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Preface

Morehouse School of Medicine (MSM) Vision and Mission

MSM Vision
Leading the creation and advancement of health equity by:
• Translating discovery into health equity
• Building bridges between healthcare and health
• Preparing future health learners and leaders

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

MSM Graduate Medical Education (GME) Goals and Objectives
GME is an integral part of the Morehouse School of Medicine medical education continuum. Residency is an essential dimension of the transformation of the medical school graduate into the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident. Residency education at MSM has the following five goals and objectives for residents:
• To obtain the clinical knowledge, competencies, and skills required for the effective treatment and management of patients;
• To prepare for licensure and specialty certification;
• To obtain the skills to become fully active participants within the United States healthcare system;
• To provide teaching and mentoring of MSM medical students and residents;
• To directly support the school’s mission of providing service and support to disadvantaged communities.

The MSM Family Medicine Residency Program
History
The MSM Family Medicine Residency Program is located in metropolitan Atlanta, Georgia, a city which is an economic and cultural center for not only the southeastern United States, but also the world at large. Morehouse School of Medicine opened in September 1975 as part of Morehouse College, with Dr. Hugh Gloster as President and Dr. Louis Sullivan as Dean of the medical school. The Department of Family Medicine, the first clinical department, was established in July 1979. In 1981, the Department started the school’s first residency program. The department has been an integral part of the development of the school and is a critical link in the school’s educational programs. The residency program serves a significant role in Georgia as a producer of family physicians who practice among underserved populations with more than 60% of its graduates remaining in the state after training. The program is accredited by the Accreditation Council for Graduate Medical Education (ACGME).
Our program aims to be the best and most effective program in the southeast in developing superb family physicians for practice in underserved communities. We offer training in all aspects of family medicine including but not limited to office procedures, community outreach, preventive medicine, and women’s health care. In our 37-year history, we have successfully recruited well-qualified graduates of accredited medical schools. To date, there are a total of 172 graduates from our program, many of whom have received recognition at the state and national level for their outstanding contributions. A full complement of the brightest, most competent and compassionate students from around the nation and abroad join our residency training program.

The Morehouse Family Medicine Practice, the Morehouse Healthcare Comprehensive Family Healthcare Center, is a model office that provides a setting that fosters educational excellence, provides research opportunities, and exposes residents to ambulatory office operations. Our faculty is a group of highly-trained, dedicated, and enthusiastic teachers who are effective in motivating their learners. They are involved in regular scholarly activities and are committed to maintaining excellence in education. Our faculty includes 22 physicians and four non-physician clinicians.

Mission

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

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

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

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

Hospital affiliates include:
- Grady Memorial Hospital (GMH)
- Children’s Healthcare of Atlanta (CHOA)
- Atlanta Veteran’s Affairs Hospital (VA)
- Atlanta Medical Center Main and South (AMC)
Residents in our program also obtain education from a number of physicians in the private and public sectors for outpatient rotations.

Training Goals
The MSM Family Medicine Residency Program goals are listed below:

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

Residency Program Location Contact Information
The Morehouse School of Medicine Family Medicine Program is physically located in East Point, GA. Our contact address is 720 Westview Drive, SW, Atlanta, GA 30310. Our phone number is 404-756-1230. Further information in relation can be found on our website at http://www.msm.edu/Education/GME/FMResidencyProgram/index.php.

Program Administration and Leadership

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

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

Associate Program Director – Dr. Walkitria Smith
The associate program director assists the program director in developing and implementing the program while completing specific assigned tasks. These tasks include developing and modifying the family medicine residency curriculum, conducting semi-annual evaluations with residents, overseeing the program operations, and assisting with didactic teaching and conference schedules. The associate program director also represents the program at official meetings within the institution and outside, as needed, in the absence of the program director. The APD also assists with the resident selection process.
Program Manager – Colleen Stevens, MBA
The program manager manages the daily operational activities of the residency program and interacts with personnel at affiliated institutions, as needed. The program manager ensures that the residents complete all required paperwork, including obtaining completed evaluations. The program manager also ensures that residents’ master files, evaluations, immunization certificates, visa documents, United States Medical Licensing Examination (USMLE) scores, and procedure and patient logs are kept up to date. The program manager is responsible for completing and filing all required paperwork and communications from internal and external entities (e.g., MSM Graduate Medical Education [GME] office, American Board of Family Medicine, American Academy of Family Physicians). The program manager coordinates the resident recruitment activities in conjunction with the program director.

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

Chief Residents – Drs. Tolani Olagunju and Aaron Cooper
The chief residents support resident teaching activities such as Grand Rounds, Morning Report, and weekly didactics. The chief residents supervise the development and modification of resident schedules, review vacation requests for feasibility, and arrange back-up coverage for unplanned absences. The chief residents attend faculty meetings of the department and serve as the resident liaisons. The chief residents are elected by the residents by February of the PGY2 year and approved by the faculty. A resident must be in his/her second year of training and in good standing for the most recent 18 months to be eligible for Chief election.

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

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

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

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

## Clinical Faculty

<table>
<thead>
<tr>
<th>Faculty Member Name</th>
<th>Board Certification</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicole Ash-Mapp, MD</td>
<td>Family Medicine</td>
<td><a href="mailto:nashmapp@msm.edu">nashmapp@msm.edu</a></td>
</tr>
<tr>
<td>Dolapo Babalola, MD</td>
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</tr>
<tr>
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<td>Family Medicine</td>
<td><a href="mailto:Dbell-carter@msm.edu">Dbell-carter@msm.edu</a></td>
</tr>
<tr>
<td>Marc Berger, MD</td>
<td>Family Medicine</td>
<td><a href="mailto:mberger@msm.edu">mberger@msm.edu</a></td>
</tr>
<tr>
<td>Kitty Carter-Wicker, MD</td>
<td>Family Medicine</td>
<td><a href="mailto:kcwicker@msm.edu">kcwicker@msm.edu</a></td>
</tr>
<tr>
<td>Kirstie Cunningham, MD</td>
<td>Obstetrics &amp; Gynecology</td>
<td><a href="mailto:kcunningham@msm.edu">kcunningham@msm.edu</a></td>
</tr>
<tr>
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</tr>
<tr>
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<td>Family Medicine</td>
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</tr>
<tr>
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<td><a href="mailto:jherbertcarter@msm.edu">jherbertcarter@msm.edu</a></td>
</tr>
<tr>
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<td><a href="mailto:rkelsey@msm.edu">rkelsey@msm.edu</a></td>
</tr>
<tr>
<td>Ashley McCann, MD</td>
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<td><a href="mailto:amccann@msm.edu">amccann@msm.edu</a></td>
</tr>
<tr>
<td>Dominic Mack, MD, MBA</td>
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<td><a href="mailto:dmack@msm.edu">dmack@msm.edu</a></td>
</tr>
<tr>
<td>Yuan Xiang Meng, MD, PhD, MSCR</td>
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<td><a href="mailto:ymeng@msm.edu">ymeng@msm.edu</a></td>
</tr>
<tr>
<td>Michelle Nichols, MD, MS</td>
<td>Family Medicine</td>
<td><a href="mailto:mnichols@msm.edu">mnichols@msm.edu</a></td>
</tr>
<tr>
<td>Lawrence Powell, MD</td>
<td>Family Medicine</td>
<td><a href="mailto:lpowell@msm.edu">lpowell@msm.edu</a></td>
</tr>
<tr>
<td>Walkitria Smith, MD</td>
<td>Family Medicine</td>
<td><a href="mailto:wasmith@msm.edu">wasmith@msm.edu</a></td>
</tr>
<tr>
<td>Charles Sow, MD, MSCR, CPEHR</td>
<td>Family Medicine</td>
<td><a href="mailto:csow@msm.edu">csow@msm.edu</a></td>
</tr>
<tr>
<td>Gregory Strayhorn, MD (retired)</td>
<td>Family Medicine</td>
<td><a href="mailto:gstrayhorn@msm.edu">gstrayhorn@msm.edu</a></td>
</tr>
<tr>
<td>Robert Williams, MD</td>
<td>Obstetrics &amp; Gynecology</td>
<td><a href="mailto:rwilliams@msm.edu">rwilliams@msm.edu</a></td>
</tr>
</tbody>
</table>

## Non-Clinical Faculty

<table>
<thead>
<tr>
<th>Faculty Member Name</th>
<th>Area of Focus</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marietta Collins, PhD</td>
<td>Behavioral and Mental Health</td>
<td><a href="mailto:mcollins@msm.edu">mcollins@msm.edu</a></td>
</tr>
<tr>
<td>Susan Robinson, PA-C</td>
<td>Geriatrics</td>
<td><a href="mailto:srobinson@msm.edu">srobinson@msm.edu</a></td>
</tr>
<tr>
<td>Arleatha Williams-Livingston, PhD</td>
<td>Community Health</td>
<td><a href="mailto:awlivingston@msm.edu">awlivingston@msm.edu</a></td>
</tr>
</tbody>
</table>

## Clinical Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Front Office Staff</strong></td>
<td></td>
</tr>
<tr>
<td>Latoyia Douglas</td>
<td>Medical Records, Patient Service Representative</td>
</tr>
<tr>
<td>Natasha Ibarra</td>
<td>Front Desk, Patient Service Representative</td>
</tr>
<tr>
<td>Shakena Jenkins</td>
<td>Front Desk, Patient Service Representative</td>
</tr>
<tr>
<td>Linda Robinson</td>
<td>Supervisor, Front Office</td>
</tr>
<tr>
<td>Nico Smith</td>
<td>Front Desk, Patient Service Representative</td>
</tr>
<tr>
<td><strong>Referral Coordinators</strong></td>
<td></td>
</tr>
<tr>
<td>Stephanie Brooks</td>
<td>Referral Coordinator</td>
</tr>
<tr>
<td>Kimberly White</td>
<td>Referral Coordinator</td>
</tr>
<tr>
<td>Melinda Morgan</td>
<td>Care Coordinator</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Latonya Sallard-Hill</td>
<td>Care Coordinator</td>
</tr>
<tr>
<td><strong>Back Office Clinical Staff</strong></td>
<td></td>
</tr>
<tr>
<td>Barbara Cobb, LPN</td>
<td>LPN</td>
</tr>
<tr>
<td>Kimberly Miller-Corneh, LPN</td>
<td>LPN</td>
</tr>
<tr>
<td>Michelle Remis, LPN</td>
<td>LPN</td>
</tr>
<tr>
<td>Teyunna Stephens, CMA</td>
<td>CMA</td>
</tr>
<tr>
<td>Shameka Tramell, CMA</td>
<td>CMA</td>
</tr>
<tr>
<td>Teyunna Stephens, CMA</td>
<td>CMA</td>
</tr>
<tr>
<td>Tan Sinclair, CMA</td>
<td>CMA</td>
</tr>
<tr>
<td>Shanikka Springer, RMA</td>
<td>RMA</td>
</tr>
<tr>
<td><strong>Support Staff</strong></td>
<td></td>
</tr>
<tr>
<td>Carmen Coggins, RN</td>
<td>Practice Manager</td>
</tr>
<tr>
<td>Alysia Coleman</td>
<td>Administrative Assistant, CCMA</td>
</tr>
</tbody>
</table>
Program Elements

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>PGY</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY-1</td>
<td>Laptop provided by the department</td>
</tr>
<tr>
<td>PGY-2</td>
<td>AAFP Board Review Course OR $750</td>
</tr>
<tr>
<td>PGY-3</td>
<td>AAFP Board Review Course OR $750</td>
</tr>
</tbody>
</table>
PGY-2 and PGY-3 residents have the option to take the Board Review Course in either the Spring of their 2nd or the Fall of their 3rd year. Whichever year the Board Review course is not taken, the resident has an allotment of $750 for CME activities or educational materials. All CME requests must be made by April 15th of the PGY-2 or PGY-3 year. Examples of items that can be purchased with CME funds are medical books related to Family Medicine only, stethoscopes, scrubs, medical software for handheld devices, and CME conferences. CME funds cannot be used for computers, computer equipment, or personal device accessories. The residency office should be consulted prior to confirm eligibility for CME funds. All CME funds must be used in the current fiscal year, no later than April 15th. CME funds do not rollover.

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

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

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

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

<table>
<thead>
<tr>
<th>PGY-1 Resident Rotations</th>
<th>Rotation Days</th>
<th>Continuity Clinic Days</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| "IM Wards Grady"         | Daily – No FM Didactics | Mondays | Dr. Cinnamon Bradley - Site Director cbradley@msm.edu  
IM Program Manager: Tiffany Donald tdonald@msm.edu |
| "ICU Grady*"             | As scheduled – No FM Didactics | Mondays | Dr. Cinnamon Bradley - Site Director cbradley@msm.edu  
IM Program Manager: Tiffany Donald tdonald@msm.edu |
| Surgery Grady            | Daily         | Tuesdays               | Dr. Clarence Clark - Site Director cclark@msm.edu  
Chief Residents: Golda Kwayisi gkwayisi@msm.edu  
Domonic Hill dhill@msm.edu |
| L&D Grady                | Daily         | Thursdays              | Dr. Franklin Geary - Site director fgeary@msm.edu  
OB Chief Resident: Heather Skanes-Devold – hskanes@msm.edu |
| OB/Gyn AMC               | Tues (AM), Thur (PM), Fri (AM)  
Mon AM @ CFHC  
Tues (AM), Thurs (PM), Fri (AM) @ WJF  
Deliveries @ AMC Main  
Tues (PM), Thurs (AM) | | Dr. Kirstie Cunningham  
Email: kcunningham@msm.edu  
Cell: 770-851-4976 |
| Neuro VA Atlanta VA Medical Center | Mon, Tues, Thur, Fri | Wed (AM) | Dr. William Tyor - Site Director  
Charlyn Thomas - Neurology Rotation Coordinator  
404-321-6111, ext. 5142 |
| ECC Grady                | As scheduled  | Wed (AM)               | Dr. James O'Shea - Site Director  
Rikka English - Program Coordinator rikka.rashi.english@emory.edu |
<table>
<thead>
<tr>
<th>Ward Type</th>
<th>Rotation Details</th>
<th>Contact Person</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peds Wards Hughes Spalding*</td>
<td>Daily for 3 weeks. NO FM didactics!!! 1 week of clinic (beginning or end of month)</td>
<td>Dr. Chevon Brooks - Site Director</td>
<td><a href="mailto:cbrooks@msm.edu">cbrooks@msm.edu</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peds Chief:</td>
<td><a href="mailto:pedschief@msm.edu">pedschief@msm.edu</a></td>
</tr>
<tr>
<td><em>Peds ER Hughes Spalding</em></td>
<td>As scheduled. No FM Didactics when on a scheduled shift Thursday</td>
<td>Dr. Funmi Salami - Site Director</td>
<td>Donna Stringfellow – Program Coordinator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Donna Stringfellow – Program Coordinator</td>
<td><a href="mailto:dstring@emory.edu">dstring@emory.edu</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If the need arises to call out from a shift, follow the below:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Call chiefs and residency admin</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Call Peds ED directly and notify attending for the day 404-785-9662 (unit secretary ask of the attending on duty)</td>
</tr>
<tr>
<td>FM Wards</td>
<td>Daily</td>
<td>Various FM Attendings</td>
<td></td>
</tr>
<tr>
<td>CFHC</td>
<td>Varies (May cover VA Gyn)</td>
<td>All Days</td>
<td>NONE</td>
</tr>
<tr>
<td>Nursery</td>
<td>Daily</td>
<td>Dr. Letitia Mobley</td>
<td><a href="mailto:lmcdowe@emory.edu">lmcdowe@emory.edu</a></td>
</tr>
</tbody>
</table>

### PGY-2 Resident Rotations

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Rotation Days</th>
<th>Clinic Days</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peds GEP</td>
<td>Mon, Wed (AM), Fri</td>
<td>Tues, Thurs (PM)</td>
<td>Dr. Jennifer Fowlkes-Callins  <a href="mailto:jfcallins@msm.edu">jfcallins@msm.edu</a>  Cell: 678-468-4981</td>
</tr>
<tr>
<td>Peds Harbin</td>
<td>Mon, Tues</td>
<td>Thurs, Fri</td>
<td>Dr. Robersteen Howard - Site Director  Email: <a href="mailto:rhoward@harbinclinic.com">rhoward@harbinclinic.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shawn McGarity - Manager  <a href="mailto:smcgarity@harbinclinic.com">smcgarity@harbinclinic.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Harbin Clinic Pediatrics  330 Turner McCall Blvd.  Physician Center, Suite 4000  Rome, GA 30165  706-238-8030</td>
</tr>
<tr>
<td>GYN (VA/WHC)</td>
<td>Mon, Wed (AM), Thurs</td>
<td>Tues, Fri</td>
<td>Anne Wiskind, MD  <a href="mailto:awiskind@msm.edu">awiskind@msm.edu</a></td>
</tr>
<tr>
<td>CFHC</td>
<td>Varies (May cover VA Gyn)</td>
<td>All Days</td>
<td>NONE</td>
</tr>
<tr>
<td>Rotation</td>
<td>Rotation Days</td>
<td>Clinic Days</td>
<td>Contact Information</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------</td>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Dermatology   | Tues/Thurs (all day)          | Mon, Wed, Fri (PM) | Dr. Jamie MacKelfresh - VA Site Director  
jpbower@msm.edu  
Elise Core-Sanders – PA  
edsande@emory.edu  
250 N. Arcadia Ave 2nd Floor Decatur, GA  
T: 404-727-3669 or  
T: 404) 321-6111 ext 6380 |
| ENT           | ENT: Tues/Thur all day        | Weds AM, Fri (all day) | ENT: Dr. Carrie Flanagan  
carrie.flanagan@va.gov |
| Ophthalmology | Ophth: Mon, Tues, Thur (all day) | Weds AM, Fri (all day) | Ophth: Dr. Urken - VA Site Director  
steven.urken@va.gov  
1670 Clairmont Road  
Atlanta, GA  
T: (404) 321-6111 ext 7422 |
<table>
<thead>
<tr>
<th>Department</th>
<th>Mon, Tues, Thursday and weekend calls as scheduled</th>
<th>Wed (Am), Fri</th>
<th>Dr. Nnamdi Nwaohiri <a href="mailto:nnwaohiri@msm.edu">nnwaohiri@msm.edu</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>CBOC</td>
<td>Mon, Tues, Thurs</td>
<td>Wed (AM), Fri</td>
<td>Dr. Kitefre Oboho <a href="mailto:Kitefre.oboho@va.gov">Kitefre.oboho@va.gov</a> 678-232-6619 VA Fort McPherson 1701 Hardee Ave., SW Atlanta, GA 30310</td>
</tr>
<tr>
<td>Urology / Radiology</td>
<td>Tues, Weds, Thurs</td>
<td>Mon, Fri</td>
<td>Radiology Dr. Ronald Mixon <a href="mailto:Ronald.Mixon@va.gov">Ronald.Mixon@va.gov</a> Office: 404-321-6111 ext. 2360 Urology Dr. Donald Finnerty Email: <a href="mailto:donald.finnerty@va.gov">donald.finnerty@va.gov</a> Office: 404-321-6111 Ext. 6601</td>
</tr>
<tr>
<td>MH/HB</td>
<td>Tues, Weds, Thurs AM</td>
<td>Mon, Fri</td>
<td>Dr. Marietta Collins – Rotation Director <a href="mailto:mcollins@msm.edu">mcollins@msm.edu</a></td>
</tr>
<tr>
<td>Research / Board Review</td>
<td>Mon/Tues/Fri AM</td>
<td>Mon/Tues PM Thur (all day)</td>
<td>Research: Dr. Yuan-Xiang Meng <a href="mailto:ymeng@msm.edu">ymeng@msm.edu</a> Board Review: Dr. Walkitria Smith <a href="mailto:wasmith@msm.edu">wasmith@msm.edu</a></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Tues/Thurs clinics</td>
<td>Mon, Wed (AM), Fri</td>
<td>Dr. Karen Atkinson, Director <a href="mailto:kvatkin@emory.edu">kvatkin@emory.edu</a> Dr. Ayesha Iqbal <a href="mailto:aiqbal@emory.edu">aiqbal@emory.edu</a></td>
</tr>
<tr>
<td>FM Wards</td>
<td>Daily</td>
<td>Tues (PM) or Thurs (PM)</td>
<td>Various FM Attendings</td>
</tr>
</tbody>
</table>

**Elective Rotations**

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Rotation Days</th>
<th>Clinic Days</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Grady OB Department</td>
<td>Mon (AM), Tues (PM), Thurs</td>
<td>Mon (PM), Tues (AM), Fri</td>
<td>Attending: Dr. Hedwige Saint-Louis <a href="mailto:hsaintlouis@msm.edu">hsaintlouis@msm.edu</a></td>
</tr>
<tr>
<td>Nephrology</td>
<td>Mon, Fri</td>
<td>Tues, Thurs</td>
<td>Dr. Lynn Schlanger <a href="mailto:lynn.schlanger@va.gov">lynn.schlanger@va.gov</a></td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Mon, Fri</td>
<td>Tues, Thurs</td>
<td>Dr. RuxSadikot - Site Director <a href="mailto:ruxana.sadikot2@va.gov">ruxana.sadikot2@va.gov</a></td>
</tr>
</tbody>
</table>
Family Medicine In-Patient Service Guidelines

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

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

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

APPENDIX A: Moonlighting Form
APPENDIX B: Hand-off Form
APPENDIX C: Acknowledgement of Promotion and PGY2-Specific Requirements
APPENDIX D: Acknowledgement of Promotion and PGY3-Specific Requirements
APPENDIX E: Evaluation of Faculty by Residency Program Form
APPENDIX F: Resident Leave Request Form
APPENDIX G: Inpatient Survival Guide
APPENDIX H: A Survival Guide for the Intern
Morehouse School of Medicine
Family Medicine Residency Program
Moonlighting Privileges Request Form

Resident Name: __________________________________ Date: __________________________________

I am requesting permission to moonlight. I currently meet the following conditions:

☐ I am a resident in good academic standing in our program. I am not on academic remediation or probation, and I have promptly fulfilled all administrative requirements of the program.
☐ I have a valid Georgia medical license and DEA number (copies are attached).
☐ I have arranged for my own malpractice insurance for this moonlighting. I understand that Morehouse School of Medicine will not provide this coverage.
☐ I will not moonlight excessive hours. I will not allow it to interfere with my patient care nor will it be so excessive that I am too tired to learn and/or to perform the requirements of the residency. The combined hours of my residency and moonlighting will not exceed 80 hours per week, and I will not moonlight more than one shift per week.
☐ I understand that I may not moonlight while on call duty or during normal duty hours, as defined by the rotation I am on. I will not moonlight between 7:00 a.m. and 5:00 p.m., Monday through Friday (except for holidays), and I may not moonlight on the day after I am on call.
☐ I will arrange coverage for my continuity obstetrical patients while moonlighting.
☐ I agree to follow all rules and policies as established by the residency and understand that failure to do so may result in revocation of moonlighting privileges and/or other disciplinary action.

Moonlighting Details:

Location and Type of Practice: ________________________________________________________________
Point of Contact (Name and Phone #):________________________________________________________
Number of Hours Planning to Work Each Week: ____________ Each Month: _________________
_____________________________________________________________________________________

Signature of Resident ___________________________________________________________ Date __________________

To be Completed by the Program Director upon Review with the Faculty Committee

The Faculty Committee and I reviewed your above request on ___________________________.

☐ Your request is granted. You must follow the rules as outlined by our program and by Morehouse School of Medicine. You must submit a monthly report to me using the required form, and must notify me in advance of any changes in your moonlighting activities other than described above.
☐ Your request is denied for the following reason(s):__________________________________________

Signature of Program Director __________________________________________________________ Date __________________
Morehouse School of Medicine  
Family Medicine Residency Program  
Assessment of Resident Giving Handoff

Attending Name________________________________________ Date__________________

Resident Name________________________________________ PGY Level________

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

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

**Quality Markers**

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

Resident is competent to perform handoffs independently ☐Yes ☐No

If no, please provide recommendations for improvement________________________________________

_____________________________________________________________________________________

Comments____________________________________________________________________________

_____________________________________________________________________________________

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

Promotion Criteria from PGY-1 to PGY-2
Following at least twelve (12) months of training, the Residency Advisory Committee will make a recommendation for promotion to PGY-2 status based on the following criteria:

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

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

Practice-Based Learning and Improvement
Regarding practice-based learning and improvement, the intern will:
● Demonstrate the ability to give and receive feedback and make improvements in his/her patient care.
● Demonstrate an ability to assimilate and apply medical information to patient care.
● Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

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

Professionalism
Regarding professionalism, the intern will:
● Have demonstrated adequate participation in academic and professional activities such as conferences, rounds, and meetings, and pursuit of certification exam completion.
- Model professional behavior to students in clinic and rotations.
- Have achieved at least the minimum required conference attendance of 75%.
- Demonstrate adherence to policies regarding procedural documentation.

**Systems-Based Practice**
Regarding systems-based practice, the intern will:
- Demonstrate ability to coordinate care with case managers and other resources.
- Demonstrate cooperation within the medical system to ensure excellent patient care as seen by timely completion of medical records, charting, and follow-up.

Comments:___________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

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

_________________________  ______________________
Program Director  Faculty Advisor

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

_________________________  ______________________
Resident  Date
Family Medicine Residency Program
Acknowledgement of Promotion and PGY-3 Duties
PROMOTION CRITERIA FROM PGY-2 TO PGY-3

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

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

Practice-Based Learning and Improvement
Regarding practice-based learning and improvement, the resident will:
- Demonstrate the ability to give and receive feedback and make improvements in their patient care and practice.
- Demonstrate an ability to independently locate, assimilate, and apply medical information to patient care.
- Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

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

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

__________________________  ______________________
Program Director            Faculty Advisor

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

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

### A. AGGREGATE EVALUATION BY RESIDENTS*

<table>
<thead>
<tr>
<th></th>
<th>YOU</th>
<th>Average of all ACGME Faculty</th>
<th>Minimum requirement (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Please rate your overall experience of the rotation/in the clinic under the supervision of this Preceptor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Please rate the availability of this Preceptor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Please rate the approachability of this Preceptor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Please rate the professionalism displayed by this preceptor through his/her interactions with you, peers, staff, patients, and families.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>How well did the preceptor practice sound ethical principles?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>How well did the preceptor clearly state his/her expectations of your performance at the beginning of the rotation/clinic session?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>How well did the preceptor teach office procedures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Did the preceptor give you midpoint feedback (either written or verbal) of your performance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Please rate the TEACHING you received by this Preceptor.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Resident evaluation completion within 2 weeks (%)
- If PEC Member, attendance %
- If CCC Member, attendance %

### # of hours of Resident lectures **

### Serves as a Course Director
- Y / N

### If course director what was average course rating (on scale of 1-5)
- N/A
<table>
<thead>
<tr>
<th>Served as a resident advisor</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Served as a resident research mentor</td>
<td>Y / N</td>
</tr>
<tr>
<td>Board Certification status in Family Medicine/Internal Medicine/Peds/ OB-Gyn as applicable</td>
<td></td>
</tr>
<tr>
<td>% Grand Rounds attended</td>
<td></td>
</tr>
<tr>
<td>Involved with PS/QI</td>
<td></td>
</tr>
<tr>
<td>Conference presentations</td>
<td></td>
</tr>
<tr>
<td>Peer-Reviewed publications</td>
<td></td>
</tr>
<tr>
<td>Other publications and presentations</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

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

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

** EXCLUDES meeting as a program/institutional official

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

PD Signature and date: ________________________________

Faculty Signature and date: ________________________________

Chairperson Signature and date: ________________________________
MOREHOUSE SCHOOL OF MEDICINE
FAMILY MEDICINE RESIDENCY PROGRAM
REQUEST FOR LEAVE FORM

____________________________   ___________________________
Last Name   First Name

TYPE OF LEAVE REQUESTED

ANNUAL _______   SICK_______   CME LEAVE___________
FLEX/NATIONAL BOARDS_______   ADMINISTRATIVE LEAVE ________
COURT/JURY LEAVE_______   BEREAVEMENT LEAVE________
LEAVE WITHOUT PAY_______

REASON FOR REQUEST (If other than stated above) ___________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

DATES OF LEAVE REQUESTED:

FROM: _____________ TO: _____________ TOTAL DAYS: ______________

____________________________   ___________________________
RESIDENT’S SIGNATURE   DATE

____________________________   ___________________________
CHIEF RESIDENT’S SIGNATURE   DATE

____________________________   ___________________________
PROGRAM MANAGER’S SIGNATURE   DATE
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<tr>
<th>Acronym/Indicator</th>
<th>Title or Signifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACGME</td>
<td>Accreditation Council for Graduate Medical Education</td>
</tr>
<tr>
<td>C.P.R.</td>
<td>Common Program Requirements</td>
</tr>
<tr>
<td>GME</td>
<td>MSM Graduate Medical Education Department</td>
</tr>
<tr>
<td>PGY-1</td>
<td>Post Graduate Year one also known as “intern,” first year resident, or R1</td>
</tr>
<tr>
<td>PGY-2</td>
<td>Post Graduate Year two, second year resident, or R2</td>
</tr>
<tr>
<td>PGY-3</td>
<td>Post Graduate Year three, third year resident, or R3</td>
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Adverse Action and Due Process Policy

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

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

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

IV. POLICY
When situations requiring adverse action occur, the program follows the GME Adverse Academic Decisions and Due Process Policy and related MSM Human Resource policies as documented in the GME Policies link at http://www.msm.edu/Education/GME/index.php.
Program Concern and Complaint Policy

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

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

III. POLICY
3.1. The process and resources available for reporting concerns and complaints are detailed below.

3.2. This process is reviewed annually with residents and faculty.

3.3. The steps of the policy are outlined below:

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

3.3.2. If the concern or complaint involves the Program Director or Rotation Director and/or cannot be addressed in Step 1, residents have the option of discussing issues with the Department Chair, Dr. Folashade Omole at fomole@msm.edu or (404) 756-1206 or the service chief of a specific hospital as appropriate.

3.3.3. If the resident is not able to resolve the concern or complaint within the Program or Department, the following resources are available:

3.3.3.1. For issues involving program concerns, training matters, or the work environment, residents can contact the Graduate Medical Education Director, Tammy Samuels at tsamuels@msm.edu or (404) 752-1011
3.3.3.2. For problems involving interpersonal issues, the Resident Association President or President-Elect is available to discuss confidential informal issues that arise outside of the Department of Family Medicine (issues within the Department should first be discussed with one of the Family Medicine Chief Residents if comfortable).

3.3.3.3. Anonymous feedback/concerns/complaints can be provided at any time by completing the online GME Feedback form available at the following website: http://fs10.formsite.com/mbanks/form33/index.html.

3.3.3.3.1. Comments made on this site are anonymous and cannot be traced back to an individual. However, a resident may elect to provide his/her name and contact information if he/she desires personal follow-up regarding how feedback/concerns/complaints have been addressed by the Departments and/or the GME office.

3.3.3.4. For issues involving compliance, the MSM Compliance Hotline at (855) 279-7520 and on-line reporting portal at https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html are available. These are anonymous and confidential mechanisms for reporting unethical, noncompliant, and/or illegal activity and should be used to report any concern that could threaten or create a loss to the MSM community, including the following:

- Harassment- sexual, racial, disability, religious, retaliation
- Environmental Health and Safety- biological, laboratory, radiation, laser, occupational chemical, and waste management and safety issues
- Other- misuse of resources, time, or property assets; accounting, audit and internal control matters; falsification of records; theft, bribes, and kickbacks
Eligibility, Selection, and Appointment Policy

I. BACKGROUND

1.1. Resident recruitment, selection, and appointment are an essential component of the MSM Family Medicine Program.

1.2. The Family Medicine Program adheres to all applicable Morehouse School of Medicine, Graduate Medical Education, and Accreditation Council for Graduate Medical Education (ACGME) regulations.

II. PURPOSE

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

III. POLICY

3.1. Resident Eligibility

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) “Institutional Requirements” of the “Essentials of Accredited Residencies in Graduate Medical Education.”

Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

3.1.1. Graduates of medical schools in the United States accredited by either the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA); graduates of Canadian medical schools approved by the Licentiate of the Medical Council of Canada (LMCC)

3.1.2. Graduates of medical schools outside the United States and Canada who have a current and valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment or who have a full and unrestricted license to practice medicine in a United States licensing jurisdiction in their current ACGME specialty/subspecialty program

3.1.3. United States citizen graduates from medical schools outside the United States and Canada who have successfully completed the licensure examination (USMLE Step 3) in a United States jurisdiction in which the law or regulations provide that a full and unrestricted license to practice
will be granted without further examination after successful completion of a specified period of Graduate Medical Education.

3.1.4. Graduates of medical schools in the United States and its territories not accredited by the LCME but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described in the paragraph above.

3.1.5. Those who have completed the fifth pathway, a period of supervised clinical training for students who obtained their premedical education in the United States, received medical undergraduate abroad, and passed Step 1 of the United States Medical Licensing Examination.

3.1.5.1. After these students successfully complete a year of clinical training sponsored by an LCME-accredited United States medical school and pass USMLE Step 2 components, they become eligible for an ACGME-accredited residency as an international medical graduate.

3.1.5.2. The Fifth Pathway program is not supported by the American Medical Association after December 2009.

3.1.6. Applicants who have passed United States Medical Licensing Examination (USMLE) Steps 1 and 2—Clinical Knowledge (CK) and Clinical Skills (CS), or have a full, unrestricted license to practice medicine issued by a United States State licensing jurisdiction.

3.1.6.1. Preference for ranking is placed on applicants with a minimum passing score of 215 on Step 1 and 230 on Step 2.

3.1.6.2. Selectees cannot begin MSM residency programs prior to passage of the Step 2 Clinical Skills (CS) examination.

3.1.6.3. This expectation must be met by the time of the MSM-GME Incoming Resident orientation.

3.1.7. Each resident in our programs must be a United States citizen, a lawful permanent resident, a refugee, an asylee, or must possess the appropriate documentation to allow the resident to legally train at Morehouse School of Medicine.

3.2. The program director (PD) is responsible for verification of the applicants' credentials. Applicants who do not meet the criteria above cannot be considered for the Residency Program.

3.3. The PD and APDs review applicants and are responsible for selection of applicants for interview.

3.4. The Residency Program shall hold a meeting at the end of the interview season with the faculty members and residents who participated in the interview process to inform the final choice of applicants to be ranked in the NRMP match.
3.5. Resident Selection

3.5.1. Applicants are selected on the basis of preparedness, ability, aptitude, academic credentials, communications skills, and personal qualities such as motivation and integrity.

3.5.2. Academic credentials include medical school grades and performance as reflected in documentation received directly from the medical school, and United States Medical Licensing Examination (USMLE) scores.

3.5.3. Prior graduate medical education training, where applicable, will also be considered.

3.5.4. Formal educational and/or testing results submitted by the applicant may also be considered. Letters of reference from supervisors, educators, and peers, when appropriate, serve to provide additional information on personal characteristics, and are required and evaluated as well.

3.5.5. The selection committee then invites selected candidates for an individual interview which is conducted in person. The interview allows in-person confirmation of information provided in the written application as well as an opportunity to assess communication and other non-cognitive skills.

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

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

3.5.8. NRMP Match:

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

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

3.5.8.3. The NRMP will only consider certain exceptions.

3.5.8.4. Program directors and administrators are required to review the terms and conditions of the applicable Match Participation Agreement for their specialty each year and comply with applicable match policies and the Match Commitment, which addresses violations of NRMP Policy.
3.5.8.5. As noted in the Match Participation Agreement, program directors are prohibited from offering positions to ineligible applicants and must use the Applicant Match History in the Registration, Ranking, and Results (R3SM) System to determine an applicant’s eligibility for appointment.

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

3.5.8.6.1. A program requesting applicants to reveal ranking preferences;

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

3.5.8.6.3. A program suggesting or informing an applicant that placement on a rank order list or a SOAP preference list is contingent upon submission of a verbal or written statement indicating the applicant’s preference;

3.5.8.6.4. A program requiring applicants to reveal the names or identities of programs to which they have or may apply; or

3.5.8.6.5. A program and an applicant in the Matching Program making any verbal or written contract for appointment to a concurrent-year residency or fellowship position prior to the release of the List of Unfilled Programs.

3.5.9. All candidates who are interviewed shall be given a copy of the MSM appointment agreement, a copy of this policy, and the program’s aims. The program will document that the candidate has received a copy of the appointment agreement by obtaining his/her signature at the time of interview.

3.6. Appointment: The following procedure is required before any resident can officially be appointed as a resident:

3.6.1. Primary verification of all credentials is required.

3.6.1.1. The Residency Program in conjunction with the Office of GME and the Human Resources office will conduct this verification.

3.6.1.2. It is the responsibility of the resident to provide sufficient information to allow these verifications to be conducted.
3.6.2. At a minimum, the MSM Family Medicine Residency Program must be able to obtain primary source verification of the following elements:

3.6.2.1. Certification of graduation from any accredited medical school or ECFMG-certified medical institution. This documentation must be submitted directly from the academic institution granting the degree or from ECFMG directly to the residency program.

3.6.2.2. ECFMG Certification must be current—certification stamped *indefinite* must be submitted with ERAs documents.

3.6.2.3. Letters of recommendation.

3.6.2.4. Documentation accounting for any lapses between the end of medical school and the present. Large gaps of time exceeding one month that are not verifiable will disqualify candidates for consideration for a GME program.

3.6.2.5. Proper documentation of employment and/or work performed since graduation from medical school. The standard for proper documentation will be imposed by the GME program.

3.6.2.6. Passing a criminal background check.

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

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

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

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

3.7. Monitoring: This process has been reviewed by members of the Graduate Medical Educational (GME) Committee and agreed upon as a uniform approach to evaluation and selection of residency applicants.

3.8. Ensuring compliance with the eligibility and selection criteria as described above is the responsibility of each program director. Oversight for GME is the responsibility of the designated institutional official (DIO) who monitors program compliance through regular annual program accreditation review and the GMEC who reviews policies and procedures on a regular basis.
IV. TECHNICAL STANDARDS AND ESSENTIAL FUNCTIONS FOR APPOINTMENT AND PROMOTION

4.1. BACKGROUND

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

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

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

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

4.2. STANDARDS

4.2.1. Observation

4.2.1.1. Observation requires the functional use of vision, hearing, and somatic sensations.

4.2.1.2. Residents must be able to observe demonstrations and participate in procedures as required.

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

4.2.1.4. They must be able to obtain a medical history directly from a patient, while observing the patient’s medical condition.

4.2.2. Communication

4.2.2.1. Communication includes: speech, language, reading, writing, and computer literacy.

4.2.2.2. Residents must be able to communicate effectively and sensitively in oral and written form with patients to elicit information, as well as to perceive non-verbal communications.

4.2.3. Motor Functioning

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

4.2.4. Intellectual—Conceptual, Integrative, and Quantitative Abilities

4.2.4.1. Residents must be able to measure, calculate, reason, analyze, integrate, and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions, which are critical skills demanded of physicians.

4.2.4.2. In addition, residents must be able to comprehend three-dimensional relationships and to understand spatial relationships of structures.

4.2.5. Behavioral and Social Attributes

4.2.5.1. Residents must possess the psychological ability required for the full utilization of their intellectual abilities, for the exercise of good judgment, for the prompt completion of all responsibilities inherent to diagnosis and care of patients, and for the development of mature, sensitive, and effective relationships with patients, colleagues, and other healthcare providers.

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

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

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

4.2.6. Accommodations

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

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

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

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

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

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

4.2.6.7. NOTE: It is important to note that the MSM enrollment of non-eligible residents may be cause for withdrawal of residency program accreditation.
Clinical Environment and Educational Work Hour Policy

I. BACKGROUND

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

II. PURPOSE

2.1. The purpose of this process is to outline the program’s monitoring and oversight of work hours and document how work hour logging issues and/or violations are addressed by the Program.

2.2. Work hours are defined as time spent on all clinical and academic activities related to the residency program, such as patient care (both in-patient and out-patient), administrative duties related to patient care, the provision for transfer of patient care, in-house call activities, and scheduled academic conferences/didactics. Hours spent moonlighting must also be included in the work hour calculation. Work hours do not include reading and academic preparation time spent away from the work site.

2.3. The ACGME considers clinical and educational work hour limits to be an important element of its comprehensive approach to promote high quality education, wellness, and safe patient care. Residents must adhere to all work hour requirements as detailed below:

2.3.1. Maximum Hours of Clinical and Educational Work per Week

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

2.3.2. Mandatory Time Free of Clinical Work and Education

2.3.2.1. The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
2.3.2.2. Residents should have eight hours off between scheduled clinical work and education periods.

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

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

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

2.3.3. Maximum Clinical Work and Education Period Length

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

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

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

2.3.4. Clinical and Educational Work Hour Exceptions

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

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

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

2.3.4.1.3. to attend unique educational events

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

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

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

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

III. PROGRAM WORK HOUR MONITORING AND REPORTING PROCESS

3.1. Reporting of resident work hours is required by the residency accrediting agency, the ACGME/Residency Review Committee, and therefore, are not optional. Daily work hour logging in New Innovations is expected and logging within 5 days is required.

3.2. The following guidelines apply to logging duties:

3.2.1. Logging should be continuous with no gaps (for example for lunch or travel between clinical sites).

3.2.2. Conferences should be logged contiguous with other duties with no gaps in between.

3.2.3. For in-house call, log work type “Call”. For back-up call assignments when the resident has to go into the hospital, log work type “Back Up Called In”. NOTE: Back-up residents do not log if they do not go into the hospital.

3.2.4. If your 24-hour shift is extended work to post-call transition of patient care or mandatory conferences, avoid a violation by logging the following two work types (1) post-call and (2) conferences for the hours that extend beyond the 24-hour period. NOTE: The post-call period must not exceed 4 hours

3.2.5. Log appropriate work types for moonlighting, vacation, holiday/day off, or sick days.

3.2.6. Each resident must enter written justification or cause in the event of a violation.

3.2.6.1. Justifications apply to violations of 24+ or short break rule.

3.2.6.2. Causes apply to any violation.

3.2.6.3. These must be entered in New Innovations as comments in the provided for each flagged violation

3.3. Work hour logging is monitored by the Program Manager who provides a weekly logging status report to the Program Director.

3.3.1. In the absence of a report, a review of the New Innovations Dashboard is performed weekly to assess compliance with work hour logging and to
determine if any work hour violations have occurred since the last review.

3.3.2. If a resident has not logged in one week or more, he/she will receive a notification from the Program Manager to encourage immediate logging. If work hours are not logged after notification from the Program Manager, the Program Director will contact the resident and a written explanation of why the work hours have not been logged must be submitted by the resident and placed in his/her file.

3.3.3. Repeated or prolonged work hour logging delinquency may result in disciplinary action, as appropriate, for deficiency in the Professionalism competency.

3.4. In the event that a work hour violation occurs, the resident’s log is immediately flagged at which time the resident must provide a justification or explanation for the violation in New Innovations.

3.4.1. Work hour violations are monitored and recorded in New Innovations and are automatically reported to the Program Director, Associate Program Director, and Program Manager electronically.

3.4.2. The Program Director must then review the violation and the resident’s explanation of the causal circumstances to determine whether or not the violation was justified.

3.4.3. In the case of an unjustifiable violation, the Program Director must provide education to the resident, faculty member, and service involved to avoid future violations.

3.5. This procedure will allow the Program Director and/or the Program Manager to both provide necessary education to individual residents and to determine if there are systemic scheduling patterns that must be adjusted.

3.6. In the short term, however, work hour restrictions should not serve as a reason to jeopardize patient safety.

IV. ALERTNESS MANAGEMENT & FATIGUE MITIGATION

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

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

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

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

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

V. **PROGRAM CALL POLICY/GUIDELINES**

5.1. **Night Float/Call Responsibilities** :

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

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

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

5.1.4. Additionally, night float assignment during the same month that a resident has a vacation is avoided although it may occur in rare instances if there are no other residents available.
5.1.5. Although every effort is made to ensure equitable assignment of night float weeks, the situation occasionally arises when one resident may have more night float sessions than another. In all cases, work hour rules are followed.

5.1.6. During the week of night float, the assigned resident will cover the Family Medicine Inpatient Service at AMC-South from 5:00pm to 6:00am from Sunday to and including Thursday and from 5:00pm Friday to 7:00am Saturday. The resident shall not report to his/her assigned rotation during the night float week.

5.1.7. During the night float shift, the night float resident assumes responsibility for the care of the patients carried by the inpatient team from the time of evening sign-out until morning handoff back to the inpatient team or to the on-call resident on Saturday. Responsibilities include but are not limited to ordering and reviewing lab tests and studies, reviewing notes from consultants, evaluating patients, as needed, responding to calls from nurses and the answering service, and admitting patients to the Morehouse Family Medicine and hospitalist services in accordance with established patient cap agreements.

5.1.7.1. Admission from the Emergency Department: The Family Medicine attending or hospitalist will contact the resident when a patient in the Emergency Department needs to be evaluated for admission.

5.1.7.2. After performing the history and physical, the resident must call the attending on call to discuss the history, physical, assessment, and proposed management for approval in order to finalize the admission orders.

5.1.7.3. Direct admissions are discouraged in the interest of patient safety. However, if an attending proposes to admit a patient directly, he/she must first discuss the patient with the inpatient attending to determine whether initial evaluation and management in the emergency department is more appropriate.

5.1.7.4. The night float resident is responsible for evaluating all ICU patient and writing interval notes before midnight.

5.1.7.5. The night float resident is responsible for writing progress notes on all patients on Saturday morning and for contacting the designated member of the inpatient team to assist with progress notes if there are more than 8 patients on service.

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

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

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

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

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

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

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

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

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

VI. UNUSUAL RESIDENT-INITIATED EXTENSIONS – ADDITIONAL DUTY

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

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

- provision of continuity of care for a severely ill, complex, or unstable patient
- provision of continuity for a maternity care continuity delivery patient with whom the resident has been involved
- provision of humanistic attention to the needs of a patient or family
- to attend unique educational events
- The extended work must not exceed 4 hours

6.3. In each circumstance, the following actions must be taken:
6.3.1. The resident must appropriately hand over the care of all other patients to the team responsible for their continuing care.

6.3.2. The resident must document the reasons for remaining to care for the patient in New Innovations.

6.3.3. The Program Director must review each submission of additional service and track both individual resident and program-wide episodes of additional work.

6.4. This program policy is consistent with Morehouse School of Medicine GME policies 7.2.2 and 7.2.3.
Leave Policy

I. BACKGROUND

1.1. The ACGME Family Medicine Program Requirements dictate that no more than 30 days may be taken away from the program during a single program year. Time away from the program for more than thirty days during a program year will result in an extension of training dates.

1.2. Leave time is any time away from the residency training program not related to educational purposes. Leave time does not carry over from one contract year to another.

II. PURPOSE

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

III. POLICIES


3.2. Holidays

3.2.1. Morehouse School of Medicine observes the following eleven days as official holidays: New Year’s Eve, New Year Day, MLK Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving, the day after Thanksgiving, Christmas Eve, and Christmas Day.

3.2.2. All Morehouse Healthcare clinics and administrative offices are closed on these days.

3.2.3. Time off for a holiday is based on a resident’s rotation assignment. When rotating on a clinic or service that closes due to a holiday, the resident may take that time off as paid holiday. Conversely, if a clinic or service is open on a holiday, the resident will be required to report to the clinical site if assigned for work on that day.

3.2.4. As hospitals are considered essential services, a resident may be required to work on a holiday.
3.2.5. The resident must clarify with his/her assigned service whether or not he/she is required to work on a holiday.

3.3. Vacation

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

3.3.2. Vacation may be taken in 5-day increments (Monday – Friday)
   - The Saturday and Sunday before and after the 5-day vacation period are not guaranteed days off.

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

3.3.4. Vacation cannot be taken during the following restricted rotations:
   - Family Medicine Wards Service
   - ICU
   - Pediatric Wards
   - Pediatric ER
   - Internal Medicine Wards

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

3.3.6. Vacation change requests must be submitted 110 days prior to the requested change and are subject to approval by the PD

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

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

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

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

3.4. Sick Time

3.4.1. Compensated Sick Leave is 15 days per year.

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

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

3.4.4. Extended Leave: In the event of the need to care for a serious health condition of oneself or an immediate family member, residents must first use his/her unused sick and vacation leave for paid time off. If additional time off is needed after all sick and vacation time has been exhausted,
the additional time off will be unpaid leave. Residents must work with Human Resources (HR) and follow HR policy regarding unpaid time off and/or eligibility for short term disability

3.5. Administrative Leave

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

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

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

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

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

3.6. Educational Leave

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

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

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

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

3.7. Family and Medical Leave

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

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

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

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

3.7.1.4. A serious health condition that makes the employee unable to perform the employee’s job.
3.7.2. Eligible residents who care for covered service members may also be eligible for up to 26 workweeks of unpaid leave in a single 12-month period.

3.7.3. Residents are eligible for FMLA leave if they have worked for MSM for at least one (1) year, have worked 1,250 hours over the previous 12 months, and have a qualifying event as outlined above.

3.7.4. Residents must direct all questions about FMLA leave to the Human Resources Department.

3.8. Leave Without Pay

3.8.1. Leave required beyond available compensated sick and/or vacation leave will be uncompensated leave without pay.

3.8.2. Requests for leaves of absence without pay shall be submitted in writing to the Program Director and reviewed by the HR Department for disposition and approval no less than 90 days in advance of any planned leave. Such requests must include the reason and duration for the proposed leave.

3.8.3. Leave without pay, when approved, shall not exceed 2 months in duration.

3.8.4. The Program Director must discuss the implications of the leave, including possible prolongation of the program and should ensure that the resident understands these implications.

3.8.5. If the resident decides to move forward with the request, the MSM Human Resources Department shall advise both the resident and the residency program director on applicable policies and procedures.

3.9. Other Types of Leave

3.9.1. All other leave types (e.g., military, bereavement, jury duty, etc.) are explained in detail in MSM’s Policy Manual which is available on the Human Resources Department Intranet webpage.

3.10. Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc. must not exceed a combined total of thirty (30) days per academic year.

3.11. The resident must complete a Leave Request form for any unplanned time off, including vacation changes, conference attendance, or administrative leave. Forms must be completed by the resident and submitted to the chief resident for schedule review and determination of feasibility. The form then must be submitted to the Program Manager for review and final approval by the Program Director. It is the resident’s responsibility to obtain the chief resident’s signature and forward the forms to the residency program manager and the director for approval.
3.12. If any changes in night call schedule are necessitated by the leave time, it is the resident’s responsibility to contact the chief resident and arrange for coverage.

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

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

3.13. Return to Duty

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

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

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

3.14. Program Leave Limitations

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

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

3.14.3. For successful completion of the program on time, and for Board eligibility in April of the PGY3 year, the American Board of Family Medicine does not permit more than 30 days leave time per year. Time away of more than 30 days will result in ineligibility to sit for the ABFM Board Examination in April of the PGY3 year. In rare instances,
the PD may, at her discretion, override this rule and permit a resident
to take the exam with his/her class. Leave time greater than 30 days
per academic year is at the discretion of the director.
Evaluation Policy

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

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

III. POLICY
3.1. Resident Performance Evaluation
3.1.1. The Program assures that all residents are systematically evaluated on their knowledge, skills, performance, and professional growth on an ongoing basis throughout their training.
3.1.2. Each form of evaluation is designed to assess the resident using the 6 core competencies of Patient Care, Medical Knowledge, Systems Based Practice, Problem Based Learning, Professionalism, and Interpersonal and Communication Skills and assesses progression along the ACGME required Milestones.
3.1.3. While on clinical rotations all residents receive written and/or verbal formative evaluations and written and verbal summative evaluation. Residents also receive feedback on their performance globally through semi-annual evaluations which provide formative evaluation throughout the course of residency training and a summative evaluation at the end of training. All information is compiled in New Innovations.
3.1.4. The Program has numerous evaluations in place to help assess the acquisition of the knowledge, skills, and abilities needed to independently practice clinical medicine. Evaluation tools include:
   - Direct observation
     - During continuity clinic and inpatient encounters
     - During OSCE
   - Multi-Source 360 Evaluations
Peer to Peer
- Clinic Staff of Resident
- Medical Student of Resident
- Self-Evaluation
- Patient Satisfaction

- Faculty Evaluation of Residents on clinical rotations
- Faculty Evaluation of Resident Clinical Performance
- Milestone Evaluation/Assessment
- Semi-annual evaluation using tools listed above, ITE performance, advisor input, and resident log data
- Summative Evaluation (final evaluation of performance prior to completion of training)
- QI project participation and performance

3.2. Clinical Competency Committee (CCC)

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

3.2.2. 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.

3.2.3. CCC Composition and Membership

3.2.3.1. The program director appoints all four to six members and the chairperson of the CCC.

3.2.3.2. The members are key faculty members involved in direct resident teaching, one of whom must be the associate or assistant program director.

3.2.3.3. The Family Medicine Residency program manager shall serve as a member.

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

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

3.2.4.1. Attend all standing and ad hoc CCC meetings.
3.2.4.2. Sign the confidentiality policy prior to the first CCC meeting of each academic year and must abide by said policy at all times.

3.2.4.3. Review the following documentation of resident performance at each standing meeting: evaluations by all evaluators, In-Training Exam scores, OSCE performance, research progress, advisor documentation, program director documentation, procedure logs, teaching activity, and record of remediation where applicable.

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

3.2.5. The committee chairperson will:

3.2.5.1. Comply with all responsibilities described above.

3.2.5.2. Review and edit, as needed, minutes of meetings as prepared by the Program Manager of Program Assistant and disseminate the minutes to all committee members, the program director and the department chairperson.

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

3.2.5.4. Report the required semi-annual milestone assignment recommendations of each resident’s performance for each Milestone to the Family Medicine Residency program director who will review the recommended Milestone assignments, revise as needed, and submit to the ACGME by ACGME-established deadlines.

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

3.2.7. Meeting Frequency

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

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

3.2.7.2.1. Reasons for ad hoc meetings may include but are not limited to consistently low performance or unsatisfactory evaluation scores of a resident; repeated lack of adherence to program requirements; or a specific incident that requires CCC review for possible probation or dismissal.
3.2.7.3. The residency program manager or designee will document each CCC meeting with meeting minutes. Minutes will be reviewed for accuracy at subsequent meetings.

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

3.2.8. Procedure for Review

3.2.8.1. The CCC shall evaluate the residents on a quarterly basis in order to produce a consensus recommendation on each resident.

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

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

3.2.8.3. Additionally, if any resident is having academic problems, he or she will be reviewed in discussion at the meeting.

3.2.8.4. The CCC can set thresholds for remediation, probation, and dismissal.

3.2.8.4.1. The CCC may recommend to the PD and APD that a “Notice of Deficiency” be given to any resident who performs below milestone benchmarks

3.2.8.4.2. The PD or designated APD will meet with each resident and communicate the recommendation and design a remediation or improvement plan.

3.2.9. Recommendations—Based on the comprehensive review of each resident’s record of performance, in the case of inadequate
performance, the CCC may recommend probation with remediation or delay or deny promotion or board recommendation as appropriate for the deficiencies identified. In accordance with MSM’s “Resident Promotion Policy” and “Adverse Academic Decisions and Due Process Policy, the CCC may make the following recommendations to the PD and APD:

3.2.9.1. Progression—Resident is performing appropriately at current level of training with no need for remediation.

Resident should continue with the current curriculum.

3.2.9.2. Promotion—Resident has demonstrated performance appropriate to move to the next level of training without the need for remediation.

Resident should progress with next PGY level as scheduled.

3.2.9.3. Notice of Deficiency—Resident has demonstrated performance below the expected level in a specific competency across multiple evaluations, but does not require remediation.

3.2.9.3.1. The resident must submit a corrective action plan to eliminate the deficiency.

3.2.9.3.2. The CCC will prepare a statement for the grounds for Notice of Deficiency, including identified deficiencies or problem behavior.

3.2.9.3.3. Notice of Deficiency may be removed from the resident file if the resident is performing at satisfactory level and deemed to have corrected his or her deficiency within a time frame defined by the CCC, not to exceed six (6) months.

3.2.9.4. Notice of Deficiency with Remediation—Resident has demonstrated performance below the expected level in a specific competency and requires remediation.

3.2.9.4.1. Notice of Deficiency REQUIRES the resident (in conjunction with the PD and advisor) to develop a REMEDIATION plan to cure the deficiency.

3.2.9.4.2. The CCC will prepare a statement for the grounds for Notice of Deficiency and Remediation, including identified deficiencies or problem behaviors.

3.2.9.4.3. The CCC or PD must review the resident’s performance every three (3) months to determine if the resident is meeting the terms of the remediation plan.
3.2.9.4.4. Remediation (total time) shall not exceed six (6) months in an academic year.

3.2.9.4.5. This recommendation remains on the resident’s permanent record.

3.2.9.4.6. Failure to successfully remediate and cure the deficiency could result in extended remediation, additional training time, non-renewal, or dismissal from the program.

3.2.9.5. Immediate Suspension—Resident has performed serious misconduct or has posed a threat to colleagues, faculty, staff, or patients.

3.2.9.5.1. This may result from gross unprofessional or unethical behavior, misconduct, or the serious threat to the safety of patients such that continuation of clinical activities by the resident is deemed potentially detrimental or compromising to patient safety or the quality of patient care, or threatening to the well-being of staff or the resident.

3.2.9.5.2. The CCC or PD will prepare a statement for the grounds for suspension, including the identified deficiencies or problem behaviors.

3.2.9.5.3. Suspension shall not exceed 30 days. The CCC must conduct a review in 30 days if additional time is recommended.

3.2.9.5.4. This recommendation remains on the resident’s permanent record.

3.2.9.6. Probation—Resident has demonstrated challenges in specific competencies that are disruptive to the program.

3.2.9.6.1. This may result when, after documented counseling, a resident continues not to perform at an adequate level of competence; demonstrates unprofessional or unethical behavior; engages in misconduct that could bring harm to patients, negatively impact the function of the healthcare team, or cause residency program dysfunction; or otherwise fails to fulfill the responsibilities of the program.

3.2.9.6.2. The CCC or PD will prepare a statement for the grounds for probation, including identified deficiencies or problem behaviors.
3.2.9.6.3. Probation (total time) shall not exceed six (6) months in a calendar year.

3.2.9.6.4. This recommendation remains in the permanent record.

3.2.9.7. Non-Promotion—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. Resident’s current level of training will be extended. Action remains in permanent record.

3.2.9.7.1. Based on repeated demonstration of deficiency(ies), the resident will not be promoted to the next level of training.

3.2.9.7.2. The CCC will prepare a statement for the grounds for non-promotion, including identified deficiencies or problem behaviors.

3.2.9.7.3. The resident’s current level of training will be extended as recommended by the CCC.

3.2.9.7.4. The resident’s contract shall be renewed for the next academic year.

3.2.9.7.5. This recommendation remains in the permanent record.

3.2.9.8. Non-Renewal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies.

3.2.9.8.1. Based on repeated demonstration of deficiency(ies), the resident will not be promoted to the next level of training.

3.2.9.8.2. The CCC will prepare a statement for the grounds for non-renewal, including identified deficiencies or problem behaviors.

3.2.9.8.3. The resident’s contract shall expire at the end of the academic year, without renewal.

3.2.9.8.4. This decision may be appealed by the resident in accordance to GME policies of Due Process (“Adverse Academic Decisions and Due Process Policy”).

3.2.9.8.5. This recommendation remains on the resident’s permanent record.

3.2.9.9. Dismissal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies;
the resident will be dismissed from the program. Action remains in permanent record.

3.2.9.9.1. Based on repeated demonstration of deficiency(ies) the resident will be immediately dismissed from the program.

3.2.9.9.2. The CCC will prepare a statement for the grounds for dismissal, including identified deficiencies or problem behaviors.

3.2.9.9.3. The decision may be appealed by the resident in accordance to GME policies of due process (“Adverse Academic Decisions and Due Process Policy”).

3.2.9.9.4. This recommendation remains on the resident's permanent record.

3.2.9.10. The CCC consensus recommendation for each resident will be submitted to the residency program director using the Clinical Competency Committee Report Form as completed by the CCC chair.

3.2.9.11. All residents who receive an adverse recommendation shall also receive written notice of the CCC recommendation of adverse action form.

3.2.9.12. The program director shall review all recommendations, and the PD and APD will meet with each resident to communicate his or her recommendation.

3.2.9.13. A copy of all adverse decisions shall also be sent to the affected resident’s advisor for review.

3.2.9.14. The advisor will then work in concert with the program director and resident to develop the remediation plan.

3.2.10. Faculty Development

3.2.10.1. In order to ensure the greatest usefulness of the data reviewed by the CCC, the CCC will conduct, with the assistance of the Morehouse School of Medicine Office of Graduate Medical Education; two faculty development sessions will be held annually.

3.2.10.1.1. One will cover completing resident evaluations

3.2.10.1.2. One will cover the Family Medicine residency milestones.

3.2.10.2. Prior to each evaluation session, a faculty committee meets to discuss the resident's performance and to arrive at the summary with specific recommendations.
3.2.10.3. The results of the faculty appraisal are shared with each resident individually by the resident faculty advisor.

3.2.10.4. The resident is asked to sign the summary form to acknowledge discussion of the evaluation.

3.2.10.5. Information used in assessment of resident performance is derived from multiple sources, which may include:

3.2.10.5.1. If any time, at or between the formal six-month evaluations a problem is identified with any portion of the resident’s performance and educational growth, this information will be shared promptly with the resident.

3.2.10.5.2. The information will be documented. If there is a deficiency that the faculty or the program director decides requires further action, a future meeting will be arranged with the appropriate faculty members and the resident to devise a plan of corrective action. Such plans will contain measurable goals and a specific timeframe for re-evaluation.

3.2.10.5.3. If the resident fails to show progress in correcting the deficiencies or fails to adhere to the plan of corrective actions, further recommendations, including possible probation or dismissal from the program, may ensue.

3.2.10.5.4. Any time formal discipline is invoked, the resident has the right to due process, as outlined in the Morehouse School of Medicine Graduate Medical Education Policies and Procedures.

3.3. Semi Annual Evaluations

3.3.1. Semi-annual evaluations are conducted by the PD and/or APD with each resident and are required by the ACGME.

3.3.2. These are formal sessions in which feedback is provided to the resident regarding his/her overall performance from July to December and from January to June.

3.3.2.1. During the Semi-annual evaluation, the resident must also be prepared to discuss his/her self-evaluation and individualized education plan.

3.3.2.2. The Semi-annual evaluation session also provides an opportunity for resident to provide feedback to the program.

3.3.3. At the final summative semi-annual evaluation prior to graduation (May or June of graduation year), the resident’s complete performance will be
reviewed and the residency director will verify whether the resident has demonstrated sufficient competence to enter practice without direct supervision. This evaluation becomes part of the resident’s permanent record maintained by the institution and is accessible for review by the resident in accordance with institutional policy.

3.4. Resident Advancement & Promotion

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

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

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

3.4.2.2. Patient Care

3.4.2.2.1. Role-model competent whole person care to other residents and medical students.

3.4.2.2.2. Demonstrate the ability to independently perform a complete history and physical exam, write appropriate orders, and appropriately document the hospital course for inpatients.

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

3.4.2.3. Medical Knowledge

3.4.2.3.1. Satisfactorily pass all required rotations.

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

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

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

3.4.2.4. Practice-Based Learning and Improvement

3.4.2.4.1. Demonstrate the ability to give and receive feedback and make improvements in his/her patient care.
3.4.2.4.2. Demonstrate an ability to assimilate and apply medical information to patient care.

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

3.4.2.5. Interpersonal and Communication Skills

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

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

3.4.2.6. Professionalism

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

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

3.4.2.6.3. Have attended all required educational conferences unless excused

3.4.2.6.4. Demonstrate adherence to policies regarding procedural documentation.

3.4.2.7. Systems-Based Practice

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

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

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

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

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

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

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

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

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

3.4.3.3. Medical Knowledge

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

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

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

3.4.3.4. Practice-Based Learning and Improvement

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

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

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

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

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

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

3.4.4. Program Graduation Criteria

3.4.4.1. The following graduation criteria apply to the PGY-3 level. The resident must:

3.4.4.1.1. Complete and pass all required rotations.

3.4.4.1.2. Not have any professionalism or ethical issues that preclude him or her from being an independent practicing physician in the opinion of the CCC.

3.4.4.1.3. Be continually eligible to practice medicine on a limited license in Georgia.

3.4.4.1.4. Be compliant with all MSM Family Medicine Residency Program policies including, but not limited to, being up to date with his or her work hour logging.

3.4.4.1.5. Have completed and presented an approved research project.

3.4.4.1.6. Have completed and logged all required procedures.

3.4.4.1.7. Have seen and documented at least 1,650 continuity patients.

3.4.4.1.8. Have completed all clinic patient notes and be cleared by the medical records department.

3.4.4.1.9. Complete the GME, HR, and MSM Family Medicine exit procedures.

3.4.4.1.10. Have achieved milestone levels for all competencies and subcompetencies demonstrating the ability to practice independently.

3.4.4.2. The program director must determine that the resident has had sufficient training to practice medicine independently as
evidenced by meeting the goals above and a final summative assessment.

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

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

3.5. Faculty Evaluations

3.5.1. ACGME Requirement

3.5.1.1. As per the ACGME requirements, at least annually, the program must evaluate faculty performance as it relates to the educational program.

3.5.1.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the education program, clinical knowledge, professionalism, and scholarly activities.

3.5.1.3. This evaluation must include at least annual written confidential evaluations by the residents.

3.5.1.4. In compliance with this requirement, the MSM Family Medicine Residency Program follows the following process for faculty evaluation.

3.5.2. Program-Specific Process

3.5.2.1. Departmental residency faculty members are evaluated by residents on a quarterly basis using the Resident Evaluation of Faculty tool in New Innovations.

3.5.2.2. Individual means for each domain are calculated for each faculty member and are compared to the overall faculty means.

3.5.2.3. Inpatient attendings are also evaluated by residents each time they rotate on the Family Medicine Wards service using the Inpatient Attending Evaluation Form.

3.5.2.4. Written feedback is provided to each faculty member every six months in the form of the Semi-Annual Evaluation of Faculty
Member by Residency Program form, which can be found in the Appendix of this document.

3.5.2.5. The evaluation is designed to assess faculty members’ clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activity.

3.5.2.6. Annually, during the months of April-June, the Program Director discusses the form with each Program faculty member and a faculty development plan is devised as needed based on the content of the evaluation.

3.5.2.7. These evaluations and development plans are remitted to the Department Chair for integration as part of the faculty members’ evaluations by the Chair.

3.5.2.8. Quarterly batching of evaluations and semi-annual reporting to faculty of aggregated evaluations is done to assure residents of the anonymity of their evaluations.

3.5.2.9. Residents are encouraged to immediately communicate pressing concerns regarding attending performance to the Program Director or, if anonymity is desired, by placing the typed documentation of the concern in the concern box located in the residency office.

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

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

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

3.6. Program Director Evaluations

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

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

3.7. Program Evaluations

3.7.1. The Morehouse School of Medicine Office of Graduate Medical Education maintains oversight of the program evaluation process, as detailed in the section 4.2.3 of the MSM GME Policy Manual.
3.7.2. All MSM programs are evaluated confidentially and anonymously by the residents and the faculty on an annual basis under the oversight and direction of the GME Office.

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

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

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

3.8. MSM Family Medicine Residency Program Evaluation Committee

3.8.1. The ACGME requires that the program is evaluated and that the program director appoint a Program Evaluation Committee (PEC) to assist in reviewing the program on an annual basis.

3.8.2. The purpose of the Program Evaluation Committee (PEC) for the Morehouse School of Medicine (MSM) Family Medicine Residency Program is to oversee and participate actively in all aspects of the program quality and improvement process.

3.8.3. At all times, the procedures and policies of the PEC will comply with those of the Graduate Medical Education Committee as outlined in the Graduate Medical Education Policy and Procedure Manual and with those stipulated by the Accreditation Council for Graduate Medical Education (ACGME) as outlined in Section V.C.1.a of the ACGME Program Requirements for Graduate Medical Education in Family Medicine.

3.8.4. Membership

3.8.4.1. The program director shall appoint all members of the PEC, including the committee chairperson.

3.8.4.2. The committee shall consist of no fewer than two (2) core program faculty members and at least one (1) resident.

3.8.5. Responsibility of Members

3.8.5.1. Committee members are expected to participate actively in the following duties in accordance with the ACGME program requirements:
3.8.5.1.1. Planning, developing, implementing, and evaluating educational activities of the program;

3.8.5.1.2. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;

3.8.5.1.3. Addressing areas of non-compliance with ACGME standards; and

3.8.5.1.4. Reviewing the Program annually using evaluations of faculty, residents, and others, as specified below:

3.8.5.1.4.1. Document formal, systematic evaluation of the curriculum at least annually, and render a written and Annual Program Evaluation (APE) based on its review and analysis of tracking in each of the following areas:

- Resident performance
- Faculty development
- Graduate performance, including performance of program graduates on the certification examination
- Program quality
- Progress on the previous year’s action plan(s).
- The Program, through the PEC must:

3.8.5.2. Prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored (per Section V.C.3 of the ACGME Program Requirements for Graduate Medical Education in Family Medicine); and attain approval of the action plan by the teaching faculty.

3.8.5.3. Review and address deficiencies in the following ACGME program requirements.

3.8.5.3.1. At least 95 percent of the program’s eligible graduates from the preceding five (5) years must
have taken the American Board of Family Medicine (ABFM) certifying examination.

3.8.5.3.2. At least 90 percent of the program’s graduates from the preceding five (5) years who take the ABFM certifying examination for the first time must pass.

3.8.5.3.3. Every five-year survey of program graduates.

3.8.5.3.4. Assessment of resident attrition and the presence of a critical mass of residents with a goal of no more than 15%.

3.8.6. Meetings

3.8.6.1. Scheduled Meetings

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

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

3.8.6.2. Ad Hoc Meetings

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

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

3.8.7. PEC Procedures

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

3.8.7.2. All PEC meetings shall be documented with agendas and meeting minutes as appropriate.
Physician Impairment and Health (Substance Abuse) Policy

I. BACKGROUND

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

II. PURPOSE

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

III. POLICY

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

I. BACKGROUND

1.1. The MSM Family Medicine Residency Program adheres to the GME Professionalism policy which can be found at http://www.msm.edu/Education/GME/index.php through the GME Policy link on the GME webpage.

1.2. Ethics is the systematic application of values.

   1.2.1. Medical ethics focuses on the prevention, recognition, clarification, and resolution of conflicts associated with medical issues and emphasizes the basic values that underlie clinical interactions, such as honesty, integrity, the primacy of the commitment to the patient’s well-being, and compassion.

II. PURPOSE

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

III. POLICY

3.1. Professionalism—Code of Conduct

   3.1.1. Residents should:

      3.1.1.1. Know how to inform patients and obtain voluntary consent for the general plan of medical care and specific diagnostic and therapeutic interventions

      3.1.1.2. Know what to do when a patient refuses a recommended medical intervention in both emergency and non-emergency situations

      3.1.1.3. Know what to do when a patient requests ineffective or harmful treatment

      3.1.1.4. Be able to assess a patient’s decision-making capacity

      3.1.1.5. Know how to select the appropriate surrogate decision-maker when a patient lacks decision-making capacity
3.1.1.6. Know the principles that apply when the physician must decide for a patient when the patient lacks decision-making capacity and there is no appropriate surrogate decision-maker

3.1.1.7. Be adept at broaching the subject of a dying patient’s eventual death and discussing with the patient the extent of medical intervention at the end of life

3.1.1.8. Understand and apply the ethical principle of balancing obligations to patients with one’s self interest

3.1.1.9. Know how to deal with the following forms of potential conflict of interest:

   3.1.1.9.1. Induced demand (physician’s ability to create a demand for his or her service)

   3.1.1.9.2. Offers of gratuities from manufacturers

3.1.1.10. Know the physician’s obligation when he or she suspects that another healthcare provider is abusing alcohol or drugs or is professionally incompetent

3.1.2. Key elements of Professionalism that must be upheld by residents include

3.1.2.1. Completing administrative duties including but not limited to responding to emails, completing work hour and other logging, and completing evaluations by established deadlines;

3.1.2.2. Adhering to the dress code;

3.1.2.3. Treating others respectfully.

3.1.3. The Program Professionalism Agreement is included in the Family Medicine Residency Program Handbook and must be reviewed and signed by all residents.

3.2. Regulatory Compliance

3.2.1. Residents are required to comply with the following laws. The MSM Office of Compliance mandates annual compliance training for review of these laws and attestation of understanding and work to follow them.

3.2.1.1. False Claims Act—imposes civil liability for making false or fraudulent claims to the government for payment;

3.2.1.2. Anti-Kickback Statute—prohibits the offer, payment, solicitation, or receipt of any form of remuneration in return for the referral of Medicare or Medicaid patients;

3.2.1.3. Stark I and II Physician Self-Referral Law—prohibits physicians from making certain Medicare referrals to entities with which the physician or his or her family members has a financial relationship;
3.2.1.4. Emergency Medical Treatment and Active Labor Act (EMTALA)—all patients must receive emergency medical treatment regardless of ability to pay; can be transferred only after being stabilized;

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

3.3. Dress Code

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

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

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

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

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

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

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

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

I. BACKGROUND

1.1. Supervision in the context of Graduate Medical Education has the goals of assuring the provision of safe and effective care to the individual patient; assuring the resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

1.2. The ACGME requires that all patient care must be supervised by approved clinical faculty. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

1.3. The Program Director and MSM Graduate Medical Education Committee (GMEC) will ensure that supervision is consistent with provision of safe and effective patient care and the educational needs of residents.

II. PURPOSE

2.1. The purpose of this supervision policy is to ensure oversight of resident supervision and progressive levels of authority and responsibility.

2.2. The program uses the following classifications of levels of supervision, consistent with ACGME guidelines.

2.2.1. Direct Supervision—The supervising physician is physically present with the resident and patient.

2.2.2. Indirect Supervision with Direct Supervision Immediately Available—The supervising physician is not physically present, but is immediately available to provide direct supervision or available to by phone and/or electronic modalities.

2.2.3. Oversight—The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

III. DEFINITIONS

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

3.2. Indirect Supervision
3.2.1. With direct supervision immediately available - the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

3.2.2. With direct supervision available - the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

3.3. Oversight - the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

IV. PROGRAM SUPERVISION POLICY

4.1. The Program Director will perform ongoing assessment for adequate and appropriate supervision of residents at all times.

4.2. All patient care is supervised by qualified faculty physicians who are appropriately credentialed and privileged.

4.3. The faculty physician is ultimately responsible for patient care.

4.4. Information to identify and contact the appropriate supervising faculty physician in the Comprehensive Family Healthcare Center (CFHC) is available at all times via the schedule in New Innovations. A schedule is also posted in the CFHC nurse’s station.

4.4.1. All faculty contact numbers are posted in the Departmental Directory which is circulated by email annually and after each update.

4.4.2. The directory is also posted in the Comprehensive Family Healthcare Center resident work area, the call room, and the Residency office.

4.5. Residents and faculty members should inform patients of their respective roles in patient care.

4.6. Residents will be provided with rapid, reliable systems for communicating with supervising faculty.

4.6.1. Faculty preceptors are physically present in the preceptors’ room in the CFHC for immediate communication between residents and supervising faculty.

4.6.2. In the inpatient setting, the supervising faculty meeting is either physically present or immediately available at the phone number listed on the resident sign-out list and posted in the call room.

4.7. Faculty schedules are structured to provide residents with appropriate supervision and consultation.

4.7.1. A maximum resident to faculty ratio of 4:1 is maintained at all times in the continuity clinic (CFHC)

4.8. Supervision is exercised through a variety of methods.
4.8.1. Some activities require the physical presence of the supervising faculty member.

4.8.2. For some aspects of patient care, the supervising physician is a more advanced resident.

4.8.3. Supervision can be provided via the immediate availability of the supervisor or, in some cases, by phone or electronic modalities.

4.8.4. On rare occasions, supervision may include post-hoc review of resident-delivered care with feedback.

4.9. Direct supervision is required for all procedures in the CFHC continuity clinic and AMC-S Family Medicine Ward service.

4.10. Lack of supervision or access to attendings must be reported to the Program Director and/or Department Chairperson.

V. PROGRESSIVE AUTHORITY & RESPONSIBILITY

5.1. Preceptors are expected to teach and provide appropriate and timely feedback to the Family Medicine residents in the preceptor’s room.

5.2. If for any reason the preceptor cannot be on time, he or she should contact the clinic. If no one in the office can be contacted, the preceptor should then contact the Program Director directly so necessary arrangements can be made.

VI. LEVELS OF SUPERVISION

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

<table>
<thead>
<tr>
<th></th>
<th>Direct</th>
<th>Indirect</th>
<th>Oversight</th>
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<tbody>
<tr>
<td></td>
<td>PGY1</td>
<td>PGY2</td>
<td>PGY3</td>
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<td>OB</td>
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<tr>
<td>High-Risk Patient</td>
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<tr>
<td>Admission</td>
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<td>Labor Check</td>
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<tr>
<td>2nd Stage of Labor</td>
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<td>X</td>
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<tr>
<td>Change of Condition</td>
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<tr>
<td>Inpatient</td>
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<tr>
<td>Admission</td>
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<tr>
<td>Change of Condition</td>
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<td>X</td>
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<tr>
<td>Transfer to New Level of Care</td>
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<td>X</td>
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<tr>
<td>Hospital Transfer</td>
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<tr>
<td>Pediatrics</td>
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<td>Surgery (procedures)</td>
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<td>Emergency</td>
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<td>Ambulatory</td>
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<td>FMP</td>
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<tr>
<td>Other (MSK, Behav, etc.)</td>
<td>X’</td>
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<tr>
<td>Home Visits</td>
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<td>SNF</td>
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</table>
Key:
A- Indirect supervision with direct supervision immediately available
B- Indirect supervision with direct supervision available
X- Appropriate level of supervision
N- Not appropriate for level of training
R- Advanced level resident may immediately supervise (Attending must still be contacted and participate in decision making)
* - All procedures must be directly supervised

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

VII. GUIDELINES FOR WHEN RESIDENTS MUST COMMUNICATE WITH THE ATTENDING

7.1. Residents must communicate with the attending to discuss all hospital admissions at the time of admission.

7.2. Each patient seen in the clinic must be discussed with the supervising attending during the visit or before the end of the clinic session as appropriate.

7.3. If the resident is uncomfortable or uncertain about how to manage a patient due to the patient’s acuity or the resident’s level of medical knowledge or experience, the resident must communicate with the attending if guidance from an upper level resident is not sufficient.

7.4. All procedures must be directly supervised by the attending physician.

VIII. RESIDENT JOB DESCRIPTIONS BY PGY LEVEL

<table>
<thead>
<tr>
<th>PGY-1 Resident Job Descriptions</th>
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</thead>
<tbody>
<tr>
<td><strong>Prerequisites</strong></td>
</tr>
<tr>
<td>● Medical doctorate from an allopathic or osteopathic medical school</td>
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<tr>
<td>● Passing scores on the USMLE I, USMLE II CK, and USMLE II CS</td>
</tr>
<tr>
<td>● Foreign medical graduates: complete all ECFMG requirements</td>
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<tr>
<td>● Eligibility for State of Georgia Family Physician training licensure</td>
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<tr>
<td>● Application through Electronic Resident Application System (ERAS)</td>
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<tr>
<td><strong>Qualities</strong></td>
</tr>
<tr>
<td>● Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.</td>
</tr>
<tr>
<td>● Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.</td>
</tr>
<tr>
<td>● Work within multiple teams that include inpatient rounding teams, class peers, curriculum development teams, outpatient care teams, and support groups.</td>
</tr>
<tr>
<td>● Communicate effectively in English both verbally and in writing.</td>
</tr>
</tbody>
</table>
### Management of Physical and Mental Demands, Environment, and Working Conditions

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergency patient care needs.
- Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.
- Read patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.
- Use judgement and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.
- Have the capacity to see five (5) or more outpatient cases in a three-hour clinic session, four (4) or more hospital admissions in a 12-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours on inpatient services.
- Use computers for literature review, patient care documentation and data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a health care team.

### Performance Responsibilities and Job Functions

#### Outpatient Care
- Provide longitudinal primary medical care to a panel of outpatients.
- Learn to perform procedures essential to family medicine including but not limited to male infant circumcision, endometrial biopsy, colposcopy, and IUD insertion and removal.
- Work effectively within a patient-care team.
- Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion.
- Work effectively with medical staff on specialty outpatient rotations.

#### Inpatient Care
- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Perform CPR on infants and adults as indicated.
- Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric attending.
- Administer injections, take blood samples, and learn to insert arterial and central lines.
- Write and dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation.
- As necessary, write orders for physical and chemical restraints and seclusion.
- Identify and report medical errors and near misses using hospital-based reporting systems.

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

## PGY-2 Resident Job Descriptions

### Prerequisites
- Completed and passed all PGY-1 rotations and met all PGY-1 requirements
- Has met the minimum competency skills needed to teach students and peers

### Qualities
- Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.
- Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient rounding teams, class peers, curriculum, development teams, outpatient care teams, and support groups.

### Management of Physical and Mental Demands, Environment, and Working Conditions
- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergency patient care needs.
- Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.
- Read patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.
- Use judgment and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.
- Have the capacity to see 6 or more outpatient cases in a three-hour clinic session, 12 or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours when taking call on the inpatient services.
- Use computers for literature review, patient care data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a healthcare team.

### Performance Responsibilities and Job Functions

#### Outpatient Care
- Provide longitudinal primary medical care to a panel of outpatients.
- Provide longitudinal primary medical care to a panel of nursing home patients.
- Learn to perform procedures essential to family medicine including male infant circumcision, colposcopy, IUD placement and removal, endometrial biopsy, and OB ultrasound.
- Work effectively within a patient-care team.
Supervision Policy

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

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

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

PGY-3 Resident Job Descriptions

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

Qualities
- Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.
- Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient-rounding teams, class peers, curriculum, development teams, outpatient care teams, and support groups.
### Supervision Policy

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

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

#### Performance Responsibilities and Job Functions

##### Outpatient Care

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

##### Inpatient Care

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

- Serve as a team leader for two (2) months during the PGY-3 year.
- Identify and report medical errors and near misses using hospital-based reporting systems.

## Educational Mission

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

I. BACKGROUND

1.1. The primary objective of a “hand-off” is to provide accurate information about a patient’s care from one physician to another physician who is assuming responsibility for the care of the patient to ensure safe continuity of care. Information transmitted in the handoff includes treatments, services, current condition, any recent or anticipated changes, and a to-do list for tasks that should be completed during the time that the resident will be caring for the patient.

1.2. The information communicated during a hand-off must be accurate in order to ensure patient safety goals.

1.3. This policy conforms to the Joint Commission’s National Patient Safety Goal 2E.

II. SCOPE

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

III. HAND-OFF COMMUNICATION PROCEDURE

3.1. Assignment of the newly admitted patient to the Family Medicine service.

3.1.1. When a patient is admitted to the Family Medicine service, the Emergency Department (ED) attending contacts the Family Medicine Attending to provide handoff.

3.1.2. If the attending accepts the patient to the service based on sign-out from the ED physician, he/she will contact the resident on duty to evaluate and admit the patient.

3.1.3. In the event that the appropriateness for admission is not clear based on the report from the ED attending, the FM attending will contact the resident on duty to evaluate the patient and discuss the patient with the attending who will determine whether admission or clinic follow-up and outpatient management is most appropriate.
3.1.4. Upon accepting the patient, the attending will formally assume responsibility for the care of the patient and transfer of care from the ED to the appropriate hospital unit occurs.

3.1.5. On Monday to Friday, between 6:00 a.m. and 5:00 p.m. the admitting resident will be the resident designated to admit the next patient as agreed by the team. On Monday to Friday between 5:00 p.m. and 6:00 a.m., this will be the night float resident.

3.2. Transfer of patients between the daytime team and night float resident.

3.2.1. Hand-off communication occurs at 6:00 p.m. and at 7:00 a.m. between the daytime and night float teams (daytime team signs off to the night resident at 5:00 p.m. and vice-versa at 6:00 a.m.).

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

3.3. Transfer of patients to new rotating residents.

3.3.1. On the last day of the rotation, the inpatient team writes “off service notes” on all patients. The note includes each patient’s initial presentation, hospital course, pertinent lab and study results, and current status including any pending results or consults.

3.3.2. A verbal sign-out is also given at 6:00 p.m. on the night before the new team begins.

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

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

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

IV. EVALUATION METHODS

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

4.2. Each resident is evaluated based on hand-off expectations in the following areas: environment, standard handoff time, use of the SBAR transition of care presentation format, appropriately identifying patient details requiring special attention by the receiving resident, and confirmation that receiving resident understands the SBAR content on all patients by presenting back.

4.3. The Attending is expected both to give immediate informal feedback on the witnessed handoffs and to complete the formal Hand-off evaluation form and submit it to the Program Manager. The Program Assistant will transfer data from the Hand-off evaluation into New Innovations.
4.4. If any resident is not considered to be competent to give or receive handoff after the required minimum of observed handoffs by the attending, the senior resident and attending must provide additional education to the resident. The attending must continue to observe handoffs until each inpatient team resident demonstrates the ability to give hand off competently. The ability to give competent handoff is a requirement of passing the Family Medicine Wards rotation.

4.5. Residents should anonymously report breakdowns/problems in the handoff process for continued improvement by reporting the feedback and dropping it off in the comment/suggestion box located in the resident area of WellStar Atlanta Medical Center South. Feedback will be collected on a regular basis and reviewed at the following PEC meeting.
USMLE & COMLEX Examination Policy

I. PURPOSE

1.1. The purpose of this policy is to ensure that the quality of Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and the Family Medicine Residency Program goals and objectives.

1.2. A resident who will be prepared to undertake independent medical practice shall have completed requirements to obtain a physician’s license.

II. SCOPE

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

III. POLICY

3.1. Family Medicine residents must sit for the USMLE or COMLEX Step 3 by their 12th month of residency.

3.2. Family Medicine residents must present the official results of their USMLE/COMLEX Step 3 examination to the residency program before the last working day of the resident’s 20th month, which is February in a normal appointment cycle.

3.2.1. Family Medicine residents who have not passed Step 3 by the end of the 20th month will receive a letter of non-renewal of contract on March 1st in a normal appointment cycle.

3.2.2. Family Medicine residents who pass Step 3 between the 21st and 24th month, will receive a reappointment letter to the residency program at the time of receipt of the results, if this is the sole reason for non-renewal.
Patient Safety & Quality Improvement Policy

I. BACKGROUND

1.1. Training in Patient Safety and Quality Improvement is an essential component of family medicine residency education.

1.2. It is the focus of the Systems Based Practice -2 (SBP-2) subcompetency. As such, participation in the following PS/QI activities is required.

II. PURPOSE

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

III. POLICY

3.1. Patient Safety

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

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

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

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

3.1.3. Education on Patient Safety

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

3.1.4. Patient Safety Events

3.1.4.1. Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program.
3.1.4.2. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

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

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

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

   3.1.4.3.3. Be provided with summary information of their institution’s patient safety reports

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

3.1.5. 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 must receive training in how to disclose adverse events to patients and families.

      3.1.5.2.2. Residents should 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 refers to access to data which is essential to prioritizing activities for care improvement and for evaluating success of improvement efforts.

      Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.
3.2.3. Engagement in Quality Improvement Activities—Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

3.2.3.1. Residents must have the opportunity to participate in interprofessional quality improvement activities.

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

3.3. Annually, residents are required to complete Institution of Healthcare Improvement (IHI) Open School PSQI modules. Instructions for module completion and the link for access to these modules are provided by the Program through the GME office. Modules must be completed before the posted deadlines.

3.4. A PS/QI project must be completed as part of the Practice Management longitudinal experience.

3.5. After each month on the Family Medicine Wards service at Atlanta Medical Center-South, a case report must be presented during Wednesday didactics. The report must include a discussion of PS/QI issues related to the case.

3.6. As a requirement of program completion, each resident must complete a research project, described in the Research/Scholarly Activity Guidelines section of this document. These projects are expected to have a PS/QI implication.

3.7. Residents must report negative events and near misses that occur in the hospital through the respective hospital’s formal reporting mechanism, including documenting the event through the hospital’s electronic reporting portal.

3.8. Negative outcomes/events that occur in the Comprehensive Family Healthcare Center should be reported through the MSM Office of Compliance hotline at (855) 279-7520 and on-line reporting system at https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html.

3.9. Physician-to-Physician patient handoffs must occur at each change of shift, change of service, transfer of care (including outpatient office to hospital transfers). A full discussion of patient handoffs is included in the Transition of Care section of this document.
Research & Scholarly Activity Policy

I. BACKGROUND
The Family Medicine Residency Program at Morehouse School of Medicine requires that each resident complete a scholarly project in order to successfully complete the program and graduate. The project is within the bounds and scope of the Accreditation Council for Graduate Medical Education.

II. PURPOSE
The purpose of this policy is to set the standards for the program’s research curriculum.

III. STANDARDS
3.1. A scholarly project is required of each resident prior to completion of residency training. Residents will not be approved for graduation without the project being received and approved by the director of research based on criteria communicated to residents. The resident is responsible for selecting the faculty who will be assisting with his or her scholarly activities through the research director.

3.2. Required Deadlines by PGY level are outlined below
   3.2.1. PGY1- By the end of the PGY1 year, each resident must have developed a research question
   3.2.2. PGY2- By December, the resident must have developed a methodology. By the end of the PGY2 year, IRB approval must be obtained
   3.2.3. PGY3- By December, data collection must be complete. The research project must be completed by June 1st but earlier completion is highly encouraged.

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

3.4. During the Research Forum, held in June, each resident will have 15 minutes to present, followed by a 10-minute discussion.
   3.4.1. Faculty research advisors are expected to participate in the discussion.

3.5. Presentations should be developed in the following format:
   3.5.1. Introduction:
3.5.1.1. Question addressed and its importance stated
3.5.1.2. Conceptual model
3.5.1.3. Testable hypothesis(es)

3.5.2. Methods:
3.5.2.1. Sample—who was studied?
3.5.2.2. Dependent/outcome variable
3.5.2.3. Independent variable(s)—what predicts or is associated with the outcome variable?
3.5.2.4. Co-variables—did you control for variables (factors) that might affect the association between the independent and dependent (outcome) variable?
3.5.2.5. Measurement—how were variables measured? What are the validity and/or reliability of measurement tool?
3.5.2.6. Analysis—what statistical analytic methods were used to describe your sample, determine the distribution of responses, and test the hypothesis(es)?

3.5.3. Results:
3.5.3.1. Characteristics of sample
3.5.3.2. Distribution of responses for independent/dependent/co-variables, i.e., what percentage of residents vs. faculty responded to a different domain:
3.5.3.3. Of the variables
3.5.3.4. Results of test of hypothesis(es)

3.5.4. Discussion:
3.5.4.1. A brief restatement of findings (results)
3.5.4.2. Interpretation of results—what do they suggest?
3.5.4.3. How are they consistent with what is known?
3.5.4.4. How do they differ with what is known and why?
3.5.4.5. What are the study’s strengths and limitations?

3.5.5. Conclusion: Recommendations based on results

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

3.6.1. For this project, the resident identifies an issue in the clinic with a patient safety implication and develops an intervention to improve patient safety related to the issue.
3.7. Residents are also required to complete all Institute for Healthcare Improvement (IHI) Open School PHQI modules during each year of training.

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

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

3.8.2. The attending-resident co-authored case reports are to be written. Submission for conference presentation or resident-attending co-authored publication is highly encouraged.
Procedure Requirements and Logging Policy

I. BACKGROUND

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

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

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

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

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

II. PURPOSE

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

2.2. Residents record procedures in their log book as directed.

2.2.1. If the log contains PHI such as a medical record number, then the log must be kept secure at all times.

2.2.2. After they have been logged, procedures are signed off by a supervising resident or an Attending physician.

2.2.3. Residents are required to log their procedures in New Innovations. Residents can log their procedures into New Innovations as often as they like, but it must be done at least monthly.

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

III. POLICY

3.1. Faculty members, peers and nursing staff expect residents to have knowledge of procedures prior to performing them. Thus, it is the resident’s responsibility to familiarize himself/herself with the procedure to be performed. If the resident is about to perform a procedure for the first time, he/she should read about it and/or watch videos about it and/or ask faculty members for reference material before performing the procedure. Even if performed several times, refreshing one’s knowledge of a procedure is good practice. Sources generally recommended for primary care procedures include:

- Pfenninger’s Procedures for Primary Care Physicians (Mosby)
- NEJM’s Videos in Clinical Medicine

3.2. It is the resident’s responsibility to ensure that his/her procedures are correctly documented in the medical record and in New Innovations.

3.3. All procedures must be logged in New Innovations. It is the resident’s responsibility to ensure that logging is up to date. All procedures for a given month must be logged by the tenth day of the next month (e.g., All April procedures must be logged by May 10th).

3.4. Clinical Procedures

3.4.1. Procedures are to be entered into the log books provided by the Residency Program and signed by the immediate supervisor of the procedure

3.4.2. PHI is not to be documented in log books

3.4.3. All procedure log data is to be transferred (documented) in the Procedure Logger section of New Innovations.

3.5. The following is a list of procedures that will be encountered in residency. It is not an exhaustive list but does include most procedures our residents experience:

<table>
<thead>
<tr>
<th>Procedure Name</th>
<th>Independent Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amniotomy</td>
<td>3</td>
</tr>
<tr>
<td>Anoscopy</td>
<td>1</td>
</tr>
<tr>
<td>Arterial Blood Gas</td>
<td>2</td>
</tr>
<tr>
<td>Arterial Line Placement</td>
<td>1</td>
</tr>
<tr>
<td>Central Line Placement</td>
<td>2</td>
</tr>
<tr>
<td>Cesarean Section Assist</td>
<td>5</td>
</tr>
<tr>
<td>Chest X-ray interpretation</td>
<td>30</td>
</tr>
<tr>
<td>Circumcision</td>
<td>5</td>
</tr>
<tr>
<td>Procedure</td>
<td>Count</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>3</td>
</tr>
<tr>
<td>Delivery Vacuum Extraction</td>
<td>1</td>
</tr>
<tr>
<td>Delivery, normal vaginal</td>
<td>20</td>
</tr>
<tr>
<td>EKG Interpretation</td>
<td>30</td>
</tr>
<tr>
<td>Endometrial Biopsy</td>
<td>3</td>
</tr>
<tr>
<td>Episiotomy 1st, 2nd Deg Rep</td>
<td>1</td>
</tr>
<tr>
<td>Fetal Scalp Electrode</td>
<td>1</td>
</tr>
<tr>
<td>I&amp;D Abscess</td>
<td>5</td>
</tr>
<tr>
<td>Induction/Augmentation of Labor</td>
<td>1</td>
</tr>
<tr>
<td>IUD Insertion</td>
<td>1</td>
</tr>
<tr>
<td>IUD Removal</td>
<td>1</td>
</tr>
<tr>
<td>IUPC Placement</td>
<td>1</td>
</tr>
<tr>
<td>joint aspiration</td>
<td>10</td>
</tr>
<tr>
<td>joint injection</td>
<td>10</td>
</tr>
<tr>
<td>Laceration Repair, Simple</td>
<td>2</td>
</tr>
<tr>
<td>Lumbar Puncture</td>
<td>2</td>
</tr>
<tr>
<td>Newborn Exams</td>
<td>40</td>
</tr>
<tr>
<td>non-ob surgery assist</td>
<td>5</td>
</tr>
<tr>
<td>OB Nonstress Test</td>
<td>20</td>
</tr>
<tr>
<td>OB Ultrasound</td>
<td>5</td>
</tr>
<tr>
<td>pap smear</td>
<td>30</td>
</tr>
<tr>
<td>Skin Tag removal</td>
<td>1</td>
</tr>
<tr>
<td>Wet Mount</td>
<td>10</td>
</tr>
</tbody>
</table>

3.6. Residents must continue to log procedures in New Innovations even after the independent targets have been met.
Patient Encounter Requirements and Logging Policy

I. BACKGROUND

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

II. PURPOSE

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

III. POLICY

3.1. All clinical procedure and patient encounters must be logged in New Innovations. It is the resident’s responsibility to ensure that logging is up to date. All patient encounters and procedures for a given month must be logged by the tenth day of the next month (e.g., All April encounters and procedures must be logged by May 10th).

3.2. The following is a list of patient encounters that residents must complete. The numbers of required encounters listed are minimums. Encounters above the minimum listed are highly encouraged. The list also details the rotation name and location at which the patient encounter can be experienced as well as the module in New Innovations to log the encounter.
### Patient Encounter Requirements and Logging Policy

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

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

I. BACKGROUND

1.1. Moonlighting is clinical work done outside the scope of our program by a resident. Its advantages (extra income, experience in other settings, etc.) must be weighed against potential negatives (less free time, sleep, and time with significant others).

1.2. As stipulated by the ACGME Family Medicine Residency Program Requirements, moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

1.3. Moonlighting activities are monitored by the program director to ensure that the quality of patient care and the resident’s educational experience are not compromised.

1.4. The MSM Family Medicine Residency Program moonlighting policy is consistent with the policy outlined in the GME Policy Manual.

II. PURPOSE

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

III. POLICY

3.1. Moonlighting is permitted for, at the discretion of the PD, PGY-2 and PGY-3 residents in good standing, with an independent medical license and proper malpractice coverage.

3.2. Residents wishing to moonlight must obtain written permission from the program director.

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

3.4. The following conditions must be met in order for the program director to consider approving a resident request to moonlight:

3.4.1. The resident must be in good academic standing in the program; he or she must not be in academic remediation or probation. The resident must also fulfill all administrative requirements of the program (e.g., prompt dictations, clinic note completion, work hour and patient logging, handling phone messages and lab results in a timely manner, etc.).
3.4.2. The training license and training DEA number may not be used to practice medicine outside of the residency program.

3.4.3. The resident must have:

3.4.3.1. Valid, full medical license from the State Medical Board of Georgia, as residents may not practice medicine outside of our residency program under the State of Georgia Training Certificate; and

3.4.3.2. A personal DEA certificate/number (the DEA number issued by the hospital for residents may be used only in carrying out clinical duties that are part of the residency program, and may not be used for moonlighting purposes).

3.4.4. The resident must arrange for his or her own malpractice insurance; the resident can either pay for this insurance personally or it can be provided by the entity employing the resident for the moonlighting. The Morehouse School of Medicine malpractice insurance plan does not cover any activities outside of a residency program.

3.4.5. Moonlighting is restricted to one (1) shift per week. It must not interfere with patient care nor be so excessive that the resident is too tired to learn and/or to perform the residency requirements. The combined hours of residency and moonlighting must not exceed 80 hours per week.

3.4.6. The resident may not moonlight during normal work hours, as defined by his/her rotation. Further, the resident is not permitted to moonlight between 7:00 a.m. and 5:00 p.m. on Monday through Friday, while on call, or on the day post-call.

3.5. The resident who meets the conditions above and desires to moonlight must submit a moonlighting request form to the program director to receive permission to moonlight. This request must document that the resident meets the conditions and that he or she will follow the moonlighting policy. The resident must also provide details as to where and how many hours each week he or she plans to moonlight. The program director will review the request and if there are no concerns, the program director will give the permission to moonlight.

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

3.7. The Moonlighting Request form can be found in the Program Handbook.
Well-Being Policy

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

II. SCOPE:
Per ACGME - in the current health care 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.

III. POLICY:
3.1. In partnership with the Graduated Medical Education Office, the program shares the responsibility of resident well-being to include:
3.1.1. efforts to enhance the meaning that each resident finds in the experience of being a physician
3.1.2. including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships
3.1.3. attention to scheduling, work intensity, and work compression that impacts resident well-being
3.1.4. evaluating workplace safety data and addressing the safety of residents and faculty members’ policies and programs that encourage optimal resident and faculty member well-being; and,
3.1.4.1. Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours
3.1.5. attention to resident and faculty member burnout, depression, and substance abuse.
3.1.5.1. 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.
3.1.5.2. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care.

3.1.6. The program, in partnership with its Sponsoring Institution, must:

3.1.6.1. encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.

3.1.6.2. provide access to appropriate tools for self-screening; and,

3.1.6.3. provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

3.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies.

3.2.1. Each program must have policies and procedures in place that ensure coverage of patient care if a resident may be unable to perform their patient care responsibilities.

3.2.2. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.
ACGME Program Specific Requirements

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

Common Program Requirements
Family Medicine Program Specific Requirements
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