be taken in 5-day increments (Monday – Friday)

- The Saturday and Sunday before and after the 5-day vacation period are not guaranteed days off.

3.3.3. Vacation is not permitted on half-month block rotations.

3.3.4. Vacation cannot be taken during the following restricted rotations:

- Family Medicine Wards Service
- ICU
- Pediatric Wards
- Pediatric ER
- Internal Medicine Wards

3.3.5. Vacation dates must be requested and assigned before the start of each academic year

3.3.6. Vacation change requests must be submitted 90 days prior to the requested change and are subject to approval by the PD

3.3.7. Leave requests must be submitted 100 days prior to the anticipated leave

3.3.8. A fair and equitable approach will be used when approving time off requests.

3.3.9. Vacations must be taken in the academic year for which the vacation is granted; vacation periods do not carry over from one year to another.

3.3.9.1. No two vacation periods may be concurrent from one PGY year into the next (e.g., last month of the PGY-2 year and first month of the PGY-3 year in sequence).

3.4. Sick Time

3.4.1. Compensated Sick Leave is 15 days per year.

3.4.2. This time can be taken for resident illness or for the care of an “immediate” family member.

3.4.3. Sick leave is not accrued from year to year.

3.4.4. Extended Leave: In the event of the need to care for a serious health condition of oneself or an immediate family member, residents must first use his/her unused sick and vacation leave for paid time off. If additional time off is needed after all sick and vacation time has been exhausted,

the additional time off will be unpaid leave. Residents must work with Human Resources (HR) and follow HR policy regarding unpaid time off and/or eligibility for short term disability

3.5. Administrative Leave

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

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

3.5.3. Due to the ACGME Program Requirements regarding time away from the program, Administrative leave granted after vacation and sick leave have been exhausted may result in extension of training dates.

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

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

3.6. Educational Leave

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

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

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

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

3.7. Family and Medical Leave

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

3.7.1.1. Incapacity due to pregnancy, prenatal medical care, or childbirth;

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

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

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

- 3.7.2.** Eligible residents who care for covered service members may also be eligible for up to 26 workweeks of unpaid leave in a single 12-month period.
 - 3.7.3.** Residents are eligible for FMLA leave if they have worked for MSM for at least one (1) year, have worked 1,250 hours over the previous 12 months, and have a qualifying event as outlined above.
 - 3.7.4.** Residents must direct all questions about FMLA leave to the Human Resources Department.
- 3.8.** Leave Without Pay
 - 3.8.1.** Leave required beyond available compensated sick and/or vacation leave will be uncompensated leave without pay
 - 3.8.2.** Requests for leaves of absence without pay shall be submitted in writing to the Program Director and reviewed by the HR Department for disposition and approval no less than 90 days in advance of any planned leave. Such requests must include the reason and duration for the proposed leave.
 - 3.8.3.** Leave without pay, when approved, shall not exceed 2 months in duration.
 - 3.8.4.** The Program Director must discuss the implications of the leave, including possible prolongation of the program and should ensure that the resident understands these implications.
 - 3.8.5.** If the resident decides to move forward with the request, the MSM Human Resources Department shall advise both the resident and the residency program director on applicable policies and procedures.
- 3.9.** Other Types of Leave
 - 3.9.1.** All other leave types (e.g., military, bereavement, jury duty, etc.) are explained in detail in MSM's Policy Manual which is available on the Human Resources Department Intranet webpage.
- 3.10.** Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc. must not exceed a combined total of thirty (30) days per academic year.
- 3.11.** The resident must complete a Leave Request form for any unplanned time off, including vacation changes, conference attendance, or administrative leave., Forms must be completed by the resident and submitted to the chief resident for schedule review and determination of feasibility. The form then must be submitted to the Program Manager for review and final approval by the Program Director. It is the resident's responsibility to obtain the chief resident's signature and forward the forms to the residency program manager and the director for approval.

3.12. If any changes in night call schedule are necessitated by the leave time, it is the resident's responsibility to contact the chief resident and arrange for coverage.

3.12.1. The names of the physicians covering call and clinic responsibilities must appear on the Leave Request Form and must be signed by the resident(s) agreeing to cover the call or clinic responsibility. Notification must be given to the appropriate contact person(s) at the affected clinical site(s). or CFHC front office staff.

3.12.2. Third-year residents are advised that there may be no leave during the last three weeks of residency except for extreme circumstances. Director approval is required.

3.13. Return to Duty

3.13.1. For leave due to childbirth or serious health conditions of the resident or a family member, a physician's written "Release to Return to Duty" or equivalent is required with the date the resident is expected to return to resume his or her residency. This information is submitted to the Human Resources Department (HRD).

3.13.2. A Release to Return to Duty statement signed by the treating physician must also be submitted to the HR Department if a resident's illness requires an absence of more than 3 days.

3.13.3. When applicable, the residency program director will record in writing the adjusted date required for completion of the PGY and/or the program because of extended resident leave. One copy is placed in the resident's educational file and a copy is submitted to the Office of Graduate Medical Education (GME) to process the appropriate Personnel Action.


3.14. Program Leave Limitations

3.14.1. Leave away from the training program includes the total of all leave categories taken within an academic year. This includes uncompensated Federal Family and Medical Leave and other Leave without Pay (LWOP). All/any should not exceed 30 days per year.

3.14.2. **The resident may be required to make up some portion of his or her share of call nights upon return to work.** Advanced notification of anticipated leave will enable the chief resident to incorporate the resident's absence into the clinic and call schedule and attempt to arrange full coverage. The chief resident will make any reassignments of call, as needed.

3.14.3. For successful completion of the program on time, and for Board eligibility in April of the PGY3 year, the American Board of Family Medicine does not permit more than 30 days leave time per year. Time away of more than 30 days will result in ineligibility to sit for the

ABFM Board Examination in April of the PGY3 year. In rare instances, the PD may, at her discretion, override this rule and permit a resident to take the exam with his/her class. Leave time greater than 30 days per academic year is at the discretion of the director.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-06
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	20
	<u>SUBJECT:</u> EVALUATION POLICY	SUPERSEDES	01/21/2015

Evaluation Policy

I. **BACKGROUND**

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

II. **PURPOSE**

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

III. **POLICY**

3.1. Faculty Evaluation of Residents

- 3.1.1. The Program assures that all residents are systematically evaluated on their knowledge, skills, performance, and professional growth on an ongoing basis throughout their training.
- 3.1.2. Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment
- 3.1.3. Evaluation must be documented at the completion of the assignment
- 3.1.4. For block rotations more than three months in duration, evaluation must be documented at least every three months.
- 3.1.5. Continuity clinic and other longitudinal experiences in the context of other clinical responsibilities, must be evaluated at least every three months and at completion
- 3.1.6. Each form of evaluation is designed to assess the resident using the 6 core competencies of Patient Care and Procedural Skills, Medical Knowledge, Systems Based Practice, Practice Based Learning and improvement, Professionalism, and Interpersonal and Communication Skills and assesses progression along the ACGME required Milestones.
- 3.1.7. While on clinical rotations all residents receive written and/ or verbal formative evaluations and written and verbal summative evaluation. Residents also receive feedback on their performance globally through semi-annual evaluations which provide formative evaluation throughout

the course of residency training and a summative evaluation at the end of training. All information is compiled in New Innovations.

3.1.8. The Program has numerous objective performance evaluations in place to help assess the acquisition of the knowledge, skills, and abilities needed to independently practice clinical medicine. Evaluation tools include:

- Direct observation
 - During continuity clinic and inpatient encounters
 - During OSCE
- Multi-Source 360 Evaluations
 - Peer to Peer
 - Clinic Staff of Resident
 - Medical Student of Resident
 - Self-Evaluation
 - Patient Satisfaction
- Faculty Evaluation of Resident Clinical Performance
 - Clinical competency examinations
 - Oral-Examinations
 - Medical Record Review
 - Milestone Evaluation/Assessment
- Semi-annual evaluation using tools listed above, ITE performance, advisor input, and resident log data
- Summative Evaluation (final evaluation of performance prior to completion of training)
- QI project participation and performance

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

3.2. Clinical Competency Committee (CCC)

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

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prepared by the Program Manager or Program Assistant and disseminate the minutes to all committee members, the program director and the department chairperson.

3.3.3.4. Prepare a written recommendation of progression, promotion or adverse action to the program director.

3.3.3.5. Report the required semi-annual progression for specialty specific milestone assignment. Recommendations will be provided on each resident's performance for each Milestone to the Family Medicine Residency program director who will review the recommended Milestone assignments, revise as needed, and submit to the ACGME by ACGME-established deadlines. The Family Medicine Residency program manager will maintain a file of all CCC reports and recommendations for each resident.

3.3.4. Meeting Frequency

3.3.4.1. The CCC will meet four (4) times per year, usually on the fourth Wednesday of the month. Standing meeting dates shall be established at the beginning of each academic year.

3.3.4.2. Additionally, the committee chair may schedule ad hoc meetings at the request of the program director to address urgent matters that must be handled before the next regularly scheduled meeting.

3.3.4.3. Reasons for ad hoc meetings may include but are not limited to consistently low performance or unsatisfactory evaluation scores of a resident; repeated lack of adherence to program requirements; or a specific incident that requires CCC review for possible probation or dismissal.

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

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

3.3.5. Procedure for Review

3.3.5.1. The CCC shall evaluate the residents on a quarterly basis in order to produce a consensus recommendation on each resident and will complete an annual summative evaluation of each resident that includes their readiness to progress to the next year of the program.

- In reviewing each resident, the CCC shall consider the following evaluation tools: Rotation evaluations
- 360 evaluations (including peer, self, clinical staff)

- In-Training Exam scores
 - OSCE performance reports
 - Research progress
 - Advisor documentation
 - Program director documentation
 - Procedure logs
 - Noon conference attendance
 - Teaching activity
 - Any reports of unprofessional behavior as submitted by the program director, faculty or peers
 - Record of remediation, where applicable
- 3.3.5.2.** Additionally, if any resident is having academic problems, he or she will be reviewed in discussion at the meeting.
- 3.3.5.3.** The CCC can set thresholds for remediation, probation, and dismissal.
- 3.3.5.4.** The CCC may recommend to the PD and APD that a “Notice of Deficiency” be given to any resident who performs below milestone benchmarks
- 3.3.5.5.** The PD or designated APD will meet with each resident and communicate the recommendation and design a remediation or improvement plan.
- 3.3.6.** Recommendations—Based on the comprehensive review of each resident’s record of performance, in the case of inadequate performance, the CCC may recommend probation with remediation or delay or deny promotion or board recommendation as appropriate for the deficiencies identified. In accordance with MSM’s “Resident Promotion Policy” and “Adverse Academic Decisions and Due Process Policy, the CCC may make the following recommendations to the PD and APD:
- 3.3.7.** Progression—Resident is performing appropriately at current level of training with no need for remediation.
Resident should continue with the current curriculum.
- 3.3.8.** Promotion—Resident has demonstrated performance appropriate to move to the next level of training without the need for remediation.
Resident should progress with next PGY level as scheduled.
- 3.3.9.** Notice of Deficiency—Resident has demonstrated performance below the expected level in a specific competency across multiple evaluations but does not require remediation.

- 3.3.10.** The resident must submit a corrective action plan to eliminate the deficiency.
- 3.3.10.1.** The CCC will prepare a statement for the grounds for Notice of Deficiency, including identified deficiencies or problem behavior.
 - 3.3.10.2.** Notice of Deficiency may be removed from the resident file if the resident is performing at satisfactory level and deemed to have corrected his or her deficiency within a time frame defined by the CCC, not to exceed six (6) months.
- 3.3.11.** Notice of Deficiency with Remediation—Resident has demonstrated performance below the expected level in a specific competency and requires remediation. Notice of Deficiency **REQUIRES** the resident (in conjunction with the PD and advisor) to develop a **REMEDATION** plan to cure the deficiency.
- 3.3.11.1.** The CCC will prepare a statement for the grounds for Notice of Deficiency and Remediation, including identified deficiencies or problem behaviors.
 - 3.3.11.2.** The CCC or PD must review the resident's performance every three (3) months to determine if the resident is meeting the terms of the remediation plan.
 - 3.3.11.3.** Remediation (total time) shall not exceed six (6) months in an academic year.
 - 3.3.11.4.** This recommendation remains on the resident's permanent record.
 - 3.3.11.5.** Failure to successfully remediate and cure the deficiency could result in extended remediation, additional training time, non-renewal, or dismissal from the program.
 - 3.3.11.6.** Immediate Suspension—Resident has performed serious misconduct or has posed a threat to colleagues, faculty, staff, or patients.
 - 3.3.11.7.** This may result from gross unprofessional or unethical behavior, misconduct, or the serious threat to the safety of patients such that continuation of clinical activities by the resident is deemed potentially detrimental or compromising to patient safety or the quality of patient care, or threatening to the well-being of staff or the resident.
 - 3.3.11.8.** The CCC or PD will prepare a statement for the grounds for suspension, including the identified deficiencies or problem behaviors.
 - 3.3.11.9.** Suspension shall not exceed 30 days. The CCC must conduct a review in 30 days if additional time is recommended.

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- 3.3.14.3.** The resident's contract shall expire at the end of the academic year, without renewal.
 - 3.3.14.4.** This decision may be appealed by the resident in accordance to GME policies of Due Process ("Adverse Academic Decisions and Due Process Policy").
 - 3.3.14.5.** This recommendation remains on the resident's permanent record.
- 3.3.15.** Dismissal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies; the resident will be dismissed from the program. Action remains in permanent record.
 - 3.3.15.1.** Based on repeated demonstration of deficiency(ies) the resident will be immediately dismissed from the program.
 - 3.3.15.2.** The CCC will prepare a statement for the grounds for dismissal, including identified deficiencies or problem behaviors.
 - 3.3.15.3.** The decision may be appealed by the resident in accordance to GME policies of due process ("Adverse Academic Decisions and Due Process Policy").
 - 3.3.15.4.** This recommendation remains on the resident's permanent record.
 - 3.3.15.5.** The CCC consensus recommendation for each resident will be submitted to the residency program director using the Clinical Competency Committee Report Form as completed by the CCC chair.
 - 3.3.15.6.** All residents who receive an adverse recommendation shall also receive written notice of the CCC recommendation of adverse action form.
 - 3.3.15.7.** The program director shall review all recommendations, and the PD and APD will meet with each resident to communicate his or her recommendation.
 - 3.3.15.8.** A copy of all adverse decisions shall also be sent to the affected resident's advisor for review.
 - 3.3.15.9.** The advisor will then work in concert with the program director and resident to develop the remediation plan.
- 3.3.16.** Faculty Development
 - 3.3.16.1.** In order to ensure the greatest usefulness of the data reviewed by the CCC, the CCC will conduct, with the assistance of the Morehouse School of Medicine Office of Graduate Medical Education; two faculty development sessions will be held annually.

- 3.3.16.2.** One will cover completing resident evaluations
- 3.3.16.3.** One will cover the Family Medicine residency milestones.
- 3.3.16.4.** Prior to each evaluation session, a faculty committee meets to discuss the resident's performance and to arrive at the summary with specific recommendations.
- 3.3.16.5.** The results of the faculty appraisal are shared with each resident individually by the resident faculty advisor.
- 3.3.16.6.** The resident is asked to sign the summary form to acknowledge discussion of the evaluation.
- 3.3.16.7.** Information used in assessment of resident performance is derived from multiple sources, which may include:
- 3.3.16.8.** If any time, at or between the formal six-month evaluations a problem is identified with any portion of the resident's performance and educational growth, this information will be shared promptly with the resident.
- 3.3.16.9.** The information will be documented. If there is a deficiency that the faculty or the program director decides requires further action, a future meeting will be arranged with the appropriate faculty members and the resident to devise a plan of corrective action. Such plans will contain measurable goals and a specific timeframe for re-evaluation.
- 3.3.16.10.** If the resident fails to show progress in correcting the deficiencies or fails to adhere to the plan of corrective actions, further recommendations, including possible probation or dismissal from the program, may ensue.
- 3.3.16.11.** Any time formal discipline is invoked, the resident has the right to due process, as outlined in the Morehouse School of Medicine Graduate Medical Education Policies and Procedures.
- 3.3.17. Semi Annual Evaluations**
 - 3.3.17.1.** Semi-annual evaluations are conducted by the PD and/or APD with each resident with input from the Clinical Competency Committee and are required by the ACGME.
 - 3.3.17.2.** These are formal sessions in which feedback is provided to the resident regarding his/her overall performance from July to December and from January to June.
 - 3.3.17.3.** The PD will meet with and review with provide each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones.

- 3.3.17.4.** The PD will Assist residents/fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and
- 3.3.17.5.** The PD will develop plans for residents/fellows failing to progress, following institutional policies and procedures
- 3.3.17.6.** During the Semi-annual evaluation, the resident must also be prepared to discuss his/her self-evaluation and individualized education plan.
- 3.3.17.7.** The Semi-annual evaluation session also provides an opportunity for resident to provide feedback to the program.
- 3.3.17.8.** At the final summative semi-annual evaluation prior to graduation (May or June of graduation year), the resident's complete performance will be reviewed, and the residency director will verify whether the resident has demonstrated sufficient competence to enter practice without direct supervision. This evaluation becomes part of the resident's permanent record maintained by the institution and is accessible for review by the resident in accordance with institutional policy.

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

- 3.4.1. Resident Advancement & Promotion.** The MSM Family Medicine Residency Promotion Policy is consistent with the MSM Graduate Medical Education Promotion Policy which can be accessed in the GME Policies & Procedures on the Office of Graduate Medical Education site at <http://www.msm.edu/Education/GME/index.php>.

3.4.2. Promotion Criteria from PGY-1 to PGY-2

- 3.4.2.1.** Following at least twelve (12) months of training, the CCC will make a recommendation for promotion to PGY-2 status based on the following criteria:
- 3.4.2.2. Patient Care**
 - 3.4.2.2.1.** Role-model competent whole person care to other residents and medical students.
 - 3.4.2.2.2.** Demonstrate the ability to independently perform a complete history and physical exam, write appropriate orders, and appropriately document the hospital course for inpatients.

3.4.2.2.3. Have demonstrated competency in basic procedures to include Pap smears, I&D, suturing, and wet preps as confirmed by clinical preceptors

3.4.2.3. Medical Knowledge

3.4.2.3.1. Satisfactorily pass all required rotations.

3.4.2.3.2. Have achieved at least 10th percentile on the composite score of the Family Medicine In-Training Exam or demonstrated equivalent level performance on a program-administered reassessment.

3.4.2.3.3. Have achieved a minimum of the level 2 milestone on the MK-1 and MK-2 subcompetencies.

3.4.2.3.4. Have taken the USMLE Step III examination by the last day of the 12th month of training.

3.4.2.4. Practice-Based Learning and Improvement

3.4.2.4.1. Demonstrate the ability to give and receive feedback and make improvements in his/her patient care.

3.4.2.4.2. Demonstrate an ability to assimilate and apply medical information to patient care.

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

3.4.2.5. Interpersonal and Communication Skills

3.4.2.5.1. Demonstrate the ability to communicate respectfully and effectively with patients, faculty, staff, and colleagues in a manner that will be conducive to assuming a supervisory role by October of the second year.

3.4.2.5.2. Demonstrate adequate documentation skills to include checkouts, on- and off-service notes, and outpatient charting.

3.4.2.6. Professionalism

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

3.4.2.6.2. Model professional behavior to students in clinic and rotations.

3.4.2.6.3. Have attended all required educational conferences unless excused

3.4.2.6.4. Demonstrate adherence to policies regarding procedural documentation.

3.4.2.7. Systems-Based Practice

3.4.2.7.1. Demonstrate ability to coordinate care with case managers and other resources.

3.4.2.7.2. Demonstrate cooperation within the medical system to ensure excellent patient care as seen by timely completion of medical records, charting, and follow-up.

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

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

3.4.3.2. Patient Care

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

3.4.3.2.2. Have documented participation in the continuity care of at least 2 patients for prenatal, intrapartum, delivery, and postpartum care OR will participate in a plan to achieve this goal.

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

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

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

3.4.3.3. Medical Knowledge

3.4.3.3.1. Complete and pass all required PGY2 rotations. Evaluations from each rotation must be received. A verbal report from the preceptor of his or her intent to give a passing grade may be taken for the final rotation of the year, if the committee meets prior to the completion of that rotation.

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

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

3.4.3.4. Practice-Based Learning and Improvement

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

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

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

3.4.3.5. Interpersonal and Communication Skills

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

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

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

3.4.4. Final Evaluation end of residency

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

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

3.4.4.3. The final evaluation must:

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

- 3.4.4.5.** Verify that the resident/fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.
 - 3.4.4.6.** Consider recommendations from the CCC
 - 3.4.4.7.** Be shared with the resident/fellow upon completion of the program
- 3.4.5. Program Graduation Criteria**
 - 3.4.5.1.** The following graduation criteria apply to the PGY-3 level. The resident must:
 - 3.4.5.1.1.** Complete and pass all required rotations.
 - 3.4.5.1.2.** Not have any professionalism or ethical issues that preclude him or her from being an independent practicing physician in the opinion of the CCC.
 - 3.4.5.1.3.** Be continually eligible to practice medicine on a limited license in Georgia.
 - 3.4.5.1.4.** Be compliant with all MSM Family Medicine Residency Program policies including, but not limited to, being up to date with his or her work hour logging.
 - 3.4.5.1.5.** Have completed and presented an approved research project.
 - 3.4.5.1.6.** Have completed and logged all required procedures.
 - 3.4.5.1.7.** Have seen and documented at least 1,650 continuity patients.
 - 3.4.5.1.8.** Have completed all clinic patient notes and be cleared by the medical records department.
 - 3.4.5.1.9.** Complete the GME, HR, and MSM Family Medicine exit procedures.
 - 3.4.5.1.10.** Have achieved milestone levels for all competencies and subcompetencies demonstrating the ability to practice independently.
 - 3.4.5.2.** The program director must consider recommendations from the CCC. The program director must also determine that the resident has had sufficient training, knowledge, skills, and behaviors necessary to enter autonomous practice. A final summative assessment will be completed by the program director and will be shared with the resident upon completion.
 - 3.4.5.3.** Upon fulfillment of these criteria, the program director must certify that the resident has fulfilled criteria, including the

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

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

3.5. Faculty Evaluations

3.5.1. ACGME Requirement

- 3.5.1.1.** As per the ACGME requirements, at least annually, the program must evaluate faculty performance as it relates to the educational program.
- 3.5.1.2.** The program does not allow faculty members to view these individual evaluations by residents/fellows. These evaluations of faculty are aggregated and made anonymous and provided to faculty members twice a year in a summary report. This summary may be released as necessary, with program director review and approval in instances where evaluations are required for faculty promotions.
- 3.5.1.3.** This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the education program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.
- 3.5.1.4.** This evaluation must include written, anonymous and confidential evaluations by the residents.
- 3.5.1.5.** 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, and regular verbal communication with residents regarding their experiences.
- 3.5.1.6.** Department chairs should be notified by the program director when faculty receive unsatisfactory evaluation scores. Faculty performance must be reviewed and discussed during the annual faculty evaluation review process conducted by the chair or division.

- 3.5.1.7.** Faculty members must receive feedback on their evaluations at least annually
- 3.5.1.8.** Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.
- 3.5.1.9.** In compliance with this requirement, the MSM Family Medicine Residency Program follows the following process for faculty evaluation.

3.5.2. Program-Specific Process

- 3.5.2.1.** Departmental residency faculty members are evaluated by residents on a quarterly basis using the Resident Evaluation of Faculty tool in New Innovations.
- 3.5.2.2.** Individual means for each domain is calculated for each faculty member and are compared to the overall faculty means.
- 3.5.2.3.** Inpatient attendings are also evaluated by residents each time they rotate on the Family Medicine Wards service using the Inpatient Attending Evaluation Form.
- 3.5.2.4.** Written feedback is provided to each faculty member every six months in the form of the Semi-Annual Evaluation of Faculty Member by Residency Program form, which can be found in the Appendix of this document.
- 3.5.2.5.** The evaluation is designed to assess faculty members' clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activity.
- 3.5.2.6.** Annually, during the months of April-June, the Program Director discusses the form with each Program faculty member and a faculty development plan is devised as needed based on the content of the evaluation.
- 3.5.2.7.** These evaluations and development plans are remitted to the Department Chair for integration as part of the faculty members' evaluations by the Chair.
- 3.5.2.8.** Quarterly batching of evaluations and semi-annual reporting to faculty of aggregated evaluations is done to assure residents of the anonymity of their evaluations.
- 3.5.2.9.** Residents are encouraged to immediately communicate pressing concerns regarding attending performance to the Program Director or, if anonymity is desired, By placing the typed documentation of the concern in the concern box located in the residency office.

3.5.2.10. Such reports are handled with the individual faculty member or the faculty as a whole as is appropriate to provide necessary faculty development by the Program Director.

3.5.2.11. Serious concerns may require intervention by the Department Chair.

3.5.2.12. This exception is intended to allow for timely correction of faculty member deficiencies.

3.6. Program Director Evaluations

3.6.1. The program director reports directly to the Chair of the Department of Family and indirectly to the Associate Dean for Graduate Medical Education.

3.6.2. The Program Director is evaluated by the residents through the annual Institutional GME Survey and by the Chair of the Department of Family Medicine. Both are confidential evaluations.

3.7. PROGRAM EVALUATION AND IMPROVEMENT:

3.7.1. The Morehouse School of Medicine Office of Graduate Medical Education maintains oversight of the program evaluation process, as detailed in the section 4.2.3 of the MSM GME Policy Manual.

3.7.2. All MSM programs are evaluated confidentially and anonymously by the residents and the faculty on an annual basis under the oversight and direction of the GME Office.

3.7.3. The results of this annual evaluation are used by the Family Medicine Residency Program to develop an annual program improvement plan which is monitored and, when appropriate, adjusted by the Program Evaluation Committee, which meets quarterly.

3.7.4. The Program Evaluation Committee (PEC) is an ACGME-mandated committee which, along with the Program Director, is responsible for generating the Annual Program Evaluation and Improvement Report which documents the program's extensive review of resident performance, faculty development, graduate performance, program quality, and program compliance with ACGME Requirements based on its ongoing monitoring process.

3.7.5. The PEC then uses this document over the course of the year as a guide to for its ongoing evaluation of program effectiveness, compliance, quality, and efficiency.

3.7.6. 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.

3.8. MSM Family Medicine Residency Program Evaluation Committee

- 3.8.1.** The ACGME requires that the program is evaluated and that the program director appoint a Program Evaluation Committee (PEC) to assist in reviewing the program on an annual basis.
- 3.8.2.** The purpose of the Program Evaluation Committee (PEC) for the Morehouse School of Medicine (MSM) Family Medicine Residency Program is to oversee and participate actively in all aspects of the program quality and improvement process.
- 3.8.3.** At all times, the procedures and policies of the PEC will comply with those of the Graduate Medical Education Committee as outlined in the Graduate Medical Education Policy and Procedure Manual and with those stipulated by the Accreditation Council for Graduate Medical Education (ACGME) as outlined in Section V.C.1.a of the ACGME Program Requirements for Graduate Medical Education in Family Medicine.
- 3.8.4. Membership**
- 3.8.4.1.** The program director shall appoint all members of the PEC, including the committee chairperson.
- 3.8.4.2.** The committee shall consist of no fewer than two (2) core program faculty members and at least one (1) resident.
- 3.8.5. Responsibility of Members.** Committee members are expected to participate actively in the following duties in accordance with the ACGME program requirements must:
- 3.8.5.1.** act as an advisor to the program director, through program oversight;
- 3.8.5.2.** Review of the program's self-determined goals and progress toward meeting them;
- 3.8.5.3.** guiding ongoing program improvement, including development of new goals, based upon outcomes; and
- 3.8.5.4.** Review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims:
- The Program Evaluation Committee should consider the following elements in its assessment of the program: Curriculum;
 - outcomes from prior Annual Program Evaluation(s);
 - ACGME letters of notification, including citations, Areas of improvement, and comments;
 - Quality and safety of patient care;

- Resident and faculty well-being;
 - Recruitment and retention;
 - Workforce diversity;
 - Engagement in quality improvement and patient safety;
 - Scholarly activity;
 - ACGME Resident and Faculty Surveys; and,
 - Written evaluations of the program.
 - Resident achievement of the milestones;
 - in-training examinations (where applicable);
 - board pass and certification rates; and,
 - graduate performance
 - Professional development.
 - The Program, through the PEC must evaluate the program's mission and aims, strengths, areas for improvement, and threats.
- 3.8.5.5.** The annual, review including the action plan, must be distributed to and discussed with the members of the teaching faculty and the residents; and, be submitted to the DIO.
- 3.8.5.6.** The program must complete a Self-Study prior to its 10 Year Accreditation Site Visit.
- 3.8.5.7.** A summary of the Self-Study must be submitted to the DIO.
- 3.8.5.8.** Review and address deficiencies in the following ACGME program requirements.
- 3.8.5.9.** At least 95 percent of the program's eligible graduates from the preceding five (5) years must have taken the American Board of Family Medicine (ABFM) certifying examination.
- 3.8.5.10.** At least 90 percent of the program's graduates from the preceding five (5) years who take the ABFM certifying examination for the first time must pass.
- 3.8.5.11.** Every five-year survey of program graduates.
- 3.8.5.12.** Assessment of resident attrition and the presence of a critical mass of residents with a goal of no more than 15%.
- 3.8.5.12.1.** Programs must report, in ADS, board certification status annually for the cohort of

board-eligible residents that graduated seven years earlier.

3.8.6. Meetings

3.8.6.1. Scheduled Meetings

3.8.6.1.1. The PEC will meet a minimum of four times per year.

3.8.6.1.2. The PEC, in entirety or in subcommittees, will meet at least annually to document the systematic and formal evaluation of the curriculum and produce a written APE.

3.8.6.2. Ad Hoc Meetings


3.8.6.2.1. The program director or committee chairperson may request an ad hoc meeting of the PEC or subcommittee to address urgent resident performance issues and those who are engaged in the grievance process for an adverse academic decision.

3.8.6.2.2. At all times, the committee will adhere to the GME policies and procedures of the “Adverse Academic Decisions and Due Process Policy.”

3.8.7. PEC Procedures

3.8.7.1. The PEC shall evaluate the Program on an ongoing basis and make recommendations to the Program.

3.8.7.2. All PEC meetings shall be documented with agendas and meeting minutes as appropriate.

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

Physician Impairment and Health (Substance Abuse) Policy

I. **BACKGROUND**


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

II. **PURPOSE**

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

III. **POLICY**

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

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

Professionalism and Ethics Policy

I. BACKGROUND

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

II. PURPOSE

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

III. POLICY

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

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the physician or his or her family members has a financial relationship;

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

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

3.3. Dress Code

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

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

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


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

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

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

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

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

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-09
		EFFECTIVE DATE	007/01/2018
		PAGE(S)	09
	<u>SUBJECT:</u> SUPERVISION POLICY	SUPERSEDES	01/21/2015

Supervision Policy

I. BACKGROUND

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

II. PURPOSE

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

III. DEFINITIONS

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

- 3.2.1.** With direct supervision immediately available- the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision
- 3.2.2.** With direct supervision available- the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- 3.3.** Oversight- the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

IV. PROGRAM SUPERVISION POLICY

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

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

V. PROGRESSIVE AUTHORITY & RESPONSIBILITY

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

VI. LEVELS OF SUPERVISION

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

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

Supervision Policy

SNF	X	X	X	N	XAB	XAB	N	X	X
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Key:

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

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

VII. GUIDELINES FOR WHEN RESIDENTS MUST COMMUNICATE WITH THE ATTENDING

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

VIII. RESIDENT JOB DESCRIPTIONS BY PGY LEVEL

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

<u>Management of Physical and Mental Demands, Environment, and Working Conditions</u>
<ul style="list-style-type: none"> • Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment. • Move around the hospital and its campus adequately to address routine and emergency patient care needs. • Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound. • Read patient charts and monitoring equipment. • Manage multiple patient care duties simultaneously. • Use judgement and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings. • Have the capacity to see five (5) or more outpatient cases in a three-hour clinic session, four (4) or more hospital admissions in a 12-hour period and have the ability to complete appropriate documentation in a timely fashion. • Work shifts up to 24 hours on inpatient services. • Use computers for literature review, patient care documentation and data retrieval, and procedure documentation. • Communicate complex medical information rapidly and effectively with other members of a health care team.
<u>Performance Responsibilities and Job Functions</u>
<p><u>Outpatient Care</u></p> <ul style="list-style-type: none"> • Provide longitudinal primary medical care to a panel of outpatients. • Learn to perform procedures essential to family medicine including but not limited to male infant circumcision, endometrial biopsy, colposcopy, and IUD insertion and removal. • Work effectively within a patient-care team. • Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion. • Work effectively with medical staff on specialty outpatient rotations. <p><u>Inpatient Care</u></p> <ul style="list-style-type: none"> • Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation. • Perform CPR on infants and adults as indicated. • Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric attending. • Administer injections, take blood samples, and learn to insert arterial and central lines. • Write and dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation. • As necessary, write orders for physical and chemical restraints and seclusion. • Identify and report medical errors and near misses using hospital-based reporting systems
<u>Educational Mission</u>
<ul style="list-style-type: none"> • Present educational material in formats appropriate adjusted for the audience (i.e. medical students, peers, medical staff, or community groups) • Complete and pass all required rotations. • Provide feedback to the program both spontaneously and when requested.

- Perform an academic self-assessment at least twice per year.
- Participate in curriculum development through the work of standing committees.
- Develop continuing quality improvement projects in conjunction with residency and faculty.

PGY-2 Resident Job Descriptions	
<u>Prerequisites</u>	
<ul style="list-style-type: none"> • Completed and passed all PGY-1 rotations and met all PGY-1 requirements Has met the minimum competency skills needed to teach students and peers 	
<u>Qualities</u>	
<ul style="list-style-type: none"> • Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine. • Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel. • Work within multiple teams that include inpatient rounding teams, class peers, curriculum, development teams, outpatient care teams, and support groups. 	
<u>Management of Physical and Mental Demands, Environment, and Working Conditions</u>	
<ul style="list-style-type: none"> • Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment. • Move around the hospital and its campus adequately to address routine and emergency patient care needs. • Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound. • Read patient charts and monitoring equipment. • Manage multiple patient care duties simultaneously. • Use judgment and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings. • Have the capacity to see 6 or more outpatient cases in a three-hour clinic session, 12 or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion. • Work shifts up to 24 hours when taking call on the inpatient services. • Use computers for literature review, patient care data retrieval, and procedure documentation. • Communicate complex medical information rapidly and effectively with other members of a healthcare team. 	
<u>Performance Responsibilities and Job Functions</u>	
<u>Outpatient Care</u>	
<ul style="list-style-type: none"> • Provide longitudinal primary medical care to a panel of outpatients. • Provide longitudinal primary medical care to a panel of nursing home patients. • Learn to perform procedures essential to family medicine including male infant circumcision, colposcopy, IUD placement and removal, endometrial biopsy, and OB ultrasound. 	

- Work effectively within a patient-care team.
- Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion.
- Work effectively with medical staff on specialty outpatient rotations.
- Periodically teach medical students basic history and physical skills during continuity clinic

Inpatient Care

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

Educational Mission

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

PGY-3 Resident Job Descriptions

Prerequisites

- Completed and passed all rotations and requirements of a PGY-2
- Taken and passed USLME III
- Has met the minimum competency skills needed to teach students and peers

Qualities

- Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.
- Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.

- Work within multiple teams that include inpatient-rounding teams, class peers, curriculum, development teams, outpatient care teams, and support groups.

Management of Physical and Mental Demands, Environment, and Working Conditions

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergency patient care needs.
- Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.
- Read patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.
- Use judgment and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.
- Have the capacity to see 10 or more outpatient cases in a three-hour clinic session, 12 or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours when taking call on the inpatient services.
- Use computers for literature review, patient care data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a healthcare team.

Performance Responsibilities and Job Functions

Outpatient Care

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


Inpatient Care

- Manage the care of ward and critical care patients under the supervision of a family physician or medical Attending.
- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Run the code team (second and third year of program).
- Perform CPR on infants and adults as indicated.
- Intubate infants, children, and adults as indicated.
- Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric Attending.
- Independently manage precipitous deliveries.
- Assist with major surgeries and C-sections.
- Administer injections, take blood samples, and learn to insert arterial and central lines.

- Write or dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation. As necessary write orders for physical and chemical restraints and seclusion.
- Serve as a team leader for two (2) months during the PGY-3 year.
- Identify and report medical errors and near misses using hospital-based reporting systems

Educational Mission

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

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-10
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	03
	<u>SUBJECT:</u> TRANSITIONS OF CARE POLICY	SUPERSEDES	1/21/2015

Transitions of Care Policy

I. BACKGROUND

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


II. SCOPE

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

III. HAND-OFF COMMUNICATION PROCEDURE

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

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

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

USMLE & COMLEX Examination Policy

I. PURPOSE


- 1.1. The purpose of this policy is to ensure that the quality of Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition) and the Family Medicine Residency Program goals and objectives.
- 1.2. A resident who will be prepared to undertake independent medical practice shall have completed requirements to obtain a physician's license.

II. SCOPE

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

III. POLICY

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

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

Patient Safety & Quality Improvement Policy

I. BACKGROUND

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

II. PURPOSE

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

III. POLICY

3.1. Patient Safety

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

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

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

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

3.1.3. Education on Patient Safety

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

3.1.4. Patient Safety Events

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

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benchmarks related to their patient populations.

3.2.3. Engagement in Quality Improvement Activities—Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

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

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

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

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-13
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	04
	SUBJECT: RESEARCH & SCHOLARLY ACTIVITY POLICY	SUPERSEDES	

Research & Scholarly Activity Policy

- I. **BACKGROUND:** The Family Medicine Residency Program at Morehouse School of Medicine requires that each resident complete a scholarly project in order to successfully complete the program and graduate. The project is within the bounds and scope of the Accreditation Council for Graduate Medical Education.
- II. **PURPOSE:** of this policy is to set the standards for the program's research curriculum. Program Responsibilities include demonstrating evidence of scholarly activities consistent with its mission(s) and aims of our program. In partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities and to advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.
 - 3.1. A scholarly project is required of each resident prior to completion of residency training. Residents will not be approved for graduation without the project being received and approved by the director of research based on criteria communicated to residents. The resident is responsible for selecting the faculty who will be assisting with his or her scholarly activities through the research director.
 - 3.2. Required Deadlines by PGY level are outlined below
 - 3.2.1. PGY1- By the end of the PGY1 year, each resident must have developed a research question
 - 3.2.2. PGY2- By December, the resident must have developed a methodology. By the end of the PGY2 year, IRB approval must be obtained
 - 3.2.3. PGY3- By December, data collection must be complete. The research project must be completed by June 1st but earlier completion is highly encouraged.
 - 3.3. Each resident is required to have a faculty discussant for his or her QI/Research project.
 - 3.4. During the Research Forum, held in June, each resident will have 15 minutes to present, followed by a 10-minute discussion.
 - 3.4.1. Faculty research advisors are expected to participate in the discussion.
 - 3.5. Presentations should be developed in the following format:

3.5.1. Introduction:

3.5.1.1. Question addressed and its importance stated

3.5.1.2. Conceptual model

3.5.1.3. Testable hypothesis(es)

3.5.2. Methods:

3.5.2.1. Sample—who was studied?

3.5.2.2. Dependent/outcome variable

3.5.2.3. Independent variable(s)—what predicts or is associated with the outcome variable?

3.5.2.4. Co-variables—did you control for variables (factors) that might affect the association between the independent and dependent (outcome) variable?

3.5.2.5. Measurement—how were variables measured? What is the validity and/or reliability of measurement tool?

3.5.2.6. Analysis—what statistical analytic methods were used to describe your sample, determine the distribution of responses, and test the hypothesis(es)?

3.5.3. Results:

3.5.3.1. Characteristics of sample

3.5.3.2. Distribution of responses for independent/dependent/co-variables, i.e., what percentage of residents vs. faculty responded to a different domain:

3.5.3.3. Of the variables

3.5.3.4. Results of test of hypothesis(es)

3.5.4. Discussion:

3.5.4.1. A brief restatement of findings (results)

3.5.4.2. Interpretation of results—what do they suggest?

3.5.4.3. How are they consistent with what is known?

3.5.4.4. How do they differ with what is known and why?

3.5.4.5. What are the study's strengths and limitations?

3.5.5. Conclusion: Recommendations based on results


3.6. In addition to the scholarly research project described above, each resident completes a PSQI “mini-project” during the PGY-1 Practice Management experience.

- 3.6.1.** For this project, the resident identifies an issue in the clinic with a patient safety implication and develops an intervention to improve patient safety related to the issue.
- 3.7.** Residents are also required to complete all Institute for Healthcare Improvement (IHI) Open School PHQI modules during each year of training.
- 3.8.** Writing for publication is highly encouraged through authorship of case reports on patients managed on the Family Medicine wards service.
 - 3.8.1.** Each faculty member must identify, with the resident team, at least one patient during his/her coverage of the service whose case can be presented in a case report.
 - 3.8.2.** The attending-resident co-authored case reports are to be written. Submission for conference presentation or resident-attending co-authored publication is highly encouraged.
 - 3.8.3. Faculty Scholarly Activity**
 - 3.8.3.1.** Faculty Scholarly Activity (both core and non-core faculty) – programs must demonstrate accomplishments in at least three of the following domains:
 - 3.8.3.1.1.** Research in basic science, education, translational science, patient care, or population health
 - 3.8.3.1.2.** Peer-reviewed grants
 - 3.8.3.1.3.** Quality improvement and/or patient safety initiatives
 - 3.8.3.1.4.** Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
 - 3.8.3.1.5.** Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
 - 3.8.3.1.6.** Contribution to professional committees, educational organizations, or editorial boards
 - 3.8.3.1.7.** Innovations in education
 - 3.8.4.** All MSM GME Programs must demonstrate dissemination of scholarly activity within and external to the program by the following methods:
 - 3.8.5.** 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

3.8.6. Peer-reviewed publication

3.8.7. Resident/Fellow Scholarly Activity

3.8.8. Residents and Fellows must should participate in scholarship activity.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-14
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	03
	SUBJECT: PROCEDURE REQUIREMENTS AND LOGGING POLICY	SUPERSEDES	04/21/2017

Procedure Requirements and Logging Policy

I. BACKGROUND

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

II. PURPOSE

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

with residents, faculty, and staff to expand exposure to those procedures.

III. POLICY


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

Procedure Name	Independent Target
Amniotomy	3
Anoscopy	1
Arterial Blood Gas	2
Arterial Line Placement	1
Central Line Placement	2
Cesarean Section Assist	5
Chest X-ray interpretation	30
Circumcision	5

Procedure Requirements and Logging Policy

Colposcopy	3
Delivery Vacuum Extraction	1
Delivery, normal vaginal	20
EKG Interpretation	30
Endometrial Biopsy	3
Episiotomy 1st, 2nd Deg Rep	1
Fetal Scalp Electrode	1
I&D Abscess	5
Induction/Augmentation of Labor	1
IUD Insertion	1
IUD Removal	1
IUPC Placement	1
joint aspiration/injection	15
Laceration Repair, Simple	2
Lumbar Puncture	2
Newborn Exams	40
non -ob surgery assist	5
OB Nonstress Test	20
OB Ultrasound	5
pap smear	30
Skin Tag removal	1
Wet Mount	10

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

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

Patient Encounter Requirements and Logging Policy

I. BACKGROUND

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

II. PURPOSE

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


III. POLICY

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

Patient Encounter Requirements and Logging Policy

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

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

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-16
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	01
	<u>SUBJECT:</u> MOONLIGHTING POLICY	SUPERSEDES	06/01/2017

Moonlighting Policy

I. BACKGROUND

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

II. PURPOSE

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

III. POLICY

- 3.1. ACGME defines Moonlighting as: "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.
- 3.2. External moonlighting: Voluntary, compensated, medically-related work performed outside the site where the resident or fellow is in training and any of its related participating sites.
- 3.3. 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.
- 3.4. PGY-1 residents are not permitted to moonlight.
- 3.5. Moonlighting is permitted for, at the discretion of the PD, PGY-2 and PGY-3 residents in good standing, with an independent medical license and proper malpractice coverage.

- 3.6.** Residents wishing to moonlight must obtain written permission from the program director and designated institutional official (DIO)
- 3.7.** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety.
- 3.8.** The following conditions must be met in order for the program director to consider approving a resident request to moonlight:
 - 3.8.1.** The resident must be in good academic standing in the program; he or she must not be in academic remediation or probation. The resident must also fulfill all administrative requirements of the program (e.g., prompt dictations, clinic note completion, work hour and patient logging, handling phone messages and lab results in a timely manner, etc.).
 - 3.8.2.** The training license and training DEA number may not be used to practice medicine outside of the residency program.
 - 3.8.3.** The resident must have:
 - 3.8.3.1.** Valid, full medical license from the State Medical Board of Georgia, as residents may not practice medicine outside of our residency program under the State of Georgia Training Certificate; and
 - 3.8.3.2.** A personal DEA certificate/number (the DEA number issued by the hospital for residents may be used only in carrying out clinical duties that are part of the residency program and may not be used for moonlighting purposes).
 - 3.8.4.** The resident must arrange for his or her own malpractice insurance; the resident can either pay for this insurance personally or it can be provided by the entity employing the resident for the moonlighting. The Morehouse School of Medicine malpractice insurance plan does not cover any activities outside of a residency program.
 - 3.8.5.** Moonlighting is restricted to one (1) shift per week. It must not interfere with patient care nor be so excessive that the resident is too tired to learn and/or to perform the residency requirements. The combined hours of residency and moonlighting must not exceed 80 hours per week.
 - 3.8.6.** The resident may not moonlight during normal work hours, as defined by his/her rotation. Further, the resident is not permitted to moonlight between 7:00 a.m. and 5:00 p.m. on Monday through Friday, while on call, or on the day post-call.
- 3.9.** The resident who meets the conditions above and desires to moonlight must submit a moonlighting request form to the program director to receive permission to moonlight. This request must document that the resident meets

the conditions and that he or she will follow the moonlighting policy. The resident must also provide details as to where and how many hours each week he or she plans to moonlight. The program director will review the request and if there are no concerns, the program director will give the permission to moonlight.

- 3.10.** When considering the request, the program director will take into account the resident's workload, academic standing, and compliance with residency requirements. If the resident is given permission, he or she must follow all rules and policies as established by the program. Moonlighting privileges may be rescinded if the rules are not followed, if the resident does not include moonlighting hours in his/her work hour log, if moonlighting activities are deemed to be excessive, or if the resident is placed on academic remediation or on probation.
- 3.11.** The Moonlighting Request form can be found in the Program Handbook.
- 3.12.** 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.

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: _____

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

Well-Being Policy

I. **PURPOSE:**

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


II. **SCOPE:**

Per ACGME – Residents and faculty members are at risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

III. **POLICY:**


- 3.1. In partnership with the Graduated Medical Education Office, the program shares the responsibility of resident well-being to include:
 - 3.1.1. efforts to enhance the meaning that each resident finds in the experience of being a physician
 - 3.1.2. including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships
 - 3.1.3. attention to scheduling, work intensity, and work compression that impacts resident well-being
 - 3.1.4. evaluating workplace safety data and addressing the safety of residents and faculty members' policies and programs that encourage optimal resident and faculty member well-being; and,
 - 3.1.5. Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours
 - 3.1.6. attention to resident and faculty member burnout, depression, and substance abuse.
 - 3.1.7. 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.
- 3.1.8.** Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care.
 - 3.1.9.** The program, in partnership with its Sponsoring Institution, must:
 - 3.1.9.1.** 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
 - 3.1.9.2.** provide access to appropriate tools for self-screening; and,
 - 3.1.9.3.** 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.
 - 3.2.** There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave.
 - 3.2.1.** Each program must allow an appropriate length of absence for residents to perform their patient care responsibilities.
 - 3.2.2.** The program must have policies and procedures in place to ensure coverage of patient care.
 - 3.2.3.** These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	FM-18
		EFFECTIVE DATE	6/1/2019
		PAGE(S)	01
	SUBJECT: Nepotism Policy	SUPERSEDES	

General Information for Residents

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. Per the MSM Human Resources Nepotism policy: “no direct reporting or supervisor to subordinate relationship may exist between individuals who are related by blood, marriage or reside in the same household. For academic purposes, no direct teaching or instructor to resident or student relationship can exist – no employee is permitted to work within “the chain of command” when one relative’s work responsibilities, salary, hours, career progress, benefits, or other terms and conditions of employment could be influenced by the other relative.” Additionally, “each employee, student or resident has a responsibility to keep his/her supervisor, the appropriate Associate Dean or Residency Program

	MOREHOUSE SCHOOL OF MEDICINE FAMILY MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	N/A
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	01
	<u>SUBJECT:</u> ACGME PROGRAM SPECIFIC REQUIREMENTS	SUPERSEDES	06/23/2017

ACGME Program Specific Requirements

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

Common Program Requirements

<https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf>

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A **SURVIVAL** GUIDE FOR THE INTERN

MOREHOUSE FAMILY MEDICINE
ACADEMIC YEAR 2019-2020



PREPARED AND COMPILED BY
CLASS OF 2021

BEFORE EACH ROTATION:

1. Coordinate with the contact person for each rotation and inform them about your arrival, 2-3 weeks prior to your starting date.
2. The contact person designated for most of the rotations are the respective Chief Residents.
3. Review your schedule and inform about any conflicts with your clinic days, vacation, and didactic days.
4. **KNOW THAT YOU DO NOT GO TO WEDNESDAY DIDACTICS ON CERTAIN ROTATIONS!!!**
 - a. Internal Medicine
 - b. ICU
 - c. Peds Wards
 - d. Peds ER
2. Obtain feedback and reviews from the person who has already completed the rotation.
3. Review some general topics and cases that you are likely to encounter during the rotation.
4. Check New-Innov.com for the official curriculum.
5. Make sure your ID badges and Parking Badges have been activated
6. Contact Ms. Etinosa Evbuomwan to forward your requests for the mid month and end of rotation evaluations in a timely manner. Though not necessary, you may remind your evaluators via email if they have not been completed in time after you leave the rotation.
- 7.
8. Know your clinic days: These are your scheduled clinic days for each rotation.
 - a. Internal Medicine: *Monday**
 - b. ICU: *Monday*
 - c. Peds Wards: *Tuesday Afternoons*
 - d. Peds ER: *Thursday*
 - e. Surgery: *Tuesday**
 - f. OB Grady: *Thursday*
 - g. Nursery Grady: *Wednesday*
 - h. VA CBOC: *Wednesday and Friday (Now 2nd year rotation)*
 - i. VA Neurology: *Wednesday*
 - j. ECC Grady: *Wednesday*
 - k. Practice Management: *varies*
 - l. OB AMC: *Monday and Thursday**
 - m. July Orientation: *varies*

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

GRADY MEMORIAL HOSPITAL

PARKING

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

How to Pay for Grady Parking

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

Go to: www.aaaparking.com.

Click on 'Customer login'

Click on 'Monthly Accounts'

Account #

.

Password: parking.

ID: LAST 5 digits of white parking card.

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

GRADY SCRUB CARD

Perioperative Services

Grady Hospital, 6th Floor

Room 6G012

Hours: 7:00 AM – 3:30 PM

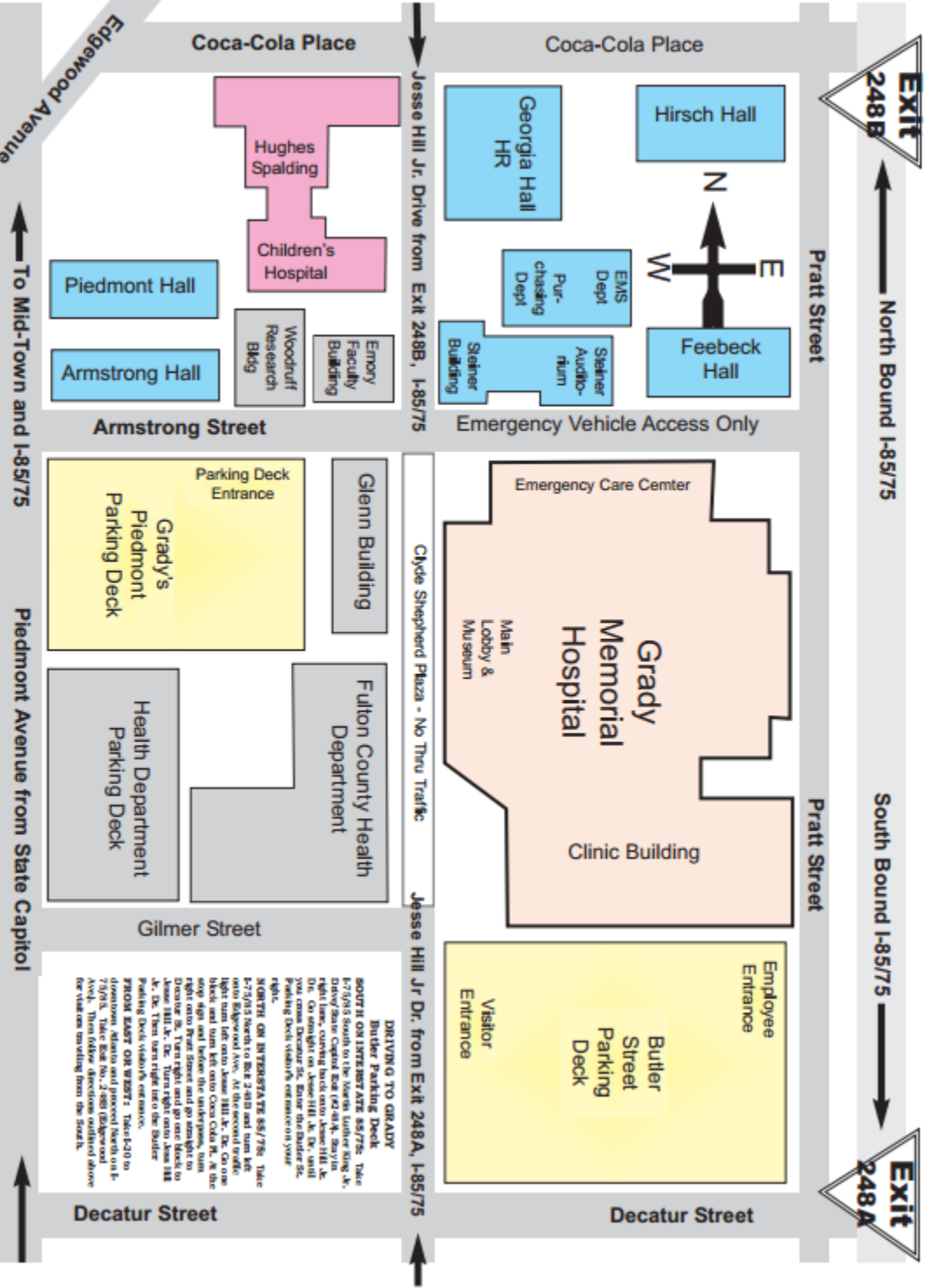
Tele #: 404-616-8911

Fill out the form attached below, then scan and email to scrubadmin@gmh.edu

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

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

GRADY HEALTH SYSTEM MAIN CAMPUS





VETERANS AFFAIRS (VA) ROTATIONS

Contact Person(s):

Initial Point of Contact:

Ken Ratcliffe

Tele: 404-321-6111, ext: 2720

Fax: 404-728-7668

Ken.Ratcliffe@va.gov

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

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

CBOC VA Coordinator/ Evaluator:

Dr. Kitefre Oboho

Tele: 404-321-6111 ext:1635

Kitefre.Oboho@va.gov

VA Process for Computer Access Codes & ID Badge

- You should have received VA paperwork with instructions sometime after 'match'. At least 3-4 weeks prior to rotation you should:
 - (1) fill out paperwork and fax to Ken Ratcliffe**AND**
 - (2) complete the online privacy and security training course on the VA website**AND**
 - (3) send email to Ken Ratcliffe with the information below:
 - Where you will be rotating [CBOC East Point or Atl VA Main Campus]
 - Height
 - Weight
 - Hair Color
 - Eye Color
 - City/State you were born in
- Once Mr. Ratcliffe has received all of the information above, he will request your computer access codes. Once he receives the codes, he will request an ID Badge on your behalf. Then you will have to follow up with security for when your ID Badge is ready for pick up. **Their phone # is 404-321-6111 ext 17807.**
- You must go to Atlanta VA Main Campus for fingerprinting and to obtain your ID Badge. [Instructions on next page with campus map].

- Important tidbits
 - Traffic to Decatur is horrible [at any time of the day]
 - You may be asked to return between 5-24hrs after the fingerprinting process for ID
 - Parking on the main campus is horrible [mostly in the middle of the day]
 - Park in 'E' or 'F' parking deck; they are closer to the main bldg.
 - **Please plan accordingly**

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

Where do I get fingerprinted?

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

When can I get fingerprinted?

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

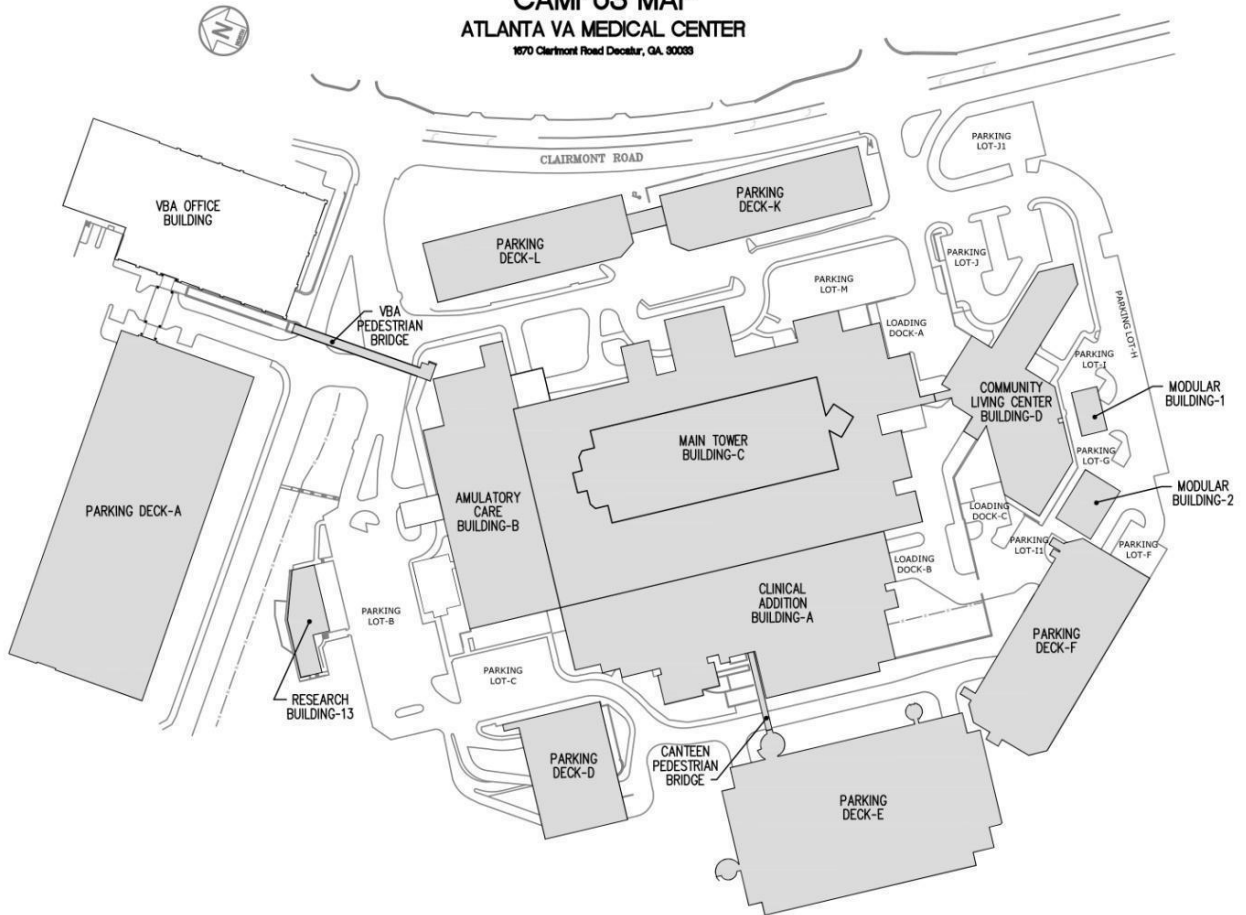
What do I need to bring?

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

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

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

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



VA Neurology Outpatient Rotation

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

Contact Person:

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

You can send your rotation notification email to Dr. William Tyor (william.tyor@va.gov)

Evaluator:

Dr. George Wilmot, MD

ID Badge: See VA page

Computer Access:

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

Parking:

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

Clinic:

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

Inpatient consults:

The upper level neurology resident may contact you to inform you where they would like to meet. They may have you meet them in room 1C445 which is the resident lounge. It is next to the EEG room on the 1st floor. You will need to walk down the long hallway after you enter through the doors closest to the E parking garage. You will walk past the C elevators and turn left. The door will be on your left.

Cafeteria:

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

Essential Reading Topics: See reading materials link on New Innovations

- Migraines
- Seizures
- Parkinson's Disease
- MS
- ALS

- Dementia
- Tremors
- EMG/Nerve conduction studies- differentiate between axon and demyelination
- Neuropathy

Schedule:

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

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

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

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

Monday

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

PM: Inpatient Consults

Tuesday

AM: Dr. Wilmot, General Neurology Clinic

PM: Dr. Wilmot, General Neurology Clinic

Wednesday

AM: Continuity Clinic at CFHC

PM: FM Didactics

Thursday

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

PM: Dr. Dholakia Clinic

Friday

AM: Inpatient Consults

PM: Inpatient Consults

Practice Management

Person of Contact: Carmen Coggins

Weekend call (AMC-S): 2-3 shifts during the month

Overview:

This rotation is by far the easiest and most relaxed rotation.

You will be required to fill out a pre and post rotation survey in addition to presenting a power point presentation regarding a topic or topics you found interesting during the rotation. You will have lectures or shadowing sessions with both the front and back office staff of CFHC. For example, you will shadow and perform some front office duties such as checking in patients, collecting co pays, and answering phones; back office duties such as shadowing the nurses in the back as they take vital signs and perform other processes. Other experiences include working with the ladies at the referral and medical records department.

You will receive lectures on compliance, the ins and outs of establishing and operating a medical practice, and medical billing. Lectures often take about half of your day so you will have clinic sessions scheduled approximately 3-4 sessions a week. You will often have half days or even days when you might not have anything scheduled (reading days). You will also take 2-3 weekend shifts at AMC south. Checking your schedule carefully during this rotation is **key** to make sure that you are not post call or scheduled for clinic when you are expected to participate in lecture. If you find any such conflicts, inform the chiefs immediately for the necessary adjustments.

Emory ECC Grady (Grady ER Rotation)

Contact Person:

Rikka R. English

Tel: 404-251-8985

rikka.rashi.english@emory.edu

emcr@listserv.cc.emory.edu

He will send you a link for the schedule. You may have a total of 18 - 19 shifts for the month where you may be scheduled to Zone 2 or Zone 3. However, when in Zone 3 you are required to see detention pts and when in Zone 2 you will see pts in ambulance waiting area. **The shifts are 8 hours each.** Shifts change happens at the end of every 8-hour shift, so plan to arrive 10 minutes before your shift. There is no pre-rounding required. The schedules are made 2-3 months in advance. He will ask you in advance what days or weekends you desire off. Please choose the ones you really want. You should have 4 days off for the month; sometimes you may get an extra day. You should also have at least 1 full weekend off, but you have to ask for it.

Important tools: Stethoscope, pen light, hammer, lots of pens!

Orientation:

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

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

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

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

It is better to request it at the beginning of each shift. It is better to request these earlier than later, because shift change can be busy and you or the attending may not have the time. You need a total of 12 completed evaluations at the end to pass the rotation. You can log into the ER website to check your evaluations every 2-3 days.

Typical Shift: You need to report to the attending and upper level according to the assigned to your zone. We work in zone 2 and 3. You will be asked to see patients in order of acuity, though patients in the critical care bays are generally seen by the upper level residents.

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

Disposition: The most important aspect of triaging patients in the ER is determining their disposition, i.e. discharge home after some intervention, admit to the CDU for observation, or admit to an inpatient team (Morehouse or Emory). To admit to CDU call extension 43522 directly to sign the patient out. For

psychiatry patients your disposition will be to 'Move to PES'. You assess a patient at risk to self or others and place a '1013' forcing them to stay and admitting them. You coordinate with the ER psychiatry staff as to what decision is best, then you call the psychiatry Emory (Morehouse doesn't have psychiatry) team on call to sign out to them before placing the admission order.

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

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

Miscellaneous:

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

Morehouse Pediatrics Inpatient Rotation/Peds Wards

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

Unit Secretary: 404-785-9840

Contact Person:

1st point of contact Pedschief@msm.edu

2nd point of contact ashepard@msm.edu

Evaluations:

Mid month: First attending

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

CFHC Clinic:

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

SCHEDULE:

The schedule will be found on www.amion.com. The password is "morehpeds".

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

EPIC: PLEASE be sure you can access CHOA - EPIC PRIOR to the start of the rotation. This will include reading through an online module and passing a proctored proficiency assessment at one of the CHOA hospitals.

PEDS WARDS:

The day shift begins at 6am with intern signout and night signout is at 7pm. It is important to arrive around 6am to round on your patients and finish your notes prior to the official signout (Between 7 - 8am). Have the night intern print you an updated sign-out list of all of the patient's on the floor. Your senior will divide the patient's evenly, with consideration towards interns keeping patients seen the day before.

Round on each of your patients (review the H&P/progress notes/consults/labs, speak with the nurse/respiratory therapists, get interim history from patient/parent, examine your patients, obtain vitals/check meds etc.). All of your notes should be done prior to the start of signout at 8am. The day and the night team have a formal sit-down sign-out, with attending present, using the I-PASS sign-out method at 8am in the resident room. Sign-out is typically led by the night intern and may be immediately followed by a didactic lesson (most days).

If you are on nights, you will stay for morning didactics and lead morning report as scheduled. Teaching rounds occur at the bedside at about 9-10 am, you will present your patients at this time. You will be required to update the signout list with new patients and updates on current patients in epic. The night shift begins at 7pm. During night you are required to complete what was signed out from the day team as well as update discharge summaries and med rec for potential discharge. You should consult your senior before flagging any orders, discharging any patients or for any concerns while on the floor.

When there is an admission from ER, you are responsible for H&P, admission orders, and adding patient to the list. A progress note must be written the following morning if admission occurs before midnight. If admission is after midnight, no progress note has to be written, but the H&P must be complete.

Parking:

Grady Parking Deck. \$21.60/month

ID Badge:

- Go to Security Desk at the Entrance of the hospital and tell the security officer that you are there for your resident badge and he will escort you up to the office on the 2nd Floor. You may also be given a temporary "student" badge
- No paperwork is needed but make sure you have your morehouse badge with you.

Computer Access:

- Desktops are limited so it is advised that you bring your laptop
- Ask other interns/residents to share EPIC smart phrase templates for H&P, discharge summary, progress notes, and A&P (for most common problems). Learn how to copy smart phrases (valuable skill in EPIC)
- Labs can be viewed in CHOA's Epic. You may have to check Grady epic for results of ECho's MRI etc (imaging done at Grady).

Physician Break Room:

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

Snacks (granola bars, bananas, sandwiches, salads) and coffee/tea are located in the physician lounge in the ED. Door code changes so ask other residents for code. **(1962# is most recent code)**

Essential Reading Topics:

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

Schedule:

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

SOAP Note

- Vital Signs: include ranges in the past 24 hrs. Include ins/outs in vitals. Ins must be recorded as **cc/kg/day**, outs (urine output) recorded as **cc/kg/hour**
- Always include 'General' in physical exam. ex: alert, playful, laughing, smiling, agitated, lethargic, etc.
- Only include new labs.
- For Assessment, say 15 wk old with (name symptoms) likely 2/2 (diagnosis).
- **Plan is listed according to systems (as seen in template)**
- When listing Medication dosages always list #mg/kg

Morehouse Peds Didactics

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

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

Nurses:

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

Notes:

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

General Notes:

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

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

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

Pediatrics Emergency Room

Location

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

Contact Person

Naghma Khan nkhan01@emory.edu
Emory Pediatric Chiefs peds@emory.edu

Schedule

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

FM Clinic days: Thursdays

FM Didactics: you do not attend FM Wed didactics during this month. Notify the designated Emory scheduling person of which day of the week your clinic is 2-3 months in advance. It may not be posted yet. So, ask our chiefs for any MSM required dates to tell Emory.

Hours:

- 10 hour shifts, scheduled at
7 AM – 5 PM | 9 AM – 7 PM | 11 AM – 9 PM | 1PM-11PM | 5 PM – 3 AM | 7 PM – 5 AM | 9PM – 7 AM
- You will be working with residents from Emory ED, Emory Pediatrics, MSM pediatrics and Emory FM.

Badge Access: If this is your 1st time at Hugh Spalding, you will need to go to the security desk as soon as you walk into the hospital to request a badge

Didactics:

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

Orientation:

- On your first day, arrive 15 minutes early => Charge Nurse and the attending will give you a brief orientation.
- There is a checklist that needs to be signed by both. Be sure to get your badge prior to beginning.
- When you arrive for your shift, always introduce yourself to the attendings, other residents and nurses.
- There is a physician workstation to the left of the nurse' station, write your name and shift on the whiteboard in the station.
- During this rotation, you will be seeing the patients in the ER.

- EPIC CHOA ER: you will be sent an email on directions to complete training online and in person (this lasts 1 hour with a proctor and you must score 90%, or better, to be granted access). This provides basic navigation of the software. This training is separate from the EPIC Inpatient training.

Workflow

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

Online Orientation

- You will be forwarded a link for orientation before the rotation starts www.classes.emory.edu
- You will receive your login info via email. You may need to call the Emory helpdesk to set up your Emory Net ID# (404-727-7777 or 404-778-4357)
- The website also has some algorithms and guidelines for the common cases seen in the ER which include sickle cell emergencies, exacerbation of asthma, bronchiolitis, AGE (acute gastroenteritis), fever, abscess drainage and suturing lacerations. There is also a neonatal LP video that is required before completion of an LP.

Procedures

- You are required to do at least 15 procedures (laceration repairs, I&Ds, foreign body retrieval, peripheral IVs, etc).. You will receive a list of acceptable procedures to do. Aim to do a lot of procedures as you can.
- The Emory Blackboard website has a template that you need to print to record all your procedures. Keep track of all your procedures on this form so you can upload the Procedure form online at the end of the rotation.
- You must have your procedures signed as you get them done by the attending of that day.

Evaluation

- You do not have to request an evaluation from your attendings online like Grady ED. Instead the program director coordinates the evaluations on her own with the attending.
- The program manager will request e-evaluations from the attendings at the ED, however you should request and obtain verbal feedback from every attending you work with at the end of your shift.

Calling in Sick

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

Family Medicine Wards

Location:

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

Hours:

=> morning signout: 6 am
=> evening signout: 5 pm

Parking/Badge

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

Residents Lounge (2nd floor)

- Get to the North elevators on any floor, once at the second floor, make an immediate right and then left => walk all the way past the double door the end of the hallway to the last two doors to your left and right. The code is 215. You will usually work in the room to your right, signout and presentations will be in the other room.
- There is a male (code: 215) and female (code: 152#) call room available.
- Meals are available for free at AMC-South, preferably at the physician's lounge located on the Ground floor next to the cafeteria. You can also get meals from the cafeteria

Evaluations

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

CFHC (Morehouse Healthcare) Clinic Days

- This varies. You may or may not shadow one of the residents on your first clinic day.
- Your clinic days will be assigned to you on the scheduling system

EHR

- Wellstar EPIC, you can access it at connect.wellstar.org
- You should have received access and training by the health informatics team at AMC, you will be guided on how to create templates for H&Ps, progress notes, etc. to improve workflow. You will receive additional guidance from residents on the floor
- For any EPIC-related questions and concerns at AMC-South, contact Ms. Walji Gulnaz at (404) 466-4938

Team

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

Patient load

- There are two team of attendings: the Morehouse Faculty and the Sound hospitalists group
- Admit all Morehouse patients from the Emergency Room, there is no cap

- Admit 2 Hospitalist patients during the day shift (and 2 during the night shift - for night float)
- Admit 2 patients from the hospitalists before 11 am on Wednesdays
- You could have up to 12 patients admitted by the Hospitalists team
- The Emergency Room is located on the 1st floor

Workflow/Roles and Responsibilities

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

Admission Process

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

Essential Reading Topics:

- COPD
- Asthma

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

Grady OB/GYN:

Location:

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

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

Contact Person:

Morehouse OB Chief Resident Dr. Des'mond Henry (dhenry@msm.edu)

CHFC Clinic Day: Thursday

This month you'll be on the rotation with two upper levels (PGY2,3 or 4) and a maybe PGY 1. The intern or 2nd year will help orient you to the labor and delivery floor and how to take care of patients while you're on the rotation. You will mostly be with the intern or 2nd year during the day along with medical students. Ask fellow FM residents for templates if you are not on service with another intern.

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

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

On Wednesday you are required to round on the patients on 4 A as usual and follow the OB residents to triage patients but make sure you leave at 11:00 am for Family Medicine didactics. (The OB chief is aware that you have to leave for didactics at 11am). On your Family medicine clinic day (Thursday), you are not required to go to Grady for rounds, you go straight to CFHC.

Access:

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

Door codes:

Morehouse OB residents lounge 4K017 (code 4646)

Scrubs:

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

Pre-rounding:

You will start the day by helping the PGY 1 or 2 round on the postpartum patients on 4A and B, usually at 6am. All postpartum patients have to be seen. FM residents usually see only the vaginal deliveries to do postpartum notes. The upper level may round after you. Your notes should be complete by the time morning report begins at 7am. The OB intern will share notes templates with you. All notes on postpartum females must contain the gravity, parity, method of delivery, sex, weight and EBL. They must also contain her preferred method of contraception. These must be reflected in the assessment and plan.

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

There's a different attending everyday. You can access the attending schedule via this link:

<https://app.qgenda.com/link/view?linkKey=03b1292c-b748-4f8a-9f01-653a14d05a8a>

You will also be required to give presentation on the topic of your choice during morning report prior to the end of the rotation. The Chief resident may assign you the topic or you may choose your own topic.

OB Didactics are every Friday 12am-5pm, at which time you may be asked to work alongside the attending or midwife, to cover the floor. The best time to procure your deliveries will be during Friday diacritics sessions as you will be the only resident with the midwives or attending.

You may also ask to attend these lectures and will be allowed to do so at the discretion of the senior resident. Please inform the team before hand of any requirements you have outside of the rotation that might conflict with these times.

Labor and Delivery: 4L

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

Triage: 4J/4K

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

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

Discharges

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

AMC OBGYN

Locations:

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

Morehouse Howell Mill Office: 1800 Howell Mill Rd NW, Suite 275, Atlanta GA 30318, 404 756-1400

CFHC Clinic: (Buggy Works)

Important AMC Numbers:

Operator 404-265-4000

L&D 404-265-4724

Mother/Baby Unit:

Interpreter 404-265-3582

Computer program: Cerner

Contact Person:

Obstetrics: Dr. Sinclair (203 522 9922)

Ob/Gyn: Dr. Simmons

Schedule:

Here is a sample schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Jan 14	Jan 15	Jan 16	Jan 17	Jan 18	Jan 19	Jan 20
am	L&D (Sinclair @ AMC)	Didactics with OB residents (Grady)	Applicant Interviews	Continuity Clinic (CFHC)	Simmons (MHC)	L&D*	L&D*
pm	L&D (Sinclair @ AMC)	Simmons (MHC)	No Didactics			L&D*	L&D*
	Jan 21	Jan 22	Jan 23	Jan 24	Jan 25	Jan 26	Jan 27
am	L&D (Sinclair @ AMC)	Didactics with OB residents (Grady)		Continuity Clinic (CFHC)	Simmons (MHC)	L&D*	L&D*
pm	L&D (Sinclair @ AMC)	Simmons (MHC)	FM Didactics			L&D*	L&D*
	Jan 28	Jan 29	Jan 30	Jan 31	Feb 1	Feb 2	Feb 3
am	L&D (Sinclair @ AMC)	Didactics with OB residents (Grady)		Continuity Clinic (CFHC)	Simmons (MHC)	L&D*	L&D*
pm	L&D (Sinclair @ AMC)	Simmons (MHC)	FM Didactics			L&D*	L&D*
	Feb 4	Feb 5	Feb 6	Feb 7	Feb 8	Feb 9	Feb 10
am	L&D (Sinclair @ AMC)	Didactics with OB residents (Grady)		Continuity Clinic (CFHC)	Simmons (MHC)	L&D*	L&D*
pm	L&D (Sinclair @ AMC)	Simmons (MHC)	FM Didactics			L&D*	L&D*

*In order to maintain work hour compliance, the resident is to work with Dr. Sinclair on only one of the two weekend days listed each week. He is to discuss these dates with Dr. Sinclair to determine which of the days he will work.

OBSTETRICS AT AMC:

OB part of this rotation will be completed at AMC main campus with Dr. Sinclair and the NPs working with her. Your schedule might be different from the sample posted above, but it will be similar. On the first day you are scheduled to work at AMC, you should:

- 1) Use the entrance on Boulevard NE. If driving north on Boulevard NE, parking deck will be to your right, and you will see the overpass that connects the parking deck to the hospital. Find the security post located on the 1st floor (not ground floor), right at the main entrance on Boulevard NE to get directions to the parking office, security main office for access, physician lounge on 1st floor, and L&D on 7th floor.
- 2) Make sure you have access to WellStar Epic. Remote access could be gained from connect.wellstar.org.
- 3) Make sure you can view the entire labor and delivery schedule. When you log into Epic under labor and delivery context/department, you should be able to view the master schedule that

shows the triage, OR schedule, scheduled c-sections, active labor schedule, and post-partum patients. Also note the listed attending because that's how you will know Dr. Sinclair's patients.

- 4) Familiarize yourself with pre-existing templates already on Epic for H&P, vaginal delivery, episiotomy. Familiarize yourself with admission and postpartum order set.
- 5) Go to the 7th floor, the OB floor, to introduce yourself to the nursing staff and get familiar with the floor, OR and call room. It's either your badge gets you in or you press the doorbell to get in on the 6/7th floors. Head straight to the nurses' station and introduce yourself. They are very territorial.
- 6) Go to the parking office to get a parking pass. (as for direction at the security located on the 2nd floor entrance)
- 7) Go to the security office to get door access especially to L&D floor, and the physician lounge.

Dr. Sinclair does all the c-sections, and she only does normal vaginal delivery when she's on call. That means the majority of normal vaginal deliveries will be done by the CNMs (certified nurse midwife) on her team. CNMs' schedule varies, and their schedule is not made available to us. As such, you have to text Dr. Sinclair whenever you are scheduled to be at AMC to ask for the name and number of the CNM on call for that day. You can either go to the hospital and wait for delivery, or login from home to see if any of Dr. Sinclair's patient is in labor. If you live close enough to the hospital and wants to stalk Epic from home, you can give the nurses your contact information so they can call you whenever a patient arrives, or whenever the status of a laboring patient change (note that they are most likely not going to call you). You can also call in periodically to check if there are any laboring patients from Dr. Sinclair's team. Also note that there are other provider group using AMC for delivery, and you can ask any of these providers to scrub in on delivery or c-section.

Here are some of the CNMs' information:

Ms Antionette: (678) 630-2669

Ms Boyce: (678) 613-4299

Ms Lacroix: (718) 344-0297

Ms Mensah: (917) 312-1005

OR: 7th floor. Shoe covers and caps are in the hall before you get to the OR. **Tips for the OR:** learn to suture, know the anatomy of the cut, layers of the skin, the parts of the uterus and ovary, what differentiates large from small bowel, the blood supply of the uterus and ovaries (right off the aorta for the ovarian artery).

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

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

Staff bathroom behind nurse's station: 753*

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

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

Morehouse OB practice:

There are different Morehouse FM attendings on-call each week for delivery at AMC main as well. Unlike Dr. Sinclair's practice, Morehouse attendings do OB, nursery, and circumcision. Mother/baby is located on the 6th floor. There's a small cubby area on the left side behind the 6th floor nurse's station, where you can write notes. The nurses use this area too. It's nice and private. **You can't eat there!**

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

Notes:

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

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

H&P: Ask your attending for specific template to use

Discharging patients: Prescriptions are usually at the back of the chart. Fill them out on the first postpartum day if not already done. All postpartum patients may resume PNV and may go home with FeSO₄ and Colace if Hgb significantly decreased from admission level. If Hgb < 10, this is severe anemia and if < 9, the attending may give patients the option of receiving an intramuscular form of iron, called Infed. Write the order for 2cc/100mL IM per hip. Write discharge orders to include: nothing per vagina for 6 weeks, precautions for when to seek immediate medical attention: fever, severe abdominal pain, heavy bleeding, and watch for signs of postpartum depression. **ALWAYS** write "may be discharged home **with attending approval**" in the discharge order. The attending must see and approve all discharges. Meaning, patients don't go home until the attending rounds on them or calls the hospital to say they can leave.

Prescriptions:

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

OBSTETRICS/GYNECOLOGY CLINIC:

Check your schedule to see when you will go to Howell Mill location for Ob/gynecology clinic with Dr. Simmons.

Didactics: Two didactics during this rotation. Regular FM didactics on Wednesday at buggy works, and Ob residents didactics on Tuesday morning at Grady on the 9th floor.

Parking: You have to pay for parking at Howell Mill location. However, you may choose to park across the street in the shopping complex parking lot, which is free.

Internal Medicine Grady

Location: Grady Hospital

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

Tulani Washington-Plaskett TWashingtonPlaskett@msm.edu

CFHC Clinic Day: Mondays

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

Evaluations: Evaluation is done through new innovation, and you are not required to initiate request for evaluation. However, if there is an attending/resident you work with the longest/have a good rapport with, you can contact such attending/resident to complete an evaluation for you.

Schedule: Hand-off is at 7am and 3-7pm (M-F), 7am and 3-7pm (weekends). During the week, you can sign-out early to the cross-cover intern on the team on call (team taking admission) after 3pm during the week, and after 1pm on weekend; otherwise, sign-out is at 7pm to night float. Plan to arrive prior to 7am to pre-round. You should arrive in enough time to finish seeing your patients and possibly getting your notes done before sign out from the night float at 7 am. On your call day, expect to be in the hospital at least from 7am to 7pm. On a non-call day, at least plan to arrive prior to 7am, and you could sign out to the call team early as mentioned above if all works are done, OR sign out to the night float at 7pm.

Location: Your call day will be spent on 9E with the rest of your team members. Otherwise, on non-call day, you could use 16th floor computer room, 2C computer room, or any of the workstations on the different floors.

Teams: 2-3 interns + an upper level who is a PGY 2 or PGY 3

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

Lounge: You mainly spend your time on 2C, 5A, 7A, 9E or 16th floor writing notes, orders, etc. There is also an IM resident room on 9E. You can store your bags here or you can request locker access on 16th floor. There is an Emory representative on the 16th floor who handles the lockers. For 9E access, you should already have access prior to starting your rotation, however, if you do not have access, you will need to email the IM chief. Ask the chief to email Angela Rogers (arogers@gmh.edu) with your ID badge number (the 5-digit code on the white parking badge) to give you access to this room.

Didactics: Wednesdays from 8am - 12noon

Location: On the second floor behind the cafeteria (the hallway behind the cashiers).

Rounds typically start after didactics but it depends on the preference of the attending. After rounds you will carry out the plans for the day which include ordering labs, following up on labs, consults or imaging, procedures, discharging patients. Then be ready to sign out at around 4-7pm to the night team/cross-cover on call. You can leave after sign out if you are done for the day. **Just be sure to check with your upper level.**

There are sometimes Grand Rounds on Wednesdays after didactics in Piedmont Hall. Ask the medicine residents for directions.

Call:

Q 3-4 days from 7am - 7pm.

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

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

You and your team can leave if there's nothing pending after 3pm by signing out to the cross-cover intern on the team on-call (the team taking admission) on that day. Otherwise, official signout is at 7pm to night float. Occasionally, the upper level may have a 24 hour call and will leave after rounds the next day.

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

- Ask your fellow intern or upper level to share the templates for H&P and Progress notes.
- Discharge medications and instructions **print out at the printer on the floor where the patient is located, not on the printer attached to the computer you are working on.**
- You may print your progress notes before rounds so you can have access to labs if needed. Try printing 4 pages on one sheet as it is easier to manage and you save paper too.
- Elevators: These can be very slow. Get there early enough to have time to wait. Familiarize yourself with the staircases, but be careful, as some of them don't open from the outside.
- If you are new to EPIC and Grady at the start of the rotation, don't be afraid to ask questions about the things you don't know and also you will have orientation to EPIC during your orientation month in July.
- You will always have to follow up on orders that you made with the nurses, labs, X Rays, CT scans etc. Usually the nursing station has a copy of all the important numbers, get a copy for yourself.
- You will spend a lot of time on the phone for consults; social workers for disposition, follow ups, updates with your attending and upper level.

Cross-cover:

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

ICU Grady

Location: Grady Hospital, 7th floor B

Contact: IM chief resident (Tulani Washington-Plaskett Email: TWashingtonPlaskett@msm.edu) who will direct you to your upper level resident

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

Patients are admitted from the ER and sometimes transferred from the floors. All the interns will be assigned to 2- 3 patients depending on the number of patients on the floor. Everyone is expected to know about all the patients assigned to the ICU team. Ask one of the ICU residents to share the ICU note templates with you on EPIC.

First day you meet in the on workroom on 7B. Use your badge to enter into the newly renovated 7B ICU unit. Walk down the hall and take a left at the first nurse area. Then take another left at the next nurse station and there is a work area in the back corner behind that nurse's station.

Shifts are either 7am-5pm, 7am-7pm, 7am-9pm or 8:30pm - 10:30am. On your call day (when you are 7am - 9pm) and night shift, you will have the intern phone and pager.

Notes: Interns write H&P, Progress notes and Treatment plans (Transfer notes and discharge summaries - are written by upper level residents. Try to get the night resident let you know how many notes you will be writing the night before or text you at some point during the night so you know what time to get there. Some do this on their own and some won't unless you remind them and some like to surprise you the morning of. The notes may have to be done before rounds (rounds start anytime b/n 7am - 10am, round time different everyday) or at some point before noon, depending on the attending. Dr. Foreman doesn't care as long as the notes are in before the end of the day but you rather finish early. Dr. King needs the notes before rounds. Dr. Micki also needs the notes before rounds. The intern on call does admissions and writes the H&P. If medical students have your patients, they present your patient. All you have to do is write your notes.

Treatment plan notes - where you document significant therapeutic changes, events throughout the day. This will help the night person and the person who will write the note in the morning. Tx plans don't need a cosigner. Tip - pend your tx plan until the end of the day so you can include everything in one note.

Labs to order. Mostly CBC, chem 14, Mg and Phos. Always order 1 view chest xray and ABG for intubated or pts on Bipap. And the rest depends on your patient. Order AM labs before you leave for the day.

Lecture: There is joint lectures for Emory and Morehouse ICU residents from 8am to 8:30ish on most days and you need to attend. Lecture location are variable but mostly 6C or 7th floor conference room.

Locations: ICU beds are in 7B, 7K, and 7J

Code blues: you respond to all codes above the 2nd floor all the way up I think the highest floor is 16. You go to the codes even if it's Emory patients and help out if they need help.

Clothing: scrubs everyday (color doesn't matter). I noticed nobody cares if you don't wear your white coat and just wear your more house jacket instead.

Resources: they will send you the ICU book pdf but I purchased the small ICU book which I found helpful. Knowing vent settings helps and there are youtube videos for this. Most common dx for me was sepsis. Respiratory therapist are helpful if you need to talk to them and get some insight about ventilators.

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

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

Recommended text: The ICU BOOK is available in electronic format and the link to the free 3rd edition is below:

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

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

Useful phone numbers:

Senior resident phone number: 404 274 2383. Intern phone number: 678 260 7807. Marina (ICU pharmacist) phone number: 51628 or 404 278 8079. Her office is to the right of the oncall room. Somewhere few doors down...she will help you out a lot with medication dosing and more..she knows a lot.

Morehouse cardio fellow cell number is 804 938 4669 (name Dr. Sartaa)

Dr. Stringer ID attending phone is 404 319 1854

As you go along, find out the Morehouse intern for each speciality for that month and save their number so you can call for consults and follow up questions. Most commonly you need renal and ID intern numbers. This will save you time.

Making calls to Emory consults: dial 404 686 5500 then dial their 5 digit number followed by the number you want them to call you back. You get the 5 digit number from the operator by dialing 0 and tell them you need the on call for such and such Emory department.

Gen Surgery at Grady

Location:

80 Jesse Hill Jr. Dr. SE, Atlanta, GA 30303

Phone: (404) 616-1000

Contact Persons:

Chief Residents (2019/20):

Adatee Okonkwo -- aokonkwo@msm.edu

Michael Williams -- mwilliams@msm.edu

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

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

Evaluator:

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

ID Badge:

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

Computer Access:

- Your Epic Username and password should grant you access to the computer. When you log into Epic under Department: enter GHS SURG GEN SUR MSM [10100219].
- Under "Shared Patient Lists" on the left hand side of the screen you should have a Block list that will contain all the General Surgery patients on the service, the trauma list and the Vascular list. You will need to ask a resident to share the list with you.
- Access from home: <https://citrixnet7.gmh.edu>

Parking: In the Piedmont Parking Garage. .

Clinic:

- Family Medicine Residents usually attend the surgery outpatient clinics once or twice a week. Your other jobs are to be on the floor or in the OR.

Resident Lounge:

- Located on the 7th floor by 7B (If you get off the elevator and walk in the opposite direction of the ICU it's the 1st door on your left)
- Phone number (404) 616-1474
- Code gets changed often (most recent code 35709) ask one of the residents for the current code. PLEASE do not give the code out there have been issues with too many outside people having access to the lounge.

Essential Reading Topics:

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

Schedule:

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

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

Nursery

Location: 4th floor in Grady Hospital. 4A.

Contact Person:

Dr. Letitia Mobley (Colleen will contact Dr. Mobley)

Schedule:

- M-F (except Wednesdays for clinic and didactics), and 3 Weekend days.
- Hours: 7am to 3pm-5pm
- You may choose any 3 weekend days you want to work, just coordinate with Dr. Mobley to determine which days.

Workflow:

You should at 7:00 am to see patients before daily morning report at 8am. Morning report is in room 5-H004 on the 5th floor. The Emory residents will be able to show you how to get to the room. On weekends morning report is at 8:30am. Dr. Mobley usually gets in around 10am-11am to round. She likes for you to have your notes prepared by then. Noon conference is at 12pm. Resident sign out is at 4pm. A resident will sign out to the overnight Nurse practitioner on call. You can call them using the nursery phone to find them or go directly to the NICU area on the 5th floor where they often stay. They may also be in the on call room that is on the left after entering through the doors to the Intermediate care/Step down area on the 5th floor.

Orientation:

Dr. Mobley will orient you to the nursery and the mother/baby floor. Dr. Mobley will send you or medical students to the Emory Faculty Office Building across from the parking garage to pick up the packet from her assistant that she has prepared for the rotation.

EPIC:

Dr. Mobley will have dot phrases and note templates that she would like for you to use. She will show you which ones to use. ZZNeonatology is the department. You can arrange the patient list by age so that new patients just born will show up at the top or bottom of the list, that way you may start to prepare their notes for babies born during rounds.

Dress Code:

You may wear scrubs during this rotation

Evaluation:

You must obtain a paper evaluation from your program manager and give it to Dr. Mobley, which she will give back to you for you to turn in

Readings:

Dr. Mobley's Teaching Module for the Term Nursery Packet

Sepsis

Hyperbilirubinemia

ABO Incompatibility

Hypoglycemia in the Newborn

Useful Numbers for Grady

Operator 0 (404-616-1000)

ER

Red zone 56435

Blue Zone 56456

Radiology

Portables 44001/54002

CT body reading room 56283

CT neuro reading room 57055

MRI reading 56767

CT 57002

IR 57006

Nuclear 54602

US 54519

Labs

Chem. 54835

Heme 54821

Micro 54847

Blood Bank 54839