Community Pediatric Residency Program Handbook

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

2026 – 2027

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

Morehouse School of Medicine
Community Pediatric Residency Program

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Table of Contents

Introduction

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

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

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

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

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

Program Overview

Morehouse School of Medicine Department of Pediatrics exists to:

- Enhance the wellness of infants, children, adolescents, young adults, their families, and communities.
- Increase the diversity of the pediatric health professional and scientific workforce and address pediatric and adolescent primary healthcare needs through programs in education, research, advocacy, and service
- With an emphasis on infants, children, and adolescents of color, and the underserved urban and rural pediatric populations in Georgia, the nation, and the world.

Mission of Morehouse School of Medicine Pediatric Residency

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

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

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

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

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

MSM Diversity Statement

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

Residency Setting

Our program hospital partners include:

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

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

Administrative Structure

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

Program Director

The program director provides the overall leadership, development, and implementation of the

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

Other responsibilities include:

- Overseeing all aspects of the residency program and resident education.
- Creating and maintaining affiliation agreements and alliances with the necessary educational and clinical entities, hospitals, clinics, and individual physicians to provide the highest quality training opportunities in the field of pediatrics.
- Updating and modifying educational goals and curricula.
- Ensuring that faculty meets the requirements to teach in the program.
- Overseeing all learning environments.
- Directly supervising the program manager, program assistant, the core pediatrics faculty, and staff involved with the residency program implementation.
- Working closely with the department's chairperson and other officials at MSM to ensure that the program reflects the mission of the institution as well as that of the department.
- Overseeing the resident selection and promotion process.

Associate Program Director

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

Chief Resident

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

Program Manager

The program manager manages the daily operational activities of the residency program and interacts with different personnel at various affiliated institutions as needed. The program manager ensures that the residents complete all required paperwork, including obtaining evaluations. The program manager also ensures that residents' master files, evaluations,

immunization certificates, visa documents, U.S. Medical Licensing Examination (USMLE) scores, and procedure and patient logs are kept up to date. The program manager is responsible for completing and filing all required paperwork and communications from internal and external entities (e.g., MSM Graduate Medical Education [GME] office, American Board of Pediatrics, American Academy of Pediatrics). The program manager coordinates the resident recruitment activities in conjunction with the program director.

Program Assistant

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

- Maintains all files and folders, correspondence, schedules, and meeting minutes and notes.
- Maintains and distributes on-call and conference schedules to residents, faculty, and affiliates.
- Schedules meetings as directed.
- The program assistant monitors incoming evaluations for the program director's perusal and files them along with other documents related to resident portfolios. They also are responsible for maintaining updated files in Medhub.

Faculty Advisors

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

The faculty advisor undertakes the following primary responsibilities:

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

- Ensures that the resident advisee is on track with requirements such as USMLE Step 3, state medical licensure, and certifying examination applications.

Pediatric Evaluation Committee (PEC)

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

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

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

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

Clinical Competency Committee (CCC)

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

The CCC should:

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

The final decisions of the program director shall be communicated to each resident and their faculty advisor.

Program Goals

Program Aims, Goals and Objectives

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

As its primary goals, the program seeks to:

- Prepare pediatricians committed to the highest level of clinical acumen, communication, ethical principles, cultural competency, and professionalism for all populations of children,

adolescents, and young adults.

- Prepare pediatricians to practice medicine in the 21st century by integrating their clinical knowledge with evidence-based medicine, quality improvement cycles, and technology for optimal patient care.
- Recruit, train, and disseminate to the community, physician leaders who understand that overall health is not only influenced by access to care but by the environment, community, and individual choices.
- Train pediatricians as leaders of intra-professional healthcare teams, where all healthcare team members are valued.
- Produce pediatricians who are efficient and who have an expressed commitment to serving the primary healthcare needs of the medically underserved.
- Develop pediatricians who practice their profession with the highest regard for professionalism, ethics, cultural diversity, and sensitivity to the healthcare needs of the medically underserved.
- Provide educational experiences that prepare residents to be competent general pediatricians who can provide comprehensive and coordinated care to a broad range of pediatric patients.
- Provide educational experiences that emphasize the competencies and skills needed to practice high quality general pediatrics in the community.
- Familiarize residents with the fields of subspecialty pediatrics to enable them to participate as team members in the care of patients with chronic and complex disorders.
- Function with other members of the healthcare team in a wide variety of settings to be competent leaders in the organization and in the management of patient care.

Program Aims

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

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

New Resident Orientation

Introduction

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

Duties and Responsibilities

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

Professional Conduct

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

Reliability

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

Conference, Grand Rounds, and Didactics Attendance

Residents are expected to attend all educational sessions. Attendance is taken at each session, and 90% attendance at conferences is mandatory for all sessions that are possible. Only through attendance will maximal educational benefit be realized. Didactics sessions are in person every Wednesday in the GME room at Hurt Plaza. In the instance of a rare scheduled absence from didactics (must be arranged ahead of time with the chief resident) the resident may view the recorded didactics session and receive credit for attending that session(s).

Communication

Residents must remain accessible via cell phone, Voalte and e-mail while on duty, except during approved vacation or sick leave.

Residents are expected to check their MSM e-mail accounts at least once daily because this is a primary mode of communication. They are expected to check and respond to phone calls and e-mails promptly. Technological problems with cell phones, iPads, and computers must be reported to the program office as soon as possible.

How to Learn in a Residency

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

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

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

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

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

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

Daily routines are learned through practice; establishing a sound database should be of primary importance. A regular reading program will help to ensure a methodical accumulation of information. Several texts are available today, as noted earlier in this document.

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

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

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

Textbook knowledge as well as knowledge of the current literature is necessary for fund of knowledge and clinical application. Review articles are obtained through appropriate internet search engines, Pediatrics in Review journal, Pedialink.org, or from faculty.

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

Faculty

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

Problems or Difficulties—What to Do?

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

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

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

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

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

Harassment Policy

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

- Social Media Policy – See page 65.
- Concern and Complaint (Grievance) Policy for Residents and Fellows – See page 71
- Resident & Fellow Eligibility, Selection, and Appointment Policy – See page 77

Morehouse School of Medicine Pediatric Residency Program Annual Leave Policy

A. Purpose

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

B. Policy

The programs will abide by the ABP's Leave of Absence and Vacations policy, which states, "Up to one month per academic year is permitted for time away from training, which includes vacation, illness, or family leave." Training must be extended to make up for any absences exceeding one month per year of training. The ABP encourages trainees to take yearly vacation and strongly discourages "banking" vacation from year to year as it can negatively affect trainees' health and well-being."

C. Application

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

Residents are allotted 15 days compensated vacation leave per academic year (from July 1 through June 30). Residents and fellows are allotted 15 days of compensated sick leave per year. This time can be taken for illness of the resident, for parental leave, or for the care of an immediate family member. In addition, the program extends an additional 5 days for wellness.

a. The resident/fellow is required to meet with the Program Director for guidance on how leave will impact duration in program, Board eligibility, and any potential need to extend training.

D. Professional Development

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

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

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

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

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

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

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

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

Early Exit:

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

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

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

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

Vacation

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

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

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

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

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

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

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

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

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

Holidays

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

Sick Leave

Each resident is allowed a maximum of 15 paid sick days per academic year. This time can be taken for illness, injury, and medical appointments for the resident or for the care of an immediate family member. Sick leave can only be used for sick days. A missed shift for sick leave may be required to be made up. See Appendix A for more detailed policy on making up missed shifts.

Other than a missed shift, sick days may not be required to be made up if they do not prevent the resident from receiving a satisfactory evaluation and appropriate exposure to the rotation as determined by the course director, program director, and CCC. If the number of sick days results in a total number of missed days over the ACGME-allowed 30 days, then those days will be made up at the end of the given academic year. **It is the resident's responsibility to notify the chief resident by phone as early as possible when they will be out.** It is also the resident's responsibility to notify the corresponding faculty member and supervising resident of sick leave. Sick leave does not accrue from year to year.

See the GME Policy

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

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

See Scheduled Rotations, page 30.

Emergency Back-up Call Schedule and Resident

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

Family and Medical Leave

The pediatrics residency program follows and complies with MSM Human Resources and GME Policies for Leave and Family Medical Leave. See the full GME Resident Leave.

Leave of Absence (without Pay)

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

Other Leave

Other leave types are explained in detail in the MSM Human Resources employment manuals. The resident is advised to fulfill the special requirements of training and of the specialty certification board, it may be necessary for a resident to spend additional time in training to make up for time lost while he or she used vacation, sick leave, the various types of emergency leave, or leave of absence without pay.
Residents are allowed three (3) days of administrative leave per academic year for fellowship interviews, job orientation, etc., and these administrative leave days must be approved by the chief resident or a program director. It is expected that switches be made with fellow residents before implementing the administrative leave option.

Wellness Days

Every resident is given 5 wellness days outside of scheduled vacation and sick leave to utilize throughout the year. The requests must be submitted to the chief resident at least 60 days in advance. The days must also be split between fall/winter and spring/summer. Either 3 days in the fall/winter and 2 days in the spring/summer or vice versa. Consideration will be given to the order in which requests are made as well as the timing of requests. For example, requests may be denied if it will impact staffing around holidays.

Moonlighting

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

Work Hours

Unless otherwise specified by the faculty, the workday generally begins at 7:00 am and continues until the end of the clinical workday for the rotation. Refer to the inpatient work guidelines for additional details. Ending times may vary from rotation to rotation, but in general, the ending time is usually between the hours of 5:00 pm and 7:00 pm. Rotations with 12-14-hour shifts include

the Intensive Care Units, and Inpatient. Residents may work 24 + 4 hours consecutively according to ACGME requirements. The final 4 hours include rounding and completing work plans. No new patients may be assigned during this final 4-hour period.

See clinical experience and education work hours on page 39.

Shift Hours

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

Resident Evaluation, Progression, and Promotion

Several evaluation tools are used, including:

- Faculty, nurse, patient/family, and peer assessments.
- Direct resident observation.
- Procedure and case logs.
- Written examinations; and
- Presentation skills assessments.
- Semi-annual meetings with a program director
- CCC assessments

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

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

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

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

- **Interpersonal Skills:** Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents must demonstrate competence in:
    - Communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.

- Communicating effectively with physicians, other health professionals, and health-related agencies.
- Working effectively as a member or leader of a healthcare team or other professional group.
- Educating patients, families, students, residents, and other health professionals.
- Acting in a consultative role with other physicians and health professionals.
- Maintaining comprehensive, timely, and legible medical records, if applicable.

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

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

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

- **Systems-based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context and system of healthcare, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal healthcare. Residents must demonstrate competence in:
  - Working effectively in various healthcare delivery settings and systems relevant to their clinical specialty.
  - Coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty.
  - Advocating for quality patient care and optimal patient care systems.
  - Working in interprofessional teams to enhance patient safety and improve patient care quality.

- Participating in identifying system errors and implementing potential systems solutions.
- Incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate.
- Understanding health care finances and its impact on individual patients' health decisions.

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

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

From PGY-1 to PGY-2

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

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

From PGY-2 to PGY-3

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

- Meet all of the requirements for PGY-1 stated above in addition:

- Pass USMLE Step 3 by the 20th month of training (It is strongly encouraged that USMLE Step 3 be taken in the first 12 months of the program.) Pediatric Residents must take and pass USMLE Step 3 by the 20th month of training to be offered a contract for their final

year of pediatric training. If the resident is off cycle for any reason, the timeline will be adjusted to reflect the 20th month rule. Failure to pass USMLE Step 3 by the deadline will result in enhanced support in the form of an additional study plan (to be determined by the intern and the PD or faculty advisor) with a requirement to retake the exam within 6 months of the initial exam attempt. Institutionally, all residents must eventually pass USMLE Step 3 by the 20th month of training to be offered a contract for their final year of pediatric training.

- Have up-to-date PALS and NRP certification.
- Be up to date on all question banks and assignments.

From PGY-3 to Graduation

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

- Meet all the requirements for PGY-2 stated above.
- Complete an approved scholarly activity.
- Complete an approved Patient Safety/Quality Improvement project.
- Complete the GME/HR/ and MSM IM exit procedures.
- Perform satisfactory or above in all six ACGME competencies.
- Receive the program director's determination that the resident has had sufficient time to complete all required AGGME and ABP training at MSM and be assessed to be able to become an independent practitioner of Pediatrics.

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

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

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

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

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

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

Residents will complete peer and self-evaluations at least twice per year. Residents will also

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

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

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

Clinical Competency Committee, page 12..

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

When to Call for Help

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

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

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

Conclusion

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

General Information

Nepotism Policy

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

Work Cell Phones

Please see appendix A on page 91 for the Mobile Device Security Policy.

Dress Code

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

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

The following clothing items are unacceptable:

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

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

- Scrubs and comfortable shoes may be worn (sneakers are acceptable).
- Wear your white coat.

- Personal grooming is expected at all times.

Paychecks

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

Parking

Parking cards for personal parking at Grady Hospital are issued during the Graduate Medical Education orientation. Residents must pay a $10 deposit and the first month's fee of $21. Subsequent months are paid through a payroll deduction. Free parking is available at other work sites (CHOA at Egleston, CHOA at Scottish Rite, Emory Decatur) with your hospital ID badge.

Licensure

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

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

Certifications

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

Mailboxes

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

Professional Organizations

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

an active member of the Georgia AAP and take full advantage of educational resources such as Pedialink.org.

Community Service

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

Board Review Materials/Self Learning Materials

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

Conference Policy (Attendance and Program Payment)

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

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

Scheduled Rotations

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

GME Policy Manual –

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

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

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

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

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

PGY - 1

- Inpatient/CHOA Hughes Spalding (three blocks), Dr. Senayit Demie
- Inpatient/CHOA Scottish Rite (two blocks), Dr. Roy Takei
- Individualized Curriculum Option (two blocks) - Various Faculty
- Emergency Medicine—CHOA Hughes Spalding (two blocks), Dr. Sonya Kheshti
- Term Nursery—Emory Decatur Hospital (one block)
- Developmental/Behavioral Pediatrics—various sites (one block), Dr. David O’Banion
- Adolescent Medicine—various sites (one block), Dr. Charisse Graham

Scheduled Rotations

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

PGY - 2

- Inpatient/CHOA Scottish Rite (two blocks), Dr. Roy Takei
- Individualized Curriculum Options (two blocks)—Various Faculty
- Emergency Medicine—CHOA Arthur M. Blank (AMBH) (one block), Dr. Sonya Kheshti
- PICU—CHOA AMBH (one block), Dr. Anna Grindy
- NICU—Grady Memorial Hospital (one block), Dr. Jessica Roberts
- Cardiology—various sites (one block), Dr. Andrea Kropf
- Pulmonology—CHOA Scottish Rite (one block), Dr. LaTresa Lang
- Pediatric Surgery/Dentistry—CHOA Scottish Rite (one block), Drs. Heather Short and Brittany Waters
- Hematology/Oncology—CHOA Scottish Rite (3 weeks) and Hughes Spalding (one week), Drs. Kirshma Khemani and Jason Payne
- Float/Community Research—CHOA Hughes Spalding (one block), Drs. Senayit Demie and advisor
- Advocacy—various locations (one block), Megan Douglas JD

PGY - 3

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

Minimum Amount of Attendance to Receive Credit for Rotation

Inpatient/ICU

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

Scheduled Rotations

Outpatient/ED/Individualized Curriculum Options

Residents are expected to be present at all scheduled outpatient, emergency department, and individualized curriculum shifts. Residents are required to work a minimum of 32 half-days for 28-day rotations of the scheduled rotation time to receive credit for completion. If a resident works less than this, he or she will be required to work additional hours to reach the 85% requirement. If a resident has worked greater than or equal to 32 clinic sessions of the scheduled time, but the rotation preceptor, the CCC and/or Program Director determines that the resident's experience has been inadequate to fulfill the objectives of the rotation due to absence, the resident may be required to work additional hours, the amount which is to be determined by the program administration.

Longitudinal Ambulatory Experience (LAE)

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

The only times when LAE is not expected are:

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

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

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

Educational Conference Requirements

Didactics

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

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

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

All didactic conferences will take place Wednesday afternoons from 2:00–5:00 pm at Hurt Plaza GME room.

Additional Educational Requirements

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

- Sick leave
- Vacation

Educational Requirements

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

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

Exceptions to Thursday morning activities attendance include the following reasons:

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

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

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

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

Collaborative IRB Training Initiative (CITI)

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

The following modules are included in the program:

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

It is recommended that all residents complete CITI training (Biomedical Sciences). A copy of the completion confirmation will be placed in the resident's file. In addition, if the resident wants to become part of any research activity, the course is mandated by the IRB prior to approval.

Educational Requirements

Patient Safety/Quality Improvement

Residents will receive education on patient safety and quality improvement in line with ACGME requirements:

ACGME Common Program Requirements - Refer to Page 22

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

Scholarly activity Requirement

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

Note: Please see the ACGME's Educational Program Requirements in Appendix A on page 91.

Study Program

Academic Preparation

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

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

All residents are expected to complete PREP questions each year. A minimum of 60 questions per quarter is required.

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

In-Training Service Exams (ITE) performance

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

Individualized Learning Plan

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

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

Study Program

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

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

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

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

In summary, ILPs include the following information:

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

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

ILPs allow you to:

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

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

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

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

Note: More information concerning the ACGME Board Pass Rate Requirements can be found in Appendix A, page 88.

Time Management and Administrative Responsibilities

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

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

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

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

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

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

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

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

Clinical and Educational Work Hour Documentation

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

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

Clinical Experience and Education

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

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

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

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

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

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

Maximum Duty Clinical Work and Education Period Length

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

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

Additional patient care responsibilities must not be assigned to a resident during this time. Clinical work and education hours do not include reading and preparation time spent away from the duty site.
Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities

Time Management and Administrative Responsibilities

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

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

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

Clinical Experience and Education Work Hours Policy

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

Shifts

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

Residents

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

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

On-call Activities

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

At Home Call

Residents do not currently take At Home Call.

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

- At-home call (or pager call) is defined as a call taken from outside the assigned institution.
- The frequency of at-home call is not subject to the every third-night limitation. At-home call,

however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with one (1) day in seven

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

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

In-House Night Team Assignments

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

Fatigue Mitigation Policy

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

Residents will be educated to recognize the signs of fatigue and sleep deprivation in Grand Rounds, retreats, and didactics held on sleep and fatigue during residency. See Sleep Deprivation and Fatigue Policy in the GME Policy Manual,
GME Policy Manual – See page 125

Patient Logs

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

Procedure Logs

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

basis and discuss issues with Residents as needed. The program director will suggest how to correct any deficiencies.

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

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

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

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

Competencies, Record-keeping, and Evaluations

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

Medical Records Completion

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

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

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

Resident Evaluation

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

The Clinical Competency Committee (CCC)

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

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

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

Recommendations That Can Be Made by the CCC

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

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

Resident Evaluation and Promotion

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

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

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

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

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

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

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

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

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

notice to appropriate faculty members, in order to develop a remedial and corrective plan.

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

Note: More information on ACGME's Semi-annuals evaluations review process can be found in Appendix A, on page 79.

Patient and Nurse Evaluation

Starting in the new academic year July 1, 2025, all residents will be required to obtain one(1) patient evaluation and one(1) nurse evaluation every six months, with a total of two(2) patient evaluations and two(2) nurse evaluations each year. This aligns with ACGME Section V.A.1.c, which mandates that residents receive evaluations from faculty, healthcare professionals, peers, and patients.

You will be able to access the evaluation form through MedHub via QR code, and it will be your responsibility to ensure these evaluations are completed.

Faculty and Program Evaluation

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

Resident Job Description

Basic expectations of effective job performance are listed in the Resident Job Description on page 67.

American Board of Pediatrics Evaluation Requirements

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

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

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

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

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

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

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

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

If the resident elects to transfer to a new program at the 18-month evaluation, the program director

will inform the ABP of the transfer. The ABP will inform the new program director that the previous program director should be contacted to discuss previous evaluations and remediation. The new program director is responsible for continuing a remediation program and evaluating the resident at the 24-month evaluation.

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

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

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

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

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

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

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

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

Support Services

Counseling Services

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

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

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

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

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

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

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

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

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

Hepatitis B Vaccination and Post-exposure Evaluation

As required by school policy on HIV and Hepatitis B Virus (HBV), all house staff, faculty members, and staff who have direct patient contact, who perform or take part in exposure-prone procedures

(as defined in the School Policy on HIV and HBV), or who have contact with potentially infectious body fluids or laboratory materials must be immunized against hepatitis B or demonstrate immunity. In accordance with this standard, each unit is responsible for establishing procedures such that all employees who have occupational exposure can obtain hepatitis B vaccinations at no cost. The vaccination is available after the employee receives training in accordance with this policy and within 10 working days of assignment to duty, unless immunity is established, or the vaccine is contraindicated for medical reasons.

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

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

Library Multi-Media Center

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

Computers

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

Concern and Complaint Policy

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

ACGME Professionalism Policy

The learning objectives of the program must:

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

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

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

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

ACGME Resident Wellbeing Policy

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

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

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

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

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

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

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

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

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Appendix A: Policies

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION PEDIATRICS RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	PED-01
		EFFECTIVE DATE	07/01/2025
		PAGE(S)	02
	SUBJECT BACKUP POLICY	SUPERSEDES	07/01/2018

Backup Policy

I. PURPOSE:

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

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

II. **Availability for Backup:**

2.1 If you are on call for a backup shift, you must always be available and ready to report to work.

Please make sure to always have your cell phone with you when on backup, even while sleeping. If we attempt to reach you for backup coverage and you do not respond within 30 minutes, backup points will be counted against you. You could be called in at any time on your specified backup day until 7 AM the following morning. Please be physically able to arrive at the hospital ready to work within 1 hour of being called. Please look at Amion to review your backup schedule.

2.2 If you are unable to perform your duties as a backup, you are responsible for finding coverage for your shift and if unable to find coverage, notice must be provided to the chief resident as soon as possible. This will be counted as a call out if alternative coverage is not found prior to calling the chief resident.

2.3 If you provide notice of unavailability to come to work at the time you are called by the chief resident to report, this will be considered as a call-out from duties.

2.4. If you are unavailable two times for backup without arrangements or notification, then you will be issued a Notice of Deficiency with Remediation.

2.5. Whether the resident must make up the missed shift or not is at the discretion of the program director.

2.6. If multiple backup coverage is needed for the same day, the chief resident will review the pool of residents “On Backup” and find the most appropriate resident to provide coverage. If more coverage is needed than what is scheduled, the resident who has the most negative or lowest Backup Number will be selected; assuming that this does not violate ACGME and program requirements and is feasible considering the resident’s schedule and post graduate year.

2.7. Backup numbers will be calculated as follows:

Each resident begins each academic year with a Backup Number of 0.

If a resident **misses a shift (whether Backup coverage is required or not)** for a half day, 0.5 points are subtracted from their number. If a resident covers for a half day, 0.5 points are added to their number.

If a resident **misses an entire shift (whether Backup coverage is required or not)**, 1 point is subtracted from their number. If a resident covers for a full shift, 1 point is added to their number.

If a resident desires to complete a make-up shift, the selected date must be discussed with and approved by the chief resident. If the shift is approved and subsequently completed, the resident must email the chief resident at the conclusion of the shift with the attending they worked with cc'd on the email in order for the Backup numbers to be readjusted.

If you have questions at any time regarding your Backup number, always feel free to email the chief resident.

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

Supervision of Pediatric Residents Policy

I. PURPOSE:

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

II. SCOPE:

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

III. POLICY:

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

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

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

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

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

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

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

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

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

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

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

Scenarios Requiring Resident to Contact Supervising Attending

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

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

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

IV. LEVELS OF SUPERVISION:

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

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

IV.1.2. **Indirect Supervision with direct supervision immediately available**: the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.

IV.1.3. **Indirect supervision with direct supervision available**: the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to provide direct supervision.

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

V. SUPERVISION OF PROCEDURAL COMPETENCY:

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

5.2. This competence shall be evaluated and documented as to success and qualifications.

The following protocol is used for administration of certifying pediatric residents' procedural competency.

5.2.1. Pediatric residents must be instructed and evaluated in procedural techniques by a licensed independent practitioner (LIP) who is certified as competent independently perform that procedure or who has been credentialed by the Medical Staff Office to perform that procedure.

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

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

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

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

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

Graduated Responsibility and Supervision Policy in Ambulatory Settings

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

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

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

VI. Graduated Responsibility and Supervision Policy in Inpatient Care Settings

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

Appendix A: Policies

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

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

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

Transitions of Care Policy

I. PURPOSE:

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

II. BACKGROUND:

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

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

III. SCOPE:

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

IV. POLICY:

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

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

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

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

A Sample Hand-Off Format

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

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

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

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

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

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

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

_____ _____

Receiving Resident's Name and Signature Date/Time

_____ _____

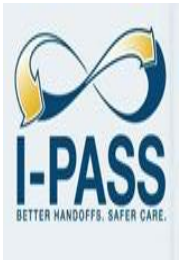
Departing Resident's Name and Signature Date/Time

Appendix A: Policies

Hand-Off Policy Checklist for Residents

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

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

	**MOREHOUSE SCHOOL OF MEDICINE** **Graduate Medical Education** **Pediatrics Residency Program Policies and Procedures**	POLICY NUMBER	PED-04
		EFFECTIVE DATE	07/01/2017
		PAGE(S)	03
	SUBJECT SOCIAL MEDIA POLICY	SUPERSEDES	N/A

Social Media Policy

I. PURPOSE:

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

II. SCOPE:

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

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

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

III. POLICY:

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

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

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

3.3. "Friending" is a way to establish online communication with others on social media sites. It is

highly recommended that you do not allow patients (former or current) to be added to your personal friend list. This may compromise patient privacy and confidentiality as well as overstep appropriate physician-patient boundaries. It is always acceptable to refuse inappropriate "friend" requests.

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

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

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

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

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

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

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

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

3.7.2. Conflict of Interest Policy

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

3.8.1. Copyrights

3.8.2. Disclosures

3.8.3. Refraining from revealing proprietary financial or intellectual property

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

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

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

3.9.2. Any sexually suggestive, humiliating, or demeaning comments

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

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

3.10.1. The improper or illegal use of drugs or alcohol

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

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

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

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

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

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

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

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

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

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

3.17.1. Human Resources Performance Improvement Counseling Policy HR-014

3.17.2. Human Resources Discharge Policy HR-015

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

IV. References:

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

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

PEDIATRICS RESIDENCY PROGRAM

Resident Job Description

Effective: 3/01/2018

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

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

Graduated Levels of Responsibility

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

Position Descriptions for Resident Physicians Specific to Level

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

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

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

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

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

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

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

PGY III

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

All Years

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

Graduate Medical Education Policies and Procedures	Policy Number	GME-302-ALL
	Effective Date	07/01/2026
Grievance Policy and Procedures	Pages	3

SCOPE:
All Morehouse School of Medicine (MSM) administrators, faculty, staff, Residents and Fellows (collectively referred to as "Residents"), and academic affiliates shall be familiar with, adhere to, and support this and all other policies and procedures that govern Residents appointed to an MSM-sponsored Graduate Medical Education (GME) program.

PURPOSE:
The Sponsoring Institution must have a policy that outlines the procedures for submitting and processing Resident grievances at the program and institutional level that minimizes conflicts of interest. This policy establishes the channels for communication, informal resolution, and formal grievances at the program and institutional level.

All residency and fellowship programs must have a program-level Concern and Complaint (Grievance) Policy that aligns with this Institutional policy and is included in the program's policy manual.

POLICY:
A grievance is a written complaint alleging that an act, omission, or policy violation has directly and adversely affected a Resident's education, training, or professional activities as a result of an arbitrary or capricious act or failure to act, or a violation of institutional policy or procedure, by the institution or anyone acting officially on its behalf.

Residents are encouraged to seek informal resolution of concerns as early as possible. Efforts should be made to resolve questions, problems, and misunderstandings through direct discussion with appropriate parties before initiating a formal grievance.

MSM strictly prohibits retaliation against any Resident who submits a grievance, participates in the review or resolution of a grievance, or serves as a witness in any grievance process under this policy. Any allegation of retaliation will be reviewed promptly and may result in corrective action.

Non-Grievable Matters
The following matters are not grievable under this policy and are governed by separate institutional policies:

- Adverse academic actions (probation, suspension, non-promotion, non-renewal, dismissal) governed by the MSM GME Adverse Academic Decisions and Due Process Policy (GME-301-ALL);
- Discrimination, harassment, sexual misconduct, and ADA accommodation matters governed by applicable MSM and site-specific policies; and
- Salary, benefits, and matters unrelated to the clinical learning and working environment, program operations, or educational activities.

PROCEDURE:

Step 1: Program Level

The Resident may seek informal resolution with the chief resident or Associate Program Director, or submit a written grievance to the Program Director (or alternate designee if a conflict of interest exists).

Written grievances must be submitted to the Program Director within thirty (30) calendar days of the event giving rise to the grievance and must include:

- A factual description of the grievance;
- The policy or procedure alleged to have been violated;
- The date the Resident first became aware of the alleged violation; and
- The remedy sought.

The Program Director will meet with the Resident within fourteen (14) calendar days of receipt and will issue a written decision within a reasonable time thereafter. A copy of the written decision will be provided to the Executive Director of GME.

If the Resident is not comfortable submitting the grievance to the Program Director, the grievance may be sent directly to the Executive Director of GME, who will fulfill the Program Director's role for Step 1. The grievance letter must explain why it was not submitted to the Program Director.

Step 2: Department/Site GME Level

If the Resident is not satisfied with the program-level resolution, the Resident may escalate to the Department Chair or, at sites without department chairs, the designated site GME lead, within fourteen (14) calendar days of the program-level decision.

A written decision will be issued to the Resident within a reasonable time and a copy provided to the Executive Director of GME.

Step 3: Institution Level

If the grievance is not satisfactorily resolved at Steps 1 or 2, the Resident may submit a written grievance to the Designated Institutional Official (DIO) within thirty (30) calendar days of the Step 2 decision.

The DIO (or designee) will meet with the Resident within fourteen (14) calendar days of receipt, review the matter in consultation with the relevant department or site, and issue a written decision within twenty-one (21) calendar days. A copy will be provided to the Program Director.

The decision of the DIO is final.

Other Grievance Resources and Options

If a Resident does not wish to use the steps above, or needs additional support, the following resources are available. Site-specific contact information is provided in Addendum A.

- Resident and Fellow Association (RFA): Residents may seek confidential, informal consultation with an RFA representative. RFA forums and meetings may be held without the DIO, faculty, or administrators present. Concerns emerging from RFA discussions may be elevated to the DIO, GMEC, or the appropriate GMEC subcommittee.
- MSM GME Feedback Form: Residents may submit anonymous feedback or concerns to the GME Office at http://www.msm.edu/Education/GME/feedbackform.php. Comments are anonymous unless the Resident chooses to provide contact information for follow-up.
- Site Anonymous Reporting Mechanisms: Each participating site maintains at least one confidential and anonymous reporting mechanism (e.g., compliance hotline, ethics reporting portal, or equivalent) for reporting concerns. Contact information for each site's mechanism is provided in Addendum A. Where a site does not have a compliance hotline, the site must identify and communicate an equivalent anonymous reporting pathway to Residents.

DEFINITIONS

- Concern (Informal): An issue related to the learning and working environment (operations, supervision, resources, interpersonal dynamics) that may be addressed through coaching, clarification, or mediation without a formal record.
- Grievance (Formal): A written complaint alleging that an act, omission, or policy violation adversely affected a

Resident's educational experience or professional activities (e.g., arbitrary/capricious actions, policy violations, academic process defects).

- Non-grievable via this policy: Matters governed by other policies (e.g., including discrimination/harassment/sexual misconduct/ADA accommodations) and adverse academic actions (suspension, non-renewal, non-promotion, dismissal) which follows the Adverse Academic Decisions & Due Process policy.

Policy Title:	Grievance Policy and Procedures
Policy Number:	GME-302-ALL
Effective Date:	07/01/2026
Applicable Programs:	All MSM-sponsored GME programs: Morehouse School of Medicine ATL and MSM CommonSpirit sites
ACGME Reference:	Institutional Requirement 3.1 (Core); Common Program Requirements Section 6
Supersedes	July 25, 2025
GMEC Review Frequency:	Annually
Last GMEC Approval Date:	5/5/2026
Approved By:	Associate Dean and Designated Institutional Official (DIO); Graduate Medical Education Committee (GMEC)

ADDENDUM A: Site Compliance, Reporting, and Grievance Contacts

GME-302-ALL

Each participating site must maintain at least one mechanism through which Residents can report concerns confidentially and anonymously, free from reprisal, consistent with ACGME Institutional Requirement 3.2.d.1. The table below identifies the compliance contact or system resource, anonymous reporting mechanism, and site GME/HR contacts for each site.

This addendum is verified and updated by the MSM GME Office at least annually. Administrative updates do not require GMEC approval but must be communicated to all Program Directors at affected sites within 30 days of any change.

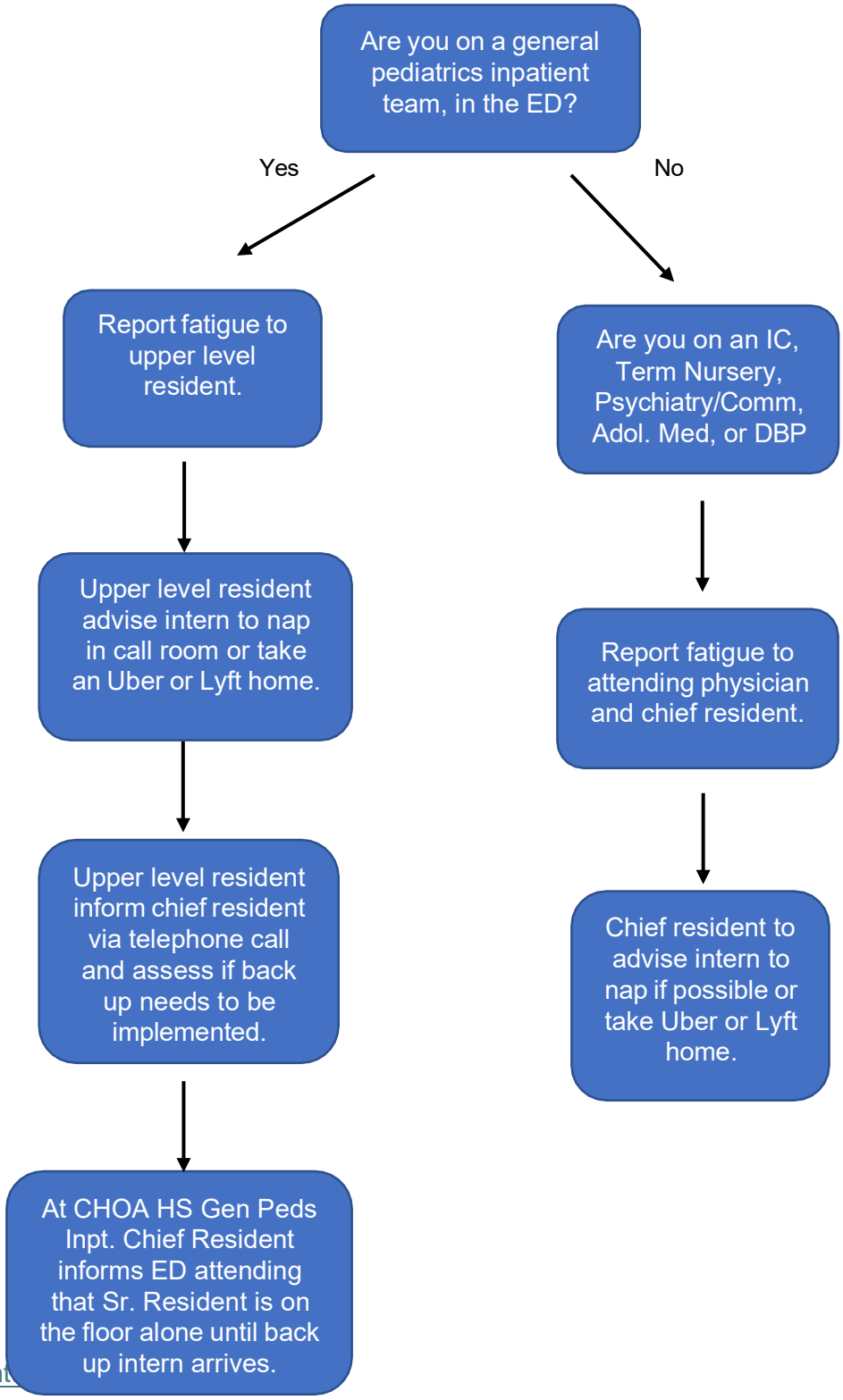
Site	Compliance Contact or System Resource	Anonymous Reporting Mechanism (hotline, portal, or equivalent)	Site GME / HR Contact
Morehouse School of Medicine ATL	MSM Office of Compliance and Corporate Integrity http://www.msm.edu/Administration/Compliance/index.php	MSM Compliance Hotline: (855) 279-7520 EthicsPoint: www.msm.ethicspoint.com	*[Site GME contact — TBD]* *[HR contact — TBD]*
Bakersfield Memorial Hospital (BMH)	CommonSpirit Health Corporate Responsibility https://employeecentral.commonspirit.org/intranet.compliancereporting	CommonSpirit Health Reporting Hotline: 1-800-845-4310 Hotline Reporting Website https://compliancehotline.commonspirit.org/	Site Education Lead — Angelica Ocampo, Director of GME angelica.ocampo@commonspirit.org 661-541-0017 HR contact — Brian Hernandez Brian.Hernandez902@commonspirit.org 661-541-0224
California Hospital Medical Center (CHMC)	*[Confirm site contact with CHMC HR — TBD]*	*[Confirm with CHMC— TBD]*	*[Site Education Lead — TBD] [HR contact — TBD] Sponsoring Institution GME Contat*
Dominican Hospital	*[Confirm site contact with Dominican HR — TBD]*	*[Confirm with Dominican — TBD]*	*[Site Education Lead — TBD] [HR contact — TBD] Sponsoring Institution GME Contact*

MSM Pediatrics Residency Program

Process for Patient Care Handoffs When Excessively Tired

INTERNS

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

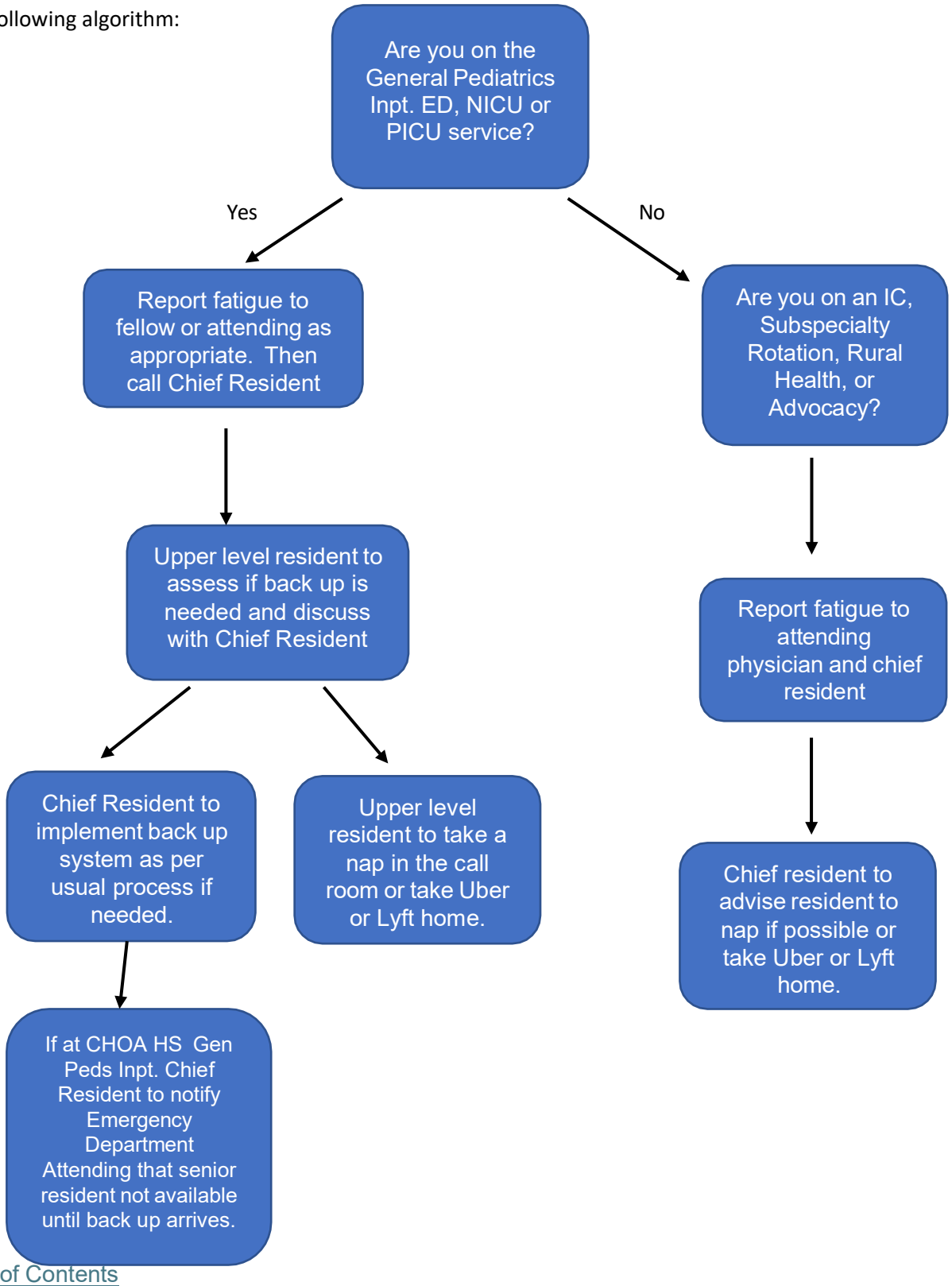


MSM Pediatrics Residency

Process for Patient Care Handoffs When Excessively Tired

2nd AND 3rd YEAR RESIDENTS

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



Appendix A: Policies

Morehouse School of Medicine Graduate Medical Education Policies and Procedures	Policy Number	GME-701-ALL
	Effective Date	07/01/2026
Eligibility, Recruitment, Selection and Appointment Policy	Pages	6

SCOPE:
All Morehouse School of Medicine (MSM) administrators, faculty, staff, Residents and Fellows (collectively referred to as "Residents"), and academic affiliates shall be familiar with, adhere to, and support this and all other policies and procedures that govern Residents appointed to an MSM-sponsored Graduate Medical Education (GME) program.

PURPOSE:
As required by the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements, the Sponsoring Institution must have written policies and procedures for Resident eligibility, recruitment, selection, and appointment, consistent with ACGME Institutional and Common Program Requirements. Additionally, the Sponsoring Institution must monitor each of its programs for compliance.

POLICY:
This policy governs residency and fellowship, eligibility, recruitment selection and appointment for all MSM-sponsored GME programs and is designed to comply with applicable ACGME requirements.

Residents in MSM-sponsored programs may be employed by MSM or by CommonSpirit Health, depending on the program and training site. Residents employed by MSM are subject to MSM Human Resources policies and procedures, while Residents employed by CommonSpirit Health are subject to applicable CommonSpirit employment policies and procedures.

Eligibility, hiring, onboarding, and appointments must comply with ACGME requirements, Sponsoring Institution and program policies, employer and site-specific HR and credentialing requirements, and applicable state licensure and regulatory requirements in the jurisdiction(s) where training occurs.

Resident Eligibility Criteria:
Consistent with the ACGME Institutional and Common Program requirements, applicants' eligibility for appointment to accredited residency programs include:

- Graduation from a medical school in the United States, 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).
- Graduation from a medical school outside of the United States, and meeting one of the following additional qualifications:
    - Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or
    - Holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty or subspecialty program.
- Applicants must have successfully completed and passed United Stated Medical Licensing Examination (USMLE) Step 1 and Step 2 (or COMLEX equivalents) prior to entry at the PGY-1 level. For California-based programs, USMLE Step 3 must be successfully completed and passed prior to entry at the PGY-2 level or higher. For Georgia-based programs, USMLE Step 3 must be successfully completed and passed prior to entry at the PGY-3 level or higher. All examination requirements must be satisfied in accordance with state licensure

regulations and employer policies.

- U.S. citizenship or status of lawful permanent resident, a refugee or asylee with permission to work in the U.S
    - or obtain a visa which provides eligibility to work in the U.S. (see immigration and work authorization requirements below)
- Must satisfy state licensure/permit requirements in the training state(s)
- Meet program eligibility requirements as defined by the ACGME's respective Review Committee (for accredited programs) or the board or accrediting body requirements that will allow a resident to practice within the program's scope of practice.

Fellowship Eligibility Exception:

- An ACGME Review Committee may allow exceptions to the fellowship eligibility requirements for qualified international graduate applicants (Eligibility Decisions by Review Committee)
- Exceptionally qualified applicants must meet all the following qualifications and conditions:
    - Evaluation by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and
    - Submission of required documents to GMEC with GMEC review and approval of the applicant's qualifications that meet exceptionally qualified applicant qualifications;
    - Satisfactory completion of the USMLE Steps 1, 2, and 3, and;
    - Verification of current, valid ECFMG certification
    - Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation.

Prior ACGME-I Accredited Training:

- Residents who have completed, or are currently enrolled in, an ACGME-I accredited residency or fellowship training program may be eligible for appointment provided they meet the following criteria:
    - The applicant must provide documentation verifying that their prior training program is accredited by ACGME-I at the time of their enrollment or completion.
    - Applicants must have successfully completed the full scope of training required by the ACGME-I accredited program for their respective specialty.
- Applicants from ACGME-I accredited programs will be evaluated using the same program-specific criteria applied to domestic candidates.
- Program directors and selection committees must assess the applicant's suitability for the program based on prior training, faculty evaluations, and performance in their ACGME-I accredited program.

Recruitment and Selection

Selection: Programs must include the GME technical standards and essential functions for appointment. Residents must, with or without reasonable accommodation, meet essential functions across five domains: Observation; Communication; Motor; Intellectual (conceptual/integrative/quantitative); and Behavioral/Social (professionalism, judgment, stress tolerance, teamwork, adaptability, ethics). Individual programs may define additional specialty-specific expectations, and requests for reasonable accommodation are handled case-by-case: for MSM-employed Residents through MSM HR/Disability Services, and for MiCA Residents through CommonSpirit Health HR/Employee Health.

NRMP and ERAS: All MSM-sponsored residency and fellowship programs participate in the National Resident Matching Program (NRMP), as applicable. MSM, its programs, and all applicants are contractually bound by NRMP rules and policies. Match violations will not be tolerated and may result in institutional or program-level corrective action, consistent with NRMP requirements.

Appendix A: Policies

All applicants to MSM-sponsored residency and fellowship programs must apply through the Electronic Residency Application Service (ERAS) or other centralized application service if available in their specialty to receive and accept applications to the Program. ERAS is used to collect and screen required applicant information. Applicants must submit a minimum of three (3) professional and/or academic letters of reference, dated within the preceding 18 months, through ERAS.

Programs may establish additional eligibility and selection criteria, such as preferred minimum examination scores or other program-specific requirements, where applicable. Any such criteria must be clearly defined and published for applicant review as part of the program's required eligibility and selection policy and must comply with ACGME and NRMP requirements.

Notification of Terms, Conditions, Benefits and Program Aims: Consistent with ACGME Institutional Requirements and NRMP policies, applicants invited to interview for a Resident position must be informed, in writing or electronically, of the current terms, conditions, and benefits of appointment. At a minimum, programs must disclose:

- Stipend/compensation structure
- Leave including vacation, parental, sick, and other leave policies
- Professional liability coverage
- Health, disability, and other insurance benefits available to residents and eligible dependents
- Program aims
- A copy of the appointment agreement (or the agreement currently in use).
- Institutional and program eligibility requirements, including required academic credentials, pre-employment drug testing and background checks, and licensure/visa or work authorization requirements

Programs must obtain a signed acknowledgment from each interviewed applicant or otherwise document that these disclosures were made available. Disclosure does not imply that an applicant will be ranked, matched, or offered a position.

GMEC and ACGME Program Positions and Appointment Approval: Program directors must not appoint more residents than approved by the ACGME Review Committee.
Available MSM resident positions are dependent on the following criteria:

- The current number of residency program positions authorized by the ACGME
- The space available in the Post-Graduate Year
- Funding and faculty resources available to support the education of residents according to the educational requirements of the specialty program

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

Selective Service Registration (Male Applicants Only): As part of the Program, a Resident may be required to rotate through a VA hospital for additional learning opportunities. As a federal requirement of working at a federal agency, males must have registered with the Selective Service System when they were between the ages of 18 to 26 years. This includes individuals who are US citizens, non-US citizens and dual nationals, regardless of their immigration status. Male for this purpose is defined as those individuals' born male on their birth certificate regardless of current gender. Only male, non-US citizens on a student or visitor visa are exempt from registration. Though exempt from registration, these males are required to request a Status Information Letter issued from the Selective Service office stating they were not required to register. Failure to meet these requirements may lead to termination of the Resident's contract.

Resident Transfers: Residents are considered transfer residents under several conditions including moving from one program to another within the same or different Sponsoring Institution and when entering a PGY-2 program requiring a preliminary year, even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2

program as part of the match (e.g., accepted to both programs directly out of medical school).

Prior to acceptance of a transferring Resident, the program must obtain verification of previous educational experiences and a summative competency-based performance evaluation, signed by the previous program director prior, all letters of recommendations, and the candidate's Milestones evaluations.

Prior to accepting a transfer resident, the program must obtain from the resident and retain written confirmation that the resident understands the impact of the transfer on their eligibility for their intended specialty board's initial certification.

Programs should contact DIO before offering transferring Residents a position.

MSM residency programs shall identify all residents who would begin the residency program and would have to continue beyond the initial residency period. The initial residency period is the length of time required to complete a general residency program (e.g., Internal Medicine: three (3) years; Psychiatry: four (4) years).

Initial Appointment

An initial appointment is a time-limited, non-faculty training appointment to an MSM-sponsored ACGME program, issued only after the applicant's eligibility has been verified and all pre-employment/onboarding requirements are satisfied. Appointment encompasses (a) MSM's academic training appointment and (b) employment with the employer of record at the training site (e.g., MSM or CommonSpirit). No clinical duties may be performed until all conditions below are met.

A Resident's initial appointment level and associated compensation are generally aligned with the minimum required experience needed to enter or continue in the program and with the program's required scope of practice for each year of training, in order to promote consistency among trainees at the same level of training. In certain circumstances, prior training or experience may warrant individual review. Such determinations are made on a case-by-case basis in consultation with the GME Office. Programs or applicants with questions regarding the appropriate appointment level or compensation are encouraged to contact the GME Office for review prior to appointment acceptance.

Programs and Residents must also comply with the credentialing and employment requirements of all affiliated training sites for the program. Fellowship programs must review milestones from residency training once available from the residency program. Advanced Match specialties must receive proof of successful completion of a prerequisite year of training.

Conditions precedent to start (all must be completed/verified):

- Possess an active Board of Medicine unlicensed physician in training or a full and unrestricted license to practice medicine in the state of training.
    - Note California training license allows 180 days after the start of the program to obtain training license
- Complete all HR pre-employment steps with the employer of record, including background check, drug screen, immunizations/occupational health clearance, and I-9/work authorization
- Have current certification in ACLS/PALS/NRP/ATLS, as based upon program and/or affiliated hospital requirements.
- Complete all required onboarding documentation and modules in the electronic Residency Management System, Medhub.
- Complete online and classroom-based training (e.g. - HIPAA, electronic medical record).
- For Residents entering a Fellowship training program – Provide documentation from core residency program director certifying one's ability to progress to the fellowship level.

Program administrative submissions: The program will verify resident names and basic demographic information to the GME Office and upload the full application record into Medhub (ERAS or equivalent), including the medical school diploma, official USMLE/COMLEX score reports (all attempts), medical licenses number with expiration date, employee

number (MSM employed residents) and, when applicable, ECFMG certificate and related documentation for international medical graduates.

Resident Contract

All residents in MSM-sponsored programs maintain an academic training appointment with Morehouse School of Medicine and an employment relationship with the employer of record at the training site.

Residents training at MSM–Atlanta are employed by MSM and receive an annual MSM Resident Appointment Agreement, issued for a maximum of one (1) year, which defines the academic and employment terms of training in accordance with ACGME requirements.

Residents training at CommonSpirit sites are employed by CommonSpirit Health and receive an annual CommonSpirit employment agreement, which governs compensation, benefits, and employment conditions. Although CommonSpirit residents do not receive an MSM employment contract, they remain subject to MSM's academic policies, ACGME requirements, and GMEC oversight as participants in MSM-sponsored programs.

All agreements must be fully executed and all onboarding requirements completed prior to the start of clinical duties. Reappointment is not automatic and is contingent upon satisfactory performance and professionalism, progression as determined by the Clinical Competency Committee, continued eligibility (including licensure and work authorization), availability of approved program complement and funding, and ongoing compliance with MSM policies, ACGME requirements, and the employer's policies (see GME Resident Promotion Policy GME-702-ALL).

Immigration and Work Authorization Requirements:

- MSM supports AAMC guidance that the J-1 (ECFMG-sponsored) is the preferred visa for non-immigrant IMGs in MSM-employed training programs.
- J-1 basics (MSM-employed only):
    - Sponsor: ECFMG (issues DS-2019 upon institution request).
    - Eligibility: ECFMG certification (incl. USMLE Step 1 & Step 2 CK for IMGs); SEVIS fee paid before visa interview.
    - Duration/return requirement: Generally, up to 7 years total; two-year home-residency requirement (212e) often applies (waiver is possible but complex).
    - Entry/exit timing: May enter ≤30 days before start; 30-day grace after program end (no work before start or during grace).
- CommonSpirit employed positions do not accept J-1 visa or H1-B visa candidates.
- MSM does not sponsor H-1B visas.
- Other statuses (e.g., asylum, TPS, EAD categories). Case-by-case review with GME and HR to confirm work authorization, licensure, and onboarding feasibility.
- Processing & liaisons. MSM GME/HR coordinate J-1 requests with ECFMG for MSM-employed positions; CommonSpirit HR manages all visa decisions for MiCA positions.

Appendix A: Policies

Policy Title:	Eligibility, Recruitment, Selection and Appointment Policy
Policy Number:	GME-701-ALL
Effective Date:	07/01/2026
Applicable Programs:	All MSM-sponsored GME programs: Morehouse School of Medicine ATL and MSM CommonSpirit sites
ACGME Reference:	Institutional Requirements 4.2; Common Program Requirements 3.2
Supersedes	July 25, 2025
GMEC Review Frequency:	Annually
Last GMEC Approval Date:	3/3/2026
Approved By:	Associate Dean and Designated Institutional Official (DIO); Graduate Medical Education Committee (GMEC)

Evaluation of Residents, Faculty, and Programs Policy

I. PURPOSE:

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

II. SCOPE:

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

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

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

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

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

III. RESIDENT/FELLOW EVALUATION – Feedback and Evaluation:

III.1. Faculty Evaluation of Residents and Fellows

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

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

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

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

III.2. Clinical Competency Committee (CCC)

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

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

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

III.2.4. The Clinical Competency Committee must:

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

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

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

IV. RESIDENT/FELLOW ASSESSMENT AND EVALUATION:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV.15. The final evaluation must:

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

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

IV.15.3. Consider recommendations from the CCC

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

V. FACULTY EVALUATION:

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

V.2. The program director must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually and include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.

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

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

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

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

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

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

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

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

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

VI. PROGRAM EVALUATION AND IMPROVEMENT:

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

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

VI.1.2. PEC responsibilities must include:

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

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

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

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

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

Appendix A: Policies

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

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

The annual review, including the action plan must:

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

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

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

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.
V.C.3.a - For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

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

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

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

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

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

Educational Program Requirements Policy

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

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

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

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

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

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

IV.D. Scholarship

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

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

3. Resident/Fellow Scholarly Activity
    a. Residents and Fellows must participate in scholarship activity.

Appendix A: Policies

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

SECTION 1: PURPOSE

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

SECTION 2: POLICY STATEMENT

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

SECTION 3: SCOPE OF POLICY

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

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

SECTION 4: DEFINITIONS

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

SECTION 5: POLICY

1.1 Technical Requirements

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

1.2 User Requirements

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

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

☐ Apple iPhone 7

☐ Apple charger

☐ Otterbox iPhone 7 case

Signature: _____

Printed Name: _____

Date _____

Contact Information:

Name:_____

Address: _____

Phone: _____

Appendix A: Policies

Resident Disaster Policy

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

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

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

Resident Closure Policy

In the event of inclement weather:

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

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

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

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

Appendix A: Policies

Morehouse School of Medicine Graduate Medical Education Policies and Procedures	Policy Number	GME-502-ALL
	Effective Date	07/01/2026
Moonlighting Policy	Pages	3

SCOPE:
All Morehouse School of Medicine (MSM) administrators, faculty, staff, Residents and Fellows (collectively referred to as "Residents"), and academic affiliates shall be familiar with, adhere to, and support this and all other policies and procedures that govern Residents appointed to an MSM-sponsored Graduate Medical Education (GME) program.

PURPOSE:
The purpose of this moonlighting policy is to ensure that MSM GME programs comply with Accreditation Council for Graduate Medical Education (ACGME) requirements, while safeguarding patient safety, resident well-being, and the primacy of the educational mission. This policy defines internal and external moonlighting; requires prior Program Director approval and ongoing good standing; mandates that all moonlighting hours count toward ACGME clinical and educational work-hour limits; and ensures compliance with licensure/credentialing, malpractice coverage, site/employer rules.

POLICY:
MSM is committed to providing the highest quality work environment for physicians in training to master their chosen disciplines. Residents appointed to a program are expected to achieve the goals and objectives of the educational program. Any professional, patient care or medical practice activities performed by Residents outside of the educational program must not interfere with the Resident's achievement of the goals and objectives of the educational program or adversely affect patient safety.

In accordance with the ACGME requirements, Residents must not be required to engage in moonlighting and all internal and external moonlighting must be counted towards the 80-hour maximum weekly hour; Residents must have an approved moonlighting form for each academic year from their program director to moonlight; the ACGME-accredited program(s) will monitor the effect of moonlighting activities on a Resident's performance in the program, including that adverse effects may lead to withdrawal of permission to moonlight; and, the Sponsoring Institution or individual program(s) may prohibit moonlighting by Residents. Oversight of work hours is the responsibility of the program, the Graduate Medical Education Committee (GMEC) and the GME Office. Program director should verify that moonlighting hours were logged in the previous academic year prior to allowing for a continuation of moonlighting privileges.

Moonlighting must be in accordance with the following guidelines:

- PGY-1 residents are **not** permitted to moonlight.
- 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.
- Moonlighting must be approved in writing by the Program Director and Designated Institutional Official (DIO).
- For J-1 physicians "supplemental clinical activities" **may** be permitted if certain criteria is met (see below).
- Time spent by the Resident in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly hour limit.
- A current, unrestricted physician license is required in the U.S. state(s) where moonlighting occurs, with all

- required privileges/credentialing completed at the site of service.
- Residents must complete the Moonlighting Request Form and sign the Professional Liability Coverage statement available from the GME office.
- Professional liability coverage provided by MSM or CommonSpirit does not cover any clinical activities not assigned to the Resident by the residency/fellowship program.
- Moonlighting activities shall not be credited as being part of the program structure or curriculum.
- MSM shall not be responsible for these extracurricular activities. The Resident must secure liability coverage for these outside activities from the respective institutions or through their own resources.

- Moonlighting Criteria
- Resident must be a PGY-2 or higher; PGY-1 residents may not moonlight.
- J-1 visa sponsored residents **may** engage in "supplemental clinical activities" within their training institution/primary clinical site when all of the following are met: (a) the activity is within the same institution/primary clinical site; (b) it is educationally appropriate and does not extend the training period; (c) prior written approvals are obtained from the Program Director and Intealth's Responsible Officer via the required institutional request; and (d) all institutional policies and ACGME work-hour limits are observed (per Intealth/ECFMG)
- A full and unrestricted medical license is required in the state where the moonlighting occurs
- The Resident must have current good standing status in the program and Program Director approval renewed at least annually or sooner if performance concerns arise.
- The Residents must log all internal and external moonlighting hours which count toward the ACGME work hours.
- Moonlighting may occur only within the U.S. state in which the resident's ACGME training program is located; approval is limited to in-state sites and the PD/DIO may revoke approval if patient safety, fitness for duty, or academic progress is at risk.

Program-Level Policy Requirement:
Each MSM-sponsored program must maintain a program-level moonlighting policy consistent with this institutional policy and ACGME requirements. Program-level policies must be reviewed annually and must address approval procedures, tracking, documentation, and enforcement specific to the program. Program Directors are responsible for managing approval, monitoring compliance, and enforcing this policy within their programs.

DEFINITIONS:

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

Appendix A: Policies

Policy Title:	Moonlighting
Policy Number:	GME-502-ALL
Effective Date:	07/01/2026
Applicable Programs:	All MSM-sponsored GME programs: Morehouse School of Medicine ATL and MSM CommonSpirit sites
ACGME Reference:	Common Program Requirements Section 6.25 (Core); Institutional Requirements 3.2.e
Supersedes	July 25, 2025
GMEC Review Frequency:	Annually
Last GMEC Approval Date:	5/5/2026
Approved By:	Associate Dean and Designated Institutional Official (DIO); Graduate Medical Education Committee (GMEC)

MOREHOUSE SCHOOL OF MEDICINE

Moonlighting Request Form

To be completed by the resident or 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 they 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 J-1 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 or fellow 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 ❒

DIO Signature: _____ Date: _____ Chinedu Ivonye, MD

Professional Liability Coverage—Moonlighting Request

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

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

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

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

Check the appropriate box:

Resident Agreement ❑ Moonlighting Request ❑

Signature: _____ Date: _____

Social Security Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Return Signed Original to Office of Graduate Medical Education.

Return to Table of Contents

Appendix A: Policies

Morehouse School of Medicine Graduate Medical Education Policies and Procedures	Policy Number	GME-801-ALL
	Effective Date	07/01/2026
Resident and Fellow Leave Policy	Pages	3

SCOPE:
All Morehouse School of Medicine (MSM) administrators, faculty, staff, Residents and Fellows (collectively referred to as "Residents"), and academic affiliates shall be familiar with, adhere to, and support this and all other policies and procedures that govern Residents appointed to an MSM-sponsored Graduate Medical Education (GME) program.

PURPOSE:
The purpose of this policy is to establish an institutional framework governing leave of absence for Residents across all MSM-sponsored GME programs. Because each participating site operates under different employer Human Resource (HR) systems, Resident Agreements of Appointment, and applicable state laws, site-specific leave policies will differ in duration, pay, and administration. This framework ensures that all site-level leave policies meet minimum Accreditation Council for Graduate Medical Education (ACGME), National Residency Matching Program (NRMP), and applicable legal requirements; are consistently communicated to Residents and faculty; and are subject to Graduate Medical Education Committee (GMEC) oversight and approval.

POLICY:
MSM recognizes that Residents may require leave during their training. Leave policies must balance Resident well-being and legal rights with the program's educational requirements and patient safety obligations. MSM is committed to ensuring that leave is administered in a manner that is fair, transparent, and consistent with applicable law.

Each participating site must maintain a written site-level leave policy for Residents that meets the minimum standards established by this institutional framework. Site-level policies govern the specific terms of leave at that site, including duration, pay, and administrative process, and must comply with applicable federal law and the state law of the site's jurisdiction. The participating sites subject to this framework, along with their applicable site-level leave policy references and HR contacts, are identified in Addendum A.
Addendum A will be updated by the MSM GME Office as needed; administrative updates (e.g., HR contact changes) do not require GMEC approval but must be communicated to the GME Office within 30 days of the change.

MINIMUM REQUIRED LEAVE TYPES:
Every site-level leave policy must address, at minimum, the following leave types. Sites may offer additional leave types or more generous terms beyond these minimums.

Leave Type	Federal / ACGME Requirement
PART A — Mandatory: Required by ACGME and/or Federal Law	
Medical, Parental, and Caregiver Leave (ACGME IR 4.8)	ACGME CORE: minimum 6 weeks approved leave for qualifying reasons; 100% salary for first 6 weeks of first leave; minimum 1 additional week paid time off outside first 6 weeks; health and disability insurance continuation for Resident and eligible dependents; available

	at least once and at any time during the program. FMLA and applicable state law run concurrently where eligible.
FMLA (Federal Family & Medical Leave Act)	Up to 12 weeks job-protected unpaid leave per year for qualifying reasons; runs concurrently with ACGME medical/parental/caregiver leave where applicable.
Military Leave (USERRA)	USERRA — job-protected leave; reemployment rights protected.
PART B — Additional: Required by Site Policy or Strongly Recommended	
Vacation Leave	Site discretion; must be clearly defined and provided to all Residents.
Sick Leave	Site discretion; must be clearly defined.
Bereavement Leave	No federal minimum. ACGME does not specify. Site discretion.
Educational / Conference Leave	Optional; site discretion; not required by ACGME.
Other Leave Types to Consider	Jury / civic duty; personal / administrative leave; pregnancy disability leave; crime victim leave; disability leave beyond FMLA. Consult site HR and applicable state law.

Minimum Required Policy Content:

Each site-level leave policy must include, at minimum, the following elements. Programs must use the MSM GME Site Leave Policy Template (Appendix A) as the basis for their site policy.

- Identification of the participating site and applicable GME programs covered by the policy;
- All required leave types listed above, with the duration, pay status (paid/unpaid), and benefit continuation terms for each. The site policy must address, at minimum: Vacation; Sick; Medical/Parental/Caregiver Leave (meeting ACGME IR 4.8 requirements in full); FMLA; Bereavement; and Military (USERRA). Educational/conference leave and other leave types should be included where offered;
- A clear statement of whether and how each leave type may affect the duration of training and the process for determining any required extension;
- The process for requesting leave, including who must be notified, required documentation, and applicable timelines.
- The impact of leave on stipend, benefits, and licensing, including any gaps in coverage during unpaid leave;
- A statement that leave will not be used as the basis for adverse action, consistent with applicable law;
- The effective date and date of last GMEC approval.

Distribution and Accessibility:

Consistent with ACGME Institutional Requirement 1.12.e and NRMP Match Participation Agreement requirements, site leave policies must be:

- Provided to all Residents upon appointment and at the start of each academic year;
- Provided to all program faculty annually;
- Accessible at all times in a location readily available to Residents and faculty; and
- Disclosed to applicants prior to the NRMP Match in accordance.

GMEC Oversight and Approval:

Site leave policies are subject to the following GMEC oversight requirements, consistent with ACGME Institutional Requirement 1.12.e:

- Each site's leave policy must be submitted to the GMEC for review and approval prior to initial implementation and prior to implementation of any substantive change.
- Proposed changes to a site leave policy must be submitted to the MSM GME Office no later than 30 days before

the next scheduled GMEC meeting to allow adequate review time.

- No substantive change to a site leave policy may be implemented until GMEC approval has been obtained. "Substantive change" includes any modification to leave duration, pay status, benefit continuation, training extension requirements, or eligibility criteria.
- Administrative or contact information updates (e.g., updated HR contact names) do not require GMEC approval but must be communicated to the MSM GME Office within 30 days of the change.

Policy Title:	Resident and Fellow Leave Policy
Policy Number:	GME-801-ALL
Effective Date:	07/01/2026
Applicable Programs:	All MSM-sponsored GME programs: Morehouse School of Medicine ATL and MSM CommonSpirit sites
ACGME Reference:	Institutional Requirements 1.12.e and 4.8.a–4.8.g (Core); NRMP Match Participation Agreement
Supersedes	July 25, 2025
GMEC Review Frequency:	Annually
Last GMEC Approval Date:	5/5/2026
Approved By:	Associate Dean and Designated Institutional Official (DIO); Graduate Medical Education Committee (GMEC)

ADDENDUM A: Participating Site Leave Policy References and HR Contacts

GME-801-ALL

Each participating site listed below is required to maintain a site-level Resident leave policy consistent with the MSM GME Institutional Leave Framework GME-801-ALL and the requirements of ACGME Institutional Requirements 1.12.e and 4.8.a–4.8.g. The table below identifies the applicable site policy reference, GMEC approval status, and HR contact for each site.

This addendum is maintained by the MSM GME Office. Administrative updates (e.g., HR contact changes, policy number revisions) do not require GMEC approval but must be submitted to the GME Office within 30 days of the change. Updates to leave terms or policy substance require GMEC review and approval prior to implementation.

Site	Site Leave Policy Title / Number	Last GMEC Approval	Site HR Contact
Morehouse School of Medicine (Atlanta, GA)	*[Site policy title and number — TBD]*	*[MM/DD/YYYY]*	*[Name, Title, Phone, Email — TBD]*
Bakersfield Memorial Hospital (BMH)	*[Site policy title and number — TBD]*	*[MM/DD/YYYY]*	*[Name, Title, Phone, Email — TBD]*
California Hospital Medical Center (CHMC)	*[Site policy title and number — TBD]*	*[MM/DD/YYYY]*	*[Name, Title, Phone, Email — TBD]*
Dominican Hospital	*[Site policy title and number — TBD]*	*[MM/DD/YYYY]*	*[Name, Title, Phone, Email — TBD]*

Morehouse School of Medicine Graduate Medical Education Policies and Procedures	Policy Number	GME-303-ALL
	Effective Date	07/01/2026
Anti-Discrimination and Harassment-Free Workplace	Pages	2

SCOPE:
All Morehouse School of Medicine (MSM) administrators, faculty, staff, Residents and Fellows (collectively referred to as "Residents"), and academic affiliates shall be familiar with, adhere to, and support this and all other policies and procedures that govern Residents appointed to an MSM-sponsored Graduate Medical Education (GME) program.

PURPOSE:
The purpose of this policy is to establish an institutional framework ensuring that all MSM-sponsored GME programs maintain a workplace and learning environment free from discrimination, harassment, and retaliation, consistent with ACGME Institutional Requirement 4.10, applicable federal law, and applicable state law at each participating site. Residents and Fellows are subject to and protected by the primary anti-discrimination and harassment policy of their training site, as identified in Addendum A. Where state law provides greater protections than federal law, state law governs.

POLICY:
MSM is committed to a diverse and inclusive training environment. All interactions among administrators, faculty, staff, Residents, Fellows, patients, and visitors shall be free from discrimination, harassment, or retaliation on the basis of any characteristic protected by law, including race, color, religion, national origin, ancestry, sex, sexual orientation, gender identity, gender expression, pregnancy, age, disability, genetic information, marital or parental status, veteran or military status, or any other characteristic protected by applicable federal or state law.
Prohibited conduct, protected characteristics, reporting procedures, investigation processes, confidentiality obligations, corrective action, and non-retaliation protections are governed by the applicable site's primary policy in conjunction with applicable federal law and, where applicable, state law. Site-specific primary policies and HR contacts are identified in Addendum A.
The following requirements apply across all MSM-sponsored programs regardless of site:

- Sexual harassment includes any unwanted physical or verbal conduct that directly or indirectly affects a term or condition of employment or the learning environment, or creates an intimidating, hostile, or offensive environment.
- Abusive conduct, defined as conduct with malice that a reasonable person would find hostile or offensive and that is unrelated to legitimate program or business interests is prohibited.
- Harassment by non-employees, including contractors, vendors, and visitors, is covered where the site knew or should have known of the conduct and failed to take corrective action.

<u>Reporting:</u>
Residents who believe they have experienced or witnessed prohibited conduct should report to their Program Director, the MSM GME Office, or site HR as identified in Addendum A. The MSM GME Office will be notified of any complaint involving a Resident and will coordinate with site HR as appropriate. Reports may also be made through site specific

reporting channels identified in Addendum A.

No Resident, faculty member, or staff member will be disciplined or retaliated against for making a good-faith report under this policy or for participating in an investigation. Anyone who believes they have experienced retaliation should report it promptly to the MSM GME Office or site HR.

Policy Title:	Anti-Discrimination and Harassment-Free Workplace
Policy Number:	GME-303-ALL
Effective Date:	07/01/2026
Applicable Programs:	All MSM-sponsored GME programs: Morehouse School of Medicine ATL and MSM CommonSpirit sites
ACGME Reference:	Institutional Requirement 4.10 (Core)
Supersedes	N/A
GMEC Review Frequency:	Annually
Last GMEC Approval Date:	5/5/2026
Approved By:	Associate Dean and Designated Institutional Official (DIO); Graduate Medical Education Committee (GMEC)

ADDENDUM A: Anti-Discrimination and Harassment Policies and HR Contacts

GME-303-ALL

Each MSM-sponsored GME site maintains its own primary anti-discrimination and harassment policy consistent with applicable federal law, applicable state law, and this institutional framework. Residents and Fellows are subject to the site's primary policy in addition to this MSM GME policy.

This addendum is maintained by the MSM GME Office and updated as needed. Administrative updates (e.g., HR contact changes) do not require GMEC approval but must be communicated to all Program Directors at affected sites within 30 days.

Site	Primary Policy Reference	Site HR Contact
Morehouse School of Medicine ATL	*MSM Equal Opportunity and Non-Discrimination Policy. Confirm current policy title and number with MSM HR. (TBD)*	*MSM Human Resources (TBD)*
Bakersfield Memorial Hospital (BMH)	Anti-Discrimination and Harassment-Free Workplace A-014 / A-014A https://CommonSpiritHealth.policymedical.net/policymed/registeredocViewer-Anti-Descrimination and Harassment-Free Workplace A-014	HR contact — Brian Hernandez Brian.Hernandez902@commonspirit.org 661-541-0224
California Hospital Medical Center (CHMC)	*CommonSpirit Health HR A-014 / A-014A as adopted by CHMC. Confirm current policy title and number with CHMC HR. (TBD)*	*CHMC Human Resources (TBD)*
Dominican Hospital	*CommonSpirit Health HR A-014 / A-014A as adopted by Dominican Hospital. Confirm current policy title and number with Dominican HR. (TBD)*	*Dominican Hospital Human Resources (TBD)*

This addendum is reviewed and updated by the MSM GME Office as needed. Updates do not require GMEC approval but must be communicated to all Program Directors at affected sites.

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