Community Pediatric Residency Program Handbook

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

2018-2019

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

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Community Pediatric Residency Program

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Introduction

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

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

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

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

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

Program Overview

Mission

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

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

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

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

MSM's Diversity statement is in the process of being finalized. This handbook will be updated with the new statement once it's available.

Residency Setting

Our program hospital partners include:

- Children's Healthcare of Atlanta (CHOA)
- Grady Memorial Hospital (GMH)
- DeKalb Medical Center (DMC)
- Gwinnett Medical Center (GMC)

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

Administrative Structure

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

Program Director

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

Other responsibilities include:

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

- Directly supervising the program manager, program assistant, the core pediatrics faculty, and staff involved with the residency program implementation;
- Working closely with the department's chairperson and other officials at MSM to ensure that the program reflects the mission of the institution as well as that of the department; and
- 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.

Assistant Program Director

The assistant program director assists the residency program director and associate program director in program operations. The assistant program director schedules and conducts resident educational conferences such as morning report, mock codes, and weekly didactic lectures. The assistant program director assists with the resident selection process, maintains the evaluation system for residents and preceptors, and oversees the chief residents in development and maintenance of the resident master schedule. The assistant program director serves as the junior faculty liaison between the program and residents.

Chief Resident

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

Program Manager

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

Program Assistant

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

- Maintains all files and folders, correspondence, schedules, and meeting minutes and notes;
- Maintains and distributes on-call and conference schedules to residents, faculty, and affiliates; and
- 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 New Innovations.

Resident Advisors

The Program Director advises all interns. After their first year, they are then moved to another faculty member. 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:

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

Pediatric Evaluation Committee (PEC)

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

The PEC meets 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 is comprised of at least three (3) members who are appointed by the program director.

The CCC actively participates in the following activities:

- Reviewing all resident evaluations and educational requirements;
- Preparing and ensuring the reporting of Milestones evaluations of each resident semiannually to ACGME; and
- Making recommendations to the program director for residents' progression, including promotion, remediation, and dismissal.

The CCC shall meet at least semi-annually but may meet as often as required to review residents' performances. The outcome of the CCC as agreed to by the program director, shall be communicated to each resident and his or her faculty advisor.

Program Goals

Overall Residency Program Goals

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

As its primary goals, the program seeks to:

- Prepare pediatricians who are 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 serve 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 are able to 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.

New Resident Orientation

Introduction

Matriculating into a residency program can be an anxiety-filled time in a physician's career. The transition from "student" to "physician" or re-engaging oneself in a training program can be a source of discomfort for many trainees. Learning new environments and familiarizing oneself with new learning requirements and ACGME requirements can be a challenge. It is our responsibility and goal to help you successfully transition into residency.

The purpose of this handbook is to help you embark on an exciting career. It is not a cookbook nor is it a textbook. Hopefully, it will point you in the right direction.

Duties and Responsibilities

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

Professional Conduct

Residents must conduct themselves in a professional manner at all times. This applies to interactions with Attending physicians, peers, supervisors, professional staff, administrative staff, support services, members of the healthcare teams, and last but not least, patients and families. Residents are expected to dress professionally according to the dress code outlined in this handbook.

Reliability

Residents must present to their assigned duty on time, including daily rotations, shifts and conferences. The resident must be available for the entire assignment, unless he or she has received permission in advance to miss any part of a responsibility. No other activity supersedes this requirement unless permission for absence is obtained from the program director. Residents should wear their pagers ***at all times*** during duty 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***. Only through attendance will maximal educational benefit be realized.

Communication

Residents must make themselves available via pager, home phone, cell phone, or e-mail at all times while on duty and from 7 am to 7 pm, except when on vacation or sick leave.

Residents are expected to check their MSM e-mail accounts at least once daily because this is a primary mode of communication. They are expected to check and respond to pages and e-mails

promptly. Technological problems with pagers, 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. No longer will one strive to “memorize and forget” a group of facts in order to pass a test. You are learning to become a competent 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 Individual 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 his or her strengths and weaknesses and determine how to achieve his or her goals. The ILP must be completed at the beginning of each academic year. See the ILP section of this handbook for further information.

All residents are provided access to pediatric books and journals, including *Nelson Essentials of Pediatrics*, Zitelli and Davis’ *Atlas of Pediatric Physical Diagnosis*, and *Pediatrics* (journal), just to name a few. All residents have access to electronic books and databases through MSM and CHOA.

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

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

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

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

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

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

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

As a resident, you can take the initiative to acquire as much information as possible from faculty, preceptors, and senior residents. All you have to do is be enthusiastic and ask questions. You will be surprised at the response and the information obtained. Conference attendance is also important. There is little excuse for missing conferences. 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 also 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 or a physician, you may encounter clinical problems or have personal problems arise that are difficult to handle. If you find you do have clinical or personal problems that you are finding difficult to handle, seek help and advice from your program director(s), advisor, the faculty, 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

United Healthcare Employee Assistance Program
Any employee or student concerned about alcohol, substance abuse, or emotional problems may contact the EAP liaison directly at (404) 752-1846 or 1 (888) 887-4114.

Vacation, Holiday, Sick Leave, Call, 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 may be needed to complete the program.

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

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

Vacation will be scheduled in 3 block intervals. 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.

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.

Vacation time is scheduled during designated rotations. Vacation may be requested for any week but it will not 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 aforementioned 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 call 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 approved, the vacation dates will appear on www.amion.com or on New Innovations 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 during psychiatry/community pediatrics, one week during Hughes Spalding inpatient, and one week during the individualized curriculum rotation.
- PGY-2—One (1) week during an individualized curriculum rotation; one (1) week during surgery; and one (1) week during the advocacy rotation.
- PGY-3—Three (3) total. Each is to be taken from a separate individualized curriculum rotation.

NOTE: PGY-3s might be able to take 1-2 days of intermittent vacation scattered throughout the year in order to go on job/fellowship interviews. Such intermittent vacation days must be approved by the chief resident or a program director. PGY-3s who plan to go to fellowship should try to take some of their vacation days at the end of residency year.

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 are not required to be made up as long as 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. It is the resident's responsibility to notify the chief resident or program designee by 8 am when he or she is out sick.

The resident must complete a leave form for all sick days as soon as possible, either when physically better or on the first day back to work. E-mail this form to both the chief resident or program designee and the program manager.

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

A combination of sick leave and vacation leave may be used to care for oneself or an immediate family member. When these two leave categories are exhausted, any additional leave days are uncompensated

See the GME Policy Handbook at http://www.msm.edu/Education/GME/index.php.

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 in order for the resident to receive full credit for the rotation.

See Scheduled Rotations, page 18.

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. In the event that a resident is unable to trade shifts, the back-up call resident is used for night and weekend shifts. The resident on back-up call is expected to fill in for the absent resident. Back-up call will be assigned to all residents and placed on amion.com. Residents who are covered for by the backup resident, should make every attempt to "pay back" the covering resident at a later date. See appendix A for more detailed policy information on paying back shifts to a covering resident. We do not routinely provide daytime back up 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 Policy at http://www.msm.edu/Education/GME/index.php

Leave of Absence (without Pay)

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

Other Leave

Other leave types are explained in detail in the MSM Human Resources employment manuals. The resident is advised that in order 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.

See the full GME Resident Leave Policy at http://www.msm.edu/Education/GME/index.php.

Moonlighting

The Pediatric Residency Training Program at Morehouse School of Medicine does not allow moonlighting.

The following statements are for informational purposes only:

Moonlighting is defined as any employment for compensation that is unrelated to the MSM Community Pediatric Residency Program.

Per ACGME, 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.

MSM's malpractice insurance does not cover the resident for moonlighting work.

The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.

Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of internal moonlighting.

See the Resident Learning and Working Environment Policy, page 28.

Work Hours

Unless otherwise specified by the faculty, the work day generally begins at 7:00 am and continues until the end of the clinical work day for the rotation. Refer to the inpatient work guidelines for additional details. Ending times may vary from rotation to rotation, but in general, ending time is usually between the hours of 5:00 pm and 7:00 pm. Rotations with 12-14 hour shifts include Emergency Medicine, Intensive Care Unit, and Inpatient. Residents may work 24 + 4 hours consecutively according to ACGME requirements.

See clinical experience and education work hours at:
http://www.msm.edu/Education/GME/index.php.

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

A number of evaluation tools are used, including:

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

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

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

- Patient Care
- Medical Knowledge
- Interpersonal Skills
- Practice-based Learning
- Professionalism
- Systems-based Practice

Reviews are provided to each resident by the program director semi-annually, unless issues arise necessitating more frequent evaluation. Each resident's progress is reviewed at least twice each year by the CCC who then makes a recommendation to the program director. 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 (i.e., 360° evaluations)
        - 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
- Successfully complete a direct observation exam.
- Not have any 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 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 duty hour and procedure and patient log.

From PGY-2 to PGY-3

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

- Meet all of the requirements for PGY-1 stated above with the exception that the resident does not have to successfully complete a direct observation exam.
- Pass USMLE Step 3 by 20 months of residency.
- Have up-to-date PALS certification.

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.
- Have completed an approved scholarly activity.
- Have completed an approved Patient Safety/Quality Initiative activity.
- Complete the GME/HR/ and MSM IM exit procedures.
- Be performing as *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.

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

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

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

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

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

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

Residents will complete peer and self-evaluations at least twice per year. Residents will also complete rotation and faculty evaluations at the end of each rotation. The evaluations will not be given to the faculty members until 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 residency program, ACGME, and institutional GME.

Evaluations are accessed on New Innovations 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 New Innovations.

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 the other tools, the Clinical Competency Committee (CCC) then maps the information on the evaluations to the actual Milestones evaluation tool. The CCC member then makes recommendations to the program about each resident's progression and promotion at least twice per year. A resident's performance as it relates to the pediatric Milestones is reported to the ACGME twice per year.

See Clinical Competency Committee, page 5.

For residents who are having academic difficulties as demonstrated by evaluations, feedback, Milestones performance review of the CCC, PEC, and program director, the resident may be subject to the Adverse Academic Action and Due Process Policy as outlined in the GME policy manual at http://www.msm.edu/Education/GME/index.php.

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.

If personal problems arises, you may discuss them with the program director and/or you may contact Human Resources and ask for the Employee Assistance Program (EAP). We maintain an open door policy for any problems.

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

Conclusion

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

General Information

Pagers

The program provides pagers and holders to all residents at no charge. The pagers are alphanumeric and receive three (3) types of messages: text, numeric, and voicemail messages.

When your pager number is displayed on the pager, you have a voicemail message. To listen to or delete your messages, call your pager, press zero, and enter your access code, which is ***1234***. Press ***3*** to listen to messages and ***2*** to delete messages.

To change your greeting, dial your pager number, press zero, enter your access code (***1234***), and then press ***11*** for the greeting menu. Press ***30*** to record, ***1*** to stop recording, and ***40*** to play the message back.

Text messages are sent on the American Messaging website www.myairmail.com. You can also send text messages via e-mail by using the e-mail address as ***pager number@myairmail.com***. For example, if you want to e-mail to pager number (404) 555-1234, you would enter the e-mail address 4045551234@myairmail.com.

Malfunctioning pagers are replaced at no additional charge to the resident. The units are exchanged in the residency office. Residents will be charged a $42 fee for lost or stolen pagers.

NOTE:

- You should respond to your pages within 10 minutes.
- You are expected to wear and respond to your pagers at all times while on duty.

Dress Code

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

- Men should wear slacks, such as khakis or chinos, not jeans or jeans-style pants, with collared or mock-collared shirts. Ties are optional, unless required by the Attending physician. Shoes should be closed-toed dress or work shoes or clogs (CHOA mandate). Clean tennis shoes are acceptable when on call.
- Women should wear professional-looking attire. This may be a dress or jumper, skirt of knee-length or longer, or dress 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 when on call.
- Scrubs should not be worn outside of the hospital. Hospital scrubs are permissible at appropriate times (post call, 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.
- Change out of scrubs before continuity clinic duty.
- Personal grooming is expected at all times.

Paychecks

Paychecks are available biweekly (26 paychecks per calendar year). If you have 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, DeKalb Medical, Gwinnett Medical Center) 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 GMDE. 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.

> **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*, and *PREP the Curriculum*. 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

Residents are required to complete 50 hours of community service each academic year for a total of 150 hours by the completion of residency. Failure to do so may result in the resident not receiving a graduation certificate.

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. 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 might include documentation of poor professional conduct in his or her permanent file or dismissal from the program, if necessary. If a resident fails a rotation, this may result in his or her dismissal or other disciplinary actions by the program.

See GME Adverse Academic Decisions and Due Process Policy:
http://www.msm.edu/Education/GME/index.php.

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

The program offers two concentrations from which residents can choose: General Pediatrics or Subspecialty. Regardless of the concentration chosen, each resident shall take all required courses. In addition, over the 3-year period, there are 6 Individualized Curriculum (IC) options. There is 1 option in the first year, 2 in the second year and 3 in the third year. These IC rotation choices should support a career in general pediatrics or chosen subspecialty training. These choices must be approved by the resident's advisor.

In order 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. The resident shall make his or her preference of concentration known at the beginning of the year and during schedule planning.

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), Drs. Latasha Bogues and Maya Eady
- Inpatient/CHOA Scottish Rite (two blocks), Dr. Chevon Brooks
- Individualized Curriculum Option (one block) - Various Faculty
- Emergency Medicine—CHOA Hughes Spalding (two blocks), Dr. Bolanle Akinsola
- Term Nursery—DeKalb Medical Center (one block), Dr. Ghada Osko
- NICU—Gwinnett Medical Center (one block), Dr. Palanisamy Rajasekaran
- Developmental/Behavioral Pediatrics—various sites (one block), Dr. David O'Banion
- Adolescent Medicine—various sites (one block), Dr. Yolanda Wimberly
- Community Pediatrics (Social Determinants of Health) (2 weeks), Dr. Lynn Gardner
- Child and Adolescent Psychiatry—various sites (one week), Dr. Sara Vinson

PGY-2

- Inpatient/CHOA Scottish Rite (two blocks), Dr. Chevon Brooks
- Individualized Curriculum Options (two blocks)—Various Faculty
- Emergency Medicine—CHOA Egleston (one block), Dr. Bolanle Akinsola
- PICU—CHOA Egleston (one block), Dr. Nga Pham
- NICU—Gwinnett Medical Center (one block), Dr. Palanisamy Rajasekaran
- Cardiology—various sites (one block), Dr. Michelle Wallace
- Pulmonology—CHOA Scottish Rite (one block), Dr. LaTresa Lang
- Pediatric Surgery—CHOA Scottish Rite (one block), Dr. Alexis Smith
- Hematology/Oncology—CHOA Scottish Rite (3 weeks) and Hughes Spalding (one week), Drs. Olufolake Adisa and Beatrice Gee respectively.
- Float/Community Research—CHOA Hughes Spalding (one block), Drs. Latasha Bogues, Maya Eady, Iris Buchanan, and advisor
- Advocacy—various locations (one block), Megan Douglas JD

PGY-3

- Inpatient/CHOA Hughes Spalding (three blocks), Drs. Latasha Bogues and Maya Eady
- Float/Quality Improvement—CHOA Hughes Spalding (one block), Dr. Lori Singleton
- Emergency Medicine—CHOA Egleston (one block), Dr. Bolanle Akinsola
- PICU—CHOA Egleston (one block), Dr. Nga Pham
- Infectious Disease—CHOA Egleston (one block), Dr. Inci Yildirim
- Individualized Curriculum- (4 Blocks)- Various Faculty. Will be 3 blocks for 2019-2020.
- Gastroenterology- (1 block)- Drs. Ben Gold and Aminu Mohammed
- Board Review- (1 block)- Dr. Maya Eady

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. If a resident works less than 200 hours, he or she will be required to work additional hours to meet the 200 hour requirement. If a resident has worked greater than or equal to 200 hours, but the rotation preceptor determines that the resident's experience has been inadequate to fulfill the objectives of the rotation due to absence, the resident may be required to work additional hours, the amount which is to be determined by the program administration.

Outpatient/ED/Individualized Curriculum Options

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

Longitudinal Ambulatory Experience (LAE)

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

The only rotation where LAE is not expected is:

- Rural health
- Vacation weeks
- Sick leave if taken.

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

Dr. Latasha Bogues is the course director for LAE. See the LAE Manual for more details.

Educational Requirements

Didactics

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

Conference	Frequency	Location
Acute Care Series	Month of July	HSRB, simulcast to SR & HS
Didactic Conference	Weekly (Wednesday)	Residency Suite/SRMC/ Egleston/ Gwinnett
Evidence-based Medicine	Quarterly	Residency Suite
Grand Rounds at HS	Weekly (1st, 3rd, and 4th Thursdays)	FOB 123
Journal Club	Weekly (2nd Thursdays)	FOB 123
Grand Rounds at SRMC	Weekly (1st, 2nd, 3rd Tuesdays)	SRMC auditorium
Morning Report at HS	Monday, Tuesday & Friday	Hughes Spalding inpatient
Board Review	Ongoing	Residency Suite
Noon Report at SRMC	Tuesday, Wednesday & Friday	SRPAC conference room
Radiology Rounds at SRMC	Monthly (2nd Thursdays)	Radiology suite

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 1:00–4:00 pm (unless otherwise noted) in the residency suite, Scottish Rite, or Egleston.

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:

- Illness
- Vacation
- Residents on NICU (should watch the Simulcast at Gwinnett)

- Residents on PICU
- Residents on rural health
- Residents on ER (if a shift is scheduled during the same time)
- If attendance would cause any duty hour violation

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

Exceptions to Thursday morning activities include the following reasons:

- ER (if a shift is scheduled during the time)
- Scottish Rite (seniors will attend SRMC Grand Rounds)
- Residents on PICU
- Residents on rural health
- PGY-2 residents on NICU
- Anesthesia rotation
- Sick leave
- Vacation

Residents are required to sign in when they arrive. A monthly attendance report is prepared for the program director in order to provide feedback to residents during one-on-one requirement compliance meetings.

For missed conferences, residents should review the lecture handouts and cataloged videos available on our website.

All residents who are on rotations at SRMC (Allergy/Immunology, Pulmonology, Neurology, PMR, Hematology/Oncology/Surgery, Otolaryngology, GI) are also expected to attend Grand Rounds and noon report at SR unless it conflicts with rotation schedule.

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

Course Objectives

The goal of this course is not only to provide all residents with the ability to critically evaluate current research literature—so that they are enabled to be lifelong learners—but also to educate residents on the design of a clinical research project and to promote resident-driven clinical research.

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

Over the course of residency, residents develop and complete a project in groups of two (2), with an identified research faculty advisor. Residents prepare a written report and an oral presentation before the end of their PGY-3 year. The Float-Community Research (Float-CR) rotation is a

concentrated opportunity for residents to work on their project. Details are provided in the course curriculum.

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

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

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

Course Requirements

All residents, including interns, are required to attend and actively participate in the EBM/CRD course that is incorporated into the regular didactic schedule on a monthly basis. During these sessions, residents learn how to appropriately evaluate articles from an evidence-based medicine perspective in a journal club format. In addition, residents are required to develop a research question and complete a research project by the end of their PGY-3 year. During the process of clinical research design, residents are required to give presentations at various stages of their research project development.

Collaborative IRB Training Initiative (CITI)

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

The following modules are included in the program:

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

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

Patient Safety/Quality Improvement

Residents will receive education on patient safety and quality improvement in line with ACGME requirements:
(https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf).

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

Community Research

The community research project is a longitudinal study developed throughout the entire three (3) years of residency. Residents develop this project in groups with an identified research faculty advisor. Residents prepare a written report and an oral presentation before the end of their PGY-3 year. Details are provided in the course curriculum.

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 ITE, faculty input, and resident input.

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

Residents will take a quarterly mini-ITE. Nationally, residents perform at the levels listed below; therefore, residents should aim for these minimums on quarterly exams:

- PGY-1 ~ 60%
- PGY-2 ~ 70%
- PGY-3 ~ 75%
- First time ABP passing minimum ~ 80%.

NOTE: Failure to participate in the study plan on a regular basis as outlined will result in extra call assignments and possibly adverse action as outlined in the GME Adverse Academic Decisions and Due Process Policy.

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 psychologist.

Individual Learning Plan

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

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

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

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

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

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

In summary, ILPs include the following information:

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

Residents build a new ILP each year, designating three (3) specific areas for development, improvement, growth, and enrichment. The ILP should 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 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 or not you're learning objectives were met
- Documents competence in PBLI, one of the required ACGME competencies
- Connects all the house staff in your program together virtually 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.

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, duty hours have become more restrictive to ease resident fatigue and optimize physical readiness of performing and learning.

Not only are residents and programs obligated to follow these rules, but often, credentialing agents request competency-based evaluation of former residents who are being presented before them. Because of this, it is very important that all of the administrative duties, logging of duty 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:

- Duty hours to be logged on a daily basis in New Innovations
- Patient and Procedure Logs to be logged as outlined
- 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

*Update ILP annually

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

Be advised that clinical experience and education (formerly duty 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. The Apple iPad provided by the program can be used to facilitate all of these activities. 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, with the exception of clinical and educational work hours, which are monitored weekly. If you are found to be out of compliance (e.g., logs are more than one (1) week out of date, less than 90% completion rate for reading assignments or Grand Rounds/didactic attendance) you will be placed on an ***Administrative Shift*** to complete or review missed materials. Administrative shifts are held on either Saturday or Sunday at SRMC or HS for 12hour shifts. The resident will be given up to six (6) hours (+/-) to complete his or her administrative duties, review professionalism modules, and then admit new patient. If the resident completes the requirements earlier than the six (6) hours allotted, he or she will begin patient care duties at that time.

ACGME Pediatric Program Requirements

> **NOTE:** These are ACGME policies to which all accredited programs must adhere. Program-specific policies and procedures are noted.

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 New Innovations 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 duty hour logs weekly.

Resident Clinical Experience and Education and the Working Environment

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, inclusive of all in-house call clinical and educational activities and clinical work done from home.

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

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.

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

Logging Requirements for Clinical Experience and Education Work Hours

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

There are seven (7) types of work hours that should be entered into New Innovations:

- Shift/Rotation—All scheduled activities (including lectures) associated with rotation
- Clinic—Longitudinal Ambulatory Experience
- Conference/Workshops/Lecture—Wednesday PM didactics, morning report, Board review, noon conference and Grand Rounds only
- Back-up call in—Any time a resident is called in for a shift as back-up
- Community service
- Vacation
- Holiday/Day off

Do ***not*** log any other type of leave into New Innovations.

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

The objective of on-call activities is to provide residents with a continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those clinical work and education work hours beyond the normal work day, when residents are required to be immediately available in the assigned institution. We do not formally have “Call”. You are either working a day shift or a night shift.

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-house 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 one (1) day in seven (7) free of clinical work and education when averaged over four (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 team work assignments must occur within the context of the 80-hour and one (1) day off in seven (7) requirements. The maximum number of consecutive weeks of night team shifts, and maximum number of months of night shift rotations per year may be further specified by the Review Committee.

Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). We do not currently have official “call”. We work shifts for all rotations.

Fatigue

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, http://www.msm.edu/Education/GME/index.php.

Patient Logs

Patient logs are to be recorded into New Innovations 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.

Procedure Logs

All procedures, both real and simulated, performed and observed, will be tracked and monitored in New Innovations. 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. These logs will then be scanned into New Innovations and become a part of the resident's permanent file. In addition, each resident will enter procedure logs into New Innovations 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 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 New Innovations.

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

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 (6) 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 three (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.

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 New Innovations 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. Educational Milestones

Patient Care

The following educational Milestones refer to patient care:

- Gather essential and accurate information about the patient.
- Organize and prioritize responsibilities to provide patient care that is safe, effective, and efficient.
- Provide transfer of care that ensures seamless transitions.
- Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment.
- Develop and carry out management plans.

Medical Knowledge

The educational Milestone referring to medical knowledge is to locate, appraise, and assimilate evidence from scientific studies related to the resident's patients' health problems.

Practice-Based Learning and Improvement

The following educational Milestones refer to practice-based learning and improvement:

- Identify strengths, deficiencies, and limits in one's knowledge and expertise.
- Identify and perform appropriate learning activities to guide personal and professional development.
- Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.
- Incorporate formative evaluation feedback into daily practice.

Interpersonal and Communication Skills

The following educational Milestones refer to interpersonal and communication skills:

- Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
- Demonstrate the insight into and understanding of emotion and human response to emotion that allows one to appropriately develop and manage human interactions.

Professionalism

The following educational Milestones refer to professionalism:

- Integrate into the resident's work a sense of humanism, compassion, integrity, and respect for others based on the characteristics of an empathetic practitioner (Humanism).
- Develop a sense of duty and accountability to patients, society, and the profession (Professionalization).
- Adopt high standards of ethical behavior which includes maintaining appropriate professional boundaries (Professional Conduct).
- Foster self-awareness of one's own knowledge, skill, and emotional limitations that leads to appropriate help-seeking behaviors.
- Develop trustworthiness that makes colleagues feel secure when one is responsible for the care of patients.
- Develop the capacity to accept that ambiguity is part of clinical medicine and to recognize the need for and to utilize appropriate resources in dealing with uncertainty.

Systems-Based Practice

The educational Milestone referring to systems-based practice is to coordinate patient care within the healthcare system relevant to the resident's specialty.

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

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 New Innovations 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

Residents are asked to sign the summary form 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 the 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.

Resident Job Description

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

Support Services

Counseling Services

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

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

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

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

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

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

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

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

All residents are required to be up to date on their immunizations, must obtain current immunization certificates from the Office of Infection Control at MSM, and make the certificates available to the Office of Residency Program for their files. In addition, Occupational Safety and Health Administration training and TB testing must be up to date. Residents are given an immunization service during the annual orientation coordinated through the GME office and Grady Health System.

Hepatitis B Vaccination and Post-exposure Evaluation

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

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

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

Library Multi-Media Center

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

Computers

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

Program Concern/Complaint Policy

In the event of interpersonal conflict that is not mutually and adequately resolved, the dispute should be brought to the attention of the Attending faculty. All parties involved will be assembled to resolve any disagreement. In the event that the dispute cannot be resolved, the matter will be presented to the program director, who will then act as arbitrator.

Residents are also able to give anonymous feedback about the programs directly to GME via this link: http://www.msm.edu/Education/GME/feedbackform.php.

Residents may raise concerns in multiple ways. Residents may bring concerns directly to program directors. Residents may share concerns via their chief resident who can share directly with program directors (anonymously or not). Residents may share concerns with their class representatives who will bring the concerns anonymously to the PEC or program directors.

Program and Faculty Evaluation

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

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

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.

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 in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.

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Appendix A: Policies

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

Backup Policy

I. PURPOSE:

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

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

II. PAYING BACK A BACKUP SHIFT:

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

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

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

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

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

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

Supervision of Pediatric Residents Policy

I. PURPOSE:

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

II. SCOPE:

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

III. POLICY:

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

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

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

3.1.3. To establish a foundation for continued professional growth

3.2. 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.

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

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

3.4.1. 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.

3.4.2. 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.

3.4.3. 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.

3.4.4. 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.

3.4.5. 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.

3.4.6. 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:

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

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

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

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

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

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

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

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

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

Patient Hand-Off Policy

I. PURPOSE:

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

II. BACKGROUND:

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

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

III. SCOPE:

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

IV. POLICY:

4.1. Hand-offs must follow a standardized approach and include the opportunity to ask and respond to questions.

4.2. A hand-off is a verbal and/or written communication which provides information to facilitate continuity of care. A hand-off or "report" occurs each time any of the following situations exist for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:

4.2.1. Move to a new unit

4.2.2. Transport to or from a different area of the hospital for care (e.g., diagnostic/treatment area)

4.2.3. Assignment to a different physician temporarily (e.g., overnight/weekend coverage) or longer (e.g., rotation change)

4.2.4. Discharge to another institution or facility

4.3. Each of the situations above requires a structured hand-off with appropriate communication.

V. CHARACTERISTICS OF A HIGH QUALITY HAND-OFF:

5.1. Hand-offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.

5.2. Hand-offs include up-to-date information regarding the patient's care, treatment and services, condition, and any recent or anticipated changes.

5.3. Interruptions during hand-offs should be limited in order to minimize the possibility that information would fail to be conveyed or would be forgotten.

5.4. Hand-offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.

VI. HAND-OFF PROCEDURES:

6.1. Hand-off procedures will be conducted in conjunction with (but not be limited to) the following physician events:

6.1.1. Shift changes

6.1.2. Meal breaks

6.1.3. Rest breaks

6.1.4. Changes in on-call status

6.1.5. When contacting another physician when there is a change in the patient's condition

6.1.6. Transfer of patient from one care setting to another

6.2. Hand-off procedures and information transfer forms and guidelines for physicians are developed and implemented by each service according to the needs of that service. The hand-off forms or guidelines may be in either paper or electronic format, and must include clinical information agreed upon by physicians on that service, as being integral to the provision of safe and effective patient care for that patient population.

6.3. Each service will develop and implement a hand-off process that is in keeping with the shift or rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.

6.4. Each service hand-off process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.

6.5. Each hand-off process must be conducted discreetly and free of interruptions to ensure a proper transfer.

6.6. Each hand-off process must include at minimum a senior resident or Attending physician.

6.7. A resident physician must not leave the hospital until a face-to-face hand-off has occurred with the Attending physician or senior resident who is coming onto the service. Telephonic hand-off is not acceptable.

VII. STRUCTURED HAND-OFF:

7.1. Within each service, hand-offs will be conducted in a consistent manner, using a standardized hand-off form or structured guideline.

7.2. Hand-offs, whether verbal or written, should include, at minimum, specific information listed below (as applicable):

7.2.1. Patient name, location, age/date of birth

7.2.2. Patient diagnosis/problems, impression

7.2.3. Important prior medical history

7.2.4. DNR status and advance directives

7.2.5. Identified allergies

7.2.6. Medications, fluids, diet

7.2.7. Important current labs, vitals, cultures

7.2.8. Past and planned significant procedures

7.2.9. Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)

7.2.10. Plan for the next 24+ hours

7.2.11. Pending tests and studies which require follow up

7.2.12. Important items planned between now and discharge **VIII. FORMATTED PROCEDURE:**

8.1. A receiving physician shall:

8.1.1. Thoroughly review a written hand-off form or receive a verbal hand-off and take notes.

8.1.2. Resolve any unclear issues with the transferring physician prior to acceptance of a patient.

8.2. In addition, the SBAR can be used to deliver or receive the information:

8.2.1. **S**ituation: What is the problem?

8.2.2. **B**ackground: Pertinent information to problem at hand

8.2.3. **A**ssessment: Clinical staff's assessment

8.2.4. **R**ecommendation: What do you want done and/or think needs to be done?

8.3. The following page shows a suggested format for programs to document information with a sign-out process.

A Sample Hand-Off Format

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

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

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

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

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

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

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

_____ _____

Receiving Resident's Name and Signature Date/Time

_____ _____

Departing Resident's Name and Signature Date/Time

Hand-Off Policy Checklist for Residents

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

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

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

Social Media Policy

I. PURPOSE:

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

II. SCOPE:

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

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

2.3. The tem “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 the 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 post graduate 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 demonstrate 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 maintain a professional appearance at all times. 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, duty hours logging, etc, in a timely manner.

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