Family Medicine Residency Program Policy Manual

Academic Year 2024-25

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Preface—Our Vision and Mission

MSM Vision

Leading the creation and advancement of health equity to achieve health justice by:

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

MSM Mission

We exist to:

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

"We are on a mission"

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

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

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

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

Graduate Medical Education (GME)

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

The five MSM residency education goals and objectives for residents are to:

- Obtain the clinical knowledge, competencies, and skills required for the effective treatment and management of patients
- Prepare for licensure and specialty certification
- Obtain the skills to become fully active participants within the United States healthcare system
- Provide teaching and mentoring of MSM medical students and residents
- Support in a direct way the school's mission of providing service and support to disadvantaged communities

Graduate Medical Education Institutional Aim

GME at MSM aims to train focused and well-balanced practitioners who will broaden the diversity in healthcare and scientific health workforce in order to eliminate health disparities and to advance health equity in urban and rural populations in Georgia, the nation, and throughout the world.

Graduate Medical Education Institutional Diversity Statement

GME at MSM recruits trainees from diverse backgrounds and perspectives and trains them to make a positive impact on healthcare while offering culturally competent and compassionate care. We strive to develop leaders who provide this culturally sensitive care to an inclusive patient population and who will develop innovative approaches to widen the pipeline for quality healthcare and promote the advancement of health equity.

Graduate Medical Education Institutional Wellness Statement

MSM creates, nurtures, and sustains a diverse and inclusive culture and work environment in which all employees are encouraged to bring their best and authentic selves to work and who are empowered to do so in support of creating and advancing health equity.

The Scope of This Manual

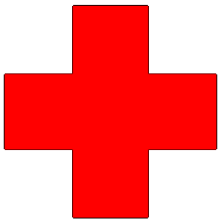
The Family Medicine Residency Program (FMRP) Policy Manual is an overview of the basic FMRP policies, practices, and procedures. These policies are consistent with the Morehouse School of Medicine Graduate Medical Education (GME) Policies, which are in accordance with ACGME Institutional and Common Program Requirements. The Manual is also consistent with the ACGME Specialty-Specific Requirements for Family Medicine and with Morehouse School of Medicine HR Policies.

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

The MSM FMRP will attempt to keep the FMRP Policy Manual and its online version current, but there may be instances when a policy will change before this material can be revised online. Therefore, you are strongly urged to contact the FMRP administrative office to ensure that you have the latest version of program policies.

Policy updates will be communicated to Program residents and faculty via email and will be posted in the residency management system. A copy of the FMRP Policy Manual can be downloaded from the Family Medicine Residency Program page of the MSM website.

This Policy Manual supersedes all prior FMRP Policy Manuals and policies. The effective date of each policy indicates the current policy and practice in effect for the Program.



Message from the Director

Greetings, and welcome to the 2024-2025 academic year!

Initially accredited in 1981, the Family Medicine Residency Program is Morehouse School of Medicine's first residency program. While we are proud of our continued accreditation status and 100% Board pass rate, our residents remain our shining stars, and the patients, families, and communities we serve remain our reason to exist and to strive for excellence.

As a program, we are committed to training residents to become family physicians who provide competent, high-quality care to individuals and families to positively impact the health of communities, with an emphasis on African American and other historically underserved communities. Through training in our program, residents build skills in providing excellent, evidence-based preventive, acute, and chronic care, including during pregnancy. The exceptional care that is modeled for and provided by our residents occurs in a variety of settings, across all age groups, and in traditional in-person and telemedicine formats. In keeping with the Morehouse School of Medicine vision, we further commit to developing in our residents the knowledge and skills necessary to provide this care through a lens aimed at eliminating health inequities. Finally, we are committed to doing all of this while supporting our residents' well-being now and in the future.

As we begin this year, we are excited about the growth and innovation that we will continue to cultivate as our residents become the future leaders in our profession. Whether their contributions are through education, scholarship, advocacy, clinical service, or community engagement, we are proud that their work will help to improve the health of the patients and communities we serve.

Life, Strength, and Health,

Riba C. Kelsey, MD, FAAFP
Family Medicine Residency Program Director
Assistant Dean of Graduate Medical Education

General Information for Faculty Members

The Graduate Medical Education Committee (GMEC) highly values the contributions of our faculty members. The GMEC agrees with, supports, and adheres to the ACGME requirements and standards as related to faculty members as follows (reference: ACGME Common Program Requirements July 1, 2024):

> Faculty members are a foundational element of graduate medical education—faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.
>
> Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents and fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the wellbeing of the residents, fellows and themselves.

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

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

Responsibilities of Faculty Members

Faculty members must:

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

Faculty Qualifications

Faculty members must:

- Have appropriate qualifications in their field and hold appropriate institutional appointments;
- Have current certification by the American Board of the specific specialty or the American Osteopathic Board of the specific specialty, or possess qualifications judged acceptable to the Review Committee;
- FM physician faculty members who are not certified by the ABFM or AOBFP must demonstrate ongoing learning activities equivalent to the ABFM or AOBFP Maintenance of Certification process, including demonstration of professionalism, cognitive expertise, self-assessment and life-long learning, and assessment of performance in practice.
- Physician faculty members from other specialties must have current certification in their specialties by a member board of Medical Specialties, or an American Osteopathic Association certifying board, or possess qualifications acceptable to the Review Committee

Core faculty members must:

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

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

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General Information for Residents

General Information for Residents and Fellows

Access to Information

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

Compensation

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

Eligibility for Specialty Board Examination

Each resident should become familiar with the requirements of the American Board of Family Medicine (ABFM) as listed on the ABFM website, including the training requirements (Training Requirements - American Board of Family Medicine (theabfm.org) and 50 Family Medicine certification points from ABFM self-assessments and performance improvement activities, including at least one Knowledge Self-Assessment (KSA) and at least one Performance Improvement (PI) activity with the resident's patient population. The Program Director, Associate Program Director, and Program Manager can further assist in resident understanding of this information.

Email Requirement

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

Exposures to Blood, Body Fluids, and Biohazardous Materials

Workers' Compensation Insurance provides compensation and/or medical care for workers who are injured or become ill as a direct result of their job. Coverage begins on the resident's first day of employment.

In addition to contacting required person(s) at the hospital or site, residents must also contact Ms. Marla Thompson, MSM Human Resources Office of Disability Services, at (404) 752-1871; mthompson@msm.edu for all work-related injuries and/or exposures, including blood, body fluids, needle sticks, and biohazardous exposures.

Prior to evaluation and/or treatment, residents MUST be assigned a Workers' Compensation number and choose from a panel of designated healthcare providers. For additional information, refer to MSM's Workers' Compensation Policy (HR 6.03).

Fringe Benefits and Resources for Residents and Fellows

- **Benefits**: In addition to salary, Morehouse School of Medicine offers health insurance benefits to residents and their eligible dependents.
    - Residents are also provided disability insurance benefits, confidential counseling and psychological services, vacation, parental, sick or other leave, with coverage starting the first recognized day of the training program.
    - These offerings are uniform for all residents and administered by MSM Human Resources in accordance with the vendor programs and/or policies in force at the time of this agreement.
    - Detailed information on fringe benefits for residents can be provided by the MSM Human Resources Department at (404) 752-1607; benefits@msm.edu.
    - Residents and fellows can also log in to MSM connect at: https://msmconnect.msm.edu/group/mycampus/89.
- **Cigna Employee Assistance Program (EAP), CARE 24/7/365**: This benefit is available for residents as a self-referral or for family assistance.
    - Residents are briefed on these programs by the Human Resources Department during in-coming orientation.
    - Residents are briefed annually on the Drug Awareness Program, resident impairment issues, and family counseling.
    - More information regarding these programs is available in the Human Resources Department at (404) 752-1600, or by calling Cigna EAP directly at (877) 622- 4327, and online at myCigna - Get Access to Your Personal Health Information. Upon logging in with your username and password, select Employee Assistance Program (EAP) from the "Coverage" menu.
- **Equipment**: iPhones, iPads, and/or laptops must be returned by residents who do not complete their program.
- **Laboratory (White) Coats**: Clinical laboratory coats are provided to residents free of charge and are subject to the requirements of MSM and the rules of the affiliates.
- **Leave**: As addressed in the resident/fellow leave policy, residents and fellows are cautioned that to fulfill the program requirements and that of the specialty certification board, it may be necessary for the resident to spend additional time in the program to make up for time lost when utilizing the various leave options. See section "Resident/Fellow Leave Policy" for more information on ACGME and ABFM requirements on leave.
- **Resident/Fellow Vacation Leave**: Residents are allotted 15 days compensated leave per academic year (from July through June).
    - Vacation leave is not accrued from year to year.
    - Each residency program is responsible for the administration of residents' leave to include scheduling, tracking, approving, and reporting leave to the department, GME, and the MSM Human Resources Department.
    - Vacation blocks shall be designed within the structure of the residency program schedules.

- **Resident/Fellow Sick Leave**: Residents are allotted up to 20 days compensated sick leave per academic year (from July through June)
    - Sick leave is not accrued from year to year.
    - Each residency program is responsible for the administration of residents' leave to include scheduling, tracking, approving, and reporting leave to the department, GME, and the MSM Human Resources Department.
    - One time during the course of a resident/fellow's training**,** trainees may be allotted six (6) weeks of approved medical, parental, and caregiver leave of absence for qualifying reasons that are consistent with applicable laws. This leave is available to the resident once at any time during an ACGME- accredited program, starting the day the resident/fellow is required to report.
        - When this six (6) weeks of approved compensated medical, parental, or caregiver leave is used, the resident/fellow will be provided with one (1) additional week of paid time off reserved for use outside of the six weeks for illness, injury, and medical appointments for the trainee or for the care of an immediate family member.
        - Documentation from a treating clinician indicating the duration of medically indicated leave needed must be provided to the Office of Disability Services in order for these six weeks of compensated leave to be approved.
        - Sick and vacation leave not used within the current academic year at the time that the six weeks of approved medical, parental, or caregiver leave is taken will be used towards the six weeks.
        - When these two (2) leave categories and the balance of the six weeks plus the one week reserved for illness, injury, and medical appointments for the trainee or for the care of an immediate family member are exhausted, any additional leave will be uncompensated (leave without pay)
        - The resident is required to meet with the Program Director for guidance on how leave will impact duration in the program and any potential need to extend training.

- **Family and Medical Leave Act (FMLA)**: Program requirements and specifications of the program specialty board apply to the time required to make up absences. For guidance and questions about FMLA, all residents and fellows can contact Marla

Thompson in the Human Resources Department (HRD) Office of Disability Services and Leave Management at (404) 752-1871 or ods@msm.edu.

- **Leave of Absence Without Pay (LWOP)**: When possible, requests for leaves of absence without pay shall be submitted by residents in writing to the residency program director for disposition far in advance of any planned leave.
    - All requests shall identify the reason for the leave and its duration.
    - Residents must discuss the impact of the leave on a possible delay in program completion with the program director.
    - The MSM Human Resources Department shall determine the feasibility and all applicable criteria prior to a resident or fellow being granted LWOP and shall advise both the resident and the corresponding residency/fellowship program regarding details and procedures.
- **Other Leave Types**: All leave types are explained in detail in the Morehouse School of Medicine Human Resource Policy Manual, available by contacting Marla Thompson at (404) 752-1871.
- **Library Services and Multimedia Services**: These services are available at Morehouse School of Medicine to include electronic media search access.
    - Libraries are available at inpatient facilities but vary in the content and services available.
    - Ambulatory care facilities have limited libraries. All residents and fellows have online search access capability through the MSM network.
- **Nepotism Policy** (See MSM Human Resources Policy 2.04): MSM permits the employment and/or enrollment for academic purposes of qualified relatives of employees as long as such employment or academic pursuit does not, in the opinion of the school, create actual conflicts of interest. The MSM Human Resources Nepotism policy states:
    - No direct reporting or supervisor-to-subordinate relationship may exist between individuals who are related by blood or marriage, or who reside in the same household.
    - For academic purposes, no direct teaching or instructor-to-resident/fellow or instructor-to-student relationship can exist. No employee is permitted to work within “the chain of command” when one relative’s work responsibilities, salary, hours, career progress, benefits, or other terms and conditions of employment could be influenced by the other relative.
    - Each employee, student, resident, or fellow has a responsibility to keep his or her supervisor, the appropriate associate dean or residency/fellowship program director and Human Resources Department informed of changes relevant to this policy.
- **Office of Disability Services**: For information regarding disabilities, contact Marla Thompson at (404) 756-1871 or email to ods@msm.edu.
- **Parking Facilities**: Parking is available at each clinical affiliate and may require payment of a reasonable fee.

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Family Medicine Residency Program

History

Morehouse School of Medicine (MSM) was founded in September 1975 as the Medical Education Program at Morehouse College, with Dr. Hugh Gloster as President and Dr. Louis Sullivan as Dean of the medical school. Morehouse School of Medicine became an independent institution in 1981.

The Department of Family Medicine, MSM's first clinical department, was established in July 1979 and started the school's first residency program in 1981. The department has been an integral part of the development of the school and is a critical link in the school's educational programs. The residency program serves a significant role in Georgia as a producer of family physicians who practice in many underserved communities with approximately 63% of its graduates remaining in the State of Georgia after training. The program is accredited by the Accreditation Council for Graduate Medical Education (ACGME).

The program offers training in all aspects of family medicine, including but not limited to office procedures; community advocacy; acute, chronic, and preventive medicine; and health care of women, men, and children. In the program's 43-year history, the Family Medicine Program has successfully recruited well-qualified graduates of accredited medical schools. To date, the program has graduated 189 physicians, many of whom have received recognition at the state and national levels for their outstanding contributions to clinical, academic, and social medicine.

The MSM Family Medicine Residency Program is a university-based program in a community setting that is affiliated with Grady Memorial Hospital, Atlanta Veterans Affairs Hospital, and Children's Healthcare of Atlanta–Hughes Spalding Hospital.

The Morehouse School of Medicine Family Medicine Practice (FMP), the Morehouse Healthcare Comprehensive Family Healthcare Center (CFHC), is a model office that provides a setting that fosters educational excellence, provides research opportunities, and exposes residents to ambulatory office operations. The faculty is a group of highly trained, dedicated, and enthusiastic teachers who are effective in motivating the program's learners. They are involved in regular scholarly activities and are committed to maintaining excellence in education and service. Residents in the program also obtain education from committed physicians in the private and public sectors for outpatient rotations.

MSM Family Medicine Residency Program Mission

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

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

Training Goals

The MSM Family Medicine Residency Program goals are to:

- Provide the Family Medicine resident with the knowledge, skills, and attitudes necessary to manage medical patients with simple and complex problems competently.
- Provide a foundation which can be expanded and refined during medical subspecialty rotations.
- Provide the resident with knowledge about how family dynamics and behavioral medicine principles apply to the ambulatory, hospitalized, and home-bound medical patient.
- Teach the resident to utilize the concept of the healthcare team in which the physician is the coordinator of the health team's efforts and utilizes the support and input from physician consultants and personnel in nursing, social work, nutrition, administration, chaplain staff, etc., to optimize the care of the patient.
- Teach the resident to recognize the limits of one's own knowledge and skills and institute timely and appropriate consultation.
- Teach the resident to exhibit patterns of inter-professional collaboration and cooperation to enhance patient care.
- Teach the resident to recognize that hospital care is merely one phase on a continuum of longitudinal and continuous medical care.
- Train family physicians to provide comprehensive, continuing care to all of their patients.
- Stimulate the critical thinking skills and systems-based practice acumen to allow the resident to make the most efficient and effective use of his/her time, personnel, and facilities to provide optimal care to patients.
- Implement preventive services and consistently educate patients about their health.
- Train Family Medicine residents in the six (6) core competencies, as identified by the ACGME:
    - Patient care and Procedure Skills
    - Medical Knowledge
    - Practice-based Learning and Improvement
    - Interpersonal and Communication Skills
    - Professionalism
    - Systems-based Practice

Program Aims

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

Program Aim 1
Train residents to be politically and socially aware physicians to match the needs of underserved populations.

Program Aim 2
Provide well-rounded training to equip residents with strong skills to practice across the full scope of Family Medicine and foster deep skill development in specific areas of interest to align with individual goals.

Program Aim 3
Equip residents with the skills necessary to conduct clinical research and other scholarly activity that can expand the body of knowledge and improve health among underserved, under-represented, marginalized, or disparate communities, with a focus on African American and other communities of color.

Program Aim 4
Create pipelines to attract residents to stay in the State of Georgia with a goal of at least 60% of our program graduates remaining in the area.

MSM Diversity Statement

MSM is committed to:

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

Residency Setting

Administrative Office
50 Hurt Plaza SE, Suite 1500
Atlanta, GA 30303
(404) 756-1256
http://www.msm.edu/Education/GME/FMResidencyProgram/index.php.

FMP (Continuity Practice)
Morehouse Healthcare
Comprehensive Family Healthcare Center
455 Lee Street SW
Atlanta, GA 30310

Hospital Affiliates
Grady Memorial Hospital (GMH)
Children's Healthcare of Atlanta (CHOA) Hughes Spalding Hospital
Atlanta Veterans Affairs (VA) Hospital

In addition, MSM has a range of private and public-sector partners for outpatient rotations.

Administrative Structure

Program Director–Dr. Riba C. Kelsey
The Program Director:

- Provides the overall leadership, development, and implementation of the residency program. The program director ensures that the program is compliant with all Accreditation Council for Graduate Medical Education (ACGME) requirements for a family medicine residency training program.
- Is responsible for residents' progression and graduation from the program, and for advising each resident of his or her progress, mainly via semi-annual resident evaluations.

- Tracks and reviews all resident evaluations, procedure and patient logs, and work hours to ensure overall resident and program compliance.

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 family medicine;
- Updating and modifying educational goals and curricula;
- Overseeing and approving topics for lectures and instruction as deemed fit by the program and the emerging guidelines of the Residency Review Committee (RC) and the American Board of Family Medicine;
- Resident Recruitment and selection;
- Overseeing the program operations;
- Directly supervising the program manager, the core family medicine faculty, and staff involved with the residency program implementation;
- Working closely with the department chairperson and other officials at MSM to ensure that the program reflects the mission of the institution and the department;
- Developing and modifying the Family Medicine residency curriculum;
- Overseeing the resident selection and promotion process; and
- Conducting semi-annual evaluations of residents.

<u>Associate Program Director—Dr. Omofolarin Fasuyi</u>

The Associate Program Director:

- Assists the program director in developing and implementing the program while completing specific assigned tasks. These tasks include:
    - Assisting with developing and modifying the Family Medicine residency curriculum;
    - Conducting semi-annual evaluations with residents;
    - Resident recruitment;
    - Advising resident remediation; and
    - Assisting with didactic teaching and conference schedules.
- Represents the program at official meetings within the institution and outside, as needed, in the absence of the program director.
- Assists with the resident selection process.

<u>Program Manager—Ms. Rita Akiyode</u>

The Program Manager:

- Manages the daily operational activities of the residency program and interacts with personnel at affiliated institutions, as needed.
- Ensures that the residents complete all paperwork required by the ACGME, State Licensing Board, GME office, etc.
- Tracks residents' completion of evaluation and obtain completed evaluations.
- Ensures that residents' master files, evaluations, immunization certificates, visa documents, United States Medical Licensing Examination (USMLE) scores, and procedure and patient logs are kept up to date.
- Is responsible for completing and filing all required paperwork and communications from internal and external entities (e.g., MSM Graduate Medical Education [GME] office, American Board of Family Medicine, American Academy of Family Physicians).
- Coordinates the resident recruitment activities in conjunction with the program director.

Program Assistant- Ms. Niya Loveless

The Program Assistant:

- Provides administrative support to the program director, associate program director, and program manager.
- Provides professional and prompt completion of data entry, expense requests, travel support, program documentation, and meeting logistics, and coordinates didactic scheduling.

Chief Residents- Dr. Ashley Absolu and Dr. Karline Saintus

Chief Residents:

- Support resident teaching activities such as Grand Rounds, Morning Report, and weekly didactics.
- Develop and modify resident schedules, review vacation requests for feasibility, and arrange back-up coverage for unplanned absences with oversight from the Program Director.
- Serve as resident liaisons at Departmental faculty meetings.
- Are elected by the residents during the PGY-2 year and approved by the faculty. (Must be in his or her second year of training and in good standing for the most recent 18 months to be eligible for chief election)

Resident Advisors

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

Residents are expected to initiate and maintain contact with their advisors throughout the duration of their residency training. Advisors are expected to document meetings with their resident advisees. Topics discussed should be noted in the residency management system for inclusion in the resident's file. Residents should meet with their resident advisors at least once each quarter.

The resident advisor should:

- Assist the resident with adapting a study plan for the three (3) years of residency.
- Review the resident's Individual Success Plan (formerly Individual Education Plan), give feedback on adjustments, and monitor the resident's progress on goals.
- Discuss the resident's performance on rotations, review his or her rotation evaluations, and provide strategies for improving weaknesses.
- Review the resident's in-training exams and guide the resident's study plan.
- Represent the resident in cases of due process in the event of disciplinary action.
- Provide information about career paths.
- Monitor the progress of the advisee's quality improvement and research projects.

Program Evaluation Committee

The Family Medicine Residency Program Evaluation Committee (PEC) is the advisory group to the program administration. At all times, the procedures and policies of the PEC will comply with those of the Graduate Medical Education Committee as outlined in the Graduate Medical Education Policy and Procedure Manual and with those stipulated by the Accreditation Council for Graduate Medical Education (ACGME) as outlined in the Program Evaluation and Improvement section of the ACGME Program Requirements for Graduate Medical Education in

Family Medicine. The PEC is comprised of core members of the Department of Family Medicine as appointed by the program director and resident member representing each PGY level.

The PEC meets at least quarterly 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 along with ITE and graduate performance data;
- Developing action plans to address areas of non-compliance with ACGME standards and monitor progress to ensure resolution; and
- Overseeing and participating actively in all aspects of program quality improvement activities.

Through the PEC, the Program tracks residents' performance, faculty performance, graduate performance, and program quality. All PEC meetings are documented with agendas and meeting minutes.

The PEC is described in greater detail in the Program Evaluation Committee Policy.

Clinical Competency Committee (CCC)

Residents' evaluation and progression are 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 is charged with:

- Reviewing all resident evaluations semi-annually;
- Preparing and recommending Milestone assessments of each resident to the program director semi-annually for reporting to the ACGME;
- Advising the program director regarding resident progress, including promotion, remediation, and dismissal.

The outcomes of the CCC meetings, upon approval by the program director, shall be communicated to each resident and his/her faculty advisor.

The CCC is described in greater detail in the Program's Clinical Competency Committee Policy.

Program Faculty and Clinical Staff

Clinical Faculty		
Nicole Ash-Mapp, MD Family Medicine nashmapp@msm.edu	Afolake Mobolaji, MD Family Medicine amobolaji@msm.edu	Walkitria Smith, MD Family Medicine wasmith@msm.edu
Kitty Carter-Wicker, MD Family Medicine kcwicker@msm.edu	Alexandria Poitier, MD Family Medicine apoitier@msm.edu	Omofolarin Fasuyi, MD Family Medicine ofasuyi@msm.edu
Macy McNair, MD Family Medicine mmcnair@msm.edu	Amber Boyd, MD Internal Medicine aboyd@msm.edu	Marissa Lapedis, MD Family Medicine mlapedis@msm.edu
Riba Kelsey, MD, MSCR Family Medicine rkelsey@msm.edu	Ashley McCann, MD Family Medicine amccann@msm.edu	Dominic Mack, MD, MBA Family Medicine dmack@msm.edu
Yuan Xiang Meng, MD, PhD, MSCR Family Medicine ymeng@msm.edu	D'Amico Johnson Family Medicine dcjohnson@msm.edu	Folashade Omole, MD Family Medicine fomole@msm.edu
Lawrence Powell, MD Family Medicine lpowell@msm.edu	David Daniels, MD Family Medicine ddaniels@msm.edu	Oluwole Akintayo, MD Family Medicine oakintayo@msm.edu
Robert Williams, MD Obstetrics and Gynecology rwilliams@msm.edu	Christopher Ervin, MD cervin@msm.edu	Shawkut Ali, MD Family Medicine saali@msm.edu
Altelisha Taylor, MD Family Medicine/Sports Medicine alttaylor@msm.edu		

Non-Physician Faculty		
Marietta Collins, PhD Mental and Behavioral Health mcollins@msm.edu		

Clinical Staff—Front Office		
Latoyia Douglas Medical Records, Patient Service Representative	Jaquayla Johnson Front Desk, Patient Service Representative	Nico Smith Front Desk, Patient Service Representative

	Linda Robinson Supervisor, Front Office	Derrick Sherman HIM Manager

Clinical Staff—Referral Coordinators		

Clinical Staff—Back Office		
Barbara Cobb, LPN	Kimberly White, CMA	Tiffany Copeland, LPN
Shanikka Springer, CMA	Marjorie Gordy, CMA	Marva McGlashan, RN Nurse Manager
Coren Curry, CMA	Bernice Cook, LPN	

Clinical Staff—Support		
Teyunna Stephens, CMA Care Coordinator, Clinical IT	Alysia Coleman, CMA Care Coordinator, CCMA	Tiffany Horn, RN, BSN, MSL, LSSYB Quality Nurse Manager

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Program Elements

Morning Report

Morning Report occurs on Fridays at 8:00 a.m. on Zoom. Morning Report is led by the residents on the inpatient team. Residents on the Family Medicine Wards rotation, residents on the CFHC rotation, and all residents assigned to Friday morning continuity clinic in the CFHC are required to attend. All other residents are encouraged to attend, rotation schedules permitting.

Conferences/Didactic Sessions

In accordance with ACGME Common and Specialty Specific Program Requirement IV.A.4.a), the program holds regularly scheduled didactic sessions on Wednesdays from 12:30 p.m. to 5:00 p.m. Didactic/workshop types that occur during Wednesday afternoon educational sessions include but are not limited to the following:

- Faculty or community physician-led didactics on core curricular topics
- Research Seminar
- Journal Club presentations
- Inpatient case presentations
- "What's New in Family Medicine" presentations
- ITE and Board Review sessions
- Procedure skills workshops

Protected time free of clinical activity is allotted for this academic half-day, which is required for all residents except in certain pre-approved circumstances or when on scheduled vacation, sick leave, participating in Continuing Medical Education, participating in an out-of-town rotation, or rotating on the following rotations:

- Internal Medicine (Grady Wards)
- Intensive Care Unit (ICU)
- Peds ER (exempt from didactics only when scheduled to work a Wednesday shift)
- Pediatric Wards
- Emergency Medicine if scheduled for a shift that night

Only through attendance at didactic sessions can maximal education be realized.
Therefore, 100% attendance is expected. A minimum of 80% attendance for these sessions is required. Didactic attendance is recorded for each session and made available in MedHub.

While on rotations that exempt the resident from attending the Family Medicine Wednesday conferences, the resident is expected to attend the regularly scheduled educational conferences held by the department through which the resident is rotating.

Clinical Rotations

ACGME-required and carefully selected program-required clinical rotations are essential to the development of the clinical and interpersonal skills necessary for future independent practice. The required clinical rotation experiences are described in section IV.C.3.d) – IV.C.3.u).(3) of the ACGME FM Program Requirements for Graduate Medical Education in Family Medicine.

All rotations have competency-based goals and objectives, which are accessible to residents and faculty electronically through the residency management suite.

See the Rotation Contact Information table for rotation days, continuity clinic days, and telephone numbers and/or email addresses for the designated contact person(s) for each rotation.

Continuity Clinic

Central to the training of a family physician is the establishment of a panel of continuity patients in the ambulatory setting. As such, each resident sees patients in our established Family Medicine Practice (FMP) site, the Morehouse Healthcare Comprehensive Family Healthcare Center, throughout all three program years. Consistent with the ACGME FMP requirements, each resident is responsible for the care of a panel of patients as part of care teams. Consistent with current AGME FMP requirements, residents will spend at least 1,000 hours in the continuity clinic caring for their personal panels of patients, which are balanced by gender and age and consisting of at least 10 percent of patients younger than the age of 18 and at least 10 percent of patients older than the age of 65. Required patient-sided and resident-sided continuity, panel management, and population health quality tracking are detailed in section IV.C.3.c) and IV.C.3.d) of the ACGME Program Requirements for Graduate Medical Education in Family Medicine.

Scholarly Activity

The program provides a longitudinal research curriculum that prepares residents to produce quality scholarly activity. In accordance with IV.D.3.b of the ACGME Family Medicine Program Requirements (effective 7/1/2023), residents are required to complete two (2) scholarly activities, one (1) of which must be a quality improvement (QI) project. A group QI project is completed during the PGY-1 year as part of the practice management rotation. The second project is a larger project started during the PGY-1 year and completed by the PGY-3 year under the direction of the departmental research director and the resident's faculty research mentor.

Aside from meeting these requirements, the program encourages scholarly activity in the form of journal publications, letters to the editor, case reports, conference presentations, non-required PSQI projects, and other scholarly activities. Residents are encouraged to disseminate their scholarly activity through publication and/or presentations in local, regional, and/or national settings. This activity fosters an environment of inquiry and establishes the habit of contributing to the body of knowledge in our discipline.

Benefits

Continuing Medical Education (CME)/Book Allowance

Each year, all PGY-2 and PGY-3 residents receive CME funds for educational purposes. Due to a vigorous schedule, first year residents are not granted continued education conference time. However, first year residents receive a laptop computer purchased by the residency program. CME funds are allocated according to the following schedule:

- PGY-1—Laptop provided by the program
- PGY-2—$750
- PGY-3—AAFP Board Review Course or the balance of $750 less the shared cost of the virtual AAFP Board Review course

All CME requests must be submitted in writing by April 15th of the PGY-2 or PGY-3 year. Requests to attend a CME activity, including the board review course, must be submitted at least three (3) months prior to the course to allow adequate time for coverage and travel arrangements. Examples of items that can be purchased with CME funds are:

- Medical books related to family medicine
- Stethoscopes
- Medical software for handheld devices
- CME conferences.
- Question bank subscriptions
- USMLE/NBOME Step 3 Exam registration

CME funds cannot be used for clothing, computers, computer equipment, medical license fees, or personal device accessories.

The residency office should be consulted prior to purchasing items for reimbursement to confirm eligibility for CME funds. All CME funds must be used in the current fiscal year, no later than April 15th. CME funds do not roll over to the next fiscal/academic year.

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

Professional Organizations

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

Leave

An overview of resident leave is provided in the General Information for Residents of this document and leave processes and procedures are described in detail in the Family Medicine Residency Leave Policy. All forms of leave available to MSM employees are further detailed in the MSM HR Policies.

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Rotation Contact Information

PGY-1 Resident Rotations

Rotation	**Rotation Days**	**Continuity Clinic**	**Contacts**
FM Wards	Daily	Tuesday p.m. or Thursday p.m.	FM Inpatient Attendings Oluwole Akintayo oakintayo@msm.edu D'Amico Johnson dcjohnson@msm.edu
IM Wards Grady	Week 1-3: Daily per IM Wards Schedule Week 4: Mon and Tuesday (eligible for Sat/Sun shift(s)) FM Didactics: week 4 only	Thursday am/pm and Friday am/pm of week 4	Nicolas Bakinde, MD, Site Director nbakinde@msm.edu *IM Chief Residents*
ICU Grady	As scheduled FM Didactics: week 4 only	Designated (Fixed) CC Day	Nicolas Bakinde, MD, Site Director nbakinde@msm.edu *IM Chief Residents*
Surgery Grady	Daily except CC Day	Designated (Fixed) CC Day	Shaneeta Johnson MD, Site Director cclark@msm.edu *Program Managers* Dollmesha Greene DGreene@msm.edu Montreka Dansby mdansby@msm.edu *Surgery Chief Residents*
OB (L&D) Grady	Daily except CC Day and off day OB Chiefs to assign day and night schedules Attend FM didactics Wed pm	Designated (Fixed) CC Day No CC during night weeks	Kiwita Philips, MD, Site Director kphillips@msm.edu *OB Chief Resident* Contact Program Manager Ms. Kelli Hooper khooper@msm.edu

Rotation	**Rotation Days**	**Continuity Clinic**	**Contacts**
Gyn/Women's Health	Tuesday: AM- Didactics with OB residents at Grady PM- Ambulatory clinic at MHC with Dr. Simmons Wednesday: AM Ambulatory clinic with Dr. Ware Thursday: AM & PM- Ambulatory clinic at MHC with Dr. Simmons Friday Simmons MHC LS	Designated CC Day or as scheduled	Barbara Simmons, MD bjsimmons@msm.edu
Neuro VA, Atlanta VA Medical Center	Monday, Tuesday, Thursday, Friday	Wednesday a.m.	Swapan Dholakia, MD, Site Director Swapan.Dholakia@va.gov Charlyn Thomas, Neurology Rotation Coordinator (404) 321-6111, ext. 5142 Charlyn.Thomas@va.gov
ECC Grady	As scheduled	Wednesday a.m.	Rachel Koval, MD, Site Director rachel.koval@emory.edu Simone Pitts, Program Coordinator lynn.simone.pitts@emory.edu
Peds Wards Hughes Spalding*	Daily except CC Day; NO FM didactics except week 4	Designated CC day (If CC day is Thursday, another day will be substituted for regular CC day)	Chevon Brooks,MD, Site Director cbrooks@msm.edu *Peds Chief* pedschief@msm.edu
Peds ER Hughes Spalding	As scheduled No FM didactics when on a scheduled shift	Wk 1-3 Designated CC Day Wk 4: Wednesday am	Naghma Khan, MD, Site Director nkhan01@emory.edu

Rotation	**Rotation Days**	**Continuity Clinic**	**Contacts**
CFHC	All days	All days	Riba C. Kelsey, MD rkelsey@msm.edu (404) 756-1257 Other: FM Chief Resident
Nursery	Daily	Wednesday a.m.	Letitia Mobley, MD (404) 310-9674 (cell)

PGY-2 Resident Rotations

Rotation	**Rotation Days**	**Continuity Clinic**	**Contacts**
Ambulatory Pediatrics	Monday, Wednesday a.m., Friday	Designated CC or as scheduled	Torey Harden, MD, Rotation Director cosmicpediatrics@gmail.com
OB (L&D) Grady	Daily except CC Day and off day OB Chiefs to assign day and night schedules Attend FM didactics Wed pm	Designated (Fixed) CC Day No CC during night weeks	Kiwita Philips, MD, Site Director kphillips@msm.edu *OB Chief Resident* Contact Program Manager Ms. Kelli Hooper khooper@msm.edu
CFHC	All Days	All Days	Riba Kelsey, MD (404) 771-0250 rkelsey@msm.edu Other: FM Chief Resident
CBOC	Three full days/wk	Wed am and one Designated CC day	Kitefre Oboho, MD, Site Director (678) 232-6619 kitefre.oboho@va.gov VA Fort McPherson 1701 Hardee Ave., SW Atlanta, GA 30310
IM Wards, Grady	Daily	Thursday am/pm and Friday am/pm of week 4	Nicolas Bakinde, MD, Site Director nbakinde@msm.edu *IM Chief Residents*
FM Wards	Daily	Tuesday p.m. or Thursday p.m.	FM Inpatient Attendings D'Amico Johnson, MD dcjohnson@msm.edu

Rotation	**Rotation Days**	**Continuity Clinic**	**Contacts**
L&D Grady	Daily except CC Day and off day OB Chiefs to assign day and night schedules Attend FM didactics Wed pm	Designated (Fixed) CC Day No CC during night weeks	Kiwita Philips, MD, Site Director kphillips@msm.edu *OB Chief Resident* Victoria Johnson vljohnson@msm.edu Contact Program Manager Ms. Kelli Hooper khooper@msm.edu
ECC Grady	As scheduled	Wednesday am	Rachel Koval, MD, Site Director rachel.koval@emory.edu Simone Pitts, Program Coordinator lynn.simone.pitts@emory.edu
Sports Medicine	Schedule created based on sports game coverages and Dr. Powell's Morehouse College clinic sessions		Lawrence Powell, MD, Attending lpowell@msm.edu Ashley McCann, MD amccann@msm.edu
Endocrinology	Tuesday, Wednesdays, Thursday	Designated CC Days	Sara Markley Webster, MD sara.markleywebster@va.gov
Geriatrics	Monday and non-CC days	Designated CC Days	Evelyn Campbell-Bayaan evelyn.campbell-bayaan@jencaremed.com

PGY-3 Resident Rotations

Rotation	**Rotation Days**	**Continuity Clinic**	**Contacts**
Dermatology	Tuesday, Thursday all day	Monday, Wednesday, Friday p.m.	Brian Pollack, MD, Site Director Brian.pollack@va.gov Coordinator: Wendy Fox wfox@emory.edu 250 N. Arcadia Ave. 2nd Floor Decatur, GA (404) 727-3669 or (404) 321-6111 ext. 6380
ENT	Two full days (historically Tuesday, Thursday all day)	Designated CC days	Carrie Flanagan, MD carrie.flan agan@va.gov
Ophthalmology	Three full days (historically Monday, Tuesday, Thursday all day)	Friday all day and a designated CC half day	Steve Urken, MD, VA Site Director 1670 Clairmont Road Atlanta, GA (404) 321-6111 ext. 422 steven.urken@va.gov
Cardiology	Three full days (historically Monday, Tuesday, Thursday, and weekend calls as scheduled)	Designated CC days	Adefisayo Oduwole, MD, Site Director aoduwole@msm.edu Jo Ann Cross jcross@msm.edu
CBOC	3 Full Days (or 6 half days)	Designated CC days with modification	Kitefre Oboho, MD (678) 232-6619 Kitefre.oboho@va.gov
Urology	Tuesday, Wednesday, Thursday	Monday, Friday	Urology Nedra Hood, MD Nedra.hood@va.gov
MH/HB	Tuesday/Thursday	Designated CC Days (modified)	Marietta Collins, MD, Rotation Director mcollins@msm.edu
Research/Board Review	Non-CC days	Designated CC Days	Yuan-Xiang Meng, MD, research ymeng@msm.edu
Rheumatology	Two full days (Thursdays and either Tues or Fri)	Designated CC Days with modification	Ayesha Iqbal, MD, Director ayesha.iqbal2@va.gov Puja Saxena, MD puja.saxena@va.gov
FM Wards	Daily	Tuesday p.m. or Thursday p.m.	Oluwole Akintayo, MD oakintayo@msm.edu D'Amico Johnson, MD dcjohnson@msm.edu

Elective Rotation Options

The following is a list of available elective options. All electives must be approved by the Program Director to ensure alignment with the resident's career and individualized educational plans. Residents can also propose an elective not listed. All elective requests must be made by submission of the Elective Proposal Form.

Rotation	**Rotation Days**	**Clinic Days**	**Contacts**
Family Planning Grady OB Department	Non-CC days	Designated CC days	Hedwig Saint-Louis, MD, Attending hsaintlouis@msm.edu
Nephrology	Non-CC days	Designated CC days	Lynn Schlanger, MD lynn.schlanger@va.gov
Pulmonary	Non-CC days	Designated CC days	Rux Sadikot, MD, Site Director ruxana.sadikot2@va.gov
Aesthetics	Non-CC days	Designated CC days	Wong Jing Jing, MD jing8808@gmail.com
Emory Hospitalist only between April and August	Varies	2-3 sessions a week	Tolu Amzat, MD ramzat@emory.edu Dhaval Desai, MD dhaval.r.desai@emory.edu
GEP-Outpatient	Per attending schedule	Designated CC days	Ashley McCann, MD amccann@msm.edu Marissa Lapedis, MD mlapedis@msm.edu
Urgent Care Grady ED	Varies- up to 20 ED sessions within 4-week rotation	1 session a week	Michael Zradzinski, MD, Site Director michael.john.zdradzinski@emory.edu Simone Pitts, Program Coordinator lynn.simone.pitts@emory.edu Elizabeth Iledare, MD elizabeth.iledare@emory.edu
Advocacy Jan/ Feb/March (during legislative session)	Varies	2-3 sessions a week	Megan Douglas, JD mdouglas@msm.edu
Lactation	Varies	Designated CC days	Riba Kelsey, MD rkelsey@msm.edu
Research	Varies	Designated CC days	Yuan Meng, MD ymeng@msm.edu
Telemedicine	Varies	Designated CC days	Walkitria Smith, MD wasmith@msm.edu

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Resident Position Descriptions by PGY Level

PGY-1 Resident Job Description

Prerequisites

- Medical doctorate from an allopathic or osteopathic medical school
- Passing scores on the USMLE I and USMLE II CK or COMLEX 1 and COMLEX 2
- Foreign medical graduates: all ECFMG requirements completed
- Eligibility for State of Georgia Family Physician training licensure
- Application through Electronic Resident Application System (ERAS)

Qualities

- Possess the attitudes, knowledge, and skills needed for learning the full scope of family medicine.
- Demonstrate effective interpersonal skills with a diverse population that includes but is not limited to patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient teams, outpatient care teams, committees, inter- and intra- class teams, and peer support groups such as Balint.
- Communicate effectively in English both verbally and in writing.

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

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergent patient care needs.
- Use diagnostic equipment essential to family medicine such as the otoscope, ophthalmoscope, tuning fork, and stethoscope.
- Read patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.
- Use judgement and make timely and appropriate decisions regarding complicated and undifferentiated disease presentations in ambulatory, emergency, and hospital settings.
- By the second half of the year, have the capacity to see six (6) or more patients in a half-day clinic session, four (4) or more hospital admissions in a 12-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours on inpatient services.
- Use computers for literature review, patient care documentation and data retrieval, and procedure documentation.
- Communicate medical information to patients and members of the medical team using the mode most appropriate for the situation.

Performance Responsibilities and Job Functions

Outpatient Care

- Provide longitudinal primary medical care to a panel of ambulatory patients.
- See a broad spectrum of undifferentiated patients with an emphasis on quality of patient evaluation and care.
- Learn to perform procedures essential to family medicine (must be performed with approval and direct supervision of Attending).
- Work effectively within a patient-care team.
- Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion.
- Work effectively with medical staff on specialty outpatient rotations.

Inpatient Care

- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Perform the initial assessment of the patient and actively participate in all aspects of patient care including history and physical, diagnostic and therapeutic planning, procedures, writing orders, and interactions with families.
- Perform CPR on infants and adults as indicated.
- Manage laboring women, perform deliveries, and repair vaginal and perineal lacerations under the supervision of a family physician or obstetric Attending.
- Administer injections, take blood samples, and learn to insert arterial and central lines.
- Write and dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation.
- Write orders for physical and chemical restraints and seclusion, as necessary.
- Identify and report medical errors and near misses using hospital-based reporting systems.

Educational Mission

- Present educational material in formats appropriately adjusted for the audience (i.e., medical students, peers, medical staff, or community groups).
- Complete and pass all required rotations.
- Provide feedback to the program spontaneously, when informally requested, and on formal evaluations.
- Perform an academic self-assessment at least twice a year.
- Participate in curriculum development through the work of standing committees.
- Develop continuing Quality Improvement projects in conjunction with residency and faculty.

PGY-2 Resident Job Description

Prerequisites

- Completed and passed all PGY-1 rotations
- Met all PGY-1 requirements
- Met the minimum competency skills needed to teach students and peers

Qualities

- Possess the attitudes, knowledge, and skills needed for learning the full scope of family medicine.
- Demonstrate effective interpersonal skills with a diverse population that includes but is not limited to patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient teams, outpatient care teams, committees, inter- and intra- class teams, and peer support groups such as Balint.

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

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergent patient care needs.
- Use diagnostic equipment essential to family medicine such as the ophthalmoscope, otoscope, stethoscope, and ultrasound.
- Manage multiple patient care duties simultaneously.
- Use judgment and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulator emergency, and hospital settings.
- Have the capacity to see eight (8) or more patients in a half-day clinic session, six (6) or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours when taking call on the inpatient services.
- Use computers for literature review, patient care data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a healthcare team.

Performance Responsibilities and Job Functions

Outpatient Care

- Provide longitudinal primary medical care to a panel of outpatients.
- Provide longitudinal primary medical care to a panel of nursing home patients.
- Maintain an emphasis on gaining experience with a full spectrum of procedures, honing proficiency, and balancing quality of patient evaluation and care with improved overall efficiency.
- Complete all procedures with Attending approval and direct supervision.
- Work effectively within a patient care team.
- Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion.

- Work effectively with medical staff on specialty outpatient rotations.
- Teach to medical students basic history and physical skills, periodically, during continuity clinic.

Inpatient Care

- Manage the care of ward and critical care patients under the supervision of a family physician or medical Attending.
- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Maintain an emphasis on gaining experience with a full spectrum of procedures, honing proficiency, and balancing quality of patient evaluation and care with improved overall efficiency.
- Maintain familiarity with all details, labs, studies, consults, and progression of patients under the resident's care
- Discuss in-depth with the attending all decisions regarding invasive procedures, change in plans, discharges, and complications.
- Gain experience in performing a full spectrum of procedures, honing proficiency, quality of patient evaluation and care with improved overall efficiency.
- Complete all procedures with Attending approval and direct supervision.
- Run the code team (second and third year of program).
- Perform CPR on infants and adults as indicated.
- Supervise students and interns with Attending oversight.
- Manage laboring women, perform deliveries, and repair vaginal and perineal lacerations under the supervision of a family physician or obstetric Attending.
- Manage precipitous deliveries independently.
- Assist with major surgeries and C-sections.
- Write or dictate admission and discharge notes, progress notes, procedure notes, delivery notes, and other necessary hospital documentation.
- Write orders for physical and chemical restraints and seclusion, as necessary.
- Identify and report medical errors and near misses using hospital-based reporting systems.
- Recognize the need for and participate in family meetings and goals of care discussions

<u>Educational Mission</u>

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

PGY-3 Resident Job Description

Prerequisites

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

Qualities

- Possess the attitudes, knowledge, and skills needed for learning the full scope of family medicine
- Demonstrate effective interpersonal skills with a diverse population that includes but is not limited to patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient teams, outpatient care teams, committees, inter- and intra- class teams, and peer support groups such as Balint.

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

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergent patient care needs.
- Use diagnostic equipment essential to family medicine such as the otoscope, ophthalmoscope, stethoscope, and ultrasound.
- Read patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.
- Use judgment and make decisions regarding complicated and undifferentiated disease.
- Give presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.
- Have the capacity to see twelve (12) or more patients in a half-day clinic session, eight (8) or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours when taking call on the inpatient services.
- Use computers for literature review, patient care data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a healthcare team.

Performance Responsibilities and Job Functions

Outpatient Care

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

Inpatient Care

- Manage the care of ward and critical care patients under the supervision of a family physician or medical Attending.
- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Maintain familiarity with all details, labs, studies, consults, and progression of patients on the service
- Emphasize development of time, resource, and efficiency management to gain competence in managing administrative, patient flow, and team coordination activities
- Further improve proficiency with a full range of medical procedures
- Lead the code team (second and third year of program).
- Perform CPR on infants and adults as indicated.
- Intubate infants, children, and adults as indicated.
- Manage laboring women, perform deliveries, and repair vaginal and perineal lacerations under the supervision of a family physician or obstetric Attending.
- Manage precipitous deliveries independently.
- Assist with major surgeries and C-sections.
- Administer injections, take blood samples, and learn to insert arterial and central lines.
- Write or dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation.
- Write orders for physical and chemical restraints and seclusion, as necessary.
- Serve as a team leader for two (2) months during the PGY-3 year.
- Identify and report medical errors and near misses using hospital-based reporting systems.
- Recognize the need for and lead family meetings and goals of care discussions when indicated

Educational Mission

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

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ACGME Program Specific Requirements

In addition to adhering to Morehouse School of Medicine GME and Human Resources Policies, the MSM Family Medicine Residency Program adheres to all common program requirements and program specific requirements of the Accreditation Council for Graduate Medical Education (ACGME). The requirements can be found at the following sites.

Common Program Requirements
Common Program Requirements - Residency (acgme.org)

ACGME Family Medicine Program Requirements
120_FamilyMedicine_2024 (acgme.org)

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Graduate Medical Education and Family Medicine Program Policies, Procedures, Processes, and Program Templates

The Family Medicine Residency Program follows and complies with all policies, procedures, and processes of Morehouse School of Medicine Human Resources and Graduate Medical Education.

All residents are responsible for reviewing and adhering to policies, procedures, and processes of MSM and affiliate training sites.

The Graduate Medical Education policy manual can be found on the residency management system and at
GME Overview | Morehouse School of Medicine (msm.edu)

Residents are particularly encouraged to review the following MSM GME policies of interest:

- Adverse Action
- Resident and Fellow Impairment Policy
- Resident and Fellow Leave Policy
- Professionalism Policy

Adverse Academic Decisions and Due Process Policy

I. PURPOSE:

1.1. Morehouse School of Medicine (MSM) shall provide residents and fellows with an educational environment that MSM believes is fair and balanced.

1.2. This policy outlines the procedures which govern adverse academic decisions and due process procedures relating to residents and fellows during their appointment periods at Morehouse School of Medicine regardless of when the resident or fellow matriculated.

1.3. Actions addressed within this policy shall be based on an evaluation and review system tailored to the specialty in which the resident/fellow is matriculating.

II. SCOPE:

2.1. All MSM administrators, faculty, staff, residents, fellows and administrators at participating affiliates shall comply with this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.

2.2. Residents and fellows shall be given a copy of this Adverse Academic Decisions and Due Process Policy at the beginning of their training.

III. DEFINITIONS:

3.1. Academic Deficiency

3.1.1. A resident/fellow's academic performance is deemed deficient if performance does not meet/does not satisfy the program and/or specialty standards.

3.1.2. Evidence of academic deficiency for a resident/fellow can include, but is not limited to:

3.1.2.1. Having an insufficient fund of medical knowledge

3.1.2.2. Inability to use medical knowledge effectively

3.1.2.3. Lack of technical skills based on the resident/fellow's level of training

3.1.2.4. Lack of professionalism, including timely completion of administrative functions such as medical records, duty hours, and case logging

3.1.2.5. Unsatisfactory written evaluation(s)

3.1.2.6. Failure to perform assigned duties

3.1.2.7. Unsatisfactory performance based on program leadership and faculty's observation

3.1.2.8. Any other deficiency that affects the resident/fellow's academic performance

3.1.2.9. In-training exams (ITE) should not be used as an indicator of an adverse action.

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

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

3.4. Corrective Action

3.4.1. Corrective action is defined as written formal action taken to address a resident's or fellow's academic, professional, and/or behavioral deficiencies and any misconduct.

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

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

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

3.6. Due Process

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

3.6.1.1. Providing notice to the resident of the deficient performance issue(s), which should be in the form of a letter or email;

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

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

3.7. Due Process Disciplinary Actions include suspension, non-renewal, non-promotion, or dismissal.

3.8. GME—Graduate Medical Education

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

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

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

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

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

3.11. Meeting

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

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

3.12. Misconduct

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

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

3.13. Non-Renewal of Appointment—if the residency program determines that a resident's performance is not meeting the academic or professional standards of MSM, the program, the ACGME program requirements, the GME requirements, or the specialty board requirements, the resident will not be reappointed for the next academic year. The program is responsible for determining the criteria for resident/fellow reappointment and non-renewals

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

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

3.14. Non-Promotion

3.14.1. Resident/fellow annual appointments are based on a full academic year: July to June.

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

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

3.16. CCC—The Clinical Competency Committee

3.16.1. Reviews all resident/fellow evaluations at least semi-annually;

3.16.2. Determine each resident/fellows' progress on achievement of the specialty-specific Milestones;

3.16.3. Meets prior to the resident/fellows' semi-annual evaluations and advises the program director regarding resident or fellow's progress and advises the program director regarding resident progress, including promotion,

remediation, or dismissal.

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

3.17.1. Providing inappropriate patient care;

3.17.2. Lacking professionalism in the education and work environments;

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

3.17.4. Negatively impacting healthcare team functioning; or

3.17.5. Causing residency/fellowship program dysfunction.

3.18. Remediation

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

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

3.19. Suspension

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

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

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

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

IV. POLICY:

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

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

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

Agreement or Reappointment Agreement.

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

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

V. PROCEDURES:

5.1. If any clinical supervisor deems a resident/fellow's academic or professional performance to be less than satisfactory, the residency/fellowship program director will review the identified concerns and may require the resident to take actions to cure the deficiencies. The Clinical Competency Committee may be engaged to review the clinical supervisor's evaluation in the context of the trainee's global performance metrics and provide a recommendation of whether to require remediation.

5.2. Notice of Academic Deficiency

5.2.1. The residency/fellowship program director may issue a Notice of Academic Deficiency to a resident to give notice that academic deficiencies exist that are not yet severe enough to require corrective action, disciplinary action, or other adverse actions but that do require the resident/fellow to take immediate action to cure the academic deficiency.

5.2.2. This notice may be concerning both progress in the program and the quality of performance.

5.2.3. Residents/fellows will be provided reasonable opportunity to cure the deficiency(ies) with the expectation that the resident/fellow's academic performance will be improved and consistently maintained.

5.2.4. It is the responsibility of the resident/fellow, using necessary resources, including advisor, faculty, PDs, chairperson, etc., to cure the deficiency(ies).

5.2.5. The residency/fellowship program director will notify the GME director in writing of all notices of deficiency(ies) within five (5) calendar days of the program director's decision.

5.3. Probation

5.3.1. A residency/fellowship program may use this corrective action when a resident/fellow's actions are associated with:

5.3.1.1. Providing inappropriate patient care;

5.3.1.2. Lacking professionalism in the education and work environments;

5.3.1.3. Negatively impacting healthcare team functioning; or

5.3.1.4. Failure to comply with MSM, GME, and/or program standards, policies, and guidelines.

5.3.1.5. Causing residency/fellowship program dysfunction.

5.3.2. Probation can be used as an option when a resident/fellow fails to cure a notice of academic deficiency or other corrective action.

5.3.3. The program director must notify and consult with the GME DIO and/or director before issuing a probation letter to a resident.

5.3.3.1. A probation letter must be organized by ACGME core competencies and detail the violations and academic deficiencies.

5.3.3.2. A probationary period must have a definite beginning and ending date and be designed to specifically require a resident/fellow to correct identified deficiencies through remediation.

5.3.3.3. The length of the probationary period will depend on the nature of the particular infraction and be determined by the program director. However, the program director should set a timed expectation of when improvement should be attained. The duration will allow the resident/fellow reasonable time to correct the violations and deficiencies.

5.3.3.4. A probation period cannot exceed six (6) months in duration and residents cannot be placed on probation for the same infraction/violation for longer than twelve (12) consecutive months (i.e., maximum of two (2) probationary periods).

5.3.4. Probation decisions shall not be subject to the formal appeals process.

5.3.5. While on probation, a resident/fellow is not in good standing.

5.3.6. A remediation plan must be a part of probation as a tool for curing the deficiency that warranted the probation. Developing a viable remediation plan consists of the following actions:

5.3.6.1. The resident/fellow must be informed that the remediation is not a punishment, but a positive step and an opportunity to improve performance by resolving the deficiency.

5.3.6.2. The resident/fellow may be required to make up time in the residency/fellowship if the remediation cannot be incorporated into normal activities and completed during the current residency year.

5.3.6.3. The resident/fellow must prepare a written remediation plan, with the express approval of the program director as to form and implementation. The program director may require the participation of the resident/fellow's advisor in this process.

5.3.6.3.1. The plan shall clearly identify deficiencies and expectations for reversing the deficiencies, organized by ACGME core competencies.

5.3.6.3.2. It is the responsibility of the resident to take actions to meet all standards, and to take the initiative to make improvements as necessary.

5.3.7. All residents placed on probation are required to meet with the Director for Graduate Medical Education.

5.3.8. If the deficiency(ies) persist during the probationary period and are not cured, the residency program director may initiate further corrective or disciplinary action including but not limited to continuation of probation with or without non-promotion, non-renewal of residency/fellowship appointment agreement, or dismissal.

5.3.9. The program director must notify and consult with the GME DIO and/or director before initiating further corrective or disciplinary action.

5.3.9.1. If the reasons for non-promotion, non-renewal of appointment, or dismissal occur within the last four (4) months of the resident/fellow's appointment year,

the program will provide the resident/fellow reasonable notice of the reasons for the decision as circumstances reasonably allow.

5.3.9.2. The decision of the program director will be communicated to the resident/fellow and to the Office of Graduate Medical Education.

5.3.9.3. The residency/fellowship program director will notify the resident/fellow in writing of non-promotion, non-renewal of appointment, or dismissal decisions.

5.4. Suspension

5.4.1. Suspension shall be used as an immediate disciplinary action because of a resident/fellow's misconduct. Suspension is typically mandated when it is in the best interest of the patients [patient care] or professional medical staff that the resident/fellow be removed from the workplace.

5.4.2. A resident/fellow may be placed on paid or unpaid suspension at any time for significant violations in the workplace.

5.4.3. A resident may be removed from clinical responsibility or program activities by a faculty member, program director, department chairperson, clinical coordinator, or administrative director of an affiliate. At their sole discretion, that individual can remove the resident/fellow if they determine that one of the following types of circumstances exist:

5.4.3.1. The resident/fellow poses a direct detriment to patient welfare.

5.4.3.2. Concerns arise that the immediate presence of the resident/fellow is causing dysfunction to the residency program, its affiliates, or other staff members.

5.4.3.3. Other extraordinary circumstances arise that would warrant immediate removal from the educational environment.

5.4.4. All acts of removal from clinical responsibility or program activities shall be documented by the initiating supervisor or administrator and submitted to the program director in writing within 48 hours of the incident/occurrence, explaining the reason for the resident/fellow's removal and the potential for harm.

5.4.5. After receiving written documentation of the incident/occurrence, the program director has up to five (5) days to determine if a resident/fellow will be suspended.

5.4.6. Only the program director has authority to suspend a resident/fellow from the program and decide the length of time of the suspension, regardless of individual hospital or affiliate policies and definitions of suspension.

5.4.7. The program director must notify and consult with the GME DIO and/or director before suspending a resident/fellow.

5.4.8. After a period of suspension is served, further corrective or disciplinary action is required.

5.4.8.1. The program director shall review the situation and determine what further disciplinary action is required.

5.4.8.2. Possible actions to be taken by the program director regarding a suspended resident/fellow may be to:

5.4.8.2.1. Return the resident/fellow to normal duty with a Notice of Academic Deficiency;

5.4.8.2.2. Place the resident/fellow on probation; or

5.4.8.2.3. Initiate the resident/fellows' dismissal from the program.

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

5.5.1. Probation/continued probation

5.5.2. Non-promotion to the next PGY level

5.5.3. Repeat of a rotation or other education block module

5.5.4. Non-renewal of residency/fellowship appointment agreement

5.5.5. Dismissal from the residency/fellowship program

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

5.6.1. Dismissal or termination from the residency/fellowship program

5.6.2. Non-renewal of the resident/fellow's appointment

5.7. Appeal Procedures—Program and Department

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

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

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

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

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

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

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

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

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

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

5.7.3.8. Appeal meetings may not be recorded.

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

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

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

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

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

5.8. Appeal to the Dean

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

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

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

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

5.8.5. The Dean shall instruct the GME office to convene an Institutional Appeal Committee to review the case and provide an advisory opinion regarding whether the residency/fellowship program afforded the resident/fellow due process in its decision to dismiss or not renew the resident's appointment. This review is program protocol and required documentation in each case. MSM's Designated Institutional Official, or his or her designee, shall chair the Institutional Appeal Committee.

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

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

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

and titles.

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

5.8.5.5. The Program Director must also provide a written summary letter and timeline of events for the committee to review at least 24 hours before the scheduled meeting.

5.8.5.6. The Institutional Appeal Committee shall give the resident/fellow an opportunity to present written and/or verbal evidence to dispute the allegations that led to the disciplinary action.

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

5.8.5.8. The resident/fellow may bring to the meeting an advocate, such as a faculty member, staff member, or other resident/fellow.

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

5.8.5.10. Recording of the meeting(s) and/or proceedings is prohibited.

5.8.6. The institutional appeals committee chair will submit a written report of the findings to the dean who will make the final determination regarding the status of the resident/fellow.

5.8.7. The final written determination by the dean may be:

5.8.7.1. That the resident/fellow is returned to the residency/fellowship program without penalty;

5.8.7.2. Recommendation for dismissal, termination, or non-renewal of appointment stands;

5.8.7.3. Other determination as deemed appropriate by the dean.

5.8.8. If a recommendation for dismissal/termination/non-renewal is confirmed, the resident/ fellow is removed from the payroll effective the day of the dean's decision.

Family Medicine Residency Adverse Academic Decisions and Due Process Policy

I. <u>PURPOSE</u>:

1.1. The Morehouse School of Medicine (MSM) Family Medicine Residency Program (FMRP) shall provide residents with an educational environment that is fair and balanced.

1.2. This policy outlines the procedures which govern adverse academic decisions and due process procedures relating to Family Medicine residents during their appointment periods at Morehouse School of Medicine regardless of when the resident matriculated.

1.3. Actions addressed within this policy shall be based on the MSM Family Medicine Residency Program's evaluation and review system.

II. <u>SCOPE</u>:

2.1. All MSM administrators, faculty, staff, residents, fellows and administrators at participating affiliates shall comply with this and all other policies and procedures that govern both the Family Medicine Residency program and Family Medicine resident appointments at MSM.

2.2. Residents and fellows shall be given a copy of this Adverse Academic Decisions and Due Process Policy at the beginning of their training.

III. POLICY:

3.1. A Family Medicine resident demonstrating deficiency(ies) as defined in the MSM GME Adverse Academic Decisions and Due Process Policy is subject to adverse action.

3.2. Adverse Academic Decision Determination

3.2.1. Upon full review of the resident's training record and based on consideration of the specific data and documentation of the factors in question, the Clinical Competency Committee may recommend an adverse academic action for a resident

3.2.2. Upon review of the Clinical Competency Committee's recommendation and consideration of all associated documentation in addition to other information that may be available to the Program Director, the Program Director may decide to accept the CCC's recommendation, assign a different adverse action, or decide adverse action is not indicated.

3.2.3. In the event that a resident imposes an immediate threat to the safety of patients, MSM employees, and/or MSM students, the Program Director may place a resident on immediate suspension in the absence of a CCC recommendation.

3.3. Notice of Adverse Action

3.3.1. The resident shall be notified of the adverse academic action both verbally and in writing

3.3.2. The resident will be offered an opportunity to ask questions about the nature of the action, its implications, and requirements for cure

3.3.3. The resident will be asked to sign the notice letter to acknowledge receipt.

3.3.4. The terms and conditions of the adverse action will proceed after notice is given regardless of the resident's agreement or disagreement to sign the notice letter.

3.4. Appeal

3.4.1. A resident wishing to appeal an adverse academic decision must submit a formal appeal to the Program Director within 7 days of receiving the letter notifying the resident of the action.

3.4.2. Upon notice of a resident's desire to appeal an adverse action eligible for appeal as defined in the MSM GME Adverse Academic Decision and Due Process Policy, the Department Chair will appoint an ad hoc appeals committee consisting of the required members outlined in the GME Adverse Academic Decision and Due Process Policy

3.4.3. The ad hoc committee will follow all processes and procedures defined in the GME Adverse Academic Decision and Due Process Policy.

3.4.4. The appeal process will proceed as outlined in the MSM GME Policy

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Concern and Complaint (Grievance) Policy for Residents and Fellows

I. PURPOSE:

1.1. The Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level that minimizes conflicts of interest (ACGME Institutional Requirements IV.E.).

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

1.3. **Note**: For purposes of this policy, a concern or complaint involves issues relating to personnel, patient care, and matters related to the program or hospital training environment, including professionalism and adherence to clinical and educational work (work hour) standards.

II. SCOPE:

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

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

2.3. Residents, fellows, and faculty agree to work in good faith to resolve any problems or issues that distract from optimal training.

III. POLICY:

3.1. Morehouse School of Medicine and affiliated hospitals encourage resident/fellow participation in decisions involving educational processes and the learning environment. Such participation should occur in both formal and informal interactions with peers, faculty, and Attending staff.

3.2. Efforts should be undertaken to resolve questions, problems, and misunderstandings as soon as they arise. Residents/fellows are encouraged to initiate discussions with appropriate parties for the purpose of resolving issues in an informal and expeditious manner.

3.3. With respect to formal processes designated to address issues deemed as complaints (grievances) under the provisions of this policy, each program must have an internal process, known to residents, through which residents may address concerns. The program director should be designated as the first point of contact for this process.

3.4. A grievance is defined as a complaint that directly and adversely affects a residents/fellows' education, training, or professional activities as a result of an arbitrary or capricious act, or

failure to act, or a violation of School policy or procedure, by the School or anyone acting officially on behalf of the School.

3.5. Matters that are not grievable include probation and corrective actions, as detailed in the GME Adverse Academic Decisions and Due Process Policy, salary and benefits, and issues not relating to personnel, patient care, program or hospital training environment, including professionalism and adherence to clinical and educational work (duty hour) standards.

3.6. If the complaint is to formally notify the institution of an incident involving harassment or discrimination, see the Morehouse School of Medicine Sex/Gender, Non-Discrimination, Anti-Harassment, and Retaliation Policy for procedures to be followed. The contact person for this policy is Marla Thompson, Title IX Coordinator for MSM, 404-752-1871, mthompson@msm.edu.

IV. PROCEDURE:

4.1. Reporting Structure "chain of command" for resident/fellow concerns and complaints (grievances)

4.1.1. Step 1: Residents and fellows should first talk to program-level persons to resolve problems and concerns.

4.1.1.1. The program's chief resident(s) should be the first point of contact.

4.1.1.2. If the resident/fellow believes their concern is not adequately addressed or there is a conflict of interest, then the resident/fellow should discuss their concerns with the program director or associate program director.

4.1.2. Step 2: If the resident/fellow is not satisfied with the program-level resolution, the individual should discuss the matter with the department chair, or service director, or chief of a specific hospital.

4.1.3. Step 3: If no solution is achieved, the resident/fellow may seek assistance from the Graduate Medical Education (GME) Designated Institutional Official (DIO), Dr. Chinedu Ivonye at civonye@msm.edu

4.2. Other Grievance Resources and Options

4.2.1. If for any reason the resident does not want to discuss concerns or complaints with the chief resident, program director, associate program director, department chair, service director or chief, or Designated Institutional Official (DIO), the following resources are available:

4.2.1.1. For issues involving program concerns, training matters, professionalism, or work environment, residents can contact the Graduate Medical Education Director at (404) 752-1011 or jgriggs@msm.edu.

4.2.1.2. For problems involving interpersonal issues, the resident/fellow may be more comfortable discussing confidential informal issues apart and separate from the resident/fellow's parent department with the Resident Association president or president elect.

4.2.1.2.1. Any resident or fellow may directly raise a concern to the Resident and Fellow Association Forum.

4.2.1.2.2. Resident and Fellow Association Forums and meetings may be conducted without the DIO, faculty members, or other administrators present.

4.2.1.2.3. Residents and fellows have the option to present concerns that arise from discussions at Resident and Fellow Association Forums to the DIO and GMEC.

4.2.2. Residents and fellows can provide anonymous feedback, concerns, and complaints by completing the GME Feedback Form at http://www.msm.edu/Education/GME/feedbackform.php.

4.2.2.1. Comments are anonymous and cannot be traced back to individuals.

4.2.2.2. Personal follow-up regarding how feedback, concerns, or complaints have been addressed by departments and/or GME will be provided only if the resident/fellow elects to include his or her name and contact information in the comments field.

4.2.3. MSM Office of Compliance and Corporate Integrity is at http://www.msm.edu/Administration/Compliance/index.php

4.2.3.1. The MSM Compliance Hotline, 1 (855) 279-7520, is an anonymous and confidential mechanism for reporting unethical, noncompliant, and/or illegal activity.

4.2.3.2. Call the Compliance Hotline or email www.msm.ethicspoint.com to report any concern that could threaten or create a loss to the MSM community including:

- Harassment—sexual, racial, disability, religious, retaliation
- Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical, and waste management safety issues
- Other reporting purposes:
  - Misuse of resources, time, or property assets
  - Accounting, audit, and internal control matters
  - Falsification of records
  - Theft, bribes, and kickbacks

Refer to the current version of the MSM GME Policy Manual for detailed information regarding the Adverse Academic Decisions and Due Process Policy for matters involving resident/fellow suspension, non-renewal, non-promotion, or dismissal.

Family Medicine Program-Specific Concern and Complaint Process

Concern and Complaint Process—for Residents and Fellows

To ensure that residents can raise concerns and complaints and provide feedback in a confidential manner and without concern for intimidation, residents have several available reporting options and resources, which are communicated to residents and faculty members annually. The following steps outline the recommended process for reporting.

Step One

Residents should first talk to program-level persons to resolve problems and concerns. The program's chief resident(s) or program director should be the first point of contact. However, at the discretion of the resident, the concern can be discussed with the program director, associate program director, program manager, and/or service director as appropriate. If the concern is related to an external (non-Family Medicine) service, the resident is encouraged to discuss the concern with the service senior or chief resident, attending, or rotation director as appropriate as well as the Family Medicine program director. Informing the Family Medicine program director

allows the program to be aware of concerning rotation conditions and to advocate or intervene as needed in real time. If the resident believes there is a conflict of interest or his or her concern is not adequately addressed in this step, the resident is encouraged to move to step two.

Step Two
If the concern or complaint involves the program director and/or cannot be addressed in step one, residents have the option of discussing issues and concerns with the Department Chair, Dr. Folashade Omole (fomole@msm.edu or 404-756-1206) or the service chief of a specific hospital, as appropriate.

Step Three
If no solution is achieved in step two, the resident may seek assistance from the Graduate Medical Education (GME) Designated Institutional Official (DIO), Dr. Chinedu Ivonye. (civonye@msm.edu). Examples of concerns that can be raised and discussed with the DIO are issues related to the Program that have not been resolved at the program level, training matters, program-level professionalism, or the work environment.

Other Resource:

- For problems involving interpersonal issues, the Resident Association president or president-elect may be a comfortable option to discuss confidential, informal issues separate and apart from the resident's parent department.

Anonymous Reporting:

Depending on the nature of the concern, anonymous reporting is available as described in 4.2.2. and 4.2.3. of the MSM GME Concern and Complaint Policy.

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Evaluation of Family Medicine Residents, Faculty, and Program Policy

I. PURPOSE:

1.1. The purpose of this policy is to ensure that the quality of the Family Medicine Residency Program at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory under the heading, "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition).

1.2. This policy also ensures that the MSM Family Medicine Residency Program and its residents and faculty are evaluated as required in the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common, and Specialty/Subspecialty-Specific Program Requirements.

II. BACKGROUND

2.1. This FMRP-specific policy is consistent with the MSM GME Evaluation of Residents, Fellows, Faculty, and Programs Policy.

III. SCOPE:

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

3.2. The FMRP uses the residency management system for all required evaluation components

3.3. The FMRP administration monitors all evaluation components and completion rates and provides feedback to residents and faculty on evaluation completion

IV. FACULTY EVALUATION AND FEEDBACK OF RESIDENTS AND FELLOWS:

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

4.2. Evaluation must be documented at the completion of the assignment (rotation).

4.2.1. Evaluations must be completed by two weeks after completion of each assignment

4.2.2. Continuity clinic and other longitudinal experiences, in the context of other clinical responsibilities, must be evaluated at least every three (3) months.

4.3. Clinical Competency Committee (CCC)

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

4.3.2. The MSM FMRP Clinical Competency Committee operates in accordance with the ACGME Common Program Requirements as described in the FMRP Clinical Competency Committee Policy in this Policy Manual

V. RESIDENT ASSESSMENT AND EVALUATION:

5.1. Evaluation concerning performance and progression in the residency program shall be provided to the resident throughout the duration of the program. Assessments and evaluations will measure performance based on core competencies and Family Medicine-specific Milestones.

5.2. Resident evaluations must identify the areas in which the resident is performing well and those in which there are deficiencies to guide performance improvement activities.

5.3. Residents are evaluated on each unique assignment (rotation or longitudinal experience)

5.3.1. The resident must receive formative feedback during each assignment, along with recommendations for improvement before the end of the rotation

5.3.2. The resident must receive an objective, competency-based summative evaluation for each rotation, submitted through the residency management system, at the completion of each rotation.

5.3.3. Summative evaluations must be available for review in the residency management system by the resident within 14 days of completing each rotation. This must be an ACGME competency-based assessment of the residents' global performance on the rotation

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

5.5. The program provides an objective performance evaluation based on the Competencies and the specialty-specific Milestones.

5.5.1. This performance evaluation uses multiple methods and evaluators including:

- Narrative evaluations by faculty members and non-faculty evaluators
- Evaluations from other professional staff members
- Clinical competency examinations
- In-training examinations
- Medical record reviews
- Peer evaluations
- Resident self-assessments
- Patient satisfaction surveys
- Direct observation evaluation

5.5.2. This information is provided to the CCC for its synthesis of progressive resident/fellow performance and improvement toward unsupervised practice data.

5.6. In addition to evaluations based on clinical performance, residents are evaluated in several other settings and in the following specific areas:

5.6.1. Residents are assessed in each of the six Core Competency areas upon entrance

into the program.

5.6.2. Residents are assigned supervisory and teaching responsibilities for medical students and junior residents as they progress through the program and are evaluated on their performance as teachers.

5.6.3. Residents are evaluated on their journal club and case presentations during didactic sessions. These evaluations are completed by residents, faculty, and medical students.

5.6.4. Residents' data gathering, clinical reasoning, patient management and procedure skills are evaluated in both inpatient and outpatient settings.

5.6.5. Residents take the ABFM In-Training Exam, an objective validated formative assessment, annually.

5.6.5.1. In-Training Exam results are used to develop and modify each resident's individualized study plan, also referred to as the individualized educational plan or the individualized success plan

5.7. Semi-Annual Evaluation

5.7.1. At least twice in each Post-Graduate Year, the residency director, or his/her designee, with input from the Clinical Competency Committee, will:

5.7.1.1. Meet with each resident and fellow to review his or her documented semi-annual evaluation of performance.

5.7.1.1.1. This evaluation includes progress along the specialty-specific Milestones.

5.7.1.1.2. The evaluation is made available for review by the resident in the residency management system.

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

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

5.8. Resident Progression Evaluation

5.8.1. At least annually, each resident is given a summative evaluation that includes her or his readiness to progress to the next year of the program.

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

5.9. Final Evaluation

5.9.1. At the end of residency, upon completion of the program, the program director provides a final evaluation for each resident.

5.9.2. Specialty-specific Milestones, continuity performance in the Family Medicine Practice, and procedure logs are included in the tools used to ensure that residents are able to engage in autonomous practice upon completion of the program.

5.9.3. The final evaluation must:

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

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

5.9.3.3. Consider recommendations from the CCC; and

5.9.3.4. Be shared with the resident upon completion of the program.

VI. FACULTY EVALUATION:

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

6.2. The program director completes and provides a written evaluation of each faculty member's performance related to the educational program twice a year

6.2.1. This evaluation is informed by quarterly anonymous and confidential evaluations by residents, which are compiled in aggregate and summarized on the Semi-Annual Residency Evaluation of Faculty form.

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

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

6.2.4. The Program does not allow faculty members to view individual evaluations by residents or fellows.

6.3. Program Director maintains continuous and ongoing monitoring of faculty performance. This includes:

- Regular surveillance of end-of-rotation evaluations, and
- Regular verbal communication with residents regarding their experiences.

6.4. The program director should notify the appropriate department chair(s) when a faculty member receives unsatisfactory evaluation scores.

6.5. Faculty performance must be reviewed and discussed during the annual faculty evaluation review process conducted by the chair or division.

6.6. Results of the faculty educational evaluations are incorporated into program-wide faculty development plans.

VII. PROGRAM EVALUATION AND IMPROVEMENT:

7.1. The Program Director appoints the Program Evaluation Committee (PEC) to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.

7.2. The PEC is composed of at least two (2) faculty members, at least one (1) of whom is a core faculty member and include at least one (1) resident from each post-graduate year.

7.3. PEC responsibilities include:

7.3.1. Advising the program director, through program oversight;

7.3.2. Reviewing the program's self-determined goals and its progress toward meeting them;

7.3.3. Guiding ongoing program improvement, including development of new goals, based on outcomes; and

7.3.4. Reviewing the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.

7.4. The PEC considers the following elements in its assessment of the program:

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

7.5. Residents and faculty evaluate the program annually using the confidential and anonymous evaluation administered through the MSM GME Office

7.5.1. The results of this survey are used by the PEC and action plans are developed to address unfavorable responses to the survey

7.5.2. Action plans are monitored by the PEC with oversight by the GME Office

7.6. Residents and faculty evaluate the program annually via the ACGME Resident Survey

7.6.1. The results of this survey are used by the PEC and action plans are developed to address unfavorable responses to the survey

7.6.2. Action plans are monitored by the PEC with oversight by the GME Office

7.7. The PEC evaluates the program's mission and aims, strengths, areas for improvement, and threats. The annual review, including the action plan, is:

7.7.1. distributed to and discussed with the members of the teaching faculty and the residents; and

7.7.2. submitted to the DIO.

7.8. The program must complete a self-study prior to its 10-year accreditation site visit, a

summary of which must be submitted to the DIO.

VIII. ACGME BOARD PASS RATE REQUIREMENTS:

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

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

8.3. Specialties pass rates

8.3.1. In the preceding three (3) years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

8.3.2. Any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.

8.4. Programs must report board certification status in ADS annually for the cohort of board-eligible residents that graduated seven (7) years earlier.

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Semi-Annual Evaluation of Faculty Member by Residency Program

Faculty Name _____

Evaluation Period _____

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

	YOU	Average of All Program Faculty	Minimum Requirement (if any)
A. AGGREGATE EVALUATION BY RESIDENTS*			
1. Please rate your overall experience of the rotation/in the clinic under the supervision of this preceptor.			
2. Please rate the availability of this preceptor			
3. Please rate the approachability of this preceptor			
4. Please rate the professionalism displayed by this preceptor through his/her interactions with you, peers, staff, patients, and families.			
5. How well did the preceptor practice sound ethical principles?			
6. How well did the preceptor clearly state his/her expectations of your performance at the beginning of the rotation/clinic session?			
7. How well did the preceptor teach office procedures?			
8. Please rate the TEACHING you received by this Preceptor.			
Total Number of evaluations			
Resident evaluation completion within 2 weeks (%)			
If PEC Member, attendance %			
If CCC Member, attendance %			
Number of hours of resident lectures **			
Serves as a course director	Y / N	N/A	
If course director what was average course rating, on a scale of 1-5			
Served as a resident advisor	Y / N		
Served as a resident research mentor	Y / N		
Board Certification status in Family Medicine/Internal Medicine/Peds/OBGYN as applicable			
Percentage of Grand Rounds attended			
Involved with PS/QI			
Conference presentations			
Peer-reviewed publications			
Other publications and presentations			

Semi-Annual Evaluation of Faculty Member by Residency Program

* The rating scale for **Section A** (Aggregate Evaluation by Residents):
1= Needs major improvement, 2 = Needs minor improvement, 3= satisfactory, 4 = good, 5 =excellent

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

Summary of Resident Comments _____

_____

_____

_____ _____

PD Signature Date

_____ _____

Faculty Signature Date

_____ _____

Chairperson Signature Date

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	FM-06
		EFFECTIVE DATE	06/01/2019
		PAGE(S)	09
	SUBJECT FAMILY MEDICINE CLINICAL COMPETENCY COMMITTEE POLICY	SUPERSEDES	06/01/2018 06/01/2014 04/01/2011

Family Medicine Clinical Competency Committee Policy

I. PURPOSE:

1.1. The ACGME requires that each residency program have a Clinical Competency Committee (CCC) appointed by the program director.

1.2. The purpose of the Clinical Competency Committee is to review all resident evaluations and prepare Milestones evaluations of each resident at least semi-annually and to advise the program director regarding resident progress, including promotion, remediation, or dismissal.

II. SCOPE:

2.1. All residency faculty and residents must understand the role and function of the Clinical Competency Committee.

2.2. Multisource evaluations of all residents must be synthesized by the CCC to establish Family Medicine sub-competency-based Milestones for each resident and recommend these Milestones to the program director at least twice annually.

2.3. The program director will review and adjust the Milestone recommendations submitted by the CCC as needed, for final reporting to the ACGME and feedback to the resident.

III. POLICY:

3.1. Clinical Competency Committee (CCC)

3.1.1. The Family Medicine Residency Program's Clinical Competency Committee (CCC) is charged with monitoring resident performance and making appropriate recommendations to the program director for a formative Milestone-based evaluation of each resident based on a review of all forms of resident evaluations every six (6) months.

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

3.2. CCC Composition and Membership

3.2.1. The program director appoints four (4) to six (6) members of the program faculty to the CCC and appoints one member to serve as the CCC chairperson.

3.2.2. Committee members include key faculty members involved in direct resident teaching, one (1) of whom must be the associate or assistant program director and at least one (1) of whom is a core faculty member.

3.2.3. All members, whether from the Family Medicine Residency Program, another Residency Program, or other health professionals, must have extensive contact and experience with the program's residents.

3.2.4. The members are appointed for one (1) year; membership may be renewed annually.

3.3. Committee Responsibilities: The Family Medicine Residency Clinical Competency Committee members will:

3.3.1. Attend all standing and ad hoc CCC meetings.

3.3.2. Sign the confidentiality policy prior to the first CCC meeting of each academic year and must abide by said policy at all times.

3.3.3. Review all resident evaluations at least semi-annually

3.3.4. Determine each resident's progress on achievement of the specialty-specific Milestones.

3.3.5. Meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.

3.3.6. Review multisource and multiple forms of evaluation of each resident

3.3.7. Make recommendations to the program director for resident progress including promotion, remediation, and dismissal, in accordance with GME policies as outlined in the MSM GME Policy Manual.

3.4. The committee chairperson will:

3.4.1. Comply with all responsibilities described above.

3.4.2. Conduct a CCC meeting prior to residents' semi-annual evaluations

3.4.3. Review and edit, as needed, minutes of meetings as prepared by the program manager or program assistant and disseminate the minutes to all committee members, the program director, and the department chairperson.

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

3.4.5. Report the required semi-annual specialty-specific Milestone assignments.

3.4.5.1. The CCC chairperson submits to the Family Medicine Residency program director recommendations for each resident's Milestone performance on each subcompetency

3.4.5.2. The Family Medicine Residency program director will review the recommended Milestone assignments, revise as needed, and submit to the ACGME by ACGME-established deadlines.

3.4.5.3. The Family Medicine Residency program manager will maintain a file of all CCC reports and recommendations for each resident.

3.5. Meeting Frequency

3.5.1. The CCC will meet at least (2) times each year. Standing meeting dates shall be established at the beginning of each academic year.

3.5.2. Additionally, the committee chair may schedule called meetings at the request of the program director to address urgent matters that must be handled before the

next regularly scheduled meeting.

3.5.3. Reasons for ad hoc meetings may include, but are not limited to, consistently low performance or unsatisfactory evaluation scores of a resident; repeated lack of adherence to program requirements; or a specific incident that, at the request of the program director, needs CCC review and input when probation or dismissal of a resident is being considered.

3.6. Procedure for Review

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

3.6.2. In reviewing each resident, the CCC shall consider the following evaluation tools:

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

3.6.3. The CCC may recommend to the program director that a notice of deficiency be given to any resident who performs below Milestone benchmarks.

3.6.4. The program director or designated associate program director will meet with each resident, communicate the recommendation, and design a remediation or improvement plan.

3.7. Recommendations—Based on the comprehensive review of each resident's record of performance, in the case of inadequate performance, the CCC may recommend probation with remediation, or delay or denial of promotion or board recommendation, as appropriate, for the deficiencies identified. The Program Director may accept, revise, or deny the recommendation.

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	FM-
		EFFECTIVE DATE	07/01/2023
		PAGE(S)	
	SUBJECT FAMILY MEDICINE RESIDENCY ELECTIVE POLICY	SUPERSEDES	

Family Medicine Residency Elective Policy

I. PURPOSE:

1.1. The purpose of this policy is to describe the requirements and processes related to elective experiences in the MSM Family Medicine Residency Program.

II. SCOPE

2.1 This policy applies to all PGY2 and PGY3 residents.

III. POLICY

3.1 Consistent with ACGME Program Specific requirements for Family Medicine, each resident will complete six electives over the course of training.

3.2 Elective selection will be made based on each resident's self-identified career goals and individualized learning plans.

3.3 Elective plans will be assessed for continued alignment with career plans and educational needs during each semi-annual evaluation.

3.4 Each resident is to complete three electives during PGY2 and three electives during PGY3.

3.5 Elective requests are to be made by submission of the Elective Rotation Proposal Form to the Program Director at least 60 days prior to established electives and at least 4 months prior to an elective not included in the list of established electives list.

3.6 All electives must be approved by the Program Director.

Family Medicine Residency
Elective Rotation Proposal Form

***Submission Due Dates*:**

Established Electives:

60 Days Prior: _____

Non-Traditional Electives:

No Schedule/Call Changes 4 Months Prior: _____

Schedule/Call Changes Needed 6 Months Prior: _____

Date of Submission:_____

Resident Name:_____ **PGY-level:** _____

Rotation Dates:_____

Title of Elective:_____

Hospital/Site Contact Information:

Name: _____

Address:_____

Rotation Director Information:

Name: _____

Address:_____

Phone:_____

E-mail:_____

Administrative Coordinator Information: (if available)

Name: _____

Email Address:_____

Phone:_____

Please answer the following questions. Each question must be answered or your application will be returned from program admin.

1. Other than the rotation director mentioned above, list other faculty, and their titles, who will assume educational and/or supervisory responsibilities for this assignment/rotation?

2. What is your educational rational for this rotation?

3. Please attach elective objectives with this form. Objectives must be stated as measurable actions (SMART objectives)

   Are elective objectives attached? _____

4. Please provide the proposed schedule discussed with the rotation preceptor as an attachment to this form.

   Is the proposed schedule attached?_____

_____
Resident

_____
Faculty Advisor

_____
Site Preceptor

_____
Program Director

International Elective Rotations Policy and Application

I. PURPOSE:

1.1. The purpose of this policy is to provide guidelines and requirements for residents and fellows interested in international health rotations.

1.2. International elective rotations are defined as educational health experiences that occur outside the United States and which are not required by the Accreditation Council for Graduate Medical Education (ACGME) program requirements.

1.2.1. Residents/fellows are employees of Morehouse School of School of Medicine (MSM), and are governed by MSM policies, procedures, and regulations.

1.2.2. Educational rationale must be clearly demonstrable (goals and objectives, competencies, mentorship/preceptorship, outcome evaluation) and consistent with Residency Review Committee program requirements.

1.2.3. There must be a reasonable expectation of safety.

1.2.4. The Institution and its GMEC support trainees interested in international health experiences.

1.2.5. An international rotation will be counted as an elective rotation according to ACGME Residency Review Committee guidelines for elective experiences.

1.2.6. International tracks and rotations will not interfere with ACGME requirements for categorical or combined residency training programs.

II. SCOPE:

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

III. POLICY:

3.1. International elective rotations must align with and support the vision and mission of Morehouse School of Medicine.

3.2. International elective rotations must be approved by the program director (PD) and designated institutional official (DIO). MSM residency and fellowship program directors must notify the GME Office of residents and fellows requesting an international educational experience using the GME International Elective Rotations Request Form and application.

3.3. International educational experiences shall not interfere with the resident/fellow's ability to meet the ACGME Specialty-specific or applicable Board Certification eligibility requirements.

3.4. The international elective rotation must be in compliance with all ACGME Common Program and Specialty-Specific Requirements.

3.5. A resident/fellow completing an international rotation may not adversely affect the education of another MSM resident/fellow.

IV. PROCEDURES AND ELIGIBILITY REQUIREMENTS:

4.1. There must be a fully executed Program Letter of Agreement with rotation-specific, competency-based goals and objectives in place at least six (6) months prior to the start date of the international rotation.

4.2. Written contact information for the international rotation site director and/or supervising physician must be provided with a signed attestation that:

4.2.1. The resident will be supervised according to ACGME requirements.

4.2.2. The supervisor has appropriate academic credentials or their equivalent as determined by the PD and DIO.

4.2.3. The resident will have reliable means of contact/communication.

4.3. The program must provide proof of funding for the resident/fellow's stipend and benefits for the international rotation.

4.3.1. Morehouse School of Medicine does not provide medical professional liability coverage outside of the United States.

4.3.2. The resident/fellow must provide proof of malpractice coverage for international work for the duration of the international elective rotation.

4.4. The resident/fellow's schedule must be approved by the program director and/or chief resident.

4.5. The resident/fellow may purchase supplemental medical travel and medical evacuation insurance additional to that provided by MSM.

4.6. Morehouse School of Medicine is not responsible for travel, living, and extra insurance expenses during the resident/fellow's international elective rotation.

4.7. A resident/fellow on a J-1 Visa must receive clearance from the training program liaison in Human Resources prior to starting the application process for an international elective rotation.

4.8. The resident/fellow must meet the following international elective rotation requirement. The resident/fellow must:

4.8.1. Be in good standing with the program (no remediation or borderline performance, no outstanding medical records, etc.).

4.8.2. Be in training beyond the first year or before the last month of training.

4.8.3. Make all necessary travel arrangements and provide the final itinerary to the program and the GME office.

4.8.4. Obtain medical clearance and the appropriate immunization and/or prophylaxis as recommended by the CDC.

4.8.5. Sign the waiver holding MSM harmless for travel-related injury or harm.

4.8.6. Remain under the direct or indirect supervision of the site director and/or supervising Attending at all times.

4.8.7. Address medical liability adequately and obtain approvals from the Office of General Counsel.

4.8.8. The international elective must be reviewed and approved by the DIO, the MSM President, the MSM Dean, Human Resources, and the Office of General Counsel.

V. APPROVAL PROCESS:

5.1. The resident/fellow must discuss the rotation with and obtain approval from the program director.

5.2. After obtaining approval from the program director, the resident/fellow and program director must complete the GME International Elective Rotations Request Form and application and submit it to the GME Office no later than six (6) months prior to the start of the rotation.

5.3. Once approved by the DIO, the program must submit the international rotation request to Human Resources, the MSM President, and the MSM Dean for approval.

5.4. The GME Office will review the submission and the DIO will determine if the rotation is granted final approval.

VI. INTERNATIONAL ELECTIVE ROTATION CHECKLIST

- ❒ Completed and signed application
- ❒ Submitted copy of Malpractice Insurance Policy
- ❒ Obtained approval from the Office of General Counsel
- ❒ Obtained approval from the Human Resources Office
- ❒ Submitted the completed and signed *Morehouse School of Medicine International Rotation Release*
- ❒ Submitted the signed program letter of agreement

For questions regarding international resident/fellow rotations, contact Jason Griggs, GME Director at jgriggs@msm.edu.

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International Elective Rotations
Release, Covenant Not to Sue and Waiver

Morehouse School of Medicine, a private, non-profit, educational organization, which operates a medical school located at 720 Westview Dr SW, Atlanta, GA 30310 (hereinafter referred to as "MSM"), has been advised that you have volunteered to further your medical training and experience by traveling to and spending time in a foreign country, specifically at _____, a medical school located at _____ (hereinafter the "Foreign Training Program") beginning _____ and ending _____.

Read the following Release, Covenant Not to Sue and Waiver ("Release") carefully, and when you have thoroughly read and agreed to its contents, sign where indicated below.

I understand and acknowledge that, while I have chosen to gain exposure to medicine in an international setting, an international training experience is not a requirement in my MSM residency program, nor does my MSM residency program require me to travel to _____, nor does it require me to obtain experience in _____. I understand that I would be able to fulfill my residency requirements successfully and completely without participating in the Foreign Training Program. I acknowledge that my participation in the Foreign Training Program is elected solely by me.

I further understand that there are significant inherent risks involved with study, research, work, training, and living abroad, and I acknowledge and voluntarily accept all of these risks. These risks include but are not limited to actual travel to and within, and returning from, one or more foreign countries, foreign political, legal, social, and economic conditions; foreign medical conditions; and foreign weather conditions. These risks also include the risk of criminal activity, violence, sexual battery, and terrorist activity.

I specifically acknowledge and I will abide by any warnings, travel alerts, and orders to evacuate that the United States Department of State has issued or may in the future issue to U.S. citizens traveling to the foreign location(s) where I have chosen to travel. I further agree to obtain medical advice about and receive current immunizations that are recommended by the U.S. Department of State and the Centers for Disease Control and Prevention for U.S. citizens traveling to the foreign location(s) where I have chosen to travel.

I understand that the MSM does NOT provide professional liability insurance coverage while I participate in the Foreign Training Program. I agree to notify the Program of this fact and understand that it is my responsibility to obtain such coverage if it is required.

I agree to indemnify and hold harmless Morehouse School of Medicine and its respective Trustees, medical staff, officers, employees, agents, and instrumentalities (the "Indemnified Parties") from any and all liability, losses, or damages, including attorneys' fees and costs of defense, which the Indemnified Parties may incur as a result of claims, demands, suits, causes of actions or proceedings of any kind or nature arising out of, relating to, or resulting from my participation in the Foreign Training Program.

It shall be my obligation to obtain additional health insurance coverage during the term of my international residency. This insurance will be for the purpose of securing health care services in the international location of the international residency rotation. I understand that the current MSM health insurance provider does not provide regular insurance coverage outside the territorial United States. I further understand that if I currently have MSM family coverage, I will be responsible for all requisite payments to maintain the dependent coverage. Additionally, I agree to purchase and provide proof of Medical Repatriation insurance coverage which includes provisions for emergency medical evacuation to the United States. Proof of coverage will be submitted to the Program Director.

I understand that any and all travel expenses, fees, and costs shall be my financial responsibility, even if my rotation at the Foreign Training Program is cancelled or terminated for any reason.

I understand that either the MSM or the Foreign Training Program may unilaterally terminate my participation in the Foreign Training Program if it is determined that I have failed to abide by the terms of this Release, applicable policies, procedures, rules, regulations, or the instructions of any supervising clinician or I have, in any manner whatsoever, compromised patient care or endangered the safety of a patient. In the event of such termination, I may be required to immediately return to the MSM, and any costs for travel and any other costs associated with the termination will be my financial responsibility.

It shall be my responsibility to take into account travel time to and from the location of the Foreign Training Program and to make sure that it does not affect my clinical or other responsibilities at the MSM.

As part of the consideration for the MSM allowing me to participate in the Foreign Training Program, I hereby release, covenant not to sue, and forever discharge the MSM, Fulton County, a political subdivision of the State of Georgia, their past, present, or future commissioners, trustees, employees, agents, officers, servants, successors, heirs, executors, administrators, and all other persons, firms, corporations, associations, or partnerships of and from any and all claims, actions, causes or action, demands, rights, damages, costs, attorneys' fees, loss of service, expenses and compensation whatsoever, which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen and unforeseen events or circumstances during the course of my participation in the Foreign Training Program and/or any travel incident thereto.

I further expressly agree that the terms of this Release shall be legally binding upon me, my heirs, executors and assigns, and all members of my family.

I expressly agree that this release shall be governed by and interpreted in accordance with the laws of the State of Georgia without regard to its conflict of laws principles. I further consent, stipulate, and agree that the exclusive venue of any lawsuit and any other legal proceeding arising from or relating to this Release or my participation in or travel to the Foreign Training Program shall be in a state or federal court located in Fulton County, Georgia, United States.

In the event that any clause or provision of this Release is held to be invalid by any court, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release.

I further declare and represent that no promise, inducement, or agreement not herein expressed has been made to me, and that this Release contains the entire agreement between the MSM and me regarding my participation in the Foreign Training Program and/or any travel incident thereto, and that the terms of this Release are contractual and not a mere recital.

In signing this Release, I hereby acknowledge that I have carefully read this entire document, that I understand and agree to comply with its terms, and that I have signed it voluntarily.

_____
Signature

_____
Printed Name

_____
Date

_____
Notary Seal

MOREHOUSE SCHOOL OF MEDICINE

GRADUATE MEDICAL EDUCATION

Application for International Elective Rotations

The completed application and all required documentation must be completed and submitted no later than six (6) months prior to the start of the rotation. Submit via Postal Service mail to Jason Griggs, Graduate Medical Education Office, 720 Westview Drive, SW, Atlanta, GA, 30310 or via email to jgriggs@msm.edu.

Direct questions to the GME Office at (404) 752-1011.

REQUIRED SUPPORTING DOCUMENTATION/ATTACHMENTS

The following items are required to complete your application for an international elective rotation at Morehouse School of Medicine.

- ❒ Completed and signed application
- ❒ Program Letter of Agreement (PLA) with Rotation Competency-based Goals and Objectives
- ❒ Curriculum Vitae
- ❒ Copy of Malpractice Insurance Policy
- ❒ Completed and signed *Morehouse School of Medicine International Rotations Release*
- ❒ Signed medical clearance

The resident/fellow applying for an international elective rotation must meet the following international elective rotation requirements:

- Be in good standing with the program (no remediation or borderline performance, no outstanding medical records, etc.).
- Be in training beyond the first year and prior to the last month of training.
- Make all necessary travel arrangements and provide the final itinerary to the program and the GME office.
- Obtain medical clearance and the appropriate immunization and/or prophylaxis as recommended by the CDC.
- Sign the waiver holding MSM harmless for travel-related injury or harm.
- Remain under the direct or indirect supervision of the site director and/or supervising Attending at all times.
- Address medical liability adequately and obtain approvals from the Office of General Counsel.

Application for International Elective Rotations

The completed Application for International Elective Rotations must be submitted with all required documentation at least six (6) months in advance of the anticipated rotation start date for processing.

RESIDENT/FELLOW INFORMATION

First Name: Last Name:

Program Name: PGY Level:

Passport # Date of Birth:

Date of Application: _____

EMERGENCY CONTACT INFORMATION

In case of emergency, I authorize Morehouse School of Medicine to contact the following person (list at least one family member who is reachable during the time you are traveling.).

Contact Name:

Address:

Relationship to Resident/Fellow:

Home Phone: Cell Phone:

Email Address:

Contact Name:

Address:

Relationship to Resident/Fellow:

Home Phone: Cell Phone:

Email Address:

ROTATION INFORMATION

Rotation Dates: _____

Name of Rotation: _____

Country of Rotation: _____

Training Site Name: _____

Supervising Faculty Name: _____

Is this elective rotation available at Morehouse School of Medicine or its affiliated institutions? Yes _____ No _____

SITE DESCRIPTION

Type of Center (Governmental, non-governmental, private)

Demonstration of the requirement that the center has an established ongoing relationship with the program. Does the site have residents rotating from other United States institutions? If yes, list examples.

Describe the general patient population.

Describe the burden of disease.

Describe the anticipated Duty hours.

List educational resources available, including reliable access to web-based educational materials.

Identify reliable forms of communication (phone, email, fax, internet) between the rotation site and the training program.

ROTATION DESCRIPTION

Explain how the proposed rotation will provide experience not available at Morehouse School of Medicine or its current affiliate sites.

Provide verification that the rotation is an elective as described in the Residency Review Committee program requirements.

Describe the physical environment for the rotation including housing, transportation, communication, safety, and language.

APPLICANT ATTESTATION

By applying for an international elective rotation, I acknowledge that I am responsible to:

- Make all travel arrangements and provide the program and the GME Office a copy of the final itinerary.
- Obtain medical clearance and appropriate immunization and/or prophylaxis as recommended by the CDC.
- Sign a waiver holding MSM harmless for travel related injury or harm.
- Obtain professional medical liability insurance adequate for and approved by Morehouse School of Medicine's Office of General Counsel.

Signature of Applicant: Date: _____

Printed Name of Applicant:

MOREHOUSE SCHOOL OF MEDICINE PROGRAM DIRECTOR APPROVAL

I confirm that the resident/fellow applicant is in good standing, and I am aware of the request to be away from residency/fellowship duties for the dates stated. I approve the rotation of the above-named resident as specified. I confirm that the resident/fellow's completion of this international elective rotation will not adversely affect the educational experience of any Morehouse School of Medicine resident and/or fellow.

Program Director Signature: Date: _____

Printed Name:

MOREHOUSE SCHOOL OF MEDICINE HUMAN RESOURCES APPROVAL

Human Resources Signature of Approval: Date: _____

Printed Name:

MOREHOUSE SCHOOL OF MEDICINE GENERAL COUNSEL APPROVAL

General Counsel Signature of Approval: Date: _____

Printed Name:

MOREHOUSE SCHOOL OF MEDICINE GME OFFICE APPROVAL

Application Received:

DIO Signature of Approval: Date: _____

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	FM-10
		EFFECTIVE DATE	07/01/2019
		PAGE(S)	05
	SUBJECT FAMILY MEDICINE-SPECIFIC MOONLIGHTING POLICY	SUPERSEDES	NA

Family Medicine-Specific Moonlighting Policy

I. PURPOSE:

The purpose of this moonlighting policy is to ensure that the MSM Family Medicine Residency Program complies with GME and ACGME requirements related to moonlighting.

II. ACGME DEFINITIONS:

2.1. Moonlighting: Voluntary, compensated, medically-related work performed beyond a resident's clinical experience and education hours and additional to the work required for successful completion of the program.

2.2. External moonlighting: Voluntary, compensated, medically-related work performed outside the site where the resident is in training and at any of its related participating sites.

2.3. Internal moonlighting: Voluntary, compensated, medically-related work performed within the site where the resident is in training or at any of its related participating sites.

III. POLICY:

3.1. Only PGY-3 residents are permitted to moonlight.

3.2. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident/fellow's fitness for work nor compromise patient safety.

3.3. Moonlighting must be approved in writing by the program director and designated institutional official (DIO).

3.4. Time spent by residents/fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly hour limit.

3.5. Each resident/fellow requesting entry into such activities shall have a State of Georgia physician's license.

3.6. Residents/fellows must complete the Moonlighting Request Form and sign the Professional Liability Coverage statement available from the GME office. Examples of these follow this policy.

3.7. Moonlighting must occur within the state of Georgia.

3.8. Professional liability coverage provided by MSM does not cover any clinical activities not assigned to the resident/fellow by the residency/fellowship program.

3.9. MSM shall not be responsible for these extracurricular activities. The resident/fellow must secure liability coverage for these outside activities from the respective institutions or through his or her own resources.

3.10. The resident must log all internal and external moonlighting hours, which count toward the ACGME duty hours.

3.11. Moonlighting activities shall not be credited as being part of the program structure or curriculum.

3.12. Moonlighting must not occur during regular business hours or concurrently with assigned program-related clinical duties.

3.13. Moonlighting without formal approval by the PD and DIO will result in disciplinary action, which may include program dismissal depending upon the circumstance.

IV. MOONLIGHTING CRITERIA:

4.1. Resident must be a PGY-3; PGY-1 and PGY-2 residents may not moonlight.

4.2. J1-Visa sponsored residents may not moonlight.

4.3. A full Georgia Physician's license is required to moonlight.

4.4. The resident/fellow must have a *good standing* status in the program.

4.5. To be considered for moonlighting approval, a resident must be in good standing in the program and must not be currently on a prescribed Individualized Study/Success Plan based on ITE performance

4.6. The resident or fellow must log all internal and external moonlighting hours which count toward the ACGME work hours.

4.7. Moonlighting must occur within the state of Georgia.

4.8. Moonlighting must not occur during regular business hours or concurrently with assigned program-related clinical duties.

4.9. Moonlighting without formal approval by the PD and DIO will result in disciplinary action, which may include program dismissal depending upon the circumstance.

Moonlighting Request Form

To be completed by the resident or fellow:

Program Name: _____ Academic Year: _____

Resident/Fellow Name: _____ PGY Level: _____

Georgia Medical License #: _____ Expiration Date: _____

Name of Malpractice Carrier: _____ Malpractice policy #: _____

Name of Moonlighting Site/Organization: _____

Address: _____ City: _____ Zip Code: _____

Moonlighting Supervisor Name: _____ Phone number:_____

Date Moonlighting Starts: _____ Date Moonlighting Ends: _____

Moonlighting Activities:

_____

_____

_____

Maximum hours per week: _____ Number of weeks: _____

Check One:

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

Resident/Fellow Acknowledgement of Moonlighting Policy and Procedures

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

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

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

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

I am not paid by the military or on a J-1 visa.

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

Resident/Fellow Signature: _____ Date: _____

To be completed by the Program Director:

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

Approved ❒ Not Approved ❒

Program Director Signature: _____ Date: _____

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

Approved ❒ Not Approved ❒

Program Director Signature: __ Date: _____ Chinedu Ivonye, MD

Professional Liability Coverage—Moonlighting Request

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

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

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

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

Check appropriate box:

Resident Agreement ❑ Moonlighting Request ❑

Signature: _____

Date: _____

Social Security Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Return Signed Original to Office of Graduate Medical Education.

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Patient Encounter Requirements and Logging Policy

I. PURPOSE:

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

1.2. The Accreditation Council for Graduate Medical Education (ACGME) requires that a diverse variety of patients be seen across a number of practice settings.

1.3. The program complies with all the requirements of the ACGME.

1.4. It is the resident's responsibility to ensure that all patient encounters and procedures are logged appropriately in the residency management system.

II. POLICY:

2.1. All clinical procedures and patient encounters must be logged in the residency management system.

2.2. It is the resident's responsibility to ensure that logging is up to date. All patient encounters and procedures for a given month must be logged by the tenth day of the next month (e.g., all April encounters and procedures must be logged by May 10th).

2.3. Failure to remain up to date with patient and/or procedure logging may result in remediation and/or disciplinary action for deficiency in the professionalism and systems-based practice competencies

2.4. Residents must complete the patient encounters listed in the chart below

2.4.1. The numbers of required encounters listed are minimums. The resident is expected to complete more than the minimum number of encounters, and all encounters must be logged.

2.4.2. Reaching the minimum requirement does not exempt a resident from subsequent clinical duties.

2.4.3. The list details the rotation name and location at which the patient encounter can be experienced as well as the module in the residency management system to log the encounter.

2.4.4. All encounters and procedures must be documented and logged in the residency management system.

2.4.5. All required encounters are tracked by the program to ensure adequate resident training and for the purposes of documentation required in credentialing requests from future employers.

2.4.6. Time-based, patient panel composition, and continuity requirements are also

tracked by the program and reported to the ACGME

2.4.6.1. At least 1,000 hours caring for patients in the FMP across 3 years of training

2.4.6.2. Annual patient-sided continuity at least 30% at end of PGY-2; annual patient-sided continuity at least 40% at end of PGY-3

2.4.6.3. Annual resident-sided continuity at least 30% at end of PGY-2; annual resident-sided continuity at least 40% at end of PGY-3

2.4.6.4. Panel Composition

2.4.6.4.1. Must include minimum of 10% patients younger than 18 years of age

2.4.6.4.2. Must include minimum of 10% patients older than 65 years of age

Patient Encounter Type	Number of Encounters or Hours	Rotation	Rotation Location	Where to Log in the residency management system
Number of patient encounters in FMP site	1,650 (FY2 volume requirement for PGY3s only)	CFHC/Clinics CBOC Home Visits	CFHC	Procedures Include diagnosis Log as "Continuity"
Number of patient encounters of hospitalized adults	750	FM Wards IM Wards	Grady Main	Procedures Include dx and rotation
Care of ICU patients	15	FM Wards IM Wards	Grady Main	Procedures Include dx and rotation
Number of patient encounters of acutely ill or injured patients in ER setting	125	ECC	Grady Main	Procedures Include dx and rotation
Number of patient encounters dedicated to the care of the older patient	125	Geriatrics NH Continuity	JenCare	Procedures Include dx and rotation
Number of patient encounters dedicated to the care of ill child patients in the hospital and/or ER setting	250	Peds Wards Peds ER	HSCH/CHOA	Procedures Include dx and rotation
Peds Inpatient encounter minimum	50	Peds Wards	HSCH/CHOA	Procedures Include dx and rotation
Peds ER encounter minimum	50	Peds ER	HSCH/CHOA	Procedures Include dx and rotation

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Procedure Requirements and Logging Policy

I. PURPOSE:

The purpose of this policy is to describe procedures residents will perform during residency and how proficiency in those procedures will be determined.

II. SCOPE:

2.1. The practice of family medicine requires a broad range of skills, including procedural skills, and the successful completion of residency requires demonstration of competency across a range of different procedures.

2.2. Some of this competency will be gained by the resident during the natural course of rotations.

2.3. Other procedural competencies must be specifically demonstrated as the resident's exposure to these may be variable (e.g., successful completion of ACLS demonstrates competency in adult resuscitation skills).

2.4. Some procedures are less commonly performed by family physicians but are still within the purview of the family physician and require additional experience to gain proficiency (e.g., vasectomy).

2.5. Residents will be exposed to these procedures but need to independently seek opportunities to perform more of these to gain proficiency in residency.

2.6. Residents record all procedures in the residency management system.

2.6.1. Residents are required to log all procedures in the residency management system.

2.6.2. Residents can log their procedures into the residency management system as often as they like, but it must be done at least monthly.

2.6.3. Procedures will be tracked by the residency program every month to ensure compliance. If there are required procedures in which residents do not appear to be gaining enough experience, the program will work with residents, faculty, and staff to expand exposure to those procedures.

III. POLICY:

3.1. Faculty members, peers and nursing staff expect residents to have knowledge of procedures prior to performing them. Thus, it is the resident's responsibility to familiarize himself or herself with the procedure to be performed.

3.2. If the resident is preparing to perform a procedure for the first time, he or she should read and watch instructional videos about it. The faculty attending can also be asked for reference material recommendations before performing the procedure. Even if the resident has performed the procedure several times, refreshing knowledge of a

procedure is good practice.

3.3. Sources generally recommended for primary care procedures include:

- Pfenninger & Fowlers Procedures for Primary Care Physicians
- NEJM's Videos in Clinical l Medicine

3.4. It is the resident's responsibility to ensure that his or her procedures are correctly documented in the medical record and in the residency management system.

3.5. All procedures must be logged in the residency management system. It is the resident's responsibility to ensure that logging is up to date. All procedures for a given month must be logged by the tenth day of the next month (e.g., all April procedures must be logged by May 10th).

3.6. Clinical Procedures

3.6.1. Procedures are to be entered into the logbooks provided by the residency program and signed by the immediate supervisor of the procedure.

3.6.2. PHI is not to be documented in logbooks.

3.6.3. All procedure log data is to be transferred (documented) in the Procedure Logger section of the residency management system.

3.7. Procedures and Independent Target Encounters

3.7.1. The following list shows some of the procedures that the resident will encounter in residency. Although not an exhaustive list, it includes many of the procedures residents experience.

3.7.2. Residents must continue to log procedures in the residency management system even after the independent targets have been met.

3.7.3. Residents must log all procedures performed including procedures that do not have program-assigned independent targets

See the procedure target table on the next page

Procedure	Independent Target
Amniotomy	3
Anoscopy	1
Arterial Blood Gas	2
Arterial Line Placement	1
Central Line Placement	2
Cesarean Section Assist	5
Chest X-ray Interpretation	30
Circumcision	5
Colposcopy	3
Delivery Vacuum Extraction	1
Delivery, normal vaginal	20 (≤5 continuity)
EKG Interpretation	30
Endometrial Biopsy	3
1st, 2nd Deg Laceration Rep	1
Fetal Scalp Electrode	1
I&D Abscess	5
Induction/Augmentation of Labor	5
IUD Insertion	1
IUD Removal	1
IUPC Placement	1
Joint aspiration/injection	15
Lumbar Puncture	2
Newborn Exams	40
OB Nonstress Test	25
OB Ultrasound	5
pap smear	30
Skin Tag removal	1
Suture	5
Wet Mount	5

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FMRP Hand-Off Communication and Transition of Care Policy

I. POLICY

1.1. The purpose of this policy is to ensure a process for safe transitions of care

II. SCOPE

2.1. All family medicine resident and inpatient faculty attendings will adhere to this policy

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

- Shift changes
- Meal breaks
- Rest breaks
- Changes in on-call status
- Contacting another physician when there is a change in the patient's condition
- Transfer of patient from one care setting to another

III. ASSIGNMENT OF NEWLY ADMITTED PATIENT TO FAMILY MEDICINE SERVICE:

3.1. When a patient is admitted to the Family Medicine service, the resident is contacted through Bed Hub.

3.2. The resident calls the attending to inform the attending of the admission.

3.3. Upon performing a full history and physical of the patient, the resident calls the attending to discuss the history, physical, assessment, and management plan

3.4. The floor team residents accept patients on Monday to Friday, between 7:00 a.m. and 6:00 p.m.

3.5. The night float resident will be the admitting resident on Sunday between 7:00 p.m. and 6:00 a.m., Monday to Thursday between 7:00 p.m. and 6:00 a.m., and Friday between 7:00pm and 6:00 am.

3.6. Admissions for patients who arrive after 6:00am during the night float session are held for admission by the day team.

3.7. Admissions for patients who arrive after 6:00pm during the day are held for admission by the night float resident.

3.8. The long call resident will be the admitting resident from 7:00am on Saturday until 6:00 am on Sunday.

3.9. The short call resident will be the admitting resident on Sunday from 7:00 a.m. until 6:00 pm.

IV. TRANSFER OF PATIENTS BETWEEN DAYTIME TEAM AND NIGHT FLOAT RESIDENT

(FM Wards):

4.1. Hand-off communication occurs between the daytime and night float teams at 7:00 p.m. and at 7:00 a.m. Daytime team signs off to the night resident at 7:00 p.m. and vice-versa at 7:00 a.m.

4.2. Both verbal and written communication is conducted. All patients are documented in the electronic sign-out list. This will also be an opportunity to ask and respond to questions.

4.3. The day and night attendings are present in person or by zoom for all resident handoffs.

V. TRANSFER OF PATIENTS TO NEW ROTATING RESIDENT:

5.1. On the last day of the rotation, the inpatient team writes off service notes on all patients. These notes include each patient's initial presentation, hospital course, pertinent lab and study results, and current status, including any pending results or consults.

5.2. A verbal sign-out is also given at 7:00 p.m. on the night before the new team begins.

5.3. The outgoing PGY-3 resident signs out all patients to the oncoming PGY-3 and highlights the patients that he or she is following.

5.4. The PGY-2 also signs out his or her patients to the oncoming PGY-2.

5.5. Any changes that occur overnight will be communicated by the night float resident to the oncoming day team as previously described.

VI. HAND-OFF EVALUATION:

6.1. The Attending must observe at least two (2) change of shift hand-offs in person and must be present for all other change of shift hand-offs by phone.

6.2. Each resident is evaluated based on hand-off expectations in the following areas:

- Environment
- Standard hand-off time
- Use of the SBAR transition of care presentation format
- Appropriately identifying patient details requiring special attention by the receiving resident
- Confirmation that receiving resident understands the SBAR content on all patients by presenting back

6.3. The Attending is expected both to give immediate informal feedback on the witnessed hand-offs and to complete the formal hand-off evaluation form (see below) and submit it to the program manager. The program assistant will transfer data from the hand-off evaluation into the residency management system.

6.4. If the Attending does not consider a resident to be competent to give or receive hand-off after the required minimum of observed transitions of care (hand-offs), the senior resident and Attending must provide additional education to the resident.

6.5. The ability to give competent hand-off is a requirement of passing the Family Medicine Wards rotation.

6.6. Residents should anonymously report breakdowns/problems in the transition of care (hand-off) process for continued improvement by reporting the feedback and placing it in the comment/suggestion box located in the resident call room/work area. Feedback will be collected on a regular basis and reviewed at the following PEC meeting. Residents may also report these concerns directly to the service attending, Program Director, or during PEC meetings, if preferred.

VII. UNUSUAL RESIDENT-INITIATED EXTENSIONS—ADDITIONAL DUTY

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

7.2. However, in unusual circumstances, a resident on his or her own initiative may remain at the clinical site beyond the 24-hour period to provide care to a single patient.

7.3. In these cases, the additional hours must be counted toward the 80 work-hour limit and the justification for extending work must meet one of the following conditions:

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

7.4. The extended work must not exceed four (4) hours.

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

7.5.1. The resident must appropriately hand over the care of all other patients to the team responsible for their continuing care.

7.5.2. The resident must document the reasons for remaining to care for the patient in the residency management system.

7.5.3. The program director must review each submission of additional service and track both individual resident and program-wide episodes of additional work.

Morehouse School of Medicine
Family Medicine Residency Program
Assessment of Resident Giving Hand-off

Attending Name _____ Date _____

Resident Name _____ PGY Level _____

Use the following rating scale: 1) poor, (2) fair, (3) good, (4) very good, and (5) excellent.

Format

Verbal Mnemonic	Description	**(5)**	**(4)**	**(3)**	**(2)**	**(1)**
Situation	Included patient's diagnosis, current treatment, and current complaints					
Background	Vital signs, code status, medication list, pertinent labs					
Assessment	Synthesis of status, anticipation of changes					
Recommendation	Clear indication of tests/labs/consults to follow up. To-do list for next shift/overnight. Recommendation for future care					
Discharge Planning Status						

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

Resident is competent to perform handoffs independently ☐ Yes ☐ No

If no, provide recommendations for improvement _____

_____

_____

Comments_____

_____

_____

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Professionalism Policy

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

The Family Medicine Residency Program follows the MSM GME Professionalism Policy, which is included here in its entirety.

I. PURPOSE:

1.1. Residents are responsible for fulfilling all obligations that the GME Office, hospitals, and residency programs deem necessary for them to begin and continue duties as a resident, including but not limited to:

1.1.1. Attending orientations, receiving appropriate testing and follow-up, if necessary, for communicable diseases, fittings for appropriate safety equipment, necessary training and badging procedures (all of which may be prior to appointment start date)

1.1.2. Completing required GME, hospital, and program administrative functions in a timely fashion and before deadlines such as medical records, mandatory on-line training modules, and surveys or other communications

1.2. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff.

1.3. All GME program directors and faculty are responsible for educating, monitoring, and providing exemplary examples of professionalism to residents.

1.4. Refer to the GME **PROCEDURE:** regarding confidential professionalism reporting systems and resources.

II. SCOPE:

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

2.2. Each program must have a program-level professionalism policy which describes how the program provides professionalism education to residents. The program director will ensure that all program policies relating to professionalism are distributed to residents and faculty. A copy of the program policy on professionalism must be included in the official program manual and provided to each resident upon matriculation into the program.

III. POLICY:

3.1. **Professionalism**—Residents and faculty members must demonstrate an understanding of their personal role in the:

3.1.1. Provision of patient- and family-centered care

3.1.2. Safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events

3.1.3. Reporting of unprofessional behavior.

3.1.3.1. Refer to the GME Concern and Complaint (Grievance) Policy for Residents and Fellows policy regarding confidential professionalism reporting systems and resources.

3.1.4. Assurance of their fitness for work, including:

3.1.4.1. Management of their time before, during, and after clinical assignments; and

3.1.4.2. Recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team

3.1.5. Commitment to lifelong learning

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

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

3.2. Professionalism—Code of Conduct

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

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

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

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

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

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

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

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

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

3.2.7. Respond promptly to phone messages, pages, email, and other correspondence.

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

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

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

3.2.8.3. Take time to ensure patient and family understanding and informed consent of medical decisions and progress.

3.2.9. Respect the sanctity of the healing relationship.

3.2.9.1. Exhibit compassion, integrity, and respect for others.

3.2.9.2. Ensure continuity of care when a patient is discharged from a hospital by documenting who will provide that care and informing the patient of how that caregiver can be reached.

3.2.9.3. Provide reliable coverage through colleagues when not available.

3.2.9.4. Maintain and promote physician/patient boundaries.

3.2.10. Respect individual patient concerns and perceptions.

3.2.11. Comply with accepted standards of dress as defined by each hospital.

3.2.12. Arrive promptly for patient appointments.

3.2.13. Remain sensitive and responsive to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

3.2.14. Respect the systems in place to improve quality and safety of patient care.

3.2.14.1. Complete all mandated on-line tutorials and public health measures (e.g., TB skin testing) within designated timeframe.

3.2.14.2. Report all adverse events within a timely fashion.

3.2.14.3. Improve systems and quality of care through critical self-examination of care patterns.

3.2.15. A professional consistently demonstrates respect for peers and co-workers.

3.2.15.1. Demonstrate respect for colleagues by maintaining effective communication.

3.2.15.2. Inform primary care providers of patient's admission, the hospital content, and discharge plans.

3.2.15.3. Provide consulting physicians all data needed to provide a consultation.

3.2.15.4. Maintain legible and up-to-date medical records, including dictating discharge summaries within approved hospital guidelines.

3.2.15.5. Inform all members of the care team, including non-physician professionals, of patient plans and progress.

3.2.15.6. Provide continued verbal and written communication to referring physicians.

3.2.15.7. Understand a referring physician's needs and concerns about his or her patients.

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

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

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

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

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

3.2.16.4. Encourage team-based care.

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

3.3. Professionalism—Dress Code

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

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

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

3.3.3. **Personal Hygiene**:

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

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

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

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

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

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

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

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

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

3.3.9. Scrubs: Residents must only wear scrubs in the following clinical situations

3.3.9.1. In the emergency department

3.3.9.2. In labor & delivery

3.3.9.3. In the OR

3.3.9.4. Inpatient wards

3.3.9.5. When not in a work area, a white coat should be worn over scrubs.

3.4. Professionalism: Social Media Guidelines

3.4.1. Because social media blurs the line between personal voice and institutional voice, these guidelines were created to clarify how best to protect personal and professional reputations when participating.

3.4.2. In both professional and institutional roles, employees need to adopt a commonsense approach and follow the same behavioral standards as they would in real life and are responsible for anything they post to social media sites either professionally or personally.

3.4.3. For these purposes, "social media" includes but is not limited to social networking sites, collaborative projects such as wikis, blogs, and microblogs, content communities, and virtual communities.

3.4.4. Best practices for all social media sites, including personal sites follow:

3.4.4.1. **Think before posting**—There is no such thing as privacy in the social media world. Before you publish a post, consider how it would reflect on you, your department/unit, and on the institution.

Search engine databases store posts years after they were published, so posts could be found even if they were deleted; and comments may be forwarded or copied.

3.4.4.2. **Be accurate**—Verify your information for accuracy, spelling, and grammatical errors before posting. If an error or omission ends up being posted, post a correction as quickly as possible.

3.4.4.3. **Be respectful**—The goal of social media is to engage your audience in conversation. At times, that comes in the form of opposing ideas. Consider how to respond or disengage in a way that will not alienate, harm, or provoke.

3.4.4.4. **Remember your audience**—Though you may have a target audience, be aware that anything posted on your social media account is also available to the public at large, including prospective students, current students, staff, faculty, and peers.

3.4.4.5. **Be a valuable member**—Contribute valuable insights in your posts and comments. Self-promoting behavior is viewed negatively and can lead to you being banned from a website or group you are trying to participate in.

3.4.4.6. **Ensure your accounts' security**—A compromised account is an open door for malicious entities to post inappropriate or even illegal material as though it were from you. If you administer the social media account for a

hospital, school, college, department, or unit, be sure to use a different password than for your personal accounts. Follow best practices in selecting and protecting your university account passwords.

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

3.4.5.1. **Protect confidential and proprietary information**—Do not post confidential information about MSM, students, faculty, staff, patients, or alumni; nor should you post information that is proprietary to an entity other than yourself.

3.4.5.2. Employees must follow all applicable Federal privacy requirements for written and visual content, such as FERPA and HIPAA. Failure to do so comes at the risk of disciplinary action and/or termination.

3.4.5.3. **Respect copyright and fair use**—When posting, be aware of the copyright and intellectual property rights of others and of the university. Refer to MSM system policies on copyright and intellectual property for more information/guidance.

3.4.5.4. **Do not imply MSM endorsement**—The logo, word mark, iconography, or other imagery shall not be used on personal social media channels. Similarly, the MSM name shall not be used to promote a product, cause, or political party/candidate.

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Research and Scholarly Activity Policy

I. PURPOSE:

1.1. Program responsibilities include demonstrating evidence of scholarly activities consistent with its mission(s) and aims of our program.

1.2. In partnership with its Sponsoring Institution, the program must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities and to advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.

1.3. This policy sets the standards for the program's research curriculum.

II. SCOPE:

2.1. In accordance with ACGME Family Medicine Program Requirements, the Family Medicine Residency Program at Morehouse School of Medicine requires that each resident complete two scholarly projects, one of which must be a quality improvement project

2.2. The scholarly projects are required for residency graduation

III. PURPOSE:

3.1. A scholarly project is required of each resident prior to completion of residency training. Residents will not be approved for graduation without the project being received and approved by the director of research based on criteria communicated to residents.

3.2. The resident is responsible for selecting the faculty who will be assisting with his or her scholarly activities along with the research director.

IV. POLICY:

4.1. Deadlines are set by specific PGY level:

4.1.1. By the end of the **PGY-1** year, each resident must have developed a research question.

4.1.2. By December, the **PGY-2** resident must have developed a methodology.

4.1.3. By the end of the **PGY-2** year, IRB approval must be obtained.

4.1.4. By December, the **PGY-3** must complete data collection.

4.1.5. The research project must be completed in time to present for the departmental resident research day; earlier completion is strongly encouraged.

4.2. Each resident is required to have a faculty discussant for his or her QI/Research project.

4.3. During the Senior Research Forum, each resident will have 15 minutes to present, followed by a 10-minute discussion.

4.4. Faculty research advisors are expected to participate in the discussion.

V. FORMAT:

Presentations should be developed in the following format:

5.1. Introduction:

5.1.1. Question addressed and its importance stated

5.1.2. Conceptual model

5.1.3. Testable hypothesis(es)

5.2. Methods:

5.2.1. Sample—who was studied?

5.2.2. Dependent/outcome variable

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

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

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

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

5.3. Results:

5.3.1. Characteristics of sample

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

5.3.2.1. Of the variables

5.3.2.2. Results of test of hypothesis(es)

5.4. Discussion:

5.4.1. A brief restatement of findings (results)

5.4.2. Interpretation of results—what do they suggest?

5.4.3. How are they consistent with what is known?

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

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

5.5. Conclusion: Recommendations based on results

VI. ADDITIONAL RESEARCH/SCHOLARLY ACTIVITY:

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

6.2. For this project, the resident identifies an issue in the clinic with a patient safety implication and develops an intervention to improve patient safety related to the issue.

6.3. Residents are also required to complete all Institute for Healthcare Improvement (IHI) Open School PSQI modules or AMA PSQI modules as indicated by the GME office during each year of training.

6.4. Writing for publication is highly encouraged through authorship of case reports on patients managed on the Family Medicine wards service.

6.4.1. Each faculty member must identify, with the resident team, at least one patient during his or her coverage of the service whose case can be presented in a case report.

6.4.2. Once identified, if an appropriate journal for publication determined, the resident-attending team should proceed with co-authoring the case report.

6.4.3. Submission for conference presentation and/or Grady Research Day is also highly encouraged.

6.5. Faculty Scholarly Activity

6.5.1. Faculty scholarly activity (both core and non-core faculty) programs must demonstrate accomplishments in at least three (3) of the following domains:

6.5.1.1. Research in basic science, education, translational science, patient care, or population health

6.5.1.2. Peer-reviewed grants

6.5.1.3. Quality improvement and/or patient safety initiatives

6.5.1.4. Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports

6.5.1.5. Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials

6.5.1.6. Contribution to professional committees, educational organizations, or editorial boards

6.5.1.7. Innovations in education.

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

- Faculty participation in Grand Rounds
- Posters
- Workshops
- Quality improvement presentations
- Podium presentations
- Grant leadership
- Non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars

- Service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor
- Peer-reviewed publication
- Resident and fellow scholarly activity

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	FM-17
		EFFECTIVE DATE	07/01/2022
		PAGE(S)	12
	SUBJECT FAMILY MEDICINE RESIDENT ELIGIBILITY, SELECTION, AND APPOINTMENT POLICY	SUPERSEDES	06/01/2019 05/0//2015 06/01/2014 04/02/2013 03/01/2011 10/01/1992

Family Medicine Resident Eligibility, Selection, and Appointment Policy

I. PURPOSE:

1.1. The purpose of this policy is to ensure that the quality of the Morehouse School of Medicine (MSM) Family Medicine Residency Program complies with the Accreditation Council for Graduate Medical Education (ACGME) requirements and meet standards outlined in the Graduate Medical Education Directory under the heading, "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition).

1.2. The processes for the selection of residents and fellows at MSM shall adhere to ACGME requirements and the standards outlined in this policy.

II. SCOPE:

The Morehouse School of Medicine (MSM) Family Medicine Residency administrators, faculty, staff, residents, and accredited affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments to the Program.

III. POLICY:

3.1. This policy is bound by the parameters of residency education and complies with MSM Human Resources policies.

3.2. Applicants MSM Family Medicine Residency Program must be academically qualified to enter into a program.

3.3. The Program shall participate in the National Resident Matching Program (NRMP).

3.3.1. All MSM FMRP Post-Graduate Year One (PGY-1) resident positions shall be made available for application by all students graduating from United States and Canadian accredited medical schools as determined by the NRMP.

3.3.2. Other applicants eligible to enter the "match," including International Medical School Graduates (IMGs), may also apply.

3.4. The MSM FMRP will select from among eligible applicants on the basis of their preparedness and ability to benefit from the program.

3.5. Aptitude, academic credentials, the ability to communicate effectively, personal characteristics such as motivation and integrity, and the ability to function within parameters expected of a practitioner in the specialty shall be considered in the selection process.

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

3.6.1. Introduction

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

3.6.1.2. Those abilities that residents must possess to practice safely are reflected in the technical standards that follow. These technical standards/ essential functions are to be understood as requirements for training in the MSM FMRP and are not to be construed as competencies for practice in the Specialty.

3.6.1.3. Residents in the MSM FMRP must be able to meet these minimum standards with or without reasonable accommodation.

3.6.2. Standards—Observation

3.6.2.1. Observation requires the functional use of vision, hearing, and somatic sensations. Residents/fellows must be able to observe demonstrations and participate in procedures as required.

3.6.2.2. Residents must be able to observe a patient accurately and completely, at a distance as well as closely.

3.6.2.3. Residents must be able to obtain a medical history directly from a patient, while observing the patient's medical condition.

3.6.3. Standards—Communication

3.6.3.1. Communication includes speech, language, reading, writing, and computer literacy.

3.6.3.2. Residents must be able to communicate effectively and sensitively in oral and written form with patients to elicit information as well as perceive non-verbal communications.

3.6.4. Standards—Motor

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

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

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

3.6.5.1. Residents must be able to measure, calculate, reason, analyze, integrate, and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions which are critical skills demanded of physicians.

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

3.6.6. Standards—Behavioral and Social Attributes

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

3.6.6.1.1. The exercise of good judgment.

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

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

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

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

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

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

3.6.7. Standards—Reasonable Accommodation

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

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

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

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

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

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

IV. Title IX Compliance:

4.1. The residency education environment shall be free of undue harassment, confrontation, and coercion because of one's gender, cultural and religious beliefs, other individual traits, and status or standing.

4.2. Therefore, in compliance with the Title IX of the Education Amendments of 1972, the Morehouse School of Medicine (MSM) Family Medicine Residency Program does not discriminate on the basis of sex in its education programs and activities and is required under Title IX and the implementing regulations not to discriminate in such a manner. Prohibited sex discrimination covers sexual misconduct including, but not limited to, sexual harassment and sexual violence, and extends to employment in and admission to such programs and activities.

4.3. The MSM FMRP adheres to the MSM policy that discrimination against any person or group of persons on the basis of race, color, national origin, religion, gender, sexual orientation, marital status, ancestry, genetic information, age, disability, veteran or military status, or any other legally protected characteristic is specifically prohibited. This is in compliance with federal law, including Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act (and ADAAA amendments).

4.4. Marla Thompson, Title IX Coordinator, has been designated to handle inquiries about and reports made under MSM's Sex/Gender Nondiscrimination and Sexual Harassment policy.

Contact information:

mthompson@msm.edu
(404) 752-1871
Fax (404) 752-1639

Morehouse School of Medicine
720 Westview Drive, SW Harris Building,
Atlanta, GA 30310

Contact the MSM Human Resources Office for the current policy.

V. RESIDENT ELIGIBILITY CRITERIA:

5.1. In accordance with ACGME Requirements, applicants with one of the following qualifications are eligible for appointment to the MSM FMRP:

5.1.1. Graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or Graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA).

5.1.2. Graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:

5.1.2.1. Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment

5.1.2.2. Holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty or subspecialty program; or

5.1.2.3. Has graduated from a medical school outside the United States and has completed a Fifth Pathway program provided by an LCME-accredited medical

school.

5.2. Graduates from a medical school outside of the United States must have graduated from a medical school recognized by the Medical Board of California to be considered for acceptance to the MSM FMRP

5.3. Each resident must be a United States citizen, a lawful permanent resident, a refugee, an asylee, or must possess the appropriate documentation to allow the resident to legally train at Morehouse School of Medicine.

5.4. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in:

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

5.5. The FMRP must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.

5.6. A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.

VI. TRANSFER RESIDENT:

6.1. Upon matriculation, the program must obtain verification of previous educational experiences and a summative competency-based performance evaluation signed by the previous program director and the candidate's Milestones evaluations prior to acceptance of the transferring resident.

6.2. Residents are considered transfer residents under several conditions including moving from one program to another within the same or different sponsoring institution

6.3. Before accepting a transfer resident, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current program director.

6.4. The term *transfer resident* and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency program.

6.4.1. MSM FMRP does not accept any applicant with prior GME training who would need to matriculate for a longer duration than the length of the applicant's initial residency to successfully complete Family Medicine training; an applicant who would begin the residency program and would have to continue beyond the initial residency period would be ineligible.

6.4.2. The initial residency period is the length of time required to complete a general residency program (e.g., Internal Medicine: 3 years; Psychiatry: 4 years).

VII. ADDITIONAL ELIGIBILITY REQUIREMENTS:

For any applicant to be eligible for appointment to the MSM FMRP, the following requirements must be met in addition to the eligibility criteria stated above.

7.1. The Program will participate in the National Resident Matching Program (NRMP) for PGY-1 level resident positions.

7.1.1. All parties participating in the match shall contractually be subject to the rules of the NRMP.

7.2. All applicants to MSM FMRP must apply through the Electronic Residency Application Service (ERAS).

7.2.1. This service shall be used to screen required information on all applicants.

7.2.2. All applicants shall request that three (3) letters of professional and/or academic reference and a letter from the Dean of his/her medical school, current within the last 18 months, be sent to the residency program administration via ERAS.

7.3. Applicants must have passed USMLE Step I to be eligible to interview and must have passed USMLE Step 2 to be eligible to rank.

7.4. Applicants shall be selected and appointed only according to ACGME, NRMP, and MSM's requirements and policies.

7.5. Selectees from a United States LCME- or AOA-accredited medical school shall provide proof of graduation or pending *on-time* graduation. They shall request that official transcripts, diplomas, or *on-time* letters be sent to the program via ERAS.

7.6. The State of Georgia and MSM consider any time spent in a residency program as time that must be declared by the applicant when applying for a Temporary Resident Postgraduate Training Permit.

7.6.1. This time is applicable whether the applicant completed the period of residency or not.

7.6.2. A letter of explanation/verification is required of the applicant and the past residency program director.

7.7. Applicants who have not graduated from a United States- or Canadian-accredited medical school shall request certification of completion (by seal) by an official of the medical school. If the medical school is not in the United States, such official letters shall be in English and/or have a certified or notarized English translation of the content.

7.8. A current (stamped indefinite) certificate from the Educational Commission on Foreign Medical School Graduates (ECFMG) must also be submitted with ERAS documents.

7.8.1. Initial ECFMG Certificates should not be pending when applicants are reporting to a residency program.

7.8.2. Failure to obtain an ECFMG Certificate by the start date of the resident appointment will void both NRMP and MSM resident agreements.

7.9. The Program Director must ensure that IMG/FMG candidates are eligible for J-1 Visa sponsorship before ranking these candidates in NRMP.

7.10. All selectees shall complete an MSM Non-Faculty Employment Application. The Human Resources Department is available for assistance.

7.11. Upon selection, all academic and employment documents referenced within this section and other documents requested by the residency program must be presented to the program administrator in their original form.

7.11.1. As a part of credentials authentication, documents shall be screened for authenticity and must be void of alterations.

7.11.2. Program administrators shall screen for signatures, seals, notarization, and other official stamps as being original.

7.12. An applicant invited to interview for a resident position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment. Information that is provided must include:

- Financial support
- Vacations
- Parental, sick, and other leaves of absence
- Professional liability, hospitalization, health, disability, and other insurance accessible to residents/fellows and their eligible dependents

7.13. Final disposition for applicant selection and ranking is done by the residency program director.

7.13.1. There are no provisions for shared or part-time positions in MSM residency programs.

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FMRP Resident Learning and Working Environment Policy

I. PURPOSE:

1.1. In compliance with the ACGME Learning and Working Environment requirements, MSM Family Medicine Residency education occurs in the context of a learning and working environment that emphasizes the following principles

1.1.1. Excellence in the safety and quality of care rendered to patients by residents today

1.1.2. Excellence in the safety and quality of care rendered to patients by today's residents in their future practice

1.1.3. Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

1.1.4. Excellence in professionalism through faculty modeling of the following:

1.1.4.1. The effacement of self-interest in a humanistic environment that supports the professional development of physicians

1.1.4.2. The joy of curiosity, problem-solving, intellectual rigor, and discovery

II. SCOPE:

2.1. All FMRP administrators, faculty, staff, and residents and administrators at participating training affiliates shall understand and support this and all other policies and procedures that govern the Family Medicine Residency program and all GME programs and resident appointments at MSM.

III. POLICY:

3.1. Patient Safety

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

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

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

3.1.2.2. The program structure, including its application of levels of supervision, the composition of inpatient teams, and continuity clinic structure promotes safe, inter-professional, team-based care.

3.1.3. Education on Patient Safety— The FMRP, through its hand-off policy and process, education on accurate documentation, and reinforcement of hospital and clinic-based near miss and adverse outcome reporting mechanisms, provides, and root cause analyses provides formal educational activities that

promote patient safety-related goals, tools, and techniques.

3.1.4. Patient Safety Events

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

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

3.1.4.3. The Family Medicine Residency program ensures that residents, faculty members, and other clinical staff members:

3.1.4.3.1. Are aware of and fulfill their responsibilities in reporting patient safety events at each clinical site;

3.1.4.3.2. Are aware of how to report patient safety events, including near misses, at the clinical site; and

3.1.4.3.3. Are provided with summary information of their institution's patient safety reports.

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

3.1.5. Resident Education and Experience in Disclosure of Adverse Events

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

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

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

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

3.2. Quality Improvement

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

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

3.2.2. Quality Metrics

3.2.2.1. Given the essential role that access to data plays in prioritizing activities for care improvement and evaluating success of improvement efforts, residents and faculty members receive data on quality metrics and benchmarks related to their patient populations on a quarterly basis.

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

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

3.2.3.2. This includes activities aimed at reducing healthcare disparities.

3.3. Clinical Experience and Education (formerly Duty Hours)

3.3.1. In compliance with ACGME Clinical Experience and Education requirements, all program activities and rotations are structured to provide residents with educational and clinical experience opportunities as well as reasonable opportunities for rest and personal activities.

3.3.2. Maximum hours of clinical and educational work per week

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

3.3.3. Mandatory time free of clinical work and education

3.3.3.1. The program structure is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. To that end, the following time-based work requirements are upheld:

3.3.3.1.1. Residents should have eight (8) hours off between scheduled clinical work and education periods.

3.3.3.1.1.1. 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.

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

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

3.3.4. Maximum clinical work and education period length

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

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

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

3.3.5. Clinical and Educational Work Hour Exceptions

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

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

3.3.5.1.2. To provide humanistic attention to the needs of a patient or family; or

3.3.5.1.3. To attend unique educational events.

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

3.4. In-House Night Float

3.4.1. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

3.4.2. Night float experiences do not exceed 50 percent of a resident's inpatient experience; on average the night float experience represents approximately one-third of the Family Medicine resident's inpatient experience, each occurring in 6-day blocks at a time

3.5. Maximum In-House On-Call Frequency

3.5.1. By ACGME requirements, residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

3.5.2. On average, MSM Family Medicine residents are typically assigned to one in-house short call (12 hours) four (4) or five (5) times per year and one in-house long call (24 hours) four (4) or five (5) times per year.

3.5.3. To maintain this balance of inpatient call frequency, when a resident determines the need for a call trade, the resident must first discuss the proposed trade with the trading resident and the Chief Residents to confirm that it will not trigger a work hour violation and once confirmed, must be presented to the Program Director for approval of the trade.

3.6. At-Home Call

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

3.6.1. The frequency of at-home call is not subject to the every-third night limitation, but it must satisfy the requirement for one-day-in-seven free of clinical work and education, when averaged over four (4) weeks.

3.6.2. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

3.6.3. Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

3.7. MSM FMRP Clinical Work and Education Oversight Procedure

3.7.1. It is the goal of the Family Medicine Residency Program and affiliated hospitals that the institution will have no duty hour violations.

3.7.2. The MSM Family Medicine Residency Program abides by all elements of the MSM GME Resident and Fellow Learning and Working Environment Policy with the RRC exception that the Review Committee for Family Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.

3.7.3. Reporting of resident work hours is required by the ACGME Residency Review Committee, the residency accrediting agency, and therefore is not optional. Daily work hour logging in the residency management system is expected and logging within five (5) days is required. All days, including days off and vacation days, must be logged.

3.7.3.1. Residents must log all work types accurately

3.7.3.2. Logging must include moonlighting, vacation, holiday, and sick days

3.7.3.3. All days off must be logged, including weekends, to avoid an inadvertent system flag for a one-day off in seven violation.

3.7.3.4. Each resident must enter justification or cause of any violation flagged in the residency management system

3.7.3.5. If a resident has not logged in one (1) week or more, he or she will receive a notification from the program manager to encourage immediate logging.

3.7.3.6. If work hours are not logged after notification from the program manager, the program director will contact the resident and then the resident must submit a written explanation of why the work hours have not been logged. This explanation is placed in his or her file.

3.7.3.7. Repeated or prolonged work hour logging delinquency may result in disciplinary action, as appropriate, for deficiency in the Professionalism competency.

3.7.4. Program Clinical Work and Education Oversight and Monitoring Process

3.7.4.1. Family Medicine Program Administration

3.7.4.1.1. Work hour logging is monitored by the program manager or

program assistant who provides a weekly logging status report to the program director.

3.7.4.1.2. In the absence of a report, the program director performs a weekly review of the residency management system dashboard is performed weekly to assess compliance with work hour logging and to determine if any work hour violations have occurred since the last review.

3.7.4.1.3. In the event of a work hour violation, the Program Director reviews the resident's log entry, including the required justification or explanation of the violation entered by the resident in the residency management system.

3.7.4.1.4. In the case of an unjustifiable violation, the program director must enter a comment in the residency management system and provide education to the resident, faculty member, and service involved to avoid future violations.

3.7.4.1.5. When upon review of work hour logging, an impending work hour violation is identified, the resident's schedule is adjusted to avoid the violation. If this violation is anticipated to occur on an external service, the resident will be advised to communicate the need for a schedule adjustment with his or her team or the appropriate Program representative (Program Director or Chief Resident as appropriate depending on the rotation) will communicate with the rotation-designated scheduler to advise of the need to adjust the resident's schedule to avoid the violation.

3.7.4.1.6. The following sections of this Policy Manual further address the program's approach to ensuring compliance with the ACGME Learning and Working Environment Policy:

3.7.4.1.6.1. Moonlighting Policy

3.7.4.1.6.2. Sleep Deprivation and Fatigue Policy

3.7.4.1.7. This procedure will allow the program director and/or the program manager to both provide necessary education to individual residents and to determine if there are systemic scheduling patterns that must be adjusted.

3.7.4.2. Program Evaluation Committee

3.7.4.2.1. The Program Evaluation Committee reviews Residency Management System data for evidence of work hour violations

3.7.4.2.2. In the event of work hour violations, an action plan will be created to prevent future work hour violations, to include resident and faculty education and development and when needed, intervention with affiliates.

3.7.4.3. ACGME Resident Survey

3.7.4.3.1. Residents are surveyed by the ACGME every year between January and April.

3.7.4.3.2. If resident responses reflect noncompliance with the ACGME work

hours, a corrective action plan will be completed

3.7.4.3.3. Follow-up and resolution of identified problems are the responsibility of the program director and the department.

3.7.4.3.4. An action plan must be created for any violation that includes identifying reasons for the violation(s) and how the program will resolve the issue(s) to prevent future violations.

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	FM-20
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	SUBJECT FAMILY MEDICINE RESIDENCY LEAVE POLICY	SUPERSEDES	

Family Medicine Residency Program-Specific Leave Policy

I. PURPOSE:

The full GME Leave policy describes all leave types. The purpose of this policy is to highlight process and procedure policies that are specific to the Family Medicine Residency program.

II. SCOPE:

2.1. Leave time is any time away from the residency training program not related to educational purposes.

2.2. This policy applies to residents at all PGY levels

2.3. This policy defines allowable time away from the program in each post-graduate year and total allowable cumulative time across the three (3) years of training.

2.4. Progression to the next PGY-level is not determined by fulfillment of minimum time requirement in each program year defined in this policy. Progression and eventual readiness for autonomous is determined by the Program Director and the CCC.

III. POLICY:

3.1. The Family Medicine Residency Program leave policies are consistent with the MSM Human Resources and GME Leave Policies. See the GME Policy Manual at http://www.msm.edu/Education/GME/index.php.

3.2. All leave must be entered by the resident in the Kronos system and into MedHub as a leave request.

3.3. Eligible Paid Sick leave is dictated by ACGME requirements and MSM GME and HR policy

- **Resident/Fellow Sick Leave**: Residents are allotted 20 days compensated sick leave per academic year (from July through June)
  - Sick leave is not accrued from year to year.
  - Each residency program is responsible for the administration of residents' leave to include scheduling, tracking, approving, and reporting leave to the department, GME, and the MSM Human Resources Department.
  - One time during the course of a resident/fellow's training, trainees may be allotted six (6) weeks of approved medical, parental, and caregiver leave of absence for qualifying reasons that are consistent with applicable laws. This leave is available to the resident once at any time during an ACGME-

accredited program, starting the day the resident/fellow is required to report.

- When this six (6) weeks of approved compensated medical, parental, or caregiver leave is used, the resident/fellow will be provided with one (1) additional week of paid time off reserved for use outside of the six weeks for illness, injury, and medical appointments for the trainee or for the care of an immediate family member.
- Documentation from a treating clinician indicating the duration of medically indicated leave needed must be provided to the Office of Disability Services in order for this six weeks of compensated leave to be approved.
- Sick and vacation leave not used within the current academic year at the time that this six weeks of approved medical, parental, or caregiver leave is taken will be used towards the six weeks.
- When these two (2) leave categories and the balance of the six weeks plus the one week reserved for illness, injury, and medical appointments for the trainee or for the care of an immediate family member are exhausted, any additional leave will be uncompensated (leave without pay)
- The resident is required to meet with the Program Director for guidance on how leave will impact duration in the program and any potential need to extend training.

- **Family and Medical Leave Act (FMLA)**: Program requirements and specifications of the program specialty board apply to the time required to make up absences. For guidance and questions about FMLA, all residents and fellows can contact Marla Thompson in the Human Resources Department (HRD) Office of Disability Services and Leave Management at (404) 752-1871 or ods@msm.edu.
- **Leave of Absence Without Pay (LWOP)**: When possible, requests for leaves of absence without pay shall be submitted by residents in writing to the residency program director for disposition far in advance of any planned leave.
    - All requests shall identify the reason for the leave and its duration.
    - Residents must discuss the impact of the leave on a possible delay in program completion with the program director.
    - The MSM Human Resources Department shall determine the feasibility and all applicable criteria prior to a resident or fellow being granted LWOP and shall advise both the resident and the corresponding residency/fellowship program regarding details and procedures.

3.4. Regardless of combinations of leave type, including all forms of paid and unpaid leave, ABFM Certification Eligibility requirements dictate that no more than 12 weeks be taken away from the program during a single program year. Additional time away from

the program will result in an extension of training time. This is not to be construed with the ACGME-required sick/family/caregiver leave. The ABFM policy specifically addresses eligibility for Board Certification,

3.4.1. Up to eight (8) of these weeks can be attributable to family leave

3.4.2. An additional four (4) weeks can be taken as other leave if MSM HR policy eligibility requirements are met

3.4.3. If a resident exceeds 12 weeks away from the program in any program year, extension of the resident's training will be necessary to cover the duration of time the individual was away from the program in excess of 12 weeks in that program year.

3.5. The ABFM Certification Eligibility requirements dictate that no more than a total of twenty (20) cumulative weeks be taken away from the program across the three (3) years of training.

3.5.1. If a resident exceeds 20 weeks total across the 3 years of training, extension of the resident's training will be necessary to cover the duration of time the individual was away from the program in excess of 20 weeks

3.6. The ABFM allows for Family Leave to cross over two academic years. In this circumstance, the Program Director will determine when the resident is advanced from one PGY level to the next.

3.7. Holidays

3.7.1. Morehouse School of Medicine observes the following 12 days as official holidays:

- New Year's Eve
- New Year Day
- MLK Day
- Good Friday
- Memorial Day
- Juneteenth
- July 4th
- Labor Day
- Thanksgiving
- The day after Thanksgiving
- Christmas Eve
- Christmas Day

3.7.2. Morehouse Healthcare clinics may be open on MSM holidays. The resident must refer to the Morehouse Healthcare holiday schedule when posted in the fall for closure dates.

3.7.3. Time off for a holiday is dictated by a resident's rotation assignment.

3.7.3.1. When rotating on a clinic or service that closes due to a holiday, the resident may take that time off as a paid holiday.

3.7.3.2. Conversely, if a clinic or service is open on a holiday, the resident will be required to report to the clinical site if assigned for work on that day.

3.7.4. Hospitals are considered essential services, so a resident may be required to work

on a holiday.

3.7.5. The resident must clarify whether he or she is required to work on a holiday with his or her assigned service.

3.8. Vacation

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

3.8.2. Vacation must be taken in five-day increments (Monday through Friday)

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

3.8.4. Vacation is not permitted on two-week block rotations.

3.8.5. Vacation can be taken during the following rotations (listed by PGY level):

- PGY1: OB-Grady, Surgery, Neurology, Nursery, Gyn/Women's Health
- PGY2: Elective, FM Clinic, Sports Medicine, Geriatrics, Obstetrics
- PGY3: Elective, Rheumatology, Human Behavior/Mental Health, Cardiology, Dermatology, Research/Board Review

3.8.5.1. Vacations during rotations not listed will not be approved

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

3.8.7. Vacation change requests will be considered only under extenuating circumstances and must be submitted in writing 120 days (4 months) prior to the requested change using the leave request form and are subject to approval by the program director. Verbal requests will not be approved.

3.8.7.1. The vacation change request must be entered by the resident in the residency management system as a time off request

3.8.7.2. Once approved, the resident must enter the new vacation dates and remove the initially scheduled vacation dates in the Kronos system.

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

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

3.9. Sick Leave Call Out

3.9.1. The Family Medicine Residency Program follows the GME and Human Resources sick leave policies as defined in the preceding policy.

3.9.2. The resident must follow the call out policy of the current rotation. Additionally, the resident must immediately notify the Family Medicine chief residents, the program director or associate program director, **and** the program manager in writing of any unscheduled absence from his/her rotation as soon as the resident knows he/she will be absent. Telephone contact (a conversation; not only a text message) must also be made with the Chief Resident **and** the Program Director, Associate Program Director, or Program Manager immediately upon recognizing that absence is needed.

3.9.3. In compliance with the GME and Human Resources policies, if a resident must be on sick leave for more than two (2) days, a return-to-work notice completed by the

treating provider must be submitted to the Human Resources Office of Disability Services (Marla Thompson mthompson@msm.edu). The note must affirm the medical necessity of the absence, anticipated date of return, and when returning, the medical clearance to return to work.

3.9.4. It is not required that sick time be made up; however, if an essential clinical experience (e.g., continuity clinic, ED shift, etc.) is missed, the resident must complete that essential clinical experience at another assigned time.

3.9.5. The resident must complete and submit the sick leave in MedHub **and** Kronos as soon as is physically possible.

3.10. Administrative/Educational

3.10.1. At the discretion of the Program Director, third-year residents can take up to five (5) days of administrative leave for exploring employment opportunities.

3.10.2. Administrative leave may not exceed 5 days each program year.

3.10.3. Time away from rotations for educational purposes, such as workshops or CME activities, are not counted as absences or time away from the program but must not exceed five (5) days annually.

3.10.3.1. The program director must approve educational conferences three (3) months (90 days) before the conference is to take place.

3.10.3.2. The program assistant in the residency office handles travel arrangements for CME.

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

3.11. The Family Medicine Residency Program follows the MSM GME and Human Resources Family Medical Leave (FMLA) policies as defined in the preceding policy.

3.12. The resident must complete and enter a leave request through the Residency Management System for any planned (e.g., vacation change, educational conferences) or unplanned (e.g., sick, bereavement) time off. If the leave is to occur during time that the resident is scheduled for clinical and educational responsibilities, the coverage for these responsibilities must be specified in the comments section of the request. If no coverage is required, this must also be entered in the comments section. The comments section must never be left empty.

3.13. Residents must complete the following steps to request planned leave:

3.13.1. Step 1: Submit the leave request form to the chief resident for schedule review to determine feasibility of the leave (**not for approval**).

3.13.2. Step 2: If dates are deemed feasible, the resident must find back-up for any continuity clinic, call, or night float missed and obtain a signature on the request form from the covering resident(s).

3.13.3. Step 3: Submit the leave request through the residency management system for approval by the program director. Indicate clinical responsibilities missed and arranged coverage in the notes/comments section of the electronic leave request.

3.14. Residents must complete the following steps to request unplanned leave:

3.14.1. Step 1: Upon determining that he or she will be absent from a clinical assignment,

the resident must immediately, or as soon as physically possible, call and speak to the program manager, program director, or associate program director, in addition to the primary contact from the clinical site from which the resident will be absent to alert them of the need for the leave. If the resident is physically unable to speak, email contact is sufficient.

3.14.2. Step 2: The resident must submit a leave request through the Residency Management System as soon as is physically possible.

3.15. Third year residents will not be granted leave during the first or last week of the final rotation block except for extreme circumstances. Director approval is required.

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	FM-20
		EFFECTIVE DATE	07/01/2022
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	SUBJECT FAMILY MEDICINE RESIDENCY DIDACTIC PARTICIPATION AND ATTENDANCE POLICY	SUPERSEDES	N/A

Family Medicine Residency Didactic Participation and Attendance Policy

I. PURPOSE:

1.1. The purpose of this policy is to ensure that the intended educational outcomes of dedicated Wednesday afternoon didactic time are actualized

II. SCOPE:

All MSM Family Medicine Residents, Program faculty, staff, and participating affiliates are to understand and support this policy administrators, faculty, staff, residents, and accredited participating affiliates shall understand and adhere to this policy.

III. POLICY:

3.1. Residents are expected to attend all didactic sessions unless on vacation or other approved leave or when on rotations during which didactic attendance is exempted

3.2. When on a rotation on which Family Medicine didactics are not required, the resident must attend the rotation-specific didactic sessions.

3.3. Unplanned Absence from Didactics

3.3.1. When urgent circumstances preclude a resident from attending a required conference, the residency program director or the associate residency program director must be called immediately (a text message or email alone will not suffice) to excuse the absence and an email must be sent to the program director and program manager for proper recording of the absence. If the urgency requires absence for a full day, the leave policy must be followed.

3.4. Resident Presentations During Didactic Sessions

3.4.1. When a resident is scheduled to present (case presentation, Journal Club, or “What’s New in Family Medicine”), he or she must request an attending physician to be a discussant on the chosen topic. The resident must send the completed presentation to the attending for review, feedback, and input no less than five (5) days before the presentation.

3.4.2. When a resident is scheduled to present, he or she is required to send the full, well-developed objectives to the program manager or assistant 10 days in advance of the presentation.

3.4.3. For journal club presentations, a pdf copy of the journal article for Journal Club presentations must also be sent to the program assistant no later than 14 days before the presentation for advance dissemination to conference attendees.

3.4.4. The Family Medicine Residency Program places high emphasis on the quality of its didactic programs. The program's expectation is that residents who are scheduled to present will do so in a professional and timely fashion. In the event that a resident is unable to present when scheduled (e.g., already scheduled for vacation or CME), the resident must contact the program director or associate program director, chief resident, and the program assistant immediately to allow ample time to schedule another well-prepared session during the vacated didactic slot and to assign another date for the resident to present. In the event of a last-minute inability to present, the program director or associate program director must be contacted directly by phone.

3.5. Didactic Evaluations

3.5.1. The resident must submit an electronic evaluation through the residency management system (MedHub) for each didactic session attended.

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Resident and Fellow Promotion Policy

I. PURPOSE:

1.1. The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition).

1.2. A resident will be prepared to undertake independent medical practice upon the successful completion of a residency program and shall have completed requirements to obtain a physician's license and prepare for certification by a specialty board.

II. SCOPE:

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

III. POLICY:

3.1. Residency and fellowship education prepares physicians for independent practice in a medical specialty or subspecialty, respectively. Residents and fellows are expected to progressively increase their level of proficiency in order to advance within a training program.

3.2. MSM's focus is on the resident's acquisition and development of pertinent skills and behaviors with the intent of providing a competent practicing physician to the community.

3.3. Appointments are made on a yearly basis with the expectation of continuation within the one-year appointment and of reappointment yearly throughout the duration of the training period.

IV. RESIDENCY PROGRAM PROMOTION:

4.1. Program Responsibilities

4.1.1. The resident will receive periodic, scheduled, written evaluations of his or her performance, progress, and competence in the program specialty as outlined in the MSM Evaluation Policy.

4.1.2. Residents must be familiar with ACGME-Residency Review Committee and MSM educational requirements to successfully complete the residency program.

4.1.2.1. This should begin on the first day of matriculation.

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

4.1.2.2.1. A copy of the MSM Graduate Medical Education (GME) Policy Manual

4.1.2.2.2. A Residency Policy Manual and/or Handbook (or equivalent) outlining at a minimum:

- The residency program goals, objectives, and expectations
- The ACGME Specialty-Specific Program Requirements
- The six ACGME competencies designed within the Program curriculum
- Clinical rotations and/or other education modules with specific goals, objectives, and expected outcomes
- Schedules of assignments to support rotations
- The educational supervisory hierarchy within the program, rotations, and education affiliates
- The residency program evaluation system

4.2. Promotion Requirements

4.2.1. In order for GME trainees to complete an MSM residency education program, they must successfully meet the following standards in addition to any program-specific requirements:

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

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

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

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

4.2.1.5. The resident must achieve a satisfactory score on the in-training examinations along with other program-specific criteria required to advance.

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

4.2.3. The continuing resident will sign an acknowledgement of promotion to the next PGY-level that includes a description of competencies required to progress to the next level (or complete training if beginning the final year of training) in 12 months.

4.3. Process and Timeline for Promotional Decisions

4.3.1. Normal promotion decisions are made no later than the eighth month of the appointment. Reappointment agreements are prepared based on the residency Clinical Competency Committee and program director's recommendation for promotion.

4.3.2. When a resident will not be promoted to the next level of training, the program will provide the resident with a written notice of intent no later than four (4) months prior to the end of the resident's current appointment agreement. If the primary reason for non-promotion occurs within the last four (4) months of the appointment agreement period, the program will give as much written notice as circumstances reasonably allow.

4.3.3. If a resident's appointment agreement is not going to be renewed, the residency program must notify the resident in writing no later than four (4) months prior to the end of the resident's current contract. If the decision for non-renewal is made during the last four (4) months of the contract period, the residency program must give the resident as much written notice as possible prior to the end of the appointment agreement expiration.

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

Morehouse School of Medicine
Family Medicine Residency Program
Acknowledgement of Promotion and PGY-2 Duties
Promotion Criteria PGY-1 to PGY-2

Promotion Criteria from PGY-1 to PGY-2
Following at least twelve (12) months of training, the Clinical Competency Committee will make a recommendation for promotion to PGY-2 status based upon successful demonstration of all aspect of the PGY-1 job description along with the following criteria:

Patient Care
Regarding patient care, the intern will:

- Role-model competent whole person care to other residents and medical students.
- Have documented participation in at least five (5) deliveries OR participate in an active plan to ensure adequate total deliveries.
- Demonstrate the ability to independently perform a complete history and physical exam, write appropriate orders, and appropriately document the hospital course for inpatients.
- Have demonstrated competency in basic procedures to include Pap smears, I&D, suturing, and wet preps as confirmed by clinical preceptors.

Medical Knowledge
Regarding medical knowledge, the intern will:

- Pass all required rotations satisfactorily.
- Have achieved at least 10th percentile on the composite score of the Family Medicine In-Training Exam or actively participated in an improvement plan assigned by the program.
- Have achieved a minimum of the Level 2 Milestone on the MK-1 and MK-2 sub-competencies.

Practice-Based Learning and Improvement
Regarding practice-based learning and improvement, the intern will:

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

Interpersonal and Communication Skills
Regarding interpersonal and communication skills, the intern will:

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

Professionalism

Regarding professionalism, the intern will:

- Have demonstrated adequate participation in academic and professional activities such as conferences, rounds, and meetings, and pursuit of certification exam completion.
- Model professional behavior to students in clinic and rotations.
- Have attended all required educational conferences, unless excused.
- Demonstrate adherence to policies regarding procedural documentation.

Systems-Based Practice

Regarding systems-based practice, the intern will:

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

Comments _____

_____

_____

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

Program Director	Faculty Advisor

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

Resident	Date

Morehouse School of Medicine
Family Medicine Residency Program
Acknowledgement of Promotion and PGY-3 Duties
Promotion Criteria from PGY-2 TO PGY-3

Promotion Criteria from PGY-2 to PGY-3

Following at least twenty-four (24) months of training, the Clinical Competency Committee will make a recommendation for promotion to PGY-3 status based upon successful demonstration of all aspect of the PGY-2 job description along with the following criteria:

Patient Care

Regarding patient care, the resident will:

- Be a role-model of competent and compassionate whole person care to junior residents and medical students.
- Have documented participation in the continuity care of at least two (2) patients for prenatal, intrapartum, delivery and postpartum care of at least two (2) patients or will participate in a plan to achieve this goal.
- Demonstrate the ability to supervise a complete history and physical exam and oversee appropriate orders for hospital care.
- Assume an active role in diagnosis and treatment plans which is based on sound medical knowledge.
- Have documented adequate procedural competency to supervise the in-patient team adequately, including competency on knowledge and skill domains on EKG interpretation, ICU management, code management, etc.

Medical Knowledge

Regarding medical knowledge, the resident will:

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

Practice-Based Learning and Improvement

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

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

Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the resident will:

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

Comments _____

_____

_____

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

_____ _____

Program Director Faculty Advisor

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

_____ _____

Resident Date

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Sleep Deprivation and Fatigue Policy

I. PURPOSE:

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

II. SCOPE:

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

III. DEFINITION OF FATIGUE:

3.1. Fatigue is a feeling of weariness, tiredness, or lack of energy. Fatigue can impair a physician's judgment, attention, and reaction time which can lead to medical errors, thus compromising patient safety.

3.2. There are many signs and symptoms that would provide insight to one's impairment based on sleep deprivation. Clinical signs include:

- Moodiness
- Depression
- Irritability
- Apathy
- Impoverished speech
- Flattened affect
- Impaired memory
- Confusion
- Difficulty focusing on tasks
- Sedentary nodding off during conferences or while driving
- Repeatedly checking work and medical errors

IV. POLICY:

4.1. Programs must educate all faculty and residents to recognize the signs of fatigue and sleep deprivation and in alertness management and fatigue mitigation processes.

4.2. Programs must encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

4.3. Each program must ensure continuity of patient care consistent with program resident wellness policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue.

4.4. The program's education and processes must be designed to:

4.4.1. Raise faculty and residents' awareness of the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care.

4.4.2. Provide faculty and residents with tools for recognizing when they are at risk.

4.4.3. Identify strategies for faculty and residents to use that will minimize the effects of fatigue (in addition to getting more sleep).

4.4.4. Help identify and manage impaired residents.

V. INDIVIDUAL RESPONSIBILITY:

5.1. Resident's Responsibilities in Identifying and Counteracting Fatigue

5.1.1. The resident will be educated on the hazards of sleep deprivation and fatigue in the workplace and in their personal lives (e.g., motor vehicle accidents).

5.1.2. The resident is expected to adopt habits that will provide him or her with adequate sleep to perform the daily activities required by the program.

5.1.3. If too fatigued to drive home at the end of a work period, the resident is encouraged to use another form of transportation (e.g., taxicab) or take a nap prior to leaving the training site.

5.2. Faculty Responsibilities in Identifying and Counteracting Fatigue

5.2.1. Faculty will be educated on the hazards of sleep deprivation and fatigue in the workplace and in the provision of care to patients.

5.2.2. Faculty members will be able to determine if residents are sleep deprived and will make the appropriate recommendations to the resident that will correct this problem.

VI. MSM IMPLEMENTATION:

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

6.2. The policy is designed to:

6.2.1. Identify strategies to assist in the prevention of these conditions;

6.2.2. Provide an early warning system for impairments and ways to effectively manage them;

6.2.3. Access appropriate referral resources; and

6.2.4. Identify an impaired resident.

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

6.3.1. Has a faculty component and a resident component;

6.3.2. Addresses policies to prevent and counteract the negative effects on patient care and learning;

6.3.3. Seeks the expertise of existing faculty to present materials;

6.3.4. Uses modules for role play, case studies that address the adverse effects of inadequate supervision and fatigue.

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

6.4.1. New residents will continue the discussion on sleep deprivation and fatigue in their residency program.

6.4.2. Each program will revisit the topic periodically throughout the year through role play, videos, and other discussions (many of these materials are available through the LIFE Curriculum).

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

6.5.1. The GME office will periodically survey each program to determine if the core faculty has received the training and over what period of time.

6.5.2. The LIFE Curriculum will suffice for this educational session; however, programs are encouraged, where appropriate, to adapt the modules or create new modules that are specific to their specialty.

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

VII. COUNSELING:

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

VIII. EVALUATION:

The effectiveness of this policy will be measured by:

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

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Supervision and Accountability Policy

I. PURPOSE:

1.1. The purpose of this policy is to ensure that the Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) comply with ACGME supervision requirements and that the programs meet the standards outlined in the Graduate Medical Education Directory: "Essentials of Accredited Residencies in Graduate Medical Education" (AMA-current edition) and the specialty program goals and objectives.

1.2. The resident physician is expected to progressively increase his or her level of proficiency with the provision of predetermined levels of supervision.

1.3. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions.

1.4. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence.

1.5. This policy ensures that the resident can assume these roles while maintaining personal safety and patient safety.

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. Ensure the provision of safe and effective care to the individual patient;

3.1.2. Ensure each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine;

3.1.3. Establish a foundation for continued professional growth.

3.2. Each patient must have an identifiable, appropriately credentialed, and privileged Attending physician (or licensed independent practitioner) who is responsible and accountable for the patient's care. This information must be available to residents, faculty members, other members of the healthcare team, and patients.

3.3. Residents and faculty members must inform patients of their respective roles in each patient's care when providing direct patient care.

3.4. All residents working in clinical settings must be supervised by a licensed physician. The supervising physician must hold a regular faculty or adjunct faculty appointment from the Morehouse School of Medicine. For clinical rotations occurring outside of Georgia the supervising physician must be approved by the residency program director.

3.5. The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

3.5.1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

- The program director must evaluate each resident's abilities based on specific criteria guided by the Milestones.
- Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and delegate him or her the appropriate level of patient care authority and responsibility.
- Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of the residents.

3.5.2. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

3.5.3. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty members.

3.5.4. All residents must know the limits of their scope of authority, and the circumstances under which they are permitted to act with conditional independence.

3.5.5. Initially, PGY-1 residents must be supervised directly

IV. LEVELS OF SUPERVISION:

4.1. To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classifications of supervision:

4.1.1. Direct Supervision:

4.1.1.1. The supervising physician is physically present with the resident and the patient during the key portions of the patient interaction or

4.1.1.2. The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

4.1.2. Indirect Supervision:

4.1.2.1. The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision

4.1.3. Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

4.2. Each program must specify in writing the type and level of supervision required for each level of the program.

4.2.1. Levels of supervision must be consistent with the Joint Commission regulations for supervision of trainees, graduated job responsibilities/job descriptions.

4.2.2. The required type and level of supervision for residents performing invasive procedures must be clearly delineated.

4.2.3. The Joint Commission Standards for GME Supervision include:

4.2.3.1. Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff.

4.2.3.2. The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.

4.2.3.3. Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner.

V. SUPERVISION OF PROCEDURAL COMPETENCY:

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

5.2. This competence shall be evaluated and documented as to success and qualifications. The following protocol is used for administration of certifying residents' procedural competency.

5.2.1. Residents must be instructed and evaluated in procedural techniques by a licensed independent practitioner (LIP) who is certified as competent to independently perform that procedure or who has been credentialed by the medical staff office to perform that procedure.

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

5.2.3. The program director for each training program will be responsible for maintaining an updated list of residents who have been certified as competent to perform procedures independent of direct supervision. This list must be available to Nursing in order to assist them in developing a physician resource listing.

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

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

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

GME PROGRAM SUPERVISION PROCEDURES AND PROCESSES:

5.3. Each program will maintain current call schedules with accurate information enabling residents at all times to obtain timely access and support from a supervising faculty member.

5.4. Verification of required levels of supervision for invasive procedures will be reviewed as part of the Annual Program Review process. Programs must advise the Associate Dean for GME, in writing, of proposed changes in previously approved levels of supervision for invasive procedures.

5.5. The GMEC Committee must approve requests for significant changes in levels of supervision.

5.6. The program director will ensure that all program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on supervision must be included in the official program manual and provided to each resident upon matriculation into the program.

5.7. The GME Office provides a Program Supervision Policy Template and Example for programs to utilize.

VI. MECHANISMS FOR RESIDENTS/FELLOWS TO REPORT INADEQUATE SUPERVISION

Residents and fellows can report inadequate supervision and accountability in a protected manner that is free from reprisal by completing the GME reporting policy *(***PROCEDURE:**) for residents and fellows as provided in this manual.

VII. CLINICAL RESPONSIBILITIES:

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

VIII. TEAMWORK:

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

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	FM-23
		EFFECTIVE DATE	7/01/2017
		PAGE(S)	07
	SUBJECT FAMILY MEDICINE RESIDENCY SUPERVISION POLICY	SUPERSEDES	06/01/2014 04/01/2011 10/01/1992

Family Medicine Residency Program-Specific Supervision Policy

I. SUPERVISION POLICY:

1.1. The program director will perform ongoing assessment for adequate and appropriate supervision of residents at all times.

1.2. All patient care is supervised by qualified faculty physicians who are appropriately credentialed and privileged.

1.3. The faculty physician is ultimately responsible for patient care.

1.4. Information to identify and contact the appropriate supervising faculty physician in the Comprehensive Family Healthcare Center (CFHC) is available at all times via the schedule published weekly and posted in the resident and preceptor work areas.

1.4.1. All faculty contact numbers are posted in the departmental directory which is circulated by email annually and after each update.

1.4.2. The directory is also posted in the Comprehensive Family Healthcare Center resident work area and the residency office.

1.5. Residents and faculty members should inform patients of their respective roles in patient care.

1.6. Residents are provided with rapid, reliable systems for communicating with supervising faculty, including faculty phone numbers and direct chat or staff messaging in the electronic health record.

1.6.1. Faculty preceptors are physically present in the preceptors' room in the CFHC for immediate communication between residents and supervising faculty and for direct supervision of interns during the first 6 months of training and as needed by residents at any level of training.

1.6.2. In the inpatient setting, the supervising faculty meeting is either physically present or immediately available on the inpatient attending shared phone number from 7am to 7pm M-F and 7am – 5pm on Saturday and Sunday and on the night attending's preferred contact number on M-F from 7pm to 7am and 5pm -7am on Saturday and Sunday.

1.7. Faculty schedules are structured to provide residents with appropriate supervision and consultation.

1.8. A maximum resident-to-faculty ratio of 4:1 is maintained at all times in the continuity clinic (CFHC).

1.9. Supervision is exercised through a variety of methods.

1.9.1. All patient care must be supervised by approved clinical faculty at the appropriate level of supervision.

1.9.2. Some activities require the physical presence of the supervising faculty member.

1.9.3. For some aspects of patient care, the supervising physician is a more advanced resident.

1.9.4. Supervision can be provided via the immediate availability of the supervisor or, in some cases, by phone or electronic modalities.

1.10. Direct supervision is required for all procedures in the CFHC continuity clinic and the Family Medicine Ward service.

1.11. Lack of supervision or access to attendings must be reported to the program director and/or the department chairperson.

1.12. Levels of Supervision

1.12.1. Direct Supervision: Defined as above in the GME Supervision Policy

1.12.1.1. Direct supervision is required for all patient encounters conducted by residents in their first six months of training.

1.12.1.2. Direct supervision is required for any encounter in which the information provided to the faculty preceptor is either incomplete or insufficiently clear for the preceptor to provide appropriate guidance regarding the assessment and management plan

1.12.2. Indirect Supervision: Defined as above in the GME Supervision Policy

1.12.3. Oversight: Defined as above in the GME Supervision Policy

See levels of supervision table on next page

	Level of Supervision by PGY Level		
	PGY-1	**PGY-2**	**PGY-3**
Pregnancy Care			
Pregnancy Care (FMP)	D/I	I	I
Pregnancy Care (L&D)	D/I	I	I
High-Risk Patient	D/I	D	X
Admission	DR/I	I	I
Labor Check	D/R/I	I	I
Vaginal Delivery	D	D	D
Change of Condition	D/R/I	D/I	D/I
Inpatient			
Inpatient Admission	D/R/I	I	I
Transfer to Increased Level of Care	D/R	I	I
Transfer to another hospital	D/R	I	I
Pediatrics Inpatient	D/R/I	I	I
Pediatrics Outpatient	D/I	I	I
Surgery (procedures)	D	D	D
Emergency Department Encounter	D/I	I	I
Ambulatory			
FMP	D/I	I	I
Other (MSK, Behavior, etc.)	X	I	I
Home Visits	D	I	I
SNF (nursing home)	X	I	I

Key

I —Indirect supervision
D—Direct supervision
O—Oversight
X—Not appropriate for level of training
R—Advanced level resident may immediately supervise (Attending must still be contacted and participate in decision making)

*All procedures must be directly supervised by an Attending.

II. GUIDELINES WHEN RESIDENTS MUST COMMUNICATE WITH ATTENDING

2.1. Residents must communicate with the Attending to discuss all hospital admissions at the time of admission.

2.2. The supervising attending must be contacted if a patient decompensates or has any other negative change in status.

2.3. Any time a patient is transferred to a higher level of care, being discharged (including discharged against medical advice), or when end-of-life decisions are being made, the supervising Attending must be notified as soon as possible, but within two (2) hours by the resident primarily caring for the patient.

2.4. For any adverse event

2.5. Each patient seen in the clinic must be discussed with the supervising Attending during the visit or before the end of the clinic session, as appropriate.

2.6. If the resident is uncomfortable or uncertain about how to manage a patient due to the patient's acuity or the resident's level of medical knowledge or experience, the resident must communicate with the attending if guidance from an upper-level resident is not sufficient.

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Telemedicine Policy

I. PURPOSE

1.1. MSM's response to the COVID-19 pandemic must include telemedicine and tele-supervision in order to ensure the safety of our patients and our trainees.

1.2. Telemedicine can foster the development of communication skills in resident and fellow physicians using this emerging and emergently needed care modality, as well as in future health care.

II. SCOPE

2.1. This policy applies to residents, fellows, and chief residents participating in Morehouse School of Medicine (MSM) Graduate Medical Education (GME) training programs, accredited by the Accreditation Council of Graduate Medical Education (ACGME).

2.2. Residents, fellows, and chief residents are hereafter referred to as "trainees."

III. BACKGROUND

3.1. Telehealth is a collection of means or methods for enhancing healthcare, public health, and health education delivery and support, using telecommunications technologies.[1]

3.2. These means and methods include telephonic, live video, mobile health, remote patient monitoring, store-and-forward, and EHR patient portal modalities.

IV. POLICY

4.1. Telehealth privileges are required for all Morehouse School of Medicine providers before performing direct, live, video provider-to-patient services via telehealth, in order to ensure patient safety, patient satisfaction, and appropriate billing procedures.

4.2. Residents and fellows (trainees) can engage in telemedicine, as long as trainees and their supervising faculty follow supervision requirements as if the same function were performed in person.

4.3. Supervision can take place through telemedicine, either by having an Attending join a synchronous interaction (telephone, video) when technically feasible, or by staffing the patient with a supervising physician at a later time, with the intent to mimic in person workflows.

[1] Center for Connected Health Policy. About telehealth. https://cchpca.org/about/about-telehealth. Published 2019. Accessed April 3, 2020.

4.4. These workflows must be compliant with the ACGME Common Program Requirements for Direct and Indirect Supervision that further stipulate:

4.4.1. Programs must define when physical presence of a supervising physician is required.

4.4.2. Direct Supervision

4.4.2.1. PGY 1 residents must initially be supervised directly with the supervising physician physically present with the resident during the key portions of the patient interaction. (VI.A.2.c).(1).(a)

4.4.2.2. The supervision physician and/or patient is not physically present with the resident within the hospital or other site of patient care and is concurrently monitoring the patient care through appropriate telecommunication technology. (VI.A.2.c.(1).(b)

4.4.2.3. Indirect Supervision – the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide direct supervision. (VI.A.2.c).(2)

4.4.2.4. Oversight—the supervising physician is available to provide review of the procedure/encounters, with feedback provided after care is delivered. (VI.A.2.c).(3)

Family Medicine Residency Program-Specific Determination of when direct supervision is required:

Direct supervision is required in the following circumstances:

- All encounters with a first year resident in the first 6 months of training
- when the resident is uncomfortable with the complexity of the complaint
- when the resident presentation to the faculty preceptor does not provide sufficient information for the attending to provide guidance on the assessment and management plan

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	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-21
		EFFECTIVE DATE	07/01/2024
		PAGE(S)	02
	SUBJECT USMLE STEP 3 REQUIREMENT POLICY	SUPERSEDES	07/01/2023 04/02/2013 04/01/2011

USMLE Step 3 Requirement Policy

I. PURPOSE:

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

II. SCOPE:

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

III. POLICY:

3.1. Residents must pass USMLE/COMLEX Step 3 by the end of their 20th month of residency.

3.1.1. Residents must present the official results of their USMLE/COMLEX Step 3 examination to the residency program director before the last working day of the resident's 20th month which is, in a normal appointment cycle, February.

3.1.2. Residents who have not passed Step 3 by the end of the 20th month will not receive a training agreement for the next academic year (formerly known as "reappointment letter") at the regular time. Instead, these residents will receive letters of non-renewal that will be rescinded upon passing the exam before the end of the 24th month.

3.2. Residents who pass USMLE/COMLEX Step 3 between the 21st and 24th month, will receive a training agreement for the next academic year at the time of receipt of the results, if this is the sole reason for not receiving an appointment letter.

3.3. A resident who passes USMLE/COMLEX Step 3 beyond the outer parameters of this policy (e.g., passes in the 25th month) shall not be waived to continue in the residency program. However, that resident may reapply to the program subject to review by the Associate Dean for Graduate Medical Education in consultation with the program director and the Director of Graduate Medical Education.

3.4. Residents who transfer to MSM at the PGY-1 or PGY-2 level are subject to this policy.

3.4.1. MSM residents who change status after beginning training in a PGY-1 preliminary position in internal medicine or surgery to a categorical position in another MSM program are recognized as a transfer resident.

3.4.2. This policy applies even if the resident remains in Internal Medicine or Surgery (preliminary to categorical).

3.5. MSM residency programs shall not select transfer residents above the PGY-2 level for an MSM appointment if they have not passed USMLE/COMLEX Step 3.

3.6. Residents shall be briefed on this policy in the annual GME and/or Program orientation.

3.6.1. Residents who have not passed USMLE/COMLEX Step 3, but are still within the time limits, must sign a letter of understanding that they acknowledge the policy.

3.6.2. A copy of the letter of understanding is co-signed by the GME Director and shall be placed in the resident's educational file as well as in the Office of Graduate Medical Education file.

3.7. Individual waivers to this policy may be considered by the Associate Dean for Graduate Medical Education under the following circumstances:

- Extended illness or personal leave, and/or
- Personal hardship or extenuating circumstances.

IV. FAMILY MEDICINE RESIDENCY PROGRAM-SPECIFIC PROCESS:

4.1. Family Medicine residents are encouraged to take the USMLE/COMLEX Step 3 examination by the 12th month of training.

4.2. Family Medicine residents who have not passed Step 3 by the end of the 20th month will receive a letter of non-renewal of contract on February 28th in a normal appointment cycle.

4.3. Family Medicine residents who pass Step 3 between the 21st and 24th month will receive a reappointment letter to the residency program at the time of receipt of the results if this is the sole reason for non-renewal.

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Visiting Resident and Fellow Rotations Policy and Application

I. PURPOSE:

The purpose of this policy is to provide guidelines for residents and fellows from other ACGME-accredited programs to rotate on clinical services offered by the Morehouse School of Medicine (MSM) residency and fellowship programs based at Grady Memorial Hospital (GMH). Visiting residents/fellows' applications must be approved by the program director, designated institutional official (DIO), and GMH.

II. SCOPE:

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

III. POLICY:

3.1. Morehouse School of Medicine residency and fellowship programs must request approval from the GME Office for all residents/fellows visiting from other ACGME-accredited programs by completion of the visiting resident/fellow's application process.

3.2. Visiting resident/fellow rotations must be in support of the mission of MSM and/or provide a unique educational experience for the visiting resident/fellow.

3.3. The education of a visiting resident/fellow must not interfere with the education of MSM residents/fellows.

3.4. MSM will not pay the salary and benefits of the visiting resident/fellow.

3.5. Visiting residents/fellows may not take vacation time during visiting rotations.

IV. VISITING RESIDENT/FELLOW REQUIREMENTS AND APPLICABLE PROCEDURES:

4.1. Visiting residents/fellows must be in good standing at their sponsoring institution/program.

4.2. The visiting resident/fellow must request approval from the program director of the MSM residency or fellowship program before between 4 to 6 months of the visiting rotation start date.

4.3. When approved, the visiting resident/fellow must work with their program and sponsoring institution to complete and submit the MSM Application for Visiting Residents/Fellows, all accompanying documents, and required GMH paperwork no later than 90 days prior to the start of the visiting rotation.

4.4. The visiting resident/fellow must provide proof in writing of continuation of compensation, benefits, and medical professional liability coverage from his or her current sponsoring institution.

4.5. The visiting resident/fellow must obtain a Georgia resident training physician permit or full physician license.

V. MSM PROGRAM DIRECTOR PROCEDURES AND REQUIREMENTS:

Prior to approving a visiting resident/fellow to rotate on an MSM service or rotation, the program director of the MSM residency/fellowship program must ensure that the following procedures have been completed.

5.1. Notify the GME office of the proposed visiting resident/fellow by completing and submitting the visiting resident/fellow request form and required documentation to the GME office within between 4 to 6 months before the start of the rotation. Required information includes:

- **5.1.1.** Resident/fellow's full name, phone number, and email address used at the home institution,
- **5.1.2.** Name of the home institution and program,
- **5.1.3.** Contact information for the resident/fellows' home training program and GME office, and
- **5.1.4.** Proposed rotation dates.

5.2. Ensure that the visiting resident/fellow education will not interfere with the education of any MSM residents/fellows while on rotation at MSM.

5.3. Ensure that the program will continue to meet the required volumes for patients and/or procedures.

5.4. Verify that the visiting resident/fellow is in good standing in an ACGME-accredited program.

5.5. Verify that the visiting resident/fellow possesses or is eligible for a Georgia physician training permit or full physician license.

5.6. Provide appropriate evaluation of the visiting resident/fellow to his or her current program within two (2) weeks of the end of the rotation.

VI. MSM GME OFFICE PROCEDURES AND REQUIREMENTS:

After the visiting resident/fellow rotation is approved by the DIO and GMS, the MSM Graduate Medical Education Office will complete the following steps:

6.1. Provide the visiting resident/fellow with the application and required paperwork to complete and return within between 3 and 4 months of the rotation start date.

6.2. Ensure compliance with the MSM and Grady visiting resident and fellow rotations policy.

6.3. Verify that the visiting resident/fellow has documented continuation of salary, benefits, and medical professional liability coverage.

6.4. Provide the visiting resident/fellow with information to complete the application process to obtain a Georgia training permit or full license per the Georgia Composite Medical Board requirements.

6.5. Work with GMH to obtain parking and ID badges.

Visiting Resident/Fellow Rotations (VR/FR) Checklist of Required Documentation

- ❒ Request form from MSM program director
- ❒ Program Letter of Agreement (PLA)
- ❒ Rotation specific competency-based goals and objectives
- ❒ VR/FR Application
- ❒ Current Curriculum Vitae
- ❒ Georgia physician training permit or physician license
- ❒ Certificate of Medical Professional Liability Coverage
- ❒ Proof of current, site-specific, required documentation for the academic year in which the rotation is occurring, including:
    - HIPAA Training
    - OSHA (Bloodborne Pathogen Training)
    - Immunization Health History (PPD and Flu compliant)
    - Others as required
- ❒ Completion of Grady Memorial Hospital site-specific training and learning modules. This information is provided when the rotation is approved.

For questions regarding visiting resident/fellow rotations, contact Yvonne Gilbert, GME Institutional Program Manager at (404) 752-1566; ygilbert@msm.edu

Application for Visiting Resident/Fellow Rotations

The completed application and all required documentation must be completed and submitted no later than 90 days prior to the start of the rotation. Submit the documentation via email to ygilbert@msm.edu or send by postal mail to Colleen Stevens, MBA, Graduate Medical Education Office, 720 Westview Drive, SW, Atlanta, GA, 30310. Direct questions to Yvonne Gilbert in the GME Office.

APPLICATION CHECKLIST

The following items are required to complete the application for a visiting rotation at Morehouse School of Medicine.

- ❒ Completed Georgia Training Permit application
- ❒ Letter of good standing from current program director
- ❒ Curriculum vitae
- ❒ Immunization record (form attached, must include up to date PPD and flu shot documentation)
- ❒ Certificate of Professional Liability Insurance Coverage
- ❒ Copy of BLS/ACLS Certification
- ❒ Completed affiliate hospital paperwork for the location of the rotation, i.e., Grady or the VA
- ❒ Proof of current academic year HIPAA Training and Bloodborne Pathogen Training
- ❒ Program Letter of Agreement (PLA)
- ❒ Rotation Competency-Based Goals and Objectives

MOREHOUSE SCHOOL OF MEDICINE

GRADUATE MEDICAL EDUCATION

Application for Visiting Resident/Fellow Rotations

Submit 90 days in advance of anticipated rotation start for processing.

MSM ROTATION INFORMATION

MSM Program: _____ Rotation Name: _____

Requested Dates of Rotation: From To: _____

VISITING RESIDENT INFORMATION

First Name: _____ Last Name: _____

Address: _____ _____

Email: _____ PGY Level:

Phone Number: _____ Date of Birth: _____

NPI: _____ Last Four Numbers of SSN: _____

EDUCATIONAL BACKGROUND

Medical School: _____

Date of Graduation: _____

CURRENT RESIDENCY PROGRAM INFORMATION

Institution Name: _____

Training Program: _____

Program Director Name: _____

Program Director Phone/Email: _____/_____

Program Coordinator Name: _____

Program Coordinator Phone/Email: _____/_____

GME Office Contact Name: _____

GME Office Contact Phone/Email: _____/_____

MALPRACTICE INFORMATION

Applicants must provide proof of malpractice insurance. Submit a copy of the certification of liability coverage with your application.

Do you have current malpractice coverage? Yes _____ No _____

Insurance Carrier Name: _____

Coverage Limits (Minimum of $1 million / $3 million): _____

APPLICANT ATTESTATION

By applying for a visiting rotation with the Morehouse School of Medicine Graduate Medical Education, I agree to abide by the rules and regulations of the hospital and service to which I am assigned. I understand that Morehouse School of Medicine will not provide a stipend, benefits, and professional liability.

Signature of Applicant: _____ Date: _____

Printed Name of Applicant: _____

HOME INSTITUTION PROGRAM DIRECTOR APPROVAL

By signing below, I confirm that the resident/fellow applying for a visiting rotation at Morehouse School of Medicine is in good standing and approved to complete the requested rotation. I also confirm that the resident/fellow's home institution will continue to provide the stipend, benefits, and professional liability insurance for the resident.

Home Institution Program Director Signature: _____

Printed Name of Home institution PD: _____

Date: _____

MOREHOUSE SCHOOL OF MEDICINE PROGRAM DIRECTOR APPROVAL

I approve the rotation of the above-named resident as specified. I confirm that the visiting resident/fellow rotation will not adversely affect the educational experience of any Morehouse School of Medicine residents and/or fellows.

Program Director Signature: _____ Date: _____

Printed Name of Program Director: _____

MOREHOUSE SCHOOL OF MEDICINE GME OFFICE APPROVAL

Approved: ❒ Approved by:_____ Date of Approval: _____

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Well-Being Policy

I. PURPOSE:

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

II. SCOPE:

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

III. POLICY:

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

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

3.1.1.1. Protecting time with patients

3.1.1.2. Minimizing non-physician obligations

3.1.1.3. Providing administrative support

3.1.1.4. Promoting progressive autonomy and flexibility

3.1.1.5. Enhancing professional relationships

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

3.1.1.7. Evaluating workplace safety data and addressing the safety of residents and faculty members

3.1.1.8. Policies and programs that encourage optimal resident and faculty member well-being

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

3.1.3. Attend to resident and faculty member burnout, depression, and substance abuse.

3.1.3.1. The program, in partnership with its sponsoring institution must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist

those who experience these conditions.

3.1.3.2. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care.

3.1.4. Encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.

3.1.5. Provide access to appropriate tools for self-screening.

3.1.6. Provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

3.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies, and parental leave.

3.2.1. Each program must have policies and procedures in place that ensure coverage of patient care.

3.2.2. These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.

IV. WELL-BEING RESOURCES:

4.1. MSM Connect Wellness Resources—

https://msmconnect.msm.edu/group/mycampus/wellness

4.2. Individual Residency and Fellowship Program Directors

contact the program director of your training program for any concerns and/or issues with resident and faculty well-being.

4.3. Cigna Employee Assistance Program (EAP), CARE 24/7/365.

4.3.1. This benefit is available for residents as a self-referral or for family assistance.

4.3.2. Residents are briefed on these programs by HR during in-coming orientation. Residents are briefed annually on the Drug Awareness Program, resident impairment issues, and family counseling.

4.3.3. More information regarding these programs is available in the Human Resources Department at (404) 752-1600, or Cigna EAP directly at (877) 622-4327, online at www.mycigna.com

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MSM Institutional Policies

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

OR

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

The Family Medicine Residency Program operates in accordance with all MSM Institutional Policies, available through the MSM Human Resources Department. Particular Institutional Policies that may be of interest to Residents are listed below:

- Accommodation and Disabilities Policy
- Affirmative Action/Equal Employment and Opportunity Policy
- Nepotism Policy
- Sex/Gender Non-Discrimination and Sexual Harassment Policy
- Interaction with Pharmaceutical, Biotechnology, Medical Device, and Hospital and Research Equipment Supply Industry Policy
- Worker's Compensation Policy

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