



EMORY UNIVERSITY SCHOOL OF MEDICINE CHILDREN'S HEALTHCARE OF ATLANTA PEDIATRIC RHEUMATOLOGY FELLOWSHIP

HANDBOOK & CURRICULUM

Kelly Rouster-Stevens, MD, MS
Fellowship Director
Professor of Pediatrics

Sampath Prahalad, MD, MS
Chief, Division of Pediatric Rheumatology
Associate Fellowship Director
Professor of Pediatrics

Maria Demery
Fellowship Program Coordinator

Elaine Flanagan, MD
Associate Professor of Pediatrics

Cynthia Manos, MD, MS
Assistant Professor of Pediatrics

Angela Taneja, MD
Assistant Professor of Pediatrics

Baruch Goldberg, MD, MSW
Assistant Professor of Pediatrics

D. Sofia Villacis-Nunez, MD
Assistant Professor of Pediatrics



OVERVIEW:

Emory University School of Medicine Rheumatology Fellowship is a 3-year, ACGME accredited training. The goal of the Rheumatology Fellowship Program is to provide training for clinical and basic science to pursue careers as independent investigators in the field of Pediatric Rheumatology.

MISSION:

The mission of the Pediatric Rheumatology Fellowship is to develop physicians that are clinically competent in the diagnosis and management of children and adolescents with rheumatic diseases and related conditions. Trainees will have acquired the skills and knowledge to succeed in an academic health care setting, and possess habits of life-long learning to build upon their knowledge, skills and professionalism.

Goals of Program

The pediatric rheumatology fellowship at CHOA/Emory is committed to training future academic pediatric rheumatologists. Our goal is to provide trainees with the necessary knowledge and skills to provide excellent care to patients in a collegial environment that fosters inquiry. The fellowship is designed to meet the requirements of the ACGME, to prepare fellows for the American Board of Pediatrics Exam in Pediatric Rheumatology and to allow fellows to follow their own passion.

Develop collaborative clinical care expertise:

- To lead the comprehensive care of children with rheumatic diseases.
- To incorporate the role of medical and allied healthcare professionals in patient care.
- To understand the role of community resources in the care of children with rheumatic diseases.

Foster independent translational and clinical investigation:

- To provide mentoring to develop and complete innovative and feasible research projects.
- To ensure academic achievement by rigorously supervising academic progress.

Invest in the future of pediatric rheumatology:

- To promote management skills for independent direction of a rheumatology team, including formal participation in divisional quality and patient safety initiatives.
- To solidify research skills to further independent research careers.
- To foster mentoring skills to educate subsequent trainees.
- To cultivate leadership skills to advance the field of pediatric rheumatology.
- To promote participation in the American College of Rheumatology, Childhood Arthritis & Rheumatology Research Alliance and the American Academy of Pediatrics.

CORE TRAINING SITES:

Center for Advanced Pediatric



Arthur M. Blank Hospital (Opening September 2024!!)



FACULTY



Kelly Rouster-Stevens, MD, MS

Professor of Pediatrics

Pediatric Rheumatology Program Fellowship Director

Director of Medicine – Children’s Healthcare of Atlanta

Dr. Rouster-Stevens assisted in development of the fellowship program at Emory. Training future pediatric rheumatologists has been one of her passions. She has a particular interest in lupus and juvenile dermatomyositis (JDM); she collaborates with other institutions in clinical research in these areas. She is involved in a novel study of calcinosis in JDM in affiliation with the National Institutes of Health. She has been invited to be a visiting professor for the American College of Rheumatology. Additionally, she has become involved in the electronic medical record (Epic) advisory team and oversees several Epic projects.

Education/Training:

Medical Degree: University Of Cincinnati College of Medicine, Cincinnati, OH

Residency: Wake Forest University Baptist Medical Center, Pediatrics, Winston-Salem, NC

Fellowship: Northwestern University/Children’s Memorial Hospital, Pediatric Rheumatology, Chicago, IL

Master’s Degree: Clinical Investigation, Northwestern University, Chicago, IL

Professional Societies:

- American Academy of Pediatrics
- American College of Rheumatology (ACR)
 - Past Co-Chair of the Fellows Subcommittee on Workforce and Training
 - Fellows Curriculum Subcommittee of Workforce and Training
 - PRYSM Meeting Planning Committee
- Childhood Arthritis and Rheumatology Research Alliance (CARRA)
 - Elections Committee, Elected Member
- Pediatric Rheumatology Collaborative Study Group
- AMIGO (ACR/CARRA) Mentoring Interest Group
 - Past Co-Chair
- American Association of Pediatric Program Directors
- Subspecialty Pediatric Investigators Network
- Lupus Foundation of America, Georgia Chapter Medical Advisory Board
- Cure JM, Medical Advisory Board
- International Myositis Assessment and Clinical Studies Group
 - Meeting Planning Committee member



Sampath Prahalad, MD, MS

Professor of Pediatrics

Chief, Division of Pediatric Rheumatology

Associate Fellowship Program Director

In addition to his role as chief of pediatric rheumatology, Dr. Prahalad assisted in the development of the pediatric rheumatology fellowship at Emory. Dr. Prahalad's is passionate about research, and his vision is to 'determine who gets juvenile arthritis and why.' He investigates genetic and epidemiological factors influencing JIA. His team has collected DNA from >3000 individuals, including >1200 children with JIA. Dr. Prahalad heads an international collaboration and has assembled DNA from > 400 children with rheumatoid arthritis, a typically adult disease. He enjoys training our fellows and has provided several lectures to our trainees.

Education/Training:

MBBS (MD): Sri Venkateswara Medical College Tirupati, India

Diploma in child health: Royal College of Physicians, London.

M.S. Epidemiology: University of Cincinnati, Cincinnati, OH

Residency: Senior House Officer in Pediatrics, Romford Essex, UK

Residency in Pediatrics: Penn State Hershey Medical Center, Hershey PA

Fellowship Pediatric Rheumatology: Cincinnati Children's Hospital Medical Center, Cincinnati, OH

Professional Society:

- American College of Rheumatology
- American Society for Human Genetics
- Editorial Board, BioMed Central Pediatric Rheumatology
- Reviewer, NIH- NIAMS Study Sections K23, R03 applications
- Elected Member, Society for Pediatric Research
- Vice Chair, JIA Research Subcommittee, Childhood Arthritis and Rheumatology Research Alliance



Elaine Flanagan, MD, RhMSUS

Associate Professor of Pediatrics
Vice-Chief, Pediatric Rheumatology

Dr. Flanagan has a special interest in medical education. She has created an elective for 4th year medical students and presented multiple lectures to the residents. She has provided educational seminars to community pediatricians. Dr. Flanagan is also musculoskeletal ultrasound certified and has a half-day/week clinic dedicated to ultrasound and joint injection procedures. Dr. Flanagan represents pediatric rheumatology on the School of Medicine Teaching Committee. She is participating in a study of post-infection joint splinting in juvenile idiopathic arthritis.

Education/Training:

Medical Degree: Medical University of South Carolina, Charleston, SC

Residency: University of Virginia, Charlottesville, VA

Fellowship: Children's Hospital of Philadelphia, Philadelphia, PA

Certification: Ultrasound School of North American Rheumatologists (USSONAR)

Professional/Scientific Societies:

- American Academy of Pediatrics
- American College of Rheumatology
- Childhood Arthritis & Rheumatology Research Alliance
- Ultrasound School of North American Rheumatologists (USSONAR)



Cynthia Manos, MD, MS

Assistant Professor of Pediatrics

Dr. Manos completed a Master's Degree in Clinical Epidemiology during fellowship with a focus on pediatric psoriatic arthritis. Her research focused on identifying risk factors for development of arthritis in children with psoriasis. She continues to have an interest in the epidemiology of JIA and also plans to pursue a focus in vasculitis.

Education/Training:

Medical Degree: SUNY Upstate Medical University, NY

Residency: Yale – New Haven Hospital, CT

Fellowship: Children's Hospital of Philadelphia, PA

Master's Degree: Masters's of Science in Clinical Epidemiology from University of Pennsylvania

Professional/Scientific Societies:

- American Medical Association
- AOA Honor Medical Society
- American Academy of Pediatrics
- American College of Rheumatology
- Childhood Arthritis & Rheumatology Research Alliance



Angela Taneja, MD, RhMSUS

Assistant Professor of Pediatrics

Dr. Taneja was awarded the USSONAR (Ultrasound School for North American Rheumatologists) fellow's scholarship and successfully passed their written and practical exams. She also became certified in muscle skeletal ultrasound by the American College of Rheumatology (ACR RhMSUS) in June 2016. She received the "Top Fellow Abstract" award by the American College of Rheumatology (ACR) at the 2017 Pediatric Rheumatology Symposium for a research project entitled "Prevalence of Celiac Antibodies and IgA Deficiency in JIA". She has clinical and research interests in Chronic Non-bacterial Osteomyelitis (CNO/CRMO) & Juvenile Idiopathic Arthritis (JIA).

Education/Training:

Medical Degree: Universidade Regional de Blumenau Faculdade de Medicina, Brazil

Residency: Woodhull Medical Center, Brooklyn, NY

Fellowship: Emory University School of Medicine, Atlanta, GA

Certification: Ultrasound School of North American Rheumatologist (ACR RhMUS)

Professional/Scientific Societies:

- American Academy of Pediatrics
- American College of Rheumatology
- Childhood Arthritis & Rheumatology Research Alliance
- Ultrasound School of North American Rheumatologists (USSONAR)



Baruch Goldberg, MD, MSW
Assistant Professor of Pediatrics

After completing his fellowship at Texas Children’s Hospital, Dr. Goldberg joined the faculty at McGovern Medical School at UT Health. While there, he established a combined rheumatology/ophthalmology uveitis clinic and a joint injection program. In April 2020, Dr. Goldberg made a brave move during the COVID-19 pandemic to join the faculty at Emory University/Children’s Healthcare of Atlanta. He appreciates the clinical aspect of pediatric rheumatology but also enjoys teaching medical students, residents and fellows. His clinical interests include uveitis, macrophage activation syndrome/hemophagocytic lymphohistiocytosis and systemic JIA.

Education/Training:

Medical Degree: Sackler School of Medicine at Tel-Aviv University

Residency: Cohen Children’s Medical Center

Fellowship: Texas Children’s Hospital

Professional/Scientific Societies:

- American Academy of Pediatrics
- American College of Rheumatology
- Childhood Arthritis & Rheumatology Research Alliance
- Histiocyte Society



D. Sofia Villacis-Nunez, MD
Assistant Professor of Pediatrics

Dr. Villacis-Nunez is the newest member of our faculty, joining in 2022 after completion of her fellowship at Emory/CHOA. During fellowship, she contributed to multiple manuscripts, including her research on corticosteroid monotherapy in Multisystem Inflammatory Syndrome in Children (MIS-C) in JAMA Pediatrics. Dr. Villacis-Nunez has presented her work at ACR, CARRA and AAP meetings. Additional activities during her fellowship included participation in USSONAR training program for musculoskeletal ultrasound, certification as an Epic Physician Builder and development of our Fellowship Handbook. Dr. Villacis is an active member on multiple local, national and international committees, including the fellow representative to the Emory House Staff committee. Notably, she is Section on Early Physician Career liaison to the Section on Integrative Medicine of the AAP and serves on the Diversity, Equity and Inclusion Taskforce at Emory University. She actively participates in resident education and education of school nurses through the Lupus Foundation Nurse Educator Program.

Of note, Dr. Villacis received ‘Best Poster’ at the Emory/CHOA Fellowship Research Day and placed 3rd at the American College of Rheumatology Research Workshop for her MIS-C treatment investigation.

Education/Training:

Medical Degree: Universidad San Francisco de Quito; Ecuador

Residency: Nicklaus Children’s Hospital; Miami, FL

Fellowship: Emory University/Children’s Healthcare of Atlanta; Atlanta, GA

Professional/Scientific Societies:

- American Academy of Pediatrics
- American College of Rheumatology
- Childhood Arthritis & Rheumatology Research Alliance
- Ultrasound School of North American Rheumatologists (USSONAR)

FELLOWS

Shalini Bijaj, MD

PGY-6

Education/Training

Medical Degree: Ravindra Nath Tagore Medical College, India

Pediatric Residency: Medical College of Georgia, Augusta, GA

Christian Oliveros, MD

PGY-5

Medical Degree: Florida International University Herbert Wertheim College of Medicine

Pediatric Residency: Children's Mercy, Kansas City, MO

METHODS OF TEACHING

In order to achieve the goals and objectives for the fellowship program, the following experiences have been established for the purpose of teaching Rheumatology fellows. These methods include: (1) the inpatient Rheumatology experience, (2) the outpatient Rheumatology experience, (3) interaction with other clinical specialties, (4) conferences, (5) research experience, (6) musculoskeletal ultrasound exposure, and (7) continuing medical education and society participation.

Level of responsibility / autonomy by proficiency level

Clinical Activity	Beginning	Developing	Proficient
Clinical data collection	Independent with staff supplementation	Independent with staff confirmation	Independent with staff confirmation of selected issues
Formulation of clinical assessments / plans	Jointly with staff	Independent with staff confirmation; independent utilization of evidence based medicine resources and sharing of information with the care team	Independent with staff confirmation of selected issues; demonstrated mastery of large sets of subspecialty based skills and is preparing to practice independently
Consult: Communication of recommendation to primary care team/referring physician	Jointly with staff	Independent with staff confirmation; independent utilization of evidence based medicine resources and sharing of information with primary team	Independent with staff confirmation of selected issues; consistently incorporates evidence based medicine and system base practices into improving the effectiveness of consultation
Supervisor of care team	Jointly with staff begins efforts at teaching other team members on subspecialty issues	Independent with staff confirmation of patient care issues; increasing responsibility for teaching of team members	Independent with staff confirmation of selected patient care issues; shared responsibility with staff for teaching of team members

PRINCIPLE EDUCATIONAL GOALS BY RELEVANT COMPETENCY

Legend for Learning Activities:

Direct Patient Care

Continuity Clinics (CC)
 Hospital Attending Rounds (HR)
 Procedure Teaching (PT)

Educational Conferences and Meetings

Board Review Seminar (BR)
 Clinical Case Conference (CCC)
 Core Curriculum Lecture (CCL)
 Multi-Disciplinary Conference (MDC)
 Graduate Medical Education Core Lectures Series (GME)
 Grand Rounds (GR)
 Journal Club (JC)
 Pathology Conference (PC)
 Research Conferences (RC)
 Society and Educational Meetings (EM)

Legend for Evaluation Methods

Attending Evaluations (AE)
 Directly Supervised Procedures (DSP)
 Program Director's Review (PDR)
 Peer Review (PR)
 Clinical In-Service Exam (CIE)

PATIENT CARE

Principal Education Goals	Learning Activities	Evaluation Methods
Perform a complete medical history	CC, HR	AE, PDR
Perform a comprehensive examination	CC, HR, PT	AE, DSP, PDR
Formulate comprehensive and accurate problem lists	CC, HR, PT, CCC, CCL, MM	AE, PDR, CIE
Generate and prioritize differential diagnosis	CC, HR, PT, CCC, CCL, MM	AE, PDR, CIE
Develop rational, evidence-based management strategies	CC, HR, CCC, CCL, MM	AE, PDR, CIE

Develop concise, accurate, rational, informative consultation	CC, HR, PT	AE, DSP, PDR
Ability to recognize major abnormalities on radiologic studies	CC, HR, PT	AE, PDR, CIE
Ability to determine and perform appropriate diagnostic and therapeutic procedures	CC, HR, PT	AE, DSP, PDR

MEDICAL KNOWLEDGE

<u>Principal Education Goals</u>	<u>Learning Activities</u>	<u>Evaluation Methods</u>
Demonstrate knowledge of basic and clinical sciences underlying patient care	BR, CC, HR, PT, CCC, CCL, MM, PC	AE, PDR, CIE
Demonstrate an analytical approach to acquiring new knowledge	BR, CC, HR, PT, CCC, CCL, JC, MM, PC, RC	AE, PDR, CIE
Demonstrate continued advancement of knowledge	BR, CC, HR, PT, CCC, CCL, JC, MM, PC, RC	AE, DSP, PDR, CIE
Apply knowledge in the development of critical thinking, problem-solving and decision-making	BR, CC, HR, PT, CCC, CCL, MM, RC	AE, PDR, CIE
Assess and critically evaluate current medical information and scientific evidence and modify knowledge base accordingly	BR, CCC, CCL, HC, MM, PC, RC	AE, PDR, CIE
Demonstrate the knowledge of the indications for, principles, complications and interpretations of specialized tests and procedures	BR, CC, HR, PT, CCC, MM	AE, DSP, PDR, CIE

EVIDENCE-BASED LEARNING AND IMPROVEMENT

Principal Education Goals	Learning Activities	Evaluation Methods
Use scientific methods and evidence to investigate, evaluate and improve patient care	CC, HR, CCC, CCL, MM	AE, PDR, CIE
Identify areas of improvement and implement strategies to improve knowledge, skills, attitudes and care processes	CC, HR, CCC, CCL, MM	AE, PDR, CIE
Analyze and evaluate practice experiences and continually improve quality of patient practice	CC, HR, PT, CCC, MM, PC	AE, PDR, CIE
Maintain a desire to learn from errors and improve the system or processes of care	CC, HR, PT, CCC, GME, MM, PC,	AE, PDR, CIE
Use information technology and other methodologies to assess and manage information	CC, HR, PT, CCC, JC, MM, PC	AE, PDR, CIE

INTERPERSONAL SKILLS AND COMMUNICATION

Principal Education Goals	<u>Learning Activities</u>	<u>Evaluation Methods</u>
Demonstrate interpersonal skills that establish and maintain professional relationships with patients, families, and members of health care teams	CC, HR, PT	AE, PDR, PR
Demonstrate interpersonal skills that establish and maintain professional relationships with members of health care teams	CC, HR	AE, PDR, PR
Provide effective and professional consultations	CC, HR, PT, CCC, MM	AE, DSP, PDR
Demonstrate effective listening, nonverbal questioning and narrative skills to communicate with patients	CC, HR, PT	AE, PDR, PR
Demonstrate respectful and appropriate interactions with consultants	CC, HR, PT	AE, PDR, PR
Maintain comprehensive, timely and legible medical records	CC, HR, PT	AE, PDR

PROFESSIONALISM

Principal Education Goals	Learning Activities	Evaluation Methods
Demonstrate a commitment to professional development and ethical practice	CC, HR, PT, CCC, CCL, GME, GR, JC, MM, PC, RS, EM	AE, DSP, PDR, PR
Demonstrate and understanding and sensitivity to diversity and responsible attitude toward patients, profession and society	CC, HR, PT, CCC, CCL, GME, MM, EM	AE, PDR, PR
Demonstrate respect, compassion, integrity and altruism in relationships with patients, families and colleagues	CC, HR, PT, CCC, GME, MM	AE, DSP, PDE, PR
Demonstrate sensitivity and responsiveness to patients and colleagues, including gender, age, culture, religion, sexual preference, socioeconomic status, beliefs, behaviors and disabilities	CC, HR, PT, CCC, GME, MM	AE, PDR, PR
Adhere to principals of confidentiality, scientific/academic integrity and informed consent	CC, HR, PT, CCC, GME, MM, PC	AE, DSP, PDR
Recognize and identify deficiencies in peer performance	CC, HR, PT, CCC, MM, PC, RC, EM	AE, PDR, PR

SYSTEMS-BASED PRACTICE

Principal Education Goals	<u>Learning Activities</u>	<u>Evaluation Methods</u>
Demonstrate and understanding of the contexts and systems in which health care is provided and demonstrate the ability to apply this knowledge to improve and optimize health care	CC, HR, PT, CCC, MM, PC	AE, PDR
Understand, access, and utilize the resources and providers necessary to provide optimal care	CC, HR, PT, CCC, MM, PC	AE, DSP, PDR
Understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient.	CC, HR, PT, CCC, MM	AE, DSP, PDR
Apply evidence-based, cost-conscious strategies to prevention, diagnosis and disease management.	CC, HR, PT, CCC, JC, MM, PC, EM	AE, DSP, PDR
Collaborate with other members of the health care team to assist patients in dealing effectively with complex systems and to improve systematic processes of care.	CC, HR, PT, CCC, MM, PC, EM	AE, DSP, PDR, PR

PEDIATRIC RHEUMATOLOGY FELLOWSHIP

CURRICULUM

FIRST YEAR FELLOW:

Outpatient Clinic

Fellows evaluate and follow a variety of new patients. They will develop a patient panel they will follow during the weekly fellows clinic (Thursday AM), which will continue into their second and third year. The first year fellow will also attend a variety of faculty clinic when they are not oncall. Feedback will be provided during and outside of the clinic. Outpatient rotations are arranged in Immunology and Adult Rheumatology clinics. If the fellow has an interest in other areas and would like to pursue an elective, this can be considered.

Inpatient Service

On alternating weeks during the first year, the fellow participates in inpatient rounds and consultations, teaches residents, and ensures all patient care plans are carried out at Egleston Hospital. During the second and third year, the fellow will assist in covering the inpatient service at Egleston Hospital approximately every 4 weeks. There is an opportunity during the third year to participate in consults at Scottish Rite Hospital. The fellow will not have outpatient clinics during inpatient service weeks. Telephone consultations are performed for primary care physicians from all over Georgia and surrounding states.

Education

Wednesday mornings each week and alternating Monday afternoons are dedicated to education. Fellows attend Rheumatology Grand Rounds, Journal Club, and Fellows Lectures in conjunction with Adult Rheumatology. Weekly Rheumatology Team Meetings and Clinical Care Conferences are held during which the fellows present patient histories for discussion. Fellows participate in monthly radiology and research conference. There is a bi-monthly board review session, which is attended by faculty. There is an opportunity for the first year fellows to attend the State-of-the-Art Meeting of the ACR in the spring. The first year fellow is encouraged to teach medical students and residents during inpatient and outpatient rotations.

Research

The first year fellow will attend the weekly "Introduction to Research" seminar presented by the Department of Pediatrics in the fall. During the latter half of the first year, the fellow should begin to develop ideas (under the guidance of Dr. Prahalad and/or Dr. Rouster-Stevens) for research that will be pursued during the 2nd/3rd year. Faculty will assist fellows in identifying Scholarship Oversight Committee members. Each fellow will complete a quality improvement project by the end of fellowship; faculty trained in QI methodology will assist the fellows; this project will start in the spring of the first year (but no later than August of the second year).

SECOND & THIRD YEAR FELLOW:

Fellows solidify clinical and team leadership skills. Fellows develop research skills through conducting a project in either translational laboratory investigation or clinical investigation. Each fellow develops a hypothesis-driven research project culminating in the publication of a manuscript or grant proposal.

Outpatient Clinic

During the weekly half-day fellows clinic, the fellow monitors a patient panel collected during year one. Fellows pursuing a clinical path will also attend an additional weekly half-day of clinic with a faculty mentor.

Inpatient Service

Thirteen weeks "pretending", in which fellows take major responsibility for patient care; with supervision and teaching of the residents and first year fellow, in consultation with the attending physician.

Joint Injections

Fellows perform at least 5 joint injections per year in the clinic and in interventional radiology while the patients are under conscious sedation. These procedures will be performed primarily during the second/third year of fellowship.

Musculoskeletal Ultrasound

We have 2 faculty certified in musculoskeletal ultrasound. All fellows will be exposed to the technique utilized in musculoskeletal ultrasound. During the second/third year, fellows will have the opportunity to train in musculoskeletal ultrasound, if this is of interest.

Education

Wednesday mornings each week and alternating Monday afternoons are dedicated to education. Fellows attend Rheumatology Grand Rounds, Journal Club, and Fellows Lectures in conjunction with Adult Rheumatology. Weekly Rheumatology Team Meetings and Clinical Care Conferences are held during which the fellows present patient histories for discussion. Fellows participate in monthly radiology and research conference. There is a bi-monthly board review session, which is attended by faculty. There is an opportunity for the second year fellow to attend the annual meeting of the Childhood Arthritis and Rheumatology Research Alliance in the spring and for the third year fellow to attend the American College of Rheumatology (ACR) Annual Scientific Meeting in the fall. There are multiple opportunities at Emory and Morehouse College of Medicine to provide formal lectures to residents. Fellows are encouraged to teach residents rotating in the outpatient rheumatology elective. Additionally, we have a relationship with the Lupus Foundation in which fellows educate community school nurses on lupus signs and symptoms.

Research

The fellow identifies a mentor and works during the first year to develop a research plan to be implemented in the second and third years. Laboratory research may be conducted at ECC or CHOA. There is an opportunity for the second year fellow to attend the annual meeting of the Childhood Arthritis and Rheumatology Research Alliance in the spring and for the third year fellow to attend the American College of Rheumatology (ACR) Annual Scientific Meeting in the fall. The 2nd/3rd year fellows will complete the QI project with the guidance of faculty trained in QI methodology.

PEDIATRIC RHEUMATOLOGY FELLOWSHIP

CURRICULUM

OUTPATIENT CLINIC ROTATION

Physician Contact: Dr. Rouster-Stevens

Office: (404) 785-5437

Other Physicians: Drs. Prahalad, Flanagan, Thakral, Manos, Taneja & Goldberg

Duration of Rotation: 12-MONTHS (1st year) / 11-MONTHS (2nd & 3rd year);

INTRODUCTION

All fellows will attend the weekly fellows continuity clinic, which they will follow a panel of patients throughout fellowship. The weekly fellows clinic will be supervised by a rotating schedule of faculty from pediatric rheumatology. During the first year the Fellow will follow patients, supervised by one of the full-time or part-time faculty, during 4-6 half-day clinics every other week. In the second and third year of fellowship, the fellow will attend 1-2 half-day clinic(s) per week (except during oncall week), resulting in a longitudinal clinical experience in managing patients with rheumatic diseases.

GOAL

Fellows will understand principles and demonstrate competency in obtaining a clinical history and relevant review of systems for patients presenting to the Rheumatology clinic. Fellows rotating on the outpatient clinic rotation will learn diagnosis, management, and treatment of children and adolescents with rheumatologic disorders seen in the setting of an ambulatory clinic.

OBJECTIVE

1. PATIENT CARE

1. Provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness and treatment of rheumatic disease.
2. Demonstrate principles and competency in performing and interpreting the examination of the structure and function of all axial and peripheral joints, particular structures, peripheral nerves and muscles.
3. Demonstrate the ability to construct a differential diagnosis in pediatric and adolescent patients presenting with signs and symptoms related to rheumatologic diseases that include the most common and probable possibilities and to outline further testing necessary to establish the correct diagnosis.
4. Demonstrate the ability to construct and implement appropriate treatment plan for the care of a patient with common rheumatologic problems, including juvenile idiopathic arthritis, lupus, juvenile dermatomyositis, vasculitis, and autoinflammatory disorders. This should include the integration of prescribing appropriate medications, counseling, rehabilitative medicine, and when required, surgical or other consultation. The fellow should be able to cogently explain the rationale and risk/benefits of the treatment plan.

2. MEDICAL KNOWLEDGE

1. Demonstrate knowledge of established and evolving biomedical, clinical and social sciences as they apply to the rheumatic diseases and to apply their knowledge to patient care and education of others.
2. Demonstrate a sound understanding of diagnostic tests in Rheumatology, including musculoskeletal ultrasound.
3. Demonstrate a working knowledge of juvenile inflammatory arthropathies, systemic connective tissue diseases, vasculitides, infectious arthropathies, and inflammatory myopathies, disorders of bone and cartilage, metabolic, endocrine and hematology disease associated rheumatic disorders, hereditary rheumatic syndromes, and common non-articular and regional musculoskeletal disorders, as well as a wide range of miscellaneous rheumatic diseases delineated in the ACR core curriculum.
4. Demonstrate a working knowledge of basic immunology, including anatomical and cellular elements of the immune system, mechanisms of immune response and inflammation, and mechanisms of cellular interactions, immunoregulation and immunomodulation.
5. Demonstrate a working knowledge of the anatomy and biology of musculoskeletal tissues.

3. PRACTICE-BASED LEARNING AND IMPROVEMENT

1. Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes, and processes of care as part of a commitment to life-long learning and self-instruction.
2. Develop and maintain a willingness to learn from errors to improve the system or processes of care.
3. Demonstrate the ability to organize learning opportunities including the selection of conference topics, coordinating speakers and scheduling conferences.

4. INTERPERSONAL AND COMMUNICATION SKILLS

1. Demonstrate interpersonal and communication skills that enable the fellow to establish and maintain professional relationships with patients, families, and other members of the health care team.
2. Provide effective and professional consultations to other physicians and health care professionals and sustain therapeutic and sound professional relationships with patients, their caregivers, and colleagues.
3. Use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families.

5. PROFESSIONALISM

1. Demonstrate compassionate use of medical skills for patients. This includes high-quality care and technology and, in the event of terminal illness, an awareness of the limits of medical intervention and the obligation to provide humane care.
2. Recognize the legal requirements of advanced directives and describe the process of assessing a patient's advance directives, including the patient's perspective.
3. Model appropriate professional attitudes and behaviors of time management and punctuality, reliability, peer support, objective peer evaluation, community teaching, and ethical behavior.

6. SYSTEM-BASED PRACTICE

1. Recognize financial issues of health care, with emphasis on understanding acute and chronic care, and medication coverage and the role of the Centers for Medicare and Medicaid Services (CMS), and other third party payers.
2. Actively participate in the multidisciplinary approach to caring for patients, including appropriate recognition of other health professional and paraprofessionals' roles and demonstrate competence in team interactions, i.e. pharmacist, physician's assistant, advanced practice nurse, nurses, occupational and physical therapist, social worker.

1ST YEAR FELLOW RESPONSIBILITIES

Fellows will demonstrate medical knowledge and understand the pathophysiology of common childhood rheumatic disease. They will develop appropriate differential diagnoses and management plans under the guidance of the rheumatology faculty as well as senior fellows.

2ND YEAR FELLOW RESPONSIBILITIES

Fellows are expected to consolidate the clinical training and education obtained during first year. Areas of medical knowledge and patient care in which they will obtain additional education are addressed via attendance at the ongoing didactic conferences and via self-directed learning. During this year, fellows are expected to develop competence in the clinical supervision of junior trainees.

3RD YEAR FELLOWS RESPONSIBILITIES

Fellows are expected to continue consolidating the clinical training obtained during previous two years and to achieve competence in patient care at the level expected of new practitioner by the end of the year. These patient care skills continue to be honed in continuity clinic and additional educational needs are addressed by ongoing attendance at didactic conferences, and via self-directed learning as the fellow prepares for subspecialty. The 3rd year fellow will also plan and organize educational conferences for junior trainees.

ASSESSMENT

Fellows will be assessed during clinic by feedback from physician and/or support staff. Quarterly fellows will be assessed by evaluation through New Innovations by all supervising physicians and support staff.

PEDIATRIC RHEUMATOLOGY FELLOWSHIP

CURRICULUM

INPATIENT CONSULT ROTATION CHILDREN'S HOSPITAL OF ATLANTA – EGLESTON 1405 Clifton Rd NE

Physician Contact: Dr. Rouster-Stevens

Office: (404)785-5437

Other Physicians: Drs. Prahalad, Flanagan, Thakral, Manos, Taneja & Goldberg

Duration of Rotation: First Year = alternating weeks; Second/Third Year = 1 week every 4 weeks

INTRODUCTION

The team may include medical students/residents and is supervised by faculty. We convene between 9:30-10:00 to have bedside rounds. The 3rd year fellow will be expected to run inpatient rounds.

GOAL

Fellows will understand principles and demonstrate competency in obtaining a clinical history and relevant review of systems for patients presenting to the Rheumatology inpatient consult service.

OBJECTIVE

PATIENT CARE

- A. Understand principles and demonstrate competency in obtaining a clinical history, relevant review of systems, and assessing functional status of patients with rheumatic disease symptoms.
- B. Understand principles and demonstrate competency in performing and interpreting the examination of the structure and function of all axial and peripheral joints, periarticular structures, peripheral nerves and muscles. Additionally, the fellow should be able to identify extraarticular findings that are associated with specific rheumatic diseases.
- C. Understand the indications for and costs of ordering laboratory tests, procedures to establish a diagnosis of rheumatologic disease and of different therapies used in the management of these diseases.
- D. Understand the principles and interpretation of results of synovial fluid analysis and become proficient in the examination and interpretation of synovial fluid under conventional and polarized light microscopy from patients with a variety of rheumatic diseases.
- E. Demonstrate understanding and competency in the assessment and interpretation of:
 1. Radiographs of normal and diseased joints, bones, and periarticular structure
 2. Ultrasound of normal and diseased joints, bones, and periarticular structures
- F. Apply the principles of clinical epidemiology to day-to-day clinical decision making, demonstrating understanding and competency in the indications for and the interpretation of results from laboratory tests and procedures to establish a diagnosis of a rheumatologic disease, including:
 1. Arthrography, computed tomography, magnetic resonance imaging of joints, bones and periarticular structures
 2. Radionuclide scans of bones and joints
 3. Arteriograms (conventional and MRI/MRA) for patients with suspected or confirmed vasculitis
 4. Computed tomography of lungs
 5. Magnetic resonance imaging of the central nervous system (brain and spinal cord)
 6. Electromyograms and nerve conduction studies
 7. Biopsy specimens including histochemistry and immunofluorescence of tissues relevant to the diagnosis of rheumatic diseases: skin, synovium, muscle, nerve, bone (e.g. metabolic bone disease), minor salivary gland, artery, kidney and lung
 8. Specific laboratory tests (including, but not limited to) erythrocyte sedimentation rate, C-reactive protein, other acute phase response proteins (e.g. ferritin), rheumatoid factor, anti-cyclical citrillunated peptides, antinuclear antibodies, anti-dsDNA, anti-SSA (anti-Ro), anti-SSB (anti-La), anti-U1RNP, anti-Sm, anti-topoisomerase I (Scl-70), anti-Jo1, anti-PM/Scl, anti-histone antibodies, anti-neutrophil cytoplasmic antibodies (including anti-myeloperoxidase and anti-proteinase-3), cryoglobulins, complement component levels, CH50, serum protein electrophoresis, serum immunoglobulin levels,

lupus anticoagulant assays, anti-cardiolipin and anti-beta2glycoprotein antibodies, HLA typing (e.g. HLA-B27), ASO and other streptococcal antibody tests, Lyme serologies, serum and urine uric acid levels, lymphocyte subset and function data, anticellular antibodies (e.g. Coombs' test, neutrophil antibodies and anti-platelet antibodies)

9. Arthroscopy

MEDICAL KNOWLEDGE

The subspecialty of rheumatology includes a wide array of autoimmune, inflammatory, and degenerative diseases that affect the musculoskeletal and other organ systems. A working knowledge of the basic and clinical sciences that relate to musculoskeletal and rheumatic disease is fundamental to the practice of rheumatology.

Understanding of normal and pathogenic processes of the immune system form the basis of reliable diagnosis and the development and use of an increasingly sophisticated range of immunomodulatory treatments for the rheumatic diseases. Similarly, knowledge of the basis for and use of laboratory tests of immune activity is a principal asset of the practicing rheumatologist. Rheumatology trainees must also have practical understanding of the approaches and modalities used by other specialists and allied health professionals for the treatment of rheumatic diseases in order to manage the care of their patients effectively. Training programs must teach and emphasize the cognitive skills that are necessary to apply this detailed knowledge to problem solving for diagnosis, treatment and research of the rheumatic diseases.

1. Diagnose the rheumatic diseases that occur primarily in children, and know how they differ from, are the same, or similar disease in adults.
 - a. Juvenile Idiopathic Arthritis (JIA)
 - b. Lupus (systemic, cutaneous, drug-induced)
 - c. Juvenile dermatomyositis (JDM)
 - d. Kawasaki Disease
 - e. Henoch-Schonlein Purpura
 - f. Acute rheumatic fever
 - g. Chronic recurrent multifocal osteomyelitis
 - h. Periodic Fever Syndromes
 - i. Systemic Vasculitis
 - j. Sarcoidosis
2. Know the major sequelae or life-threatening complications of rheumatic diseases that occur primarily in children:
 - a. Systemic onset JIA
 - (1) Macrophage activation syndrome
 - (2) Cardiac tamponade
 - b. JIA
 - (1) Chronic uveitis
 - c. JDM
 - (1) GI vasculitis
 - (2) Calcinosis
 - d. Kawasaki Disease
 - (1) Aneurysms of coronary and other arteries
 - e. Henoch-Schonlein Purpura
 - (1) GI- intussusception, intestinal infarction
 - (2) Renal - chronic nephritis
 - f. Neonatal lupus syndrome
 - (1) Congenital heart block
 - (2) Thrombocytopenia
3. Know the appropriate treatments of the above childhood rheumatic disorders, and complications of treatment.
4. Recognize non-rheumatic disorders in children that can mimic rheumatic diseases:
 - a. Infectious or post-infectious syndromes

- (1) Septic arthritis and osteomyelitis
 - (2) Transient synovitis of the hip
 - (3) Post-infectious arthritis and arthralgia
 - (4) Post-viral myositis
 - b. Orthopedic conditions
 - (1) Legg-Calve-Perthes Disease and other avascular necrosis syndromes
 - (2) Slipped capital femoral epiphysis
 - (3) Spondylolysis and spondylolisthesis
 - (4) Patellofemoral syndrome
 - c. Non-rheumatic pain
 - (1) Benign limb pains of childhood (“growing pains”)
 - (2) Benign hypermobility syndrome
 - (3) Pain amplification syndromes
 - d. Neoplasms
 - (1) Leukemia
 - (2) Lymphoma
 - (3) Primary bone tumors (in particular, osteosarcoma and Ewing’s sarcoma)
 - (4) Tumors metastatic to bone (in particular, neuroblastoma)
 - e. Bone and cartilage dysplasias and inherited disorders of metabolism
5. Know aspects of rheumatic disease and treatments specific to children:
- a. Disease effects on growth
 - (1) Accelerated or decelerated growth of limbs or digits affected by arthritis
 - (2) Altered growth of mandible in TMJ arthritis
 - (3) Short stature and failure to thrive
 - b. Regular surveillance for uveitis in JIA
 - c. Drugs
 - (1) FDA approved drugs for childhood rheumatic diseases
 - (2) Drug metabolism and dosing different from adults
 - d. Child-specific side effects of chronic corticosteroid treatment
 - (1) Growth retardation
 - (2) Delay of puberty
 - e. Physical and occupational therapy
 - (1) Exercises
 - (2) Splinting
 - f. Psychosocial and developmental issues
 - (1) Peer and sibling interaction
 - (2) Family adjustment
 - (3) School accommodations for disability
 - (4) School and recreational activities

PRACTICE-BASED LEARNING AND IMPROVEMENT

The practice of rheumatology entails the assessment and treatment of patients with clinical disorders that are often complex with regard to the variable organ systems involved, variations in musculoskeletal and immune system biology, and impact upon patient lifestyle and livelihood. This complexity and the rapid advances in understanding of both disease pathogenesis and treatment of the rheumatic diseases demands that the rheumatologist continually evaluate and improve the quality of their care in the context of their own clinical practice. The development of skills in self-directed, reflective learning and practice improvement will facilitate the delivery of state-of-the-art, evidence-based patient care that maximizes the likelihood for successful clinical outcomes.

1. Independent learning

The ability to access and critically appraise appropriate information systems and sources to improve understanding of underlying pathology, assess the accuracy of diagnoses, and gauge appropriateness of therapeutic interventions for the patient population they encounter.

2. Self-evaluation of performance

The effective rheumatologist must engage in ongoing self-assessment activities. This includes the ability to continuously self-evaluate learning needs and to monitor practice behaviors and outcomes to ascertain whether clinical decisions and therapeutic interventions are effective, and adhere to accepted standards of care.

3. Incorporation of feedback into improvement of clinical activity

The ability to appropriately interpret results of clinical outcome studies, practice data, quality improvement measures, and faculty/peer feedback and evaluations and apply them to patient care and practice behavior.

INTERPERSONAL AND COMMUNICATION SKILLS

1. Use effective verbal, nonverbal, listening, questioning and explanatory skills to obtain a complete and accurate history.
2. Obtain properly informed consent.
3. Reliably and accurately communicate the patient's and their family's views and concerns to others.
4. Interact with patients in an empathic and understandable manner.
5. Write clear and effective consultations in the electronic medical record.
6. Work effectively with colleagues and peers as a member and eventual leader of a health care team.
7. Clearly explain benefits and risks of treatment.
8. Display effective teaching skills to colleagues and patients.

PROFESSIONALISM

Trainees in many programs also interact with patients from a wide range of cultural and socioeconomic backgrounds. A substantial level of professionalism is thus required to maintain the balance required by an effective rheumatologist.

1. Demonstrate compassionate use of medical skills for patients. This includes high-quality care and technology and, in the event of terminal illness, an awareness of the limits of medical intervention and the obligation to provide humane care.
2. Recognize the legal requirements of advanced directives and describe the process of assessing a patient's advance directives, including the patient's perspective.
3. Model appropriate professional attitudes and behaviors of time management and punctuality, reliability, peer support, objective peer evaluation, community teaching, and ethical behavior.

SYSTEM-BASED PRACTICE

1. Demonstrate knowledge about how different health care delivery systems affect the management of patients with rheumatic diseases.
2. Practice management: be familiar with types of practice, equipment, insurance, economics, personnel, ethical aspects, quality assurance, and managed care issues relating to the practice of rheumatology.
3. Identify the strengths and weaknesses of the system in which they are training and practicing. They should also demonstrate the ability to develop strategies to overcome systematic problems they have identified, and QI projects to improve it.
4. Be familiar with the history of rheumatology, and national organizations such as the American College of Rheumatology, the Association of Rheumatology Health Professionals, and the Childhood Arthritis and Rheumatology Research Alliance.
5. Understand the influence on rheumatology of the American Medical Association, Food and Drug Administration, CMS and other governmental agencies involved in health care legislation, and peer review organizations.

1ST YEAR FELLOW RESPONSIBILITIES

Fellows will demonstrate medical knowledge and understand of the pathophysiology of common childhood rheumatic disease. They will develop appropriate differential diagnoses and management plans under the guidance of the Rheumatology faculty as well as senior fellows.

2ND YEAR FELLOW RESPONSIBILITIES

Fellows are expected to consolidate the clinical training and education obtained during the first year. Areas of medical knowledge and patient care in which they will obtain additional education are addressed via attendance at the ongoing didactic conferences and via self-directed learning. During this year, fellows are expected to develop competence in the clinical supervision of junior trainees.

3RD YEAR FELLOWS RESPONSIBILITIES

Fellows are expected to continue consolidating the clinical training obtained during previous two years and to achieve competence in patient care at the level expected of a new practitioner by the end of the year. These patient care skills continue to be honed in continuity clinic and additional educational needs are addressed by ongoing attendance at didactic conferences, and via self-directed learning as the fellow prepares for subspecialty.

ASSESSMENT

Fellows will be assessed during clinic by feedback from physician and/or support staff. Quarterly fellows will be assessed by evaluation through New Innovations by all supervising physicians and support st

PEDIATRIC RHEUMATOLOGY FELLOWSHIP

CURRICULUM

RESEARCH ROTATION

EMORY HEALTH SCIENCES RESEARCH BLDG./CHILDREN'S HEALTHCARE OF ATLANTA

Physician Contact: Sampath Prahalad, MD

Duration of Rotation: 20 months

INTRODUCTION

Fellows will develop sufficient data for presentation at national meetings, peer-reviewed publication, and or other tangible scholarly work product in keeping with subspecialty certification requirements set forth by the American Board of Pediatrics and determined at the local level by the Scholarship Oversight Committee (SOC).

GOAL

To provide the fellow with training in research design, data collection, and data analysis through all 3-years of fellowship.

OBJECTIVE

- Write, manage, analyze, and report a clinical treatment protocol or clinical correlative.
- Analyze, write, and report a historical chart review study of a defined group of patients.
- Perform and report an epidemiological study on cancer incidence, quality of life, and patterns of care, or outcomes.
- Perform and report a basic laboratory study in a defined area of Rheumatology.
- Case reports and literature searches are not acceptable.

1ST YEAR FELLOW RESPONSIBILITIES

Fellows will attend the Annual Introduction to Research course in the fall (typically in October) to describe basic research processes and conducting research at Emory/CHOA. During the latter half of this year, selection of mentors and a specific project is done with input from the SOC, the Fellowship Program Director, and the Division Director.

2ND YEAR FELLOW RESPONSIBILITIES

Fellows are expected to finalize their mentor and selected projects within the first 2-months of their second year. Fellows have 8-months available for research emphasis. The fellow will present their project periodically at the Division Research meeting.

3RD YEAR FELLOWS RESPONSIBILITIES

Fellows are expected to complete a main research project (as defined by the American Board of Pediatrics Scholarly Activity). Fellows have 8-months available for research emphasis, and will present their finalized project at the Division Research meeting. The third year fellow is expected to present at the annual Emory/CHOA Fellow Research Day in the spring and to submit abstracts to the American College of Rheumatology and Childhood Arthritis and Rheumatology Research Alliance annual meetings.

ROTATION SCHEDULE

Emory - Pediatric Rheumatology

[Tell me more](#)

1st Year Fellow

Month/4WKS	1	2	3	4	5	6	7	8	9	10	11	12	13
Experience	OP/IPC/CC	OP/IPC/CC	OP/CC	OP/IPC/CC/RES	OP/IPC/CC	OP/CC	OP/IPC/CC	OP/IPC/CC	OP/CC	OP/IPC/CC	OP/IPC/CC	OP/CC	OP/IPC/CC
Site	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1
% Outpatient/Inpatient	100	100	100	75	100	100	100	100	100	100	100	100	100
% Research	0	0	0	25	0	0	0	0	0	0	0	0	0

2nd Year Fellow

Month/4WKS	1	2	3	4	5	6	7	8	9	10	11	12	13
Experience	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH H CC/IPC	RESEARCH CC/IPC
Site	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1
% Outpatient/Inpatient	25	25	25	25	25	25	25	25	25	25	25	25	25
% Research	75	75	75	75	75	75	75	75	75	75	75	75	75

3rd Year Fellow

Month/4WKS	1	2	3	4	5	6	7	8	9	10	11	12	13
Experience	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC	RESEARCH CC/IPC
Site	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1/2	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1	Hosp1/2	Hosp1
% Outpatient/Inpatient	25	25	25	25	25	25	25	25	25	25	25	25	25
% Research	75	75	75	75	75	75	75	75	75	75	75	75	75

OP = Outpatient Clinic

IPC = Inpatient Clinic

CC = Continuity Clinic

RES = Research

EL = Elective

Total number of Clinical months: 19/39

Total number of Research months: 20/39

CONFERENCE SCHEDULE

Weekly:

Clinical Care Conference	Required Attendance
Adult Rheumatology Grand Rounds	Required Attendance
Pediatric Rheumatology Clinical Care Conference	Required Attendance
Fellows Thursday Conference (Adult Rheum)	Optional Attendance

Monthly:

Cassidy Club	Required Attendance
Pediatric Rheumatology Radiology Conference	Required Attendance
Rheumatology Research Conference	Required Attendance
Nephrology/Rheumatology Journal Club	Required Attendance
Board Review	Required Attendance

Quarterly:

Pediatric Rheumatology Case Conference	Required Attendance
Faculty Development Lectures	Optional Attendance

Department of Pediatrics Seminars:

Introduction to Research (1 st Year Fellow)	Required Attendance
QI Course (1 st Year/2 nd Year Fellows)	Required Attendance
Teaching Symposium (6 Sessions) (2 nd /3 rd Year Fellows)	Required Attendance
Ethics Forum (6 Sessions) (2 nd Year Fellows)	Required Attendance
QI Course (1 st Year/2 nd Year Fellows)	Required Attendance
Intro to Finance/Business of Medicine	Required Attendance

EVALUATIONS

All evaluations will be completed using New Innovations. <https://www.new-innov.com/Login/>

METHODS OF EVALUATION

In order for the Rheumatology training program to assess its ability to achieve the goals and objectives, an evaluation process that includes global assessments, observation, standardized patients and written examinations has been developed.

- **GLOBAL ASSESSMENTS**

- These assessments are conducted every quarter by Rheumatology faculty and division nurses. They are included in the permanent record. Twice annually the program director reviews the performance of the fellows in writing evaluation. These are compiled on standard forms that assess medical knowledge, clinical skills, clinical judgment, humanistic qualities, professional attitudes and commitment to scholarship. Evaluations of the fellows are also solicited from residents, staff and patients (360° evaluation). The program director receives all of the written evaluations, which are kept in the fellow's master file through New Innovations Data Base. Fellows may request a meeting at any time to personally review their files.
- Semiannually, fellows meet individually with the program director to formally review their evaluations. The meeting is to provide feedback to the fellow on their performance and to identify areas for professional enhancement. The program director reviews the log of each fellow's procedure, consults and conference attendance. A written summary of this session is placed in the fellow's permanent record.

- **OBSERVATION**

- Focused, personal observation assessments will be completed using New Innovations Data Base.

EVALUATION OF THE PROGRAM AND FACULTY

The program director specifically inquires about the strengths and weaknesses of the program at regular meetings with the fellows together and separately. At times, programmatic adjustments are made on the basis of this feedback. At the end of each academic year fellows and faculty complete a program evaluation through New Innovations, and are allowed to make comments. A summary of the evaluations is given to the program director for review. Upon completion of the fellowship, individuals are contacted for a formal evaluation of the program. This is reviewed by the program director with a focus on the perceived deficiencies. The findings are discussed with the faculty so that programmatic alterations can be made as necessary.

House Staff General Responsibilities

Each resident participating in the Emory University School of Medicine Residency Training program (TRAINING PROGRAM) has the responsibility to:

- Provide compassionate, timely, and appropriate patient care; accept the duties, responsibilities and rotations assigned by the resident's department Chair or the Chair's designee; abide by the rules, regulations and policies of Emory University, Emory University School of Medicine, and the hospitals to which the resident is assigned; and conform to the ethical and professional standards of the medical profession;
- Develop a personal program of self-study and professional growth with guidance from the teaching staff;
- Participate fully in educational activities, accept and follow direction provided by faculty members and more senior residents and, as directed, assume responsibility for teaching and supervising other residents, medical students, and other health care students;
- Participate, as appropriate, in institutional committees and councils, especially those that relate to patient care review and activities;
- Apply reasonable cost containment measures in the provision of patient care;
- Obtain a GA Temporary Postgraduate Permit or a GA Medical License. Each PGY 1- PGY 7 resident/fellow participating in Emory University Residency Training program has the responsibility to obtain a GA Temporary Postgraduate Training Permit. If you already have a GA Medical License, you are not obligated to get a permit. If you are PGY 8 or higher, you must obtain a GA Medical License. Refer to sections 5.04, 5.05, and 5.06.
- Maintain complete and up-to-date immunity and health records in the OGME (See Section 3);
- Inform OGME and the Program Director of changes in address and personal phone number;
- Inform the Benefits Section of Emory University's Human Resources Department (404.727.7613) of any events requiring a change of benefits or tax status (e.g., change in marital status, birth or the adoption of a child).

Pediatric Rheumatology Fellowship

Recruitment & Selection Policy

It is the policy of the Emory University Pediatric Rheumatology Fellowship Training Program to follow the general guidelines set forth by Emory University School of Medicine as outlined below, in addition to those specific to pediatric subspecialty fellowships. This policy will be reviewed and updated accordingly.

This policy is intended to establish valid, fair, effective, and ethical criteria for the screening of recruitment and appointment for Emory University School of Medicine's graduate medical education program.

Resident Recruitment

Applicants are required to meet the following qualifications to be eligible for a position in the Emory Pediatric Rheumatology Fellowship Program:

- Have completed (or will complete by July 1st of expected start year) an ACGME-accredited residency program. A complete listing of ACGME-accredited residency programs is available on-line at: <http://www.acgme.org/adspublic/>.
- Have passed all components of the U.S. Medical Licensure Examination, including:
 - Step 1
 - Step 2 (Clinical Knowledge)
 - Step 2 (Clinical Skills)
 - Step 3
- Have fulfilled the eligibility requirements for certification by the [American Board of Pediatrics](#).
- Are eligible for medical licensure in the state of Georgia as stated on their website: [Composite State Board of Medical Examiners](#).

International applicants must also provide evidence of the following:

- Certification by the Educational Commission of Foreign Medical Graduates (ECFMG). Information on ECFMG Certification may be obtained at <http://www.ecfm.org>.
- Successful completion of the ECFMG English Examination.

Non-eligible applicants will not be considered for selection in Emory's graduate medical education program.

Resident Selection

- I. Eligible applicants can be considered for possible appointment based on their:
 - a. Academic credentials,
 - b. Ability,
 - c. Overall preparedness,
 - d. Communication skills,
 - e. Aptitude,
 - f. Personal qualities (such as motivation and integrity)
- II. In determining resident recruitment and appointment criteria, Emory will not discriminate with regard to a resident's age, gender, race, religion, color, creed, national origin, disability, sexual orientation or veteran status.
- III. On behalf of Emory as the sponsoring institution, the Office of Graduate Medical Education will be responsible for periodically reviewing whether resident selection activities are consistent with this Policy. The Office of Graduate Medical Education may delegate these review activities to individual Program Directors or their designees.

Selection for interviews is based on the review of applications by the Program Director and division faculty. After interviews, the faculty ranks applicants on the basis of personal interviews, prior performance, letters of recommendations

and academic promise. The faculty meets at the end of the interview process to review the interviewed applicants and prepares the rank order list that will be submitted to the National Resident Matching Program (NRMP) Specialties Matching Service.

Questions regarding this policy and procedure should be directed to the Office of Graduate Medical Education. Please refer to their website for further information www.med.emory.edu/GME.

Pediatric Rheumatology Fellowship

Resident/Fellow Supervision Policy

It is the policy of the Emory University Pediatric Rheumatology Fellowship Training Program to follow the guidelines set forth by Emory University School of Medicine. This policy will be reviewed and updated accordingly.

The Program Director provide explicit written descriptions of lines of responsibility for the care of patients, which are made clear to all members of the teaching teams. Fellows are given a clear means of identifying supervising physicians who share responsibility for patient care on each rotation. In outlining the lines of responsibility, the Program Director will use the following classifications of supervision:

1. **Direct Supervision**: the supervising physician is physically present with the resident and patient.
2. **Indirect Supervision, with Direct Supervision immediately available**: the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.
3. **Indirect Supervision with Direct Supervision available**: the supervising physician is not physically present within the hospital or other site of patient care but is immediately available to provide Direct Supervision.
4. **Oversight**: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Supervision shall be structured to provide fellows with progressively increasing responsibility commensurate with their level of education, ability, and attainment of milestones. The Program Director in conjunction with the program's faculty members make determinations on advancement of house officers to positions of higher responsibility and readiness for a supervisory role in patient care and conditional independence through assessment of competencies based on specific criteria (guided by national standards-based criteria when available). Faculty members functioning as supervising physicians should assign portions of care to residents based on the needs of the patient and the skills of the resident. Based on these same criteria and in recognition of their progress toward independence, senior residents or fellows should serve in a supervisory role of junior residents.

Fellows are assigned a faculty supervisor for each rotation or clinical experience (inpatient or outpatient). The faculty supervisor shall provide to the Program Director a written evaluation of each resident's performance during the period that the resident was under his or her direct supervision. The Program Director provides structured faculty supervision assignments of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

LINES OF RESPONSIBILITIES

RESPONSIBILITY OF FACULTY

- The faculty preceptor will be available to the fellow for mentoring during assigned laboratory and clinic times, and will assist the fellow in the selection of test to be reviewed and patients to be seen by the fellow.
- The faculty will supervise the fellow's exposure to, and interpretation of tests.
- After the fellow sees a patient, the clinic faculty preceptor will listen to the fellow's presentation, giving feedback as appropriate, and will also discuss the case with the fellow, providing timely teaching as a treatment plan formulated.
- The faculty preceptors will focus on role-modeling appropriate patient interaction skills for the fellow during each laboratory and clinic session.
- The faculty preceptors will role model professionalism in reading and other means of self-education.

RESPONSIBILITY OF FELLOW

Fellows are expected to be in attendance from 7:00 am until 6:00 pm daily, except for conferences and outpatient ambulatory clinic. All activities and notes will be reviewed and supervised by attending. Didactic lectures will be delivered at least once weekly.

Pediatric Rheumatology Fellowship

Fellowship Promotion Policy

It is the policy of the Emory University Pediatric Rheumatology Fellowship Training Program to follow the guidelines set forth by Emory University School of Medicine as outlined below. This policy will be reviewed and updated accordingly.

All new residents receive a formal offer and appointment agreement to the Emory University Affiliated Hospitals' Residency Training Program. The appointment is contingent upon successful completion of all requirements of the Office of Graduate Medical Education prior to assuming training program duties, as well as all requirements specified by the department offering the house staff appointment. This includes following state law regarding license and permits to practice medicine in the state of Georgia.

- The initial appointment period is twelve months, and residents are typically offered appointments covering a July 1 through June 30 academic year period.
- The number of available house staff positions in each training program is determined each year by the chair of each department, in consultation with the Dean of the School of Medicine and the chief executive officers of Emory University affiliated hospitals. This number is determined by the number of ACGME approved positions and, in part, by available funding.

Faculty members will assess resident progress and promotion through residency. Semiannually, resident attendance at required conferences, case and procedure log entry, and performance evaluations will be assessed. A determination of whether a resident is ready to advance to the next academic year/complete training will be made based on this. All residents who are determined to be marginal or unacceptable will have a written, documented plan of remediation. This plan will be communicated to the resident for their signed acknowledgment.

- Official offers of re-appointment and re-appointment agreements for those residents continuing in the training program after the expiration of an earlier appointment period will be mailed by the OGME to the home address of the resident. Residents who choose to accept re-appointment offers must sign and deliver the re-appointment agreement to the OGME.
- A promotion policy in place will apply to residents in the first, second, and third year.
- The Program Director establishes the yearly rotation schedule for all residents in consideration of the ACGME, American Board of Pediatrics guidelines and recommendations of the subspecialty review boards.
- The resident will be evaluated after each monthly rotation on the basis of competencies, which have been generated to assess adequate completion of each month of training based on the level of year of training.
- The resident will be responsible for knowing the duties, goals, and competencies for each rotation. At the end of the rotation, the faculty attending for the rotation will grade the resident on the competencies with the scale of pass, marginal, or fail. Semiannually, the performance evaluations of each resident will be reviewed by the Program Director and faculty.
- A marginal pass can be assigned if the resident has not met the competency requirements, but has demonstrated significant improvement through the rotation month and it is the anticipation of the attending faculty that a second rotation within this sub discipline will allow the resident "catch up" to full competency at the designated training level.
- If the resident fails a rotation he/she is given a Letter of Warning and a remediation process is established. The remediation process (outlined separately) will address the specific deficiencies of the individual resident. If satisfactory remediation is achieved, the Letter of Warning will be expunged from the resident's file. Failure of a rotation should be communicated immediately to the Program Director.
- If adequate remediation has not been achieved, the program director will notify the institutional GME office—this notification will occur by February 1st of the resident year for anticipated promotion in July.
- Residents will be notified, in writing, by March 1st or four months prior to the expiration of their position appointment agreement, of the decision to not renew their position appointment agreement.

- Once probation has been established the process of remediation may continue up until the time of the first day of the next resident year and if remediation has not resulted in the achievement of the necessary skills to proceed to the next level of training then the resident's annual contract will not be renewed.
- The decision not to offer a resident re-appointment may be due to a variety of reasons, including but not limited to the resident's unacceptable performance, unacceptable conduct of the resident, and/or lack of available funding.

Residents who have had leaves of absence may be subject to an extension of training in order to fulfill board training-requirements. Individual boards will control this issue, and residents should be informed.

Questions regarding this policy and procedure should be directed to the Office of Graduate Medical Education. Please refer to their website for further information www.med.emory.edu/GME.

Emory University Pediatric Rheumatology Fellowship Training Program Policy on Duty Hours

It is the policy of the Emory University Pediatric Rheumatology Fellowship Training Program to follow the guidelines set forth by Emory University School of Medicine and the ACGME. This policy will be reviewed and updated accordingly.

General Guidelines

Residents are responsible for accurately reporting their duty hours, including all time spent in Internal and External Moonlighting, per program requirements.

Program Directors must monitor and enforce compliance with duty hour guidelines.

If specialty/subspecialty-specific program duty hour requirements as defined by an individual RRC for that specialty/subspecialty are more restrictive than the common program requirements, then the duty hour requirements of that RRC must be included in the policy of that specialty/subspecialty program and will supersede the institutional requirements.

Concerns regarding duty hours should be reported to the Associate or Assistant Dean for GME or through the Confidential Helpline 1-888-594-5874. Concerns reported through the helpline are anonymous.

Maximum Hours of Work per Week

Duty hours must be limited to **80 hours**, averaged over a **four-week period** per rotation or a **four-week period** within a rotation excluding vacation or approved leave. Requests for exceptions to the maximum weekly limit on duty hours must be presented by the Program Director to the GMEC for review and approval. Exceptions must conform to the Policy and Procedures for Resident **Weekly Duty Hour Limit Exceptions**.

Time spent in Internal and External Moonlighting will be counted toward the eighty-hour maximum weekly hour limit on duty hours as outlined in #5 above.

Mandatory Time Free of Duty

Residents must be scheduled for a minimum of **one day free of duty every seven days averaged over four weeks**. "Duty" includes all clinical and academic activities related to the program as described above. At-home call cannot be assigned on these free days.

Maximum Duty Period Length

EUSOM encourages residents to use alertness management strategies, including strategic napping, in the context of patient care responsibilities, especially after 16 hours of continuous duty and between the hours of 10pm and 8am.

In unusual circumstances and on their own initiative, PGY-2 residents and above may remain beyond their scheduled period of duty to continue to provide care to a single patient. Under such circumstances - which include only continuity of care for a severely ill or unstable patient, a transpiring event of unusual academic importance, or humanistic attention to the needs of a patient or family – the resident must appropriately hand over the care of all other patients responsible for their continuing care and document the reasons for remaining to care for the patient in question. Such documentation must be submitted to the Program Director in every circumstance. The Program Director is responsible for tracking both individual resident and program-wide episodes of additional duty.

Minimum Time Off Between Scheduled Duty Periods

Intermediate level residents as defined by the respective Residency Review Committees should have ***10 hours free of duty, must have 8 hours between scheduled duty periods, and must have at least 14 hours free of duty after 24 hours of in-house duty.***

Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these house officers must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

At-Home Call

At-home call, or “pager call,” is defined as call taken from outside the assigned site. ***When residents are called into the hospital from home, they may care for new or established patients and the hours spent in-house, exclusive of travel time, are counted toward the eighty-hour limit.*** Such episodes will not initiate a new “off-duty period.” ***At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.*** At-home call may not be scheduled on the resident’s one free day per week (averaged over four weeks). Any concerns or questions concerning the duty hour guidelines must be directed to the Associate or Assistant Dean for GME.

Monitoring

Program Directors must monitor call-from-home duty hours in terms of frequency and characteristics to assure that residents and fellows are following basic guidelines established by the ACGME.

It is the responsibility of the oncall faculty to check in when the fellow is in the middle of a call week (typically, this occurs on Sunday) to ask about fatigue; if there is concern for fellow fatigue, the faculty will cover ‘at-home call’ Sunday night until Monday 7am. If the fellow feels fatigue at any other time during the call week, the fellow is encouraged to discuss this with the oncall faculty, so the faculty may cover call for that night.

Fellows are expected to log duty hours daily in New Innovations on a weekly base (unless directed otherwise).

Education

Program Directors must provide information to residents, fellows and faculty members regarding effects of loss of sleep and chronic fatigue. Currently, the GMEC recommends using the ***SAFER program*** available on the GME Website- and asking faculty members of Emory University School of Medicine who have expertise in this area.

REPORTING STRUCTURE FOR OFF-SERVICE ROTATIONS

It is the intention of this section of the Duty Hour Policy to establish a process that will address duty hour compliance in a rapid and timely manner when a resident is rotating off service. Problems regarding compliance with duty hour guidelines should be reported to the Program Director.

The GME office maintains a direct phone line to receive confidential complaints about all issues including duty hours. This phone number 1-888-594-5874 is private and secure. The Associate Dean and DIO will respond to the recorded messages as appropriate.

FATIGUE EDUCATION INFORMATION

American Academy of Sleep Medicine (PowerPoint) <http://www.uthscsa.edu/gme/documents/SAFERProgram.pdf>

Resident Sleep and Fatigue (PowerPoint) <http://www.uthscsa.edu/gme/documents/ResidentSleepandFatigue.pdf>

“Screen” the Epworth Sleepiness Scale (Survey) <http://www.stanford.edu/~dement/epworth.html>

YourSleep <http://yoursleep.aasmnet.org/SleepScale.aspx>

Taxi Service Procedure for Residents/Fellows too Fatigued to Drive Home

ACGME requires residency/fellowship programs or the sponsoring institution to provide transportation options for residents/fellows who may be too fatigued to drive home. The GME Office has arranged for residents/fellows' transportation home with a return trip the next day through **LIFT**.

Emory University Pediatric Rheumatology Fellowship Training Program Policy on Moonlighting

It is the policy of the Emory University Pediatric Rheumatology Fellowship Training Program and Emory Graduate Medical Education to follow guidelines established by the ACGME and the School of Medicine regarding moonlighting for residents in accredited training programs. This policy will be reviewed and updated accordingly.

“Moonlighting” refers to a service performed by a resident in the capacity of an independent physician, completely outside the scope of his/her training program. “External moonlighting” refers to moonlighting at a facility that is not part of the resident’s training program. “Internal moonlighting” refers to moonlighting at an Emory facility or any other facility where the resident is receiving training as part of the residency-training program.

Residents are not required to engage in moonlighting. Residents do not have insurance coverage through Emory’s Residency Training Program for any moonlighting services, whether external or internal.

Residents are prohibited from external or internal moonlighting UNLESS they have the written approval of the Program Director

All hours devoted to moonlighting must be counted toward the duty hour requirements.

Specific details related to ACGME guidelines can be found at the ACGME website: www.acgme.org. Please refer to the House Staff Policies and Procedures Manual at www.med.emory.edu/GME for specific details related to the policies of the Emory University School of Medicine.

Request to Moonlight at a Location Outside of Emory Healthcare Facilities

I submit this request to be approved to moonlight during the period _____ - _____
(The period may not be longer than six months);

I agree to have a signed contract to moonlight at _____ (Name of hospital(s) or other facility). The contract must state that the facility will provide professional liability insurance coverage with respect to the services that I provide during my moonlighting assignment or that I have my own personal professional liability insurance to cover this moonlighting, for no less than \$1mm per claim and \$3mm in the annual aggregate.

I am fully licensed to practice medicine in the state where the moonlighting will occur; I am NOT in training on a J-1 visa;

I agree NOT to wear anything identifying me as a trainee in the Emory training program (including, but not limited, to Emory photo ID cards, uniforms, lab coats);

- I agree not to exceed any restrictions the training program has regarding the total number of hours I may work per week;
- I acknowledge any activities, including moonlighting, which interfere with residency training or impact on my performance in the training program, may be grounds for disciplinary action up to and including my dismissal from the residency program;
- I understand I may moonlight only in outpatient settings or in the Emergency Department if I am moonlighting at a hospital related to Emory Healthcare, Grady Hospital, CHOA Hospitals and the VAMC.

By signing below, I attest to the completeness and accuracy of the above information.

Signature of resident requesting permission to moonlight

Date

Print name of resident/ PGY

Request for moonlighting **is** or **is not** (circle one) approved

Signature of Program Director

Date



Policy Number:	4.54	Original Date Issued:	November 5, 2009
Section:	Human Resources	Date Reviewed:	February 2, 2016
Title:	Social Media and Social Networking	Date Revised:	
Regulatory Agency:			

I. POLICY:

Children's recognizes that some employees may choose to create and/or maintain personal web logs or "blogs" and / or engage in social media and networking through various internet web sites, including but not limited to My Space, Facebook, Twitter, Plaxo, YouTube, Care Pages and other similar or related sites. While Children's recognizes and respects employee's rights to personal expression and views, employees must also be aware of the ways that his or her personal communications on such social web sites can impact Children's.

II. PROCEDURE:

Employees should be cautious about their communications and postings on social media and networking sites that are related in any way to Children's. If an employee is unsure about whether a particular communication or posting is appropriate and consistent with Children's policies, the employee should contact his or her manager or human resources representative. The following guidelines apply to Children's employee communications or postings in social media or networking sites:

1. Employees may not access any social networking websites during working hours, whether from a personal device or Children's computer, unless specifically allowed for work-related purposes. Employees are expected to comply with all Children's policies, including but not limited to the [4.06 Electronic Communications](#) and [4.49 Electronic Devices/Photography Usage](#).
2. Employees are prohibited from using or disclosing any confidential, sensitive, proprietary, or other business information specific to Children's. This includes information about company strategy, billing, finances, intellectual property, employee information, and any other information that has not been publicly released by the company.
3. If an employee discusses his or her employment with Children's or identifies him or herself as an employee of Children's, the employee must include a disclaimer that the views expressed on the site do not necessarily reflect the views of Children's. Employees should make clear that they are speaking for themselves and not on behalf of Children's.

4. Unless given permission by a Children's VP, employees are not authorized to speak on behalf of the company, nor represent that they do so on such social media sites.
5. Employees communication with patients, or patient family members, on social networking sites should be kept to a minimum and at all times remain professional.
6. Employees must comply with HIPAA and are prohibited from using or disclosing any protected health information (PHI) of any patient of Children's, regardless of whether the patient and/or patient's family has given permission. This includes patient medical or health information, patient contact information, pictures of patients or patient families, stories, etc.
7. Children's will not tolerate harassment, bullying or intimidation of other Children's employees on group websites. Employees are expected to be respectful of others and should assume that other people, including co-workers are reading their comments on public and social media sites.
8. Employees are prohibited from using any of Children's corporate logos and service marks on social networking websites without Children's written consent.
9. Employees are prohibited from posting any copyrighted Children's materials without Children's authorization.

Children's reserves the right to take disciplinary action up to and including termination if employee's communications violate this policy or any other Children's policy.

PEDIATRIC RHEUMATOLOGY FELLOWSHIP

Transitions of Care/Handoffs Policy

It is the policy of the Emory University Pediatric Rheumatology Fellowship Training Program to follow the guidelines set forth by Emory University School of Medicine as outlined below. This policy will be reviewed and updated accordingly. GME Committee approved the Institutional Policies below effective July 1, 2014.

I. Purpose:

To establish protocol and standards within the Emory University School of Medicine residency and fellowship programs to ensure the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances.

II. Definition:

A handoff is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another. Transitions of care are necessary in the hospital setting for various reasons. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

1. Change in level of patient care, including inpatient admission from an outpatient procedure or diagnostic area or ER and transfer to or from a critical care unit.
2. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas
3. Discharge, including discharge to home or another facility such as skilled nursing care
4. Change in provider or service change, including change of shift for nurses, resident sign-out, and rotation changes for residents.

III. Policy:

Individual programs must design schedules and clinical assignments to maximize the learning experience for residents as well as to ensure quality care and patient safety, and adhere to general institutional policies concerning transitions of patient care. Examples of strategies which have successfully minimized transitions include day/night teams, staggering of intern/resident/attending switch times and/or days to maintain continuity, outpatient clinic "pods" or teams, etc. All training programs must design call and shift schedules to minimize transitions in patient care. Schedule overlaps should include time to allow for face-to face handoffs to ensure availability of information and an opportunity to clarify issues.

IV. Procedure:

The transition/hand-off process should involve verbal and written/computerized communication, with opportunity for the receiver of the information to ask questions or clarify specific issues. The hand-off process may be conducted by telephone conversation. The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:

1. Identification of patient, including name, medical record number, and date of birth
2. Identification of admitting/primary/supervising physician and contact information
3. Diagnosis and current status/condition (level of acuity) of patient
4. Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
5. Outstanding tasks – what needs to be completed in immediate future
6. Outstanding laboratories/studies – what needs follow up during shift
7. Changes in patient condition that may occur requiring interventions or contingency plans

Each residency program must develop components ancillary to the institutional transition of care policy that integrate specifics from their specialty field. Programs are required to develop scheduling and transition/hand-off procedures to ensure that:

1. Residents comply with specialty specific/institutional duty hour requirements
2. Faculty are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents.
3. All parties involved in a particular program and/or transition process have access to one another's schedules and contact information. All call schedules should be available on department-specific password-protected websites and also with the hospital operators.
4. Patients are not inconvenienced or endangered in any way by frequent transitions in their care.
5. All parties directly involved in the patient's care before, during, and after the transition have opportunity for communication, consultation, and clarification of information.
6. Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency.
7. Programs should provide an opportunity for residents to both give and receive feedback from each other or faculty physicians about their handoff skills.

Residents must demonstrate competency in performance of this task. There are numerous mechanisms through which a program might elect to determine the competency of trainees in handoff skills and communication. These include:

1. Direct observation of a handoff session by a supervisory level clinician by a peer or by a more senior trainee
2. Evaluation of written handoff materials by clinician or by a peer or by a more senior trainee
3. Didactic sessions on communication skills including in-person lectures, web-based training, review of curricular materials and/or knowledge assessment
4. Assessment of handoff quality in terms of ability to predict overnight events
5. Assessment of adverse events and relationship to sign-out quality through:
 - o Survey
 - o Reporting hotline
 - o Chart review

Programs must develop and utilize a method of monitoring the transition of care process and update as necessary. Monitoring of handoffs by the program to ensure:

1. There is a standardized process in place that is routinely followed
2. There consistent opportunity for questions
3. The necessary materials are available to support the handoff (including, for instance, written sign-out materials, access to electronic clinical information)
4. A setting free of interruptions is consistently available, for handoff processes that include face-to-face communication
5. Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines

Leave Time

This section outlines general information concerning leave time. Specific questions regarding leave should be directed to the resident's Program Director. Each Program Director is responsible for maintaining accurate records of the amount of leave time his/her residents have used.

Paid Leave:

Emory University School of Medicine provides three weeks (specifically = 15 weekdays; at least 1 week is taken in the first half of the academic year and no more than 2 weeks may be taken during the second half of the academic year) of paid vacation/holiday leave during an annual academic contract period to each resident receiving a stipend in the Graduate Medical Education Program. More restrictive Board requirements override university permitted leaves. Those registered in the training program without a stipend are NOT eligible for any paid vacation/holiday leave time. A resident's unused vacation/holiday leave during one annual contract period does NOT transfer to the following appointment year. A resident shall not be paid for unused vacation/holiday leave if the resident voluntarily or involuntarily leaves the program during the contract period. Residents MUST follow the policies of their training program in requesting and scheduling a vacation/holiday leave. Failure to follow departmental policies may result in the request being rejected. In general, each resident must submit a leave request in writing to his/her Program Director. Program Directors, or their designees, have the final authority to approve or reject leave time requests.

Paid Sick Leave:

The School of Medicine provides paid sick leave to residents who are enrolled in training programs and who receive a stipend. This paid sick leave is intended for residents who are unable to complete their duties for a short period of time due to illness or injury. Most programs have specific times by which residents are required to notify the Program Director or Chief Resident of absence or tardiness prior to reporting to work. It is the responsibility of each resident to know and understand his/her program's notification procedures.

Residents have up to twelve (12) calendar days of paid sick leave during the academic year contract period. More restrictive Board requirements override university permitted leaves. Residents participating in the program on less than a full time schedule have their sick leave determined on a pro rata basis. Unused sick leave does NOT transfer to a resident's appointment for an additional training year(s). Residents shall not be compensated for unused sick leave balances upon voluntary or involuntary removal from the program, either during a contract period or at the end of the contract period. It is the responsibility of the resident to follow the policies of their department in using sick leave. The resident will be expected to provide evidence of the need for sick leave as required by his/her Program Director.

Funeral Leave:

Paid funeral leave is provided to residents to attend funeral services for relatives, same-sex domestic partner, or close personal friends. A resident's Program Director may approve up to five (5) days for funeral leave per occurrence. A resident should notify his/her Program Director as soon as possible of the need for funeral leave so that appropriate scheduling may occur. During individual departmental orientation, each resident will be informed of any other departmental requirements in completing the funeral leave request.

Paid Medical Leave:

Paid medical leave is to be used by eligible (i.e., those receiving a stipend) residents who are unable to complete their responsibilities for a prolonged period of time due to serious illness, injury, or pregnancy. This leave is to be used in conjunction with Family and Medical Leave Act (FMLA sub-section 4.05). When a resident qualifies for FMLA leave, the paid medical leave provisions described in this sub-section are used concurrently with the FMLA leave, so that approved time away from the residency training program is credited against a resident's maximum amount of paid medical leave and FMLA leave. A FMLA qualifying resident must apply for FMLA leave when seeking paid medical leave described in this sub-section.

In the event of pregnancy, a disabling illness or injury, an eligible resident may receive up to six weeks paid medical leave for the purposes of recuperation or convalescence. The resident's personal physician must document the condition necessitating leave. The documentation must include (a) a statement that the resident temporarily cannot perform the responsibilities of the training program, (b) an explanation for the resident's needed leave, and (c) the expected length of time before the resident can resume his/her duties. The six weeks of paid medical leave includes the resident's use of all available paid sick leave, followed by the use of two of the three weeks of the resident's vacation/holiday leave (if needed

and available). If a resident needs to exhaust vacation/holiday leave for medical reasons, the resident will be granted one week of vacation time after returning from leave if he/she had one or more weeks of vacation/holiday time when the leave began. If the resident has exhausted his/her vacation/holiday time before beginning medical leave, the resident will not have any vacation/holiday leave available when returning from leave. Before returning from leave, the resident must provide documentation from a treating physician verifying that the resident is medically fit to resume responsibilities in the training program. This documentation must be addressed to the resident's Program Director.

Family and Medical Leave:

Family and Medical Leave Act (FMLA) is intended to promote the well-being of residents and their families by allowing eligible residents an unpaid leave of absence for the birth of a child, to care for a new child, seriously ill family member, or for their own recuperation or convalescence.

Residents are eligible for (FMLA) leaving if they have been in the residency training program for at least twelve (12) months and have worked in the program at least 1,250 hours during the twelve (12) month period immediately preceding the leave.

Subject to the requirements set forth below, eligible residents may request and receive up to twelve (12) workweeks of leave during a 12-month period (measured backward from the date on which the leave begins) for any of the following reasons:

- The birth and care of a newborn child of the resident;
- The resident's adoption of a child or the placement of a child for foster care in the resident's home;
- The care of the resident's child, spouse/same sex domestic partner, or parent (but not in-laws) with a serious health condition;
- The serious health condition of a resident which renders the resident unable to perform the essential functions of his/her position in the resident training program.

General Provisions

An eligible resident is entitled to up to twelve (12) work weeks of leave during a 12-month period for a qualifying reason. If a resident's spouse is also a resident or employee at Emory, the resident and spouse are limited to a combined total of twelve (12) workweeks of FMLA leave during the period if the reason for the leave is the birth and care of a newborn child, the foster care placement or adoption of a child, or the care of a parent or a child with a serious health condition. However, for the purpose listed above, if one of the spouses has a serious health condition, each is entitled to twelve (12) workweeks of FMLA leave.

FMLA leave for the birth/care of a newborn child or for the placement of a child for adoption or foster care must be taken and conclude within twelve (12) months of the birth or placement. Unless specifically permitted, FMLA leave for these purposes cannot be taken on an intermittent basis or reduced leave schedule.

Payment Provisions and Use of Paid Leave:

Residents who are granted FMLA leave must use any accrued paid leave beginning with the effective date of the leave. Specifically, in conjunction with the Paid Medical Leave described above, the first six weeks of FMLA leave may run concurrently with any available paid leave. As detailed in the Paid Medical Leave sub-section, the six weeks of paid leave include all accrued, available sick leave and two of the three weeks of vacation/holiday leave, if available. Upon exhaustion of any applicable paid leave, the remainder of any FMLA leave during the academic year will be unpaid. The combination of paid and unpaid leave may not exceed twelve (12) workweeks in the 12-month period.

Required Documentation from the Resident:

A resident who foresees that he/she will need a leave for the birth and care of a newborn child or for the foster care placement or adoption of a child must notify his/her Program Director in writing and provide a completed health care provider's statement not less than thirty (30) calendar days in advance of the start of the leave, or generally within two (2) working days of learning of the need for leave. If not foreseeable, the resident must provide as much written notice as is practicable under the circumstances. A certification from a health care provider is required for leave requests related to the birth and care of a newborn child. Appropriate supporting court documents are required for leave requests related to the foster care placement or adoption of a child.

A resident who foresees that he/she will need a leave due to his/her planned medical treatment or to care for his/her spouse, same-sex domestic partner, child or parent with a serious health condition must notify his/her Program Director in writing as early as possible so that the absence can be scheduled at a time least disruptive to the training program. Such notice should be at least thirty (30) calendar days in advance of the start of the leave, unless impracticable, in which case

the resident must provide written notice, as early as circumstances permit, generally within two (2) working days of learning of the need for leave. A completed certification of the necessity of the leave from a health care provider is required. Preliminary designation of FMLA leave may be made pending receipt of this certification. Subject to the limitation and certifications allowed by the FMLA, leaves taken care for a spouse, same-sex domestic partner, child, parent or for the resident's own illness, may be taken on an intermittent or reduced leave schedule when medically necessary, provided a health care provider certifies the expected duration and schedule of such leave. The resident may be required to transfer temporarily to an available alternative position for which the resident is qualified but has equivalent pay and benefits and better accommodates recurring periods of leave than the resident's regular position. A resident must inform his/her Program Director every thirty (30) days regarding his/her status and intent to return to the training program upon conclusion of the leave. A resident is required to submit to his/her Program Director a Return-to-work Certification from a health care provider before returning to the training program. Where there is reason to doubt the validity of the health care provider's statement of certification for leaves taken to care for a spouse, same-sex domestic partner, child, parent, or for the resident's illness, Emory may, at its own expense, require second and third opinions, as specified by the FMLA to resolve the issue.

Benefits:

A resident on FMLA leave may elect to continue participation in his/her health, dental, and Beneflex and other benefit plans for the duration of the FMLA leave. In that circumstance, the resident will be responsible for paying his/her share of the benefit contributions as if he/she was actively performing in the training program, and Emory will continue to provide the benefits and pay the portion of premiums it provides for the resident when actively participating in the program. Emory will continue to provide its premium contributions and benefits throughout the FMLA leave, whether such leave is paid or unpaid.

While on paid leave, the resident's contributions (if any) will be deducted from his/her stipend check. While on an unpaid leave, the resident will be responsible for submitting his/her premium contributions on or before the date specified by the Human Resources Department. If a resident does not pay the required premium contributions, coverage will be canceled. However, the resident will be given fifteen (15) days notice before coverage is canceled. When a resident returns from FMLA leave, Emory may elect to recover the resident's share of contributions paid by Emory for maintaining coverage(s) for the resident while on FMLA leave.

Residents who elect not to continue benefits' participation while on FMLA leave, must notify Human Resources to cancel the coverage. If the resident returns to the program work in an eligible status, the resident has thirty-one (31) days from that date to reinstate coverage.

Unpaid Personal Leave of Absence:

A leave of absence without compensation is intended for those residents who need an extended period of time away from their training program but have no vacation/holiday leave balance and do not qualify for or have expended their sick leave, Paid Medical Leave, and FMLA leave balances. An unpaid personal leave of absence may be requested and granted for compelling personal reasons. Requests for this leave must be submitted, in writing, to the resident's Program Director for his/her consideration. The duration of the unpaid personal leave of absence is limited to the time approved by the Program Director, but in no event longer than 120 days.

During an unpaid personal leave of absence, health care coverage, dental, and life insurance shall be continued ONLY if full payment for this coverage is made by the resident each month while on leave. It is the sole responsibility of the resident to assure that premium payments are made on a timely basis. Coverage arrangements must be made with the Benefits Department of Emory University's Human Resources Division, which may be reached at 404.727.7613.

Leave for Jury/Witness Duty:

Jury/Witness duty leave is provided to residents who are subpoenaed to serve on a jury or as a witness in a litigation proceeding. Each resident must notify his/her Program Director of jury/witness duty by submitting a copy of the subpoena. Jury/witness fees received by the resident for jury/witness duty may be retained by the resident. Time served on jury/witness duty will not count against the resident's vacation/holiday time.

Leave for Military Duty:

Residents will be granted an unpaid military leave of absence to serve or train in the Armed Forces, the Army National Guard, the Air National Guard, or the commissioned corps of the Public Health Services, as required by the federal Uniformed Services Employment and Reemployment Rights Act (USERRA) and state law. Residents may elect to use available paid leave to receive compensation during their military leave until such pay entitlement expires. The resident

may be entitled to continue health insurance coverage for a period of time. Residents MUST notify their Program Director as soon as is practicable when military leave will be required, and must provide their Program Director with appropriate documentation of their military service.

Effect of Leave of Absence on Board Eligibility:

To meet the training requirements of various certifying Boards, residents may be required to spend additional time in training to make up training time lost while on a prolonged leave of absence. The residents' Program Director determines if and how much additional residency training time is required in each prolonged leave of absence circumstance.

Boards vary in their requirements regarding board eligibility and certification. Residents are strongly advised to access the specific relevant information from their certifying boards which can be found at the following website:

http://www.abms.org/Who_We_Help/Physicians/process.aspx

Reinstatement after Leave:

A resident who obtains a Family Leave of Absence or Unpaid Personal Leave of Absence will be reinstated to the same or equivalent position within the same academic year, except where there has been a reduction in the number of positions during the leave period due to lack of funding, a reduction of, or reorganization in, the clinical service. Reinstatement in the following academic year will require a new letter of appointment.

Emory University Pediatric Rheumatology Fellowship Training Program Policy on Disciplinary Actions

It is the policy of the Emory University Pediatric Rheumatology Fellowship Training Program and Emory Graduate Medical Education to follow guidelines established by the School of Medicine regarding Disciplinary Action for residents in accredited training programs. This policy will be reviewed and updated accordingly.

The School of Medicine expects all residents to fulfill their responsibilities and conduct themselves in a competent, professional manner, and to follow the rules, regulations and policies of Emory University and affiliated hospitals, as well as federal and state law. In the event a resident falls short of these expectations, and/or engages in misconduct, violates rules, or fails to satisfactorily perform the training program, the resident will be counseled and/or disciplined for his/her actions or inactions. This Section outlines some of the common disciplinary actions available to each residency training program. Typically the steps involved in corrective discipline of a resident include one or all of the following: verbal warnings, written warnings, probation, suspension, and termination. However, depending on the circumstances of the resident and his/her misconduct or other inappropriate action, the School of Medicine may choose any of the described disciplinary actions for a single infraction including immediate termination from the training program without first providing the resident lesser disciplinary actions. All disciplines received by a resident will be taken into account in determining whether the resident will receive a reappointment offer.

Administrative Notice:

Administrative Notice is a remedial action by which a resident is temporarily relieved of clinical duties without pay for violation of university, institutional, or departmental policy pertaining to administrative matters. Examples of inappropriate activities triggering an administrative notice include, but are not limited to, failure to maintain an active medical license in the GME office, failure to provide evidence of training in basic life support techniques, failure to obtain PPD tests, and failure to provide OGME with a copy of his/her medical school diploma or ECFMG certificate. Administrative Notice is not necessarily considered censure, and the Chair or Program Director will decide whether it will become a part of the resident's permanent academic file.

The Department Chair, Program Director, or their designee may impose an Administrative Notice upon a resident for failure to appropriately discharge his/her administrative responsibilities. Administrative Notice may not be invoked for deficiencies in academic performance, patient care, or any other non-program related administrative action or conduct, as those deficiencies should be addressed through verbal warnings, written warnings, probation, suspension, and/or termination. The resident may not appeal his/her receipt of an Administrative Notice.

The resident will be notified promptly of his/her placement on Administrative Notice. Such notice shall, if possible, be hand-delivered (with the resident signing and dating a copy to acknowledge receipt) or sent by certified mail (return receipt requested) to the president's address of record. The Department Chair, Program Director, or their designee will also, if possible, verbally inform the resident of the action. The Administrative Notice shall clearly delineate the resident's area(s) of deficiency and establish a reasonable period of time no longer than 10 calendar days within which the resident must correct his/her deficiencies. During the period of Administrative Notice, the resident is relieved of all clinical responsibilities without pay. Failure to appropriately address the areas of deficiency in the appropriate time frame as outlined in the letter of notification is considered grounds for additional disciplinary action, up to and including termination from the residency program.

Verbal Warning:

A verbal warning, which may be given to a resident by a departmental Chair, Program Director, or other faculty member, is designed to identify a resident's minor or initial infraction of policies, standards, or expectations. The warning should be firm and fair, with the faculty member assuring that the resident understands the policies, standards, and expectations. A written record of the date and the content of the discussion, as well as the underlying situation which precipitated the warning, shall be maintained in the resident's academic file.

Written Warning (Letter of Reprimand):

A written warning may be issued only by a resident's Department Chair or Program Director. A written warning is appropriate when a prior verbal warning has not resulted in the needed improvement or when the initial misconduct violation or performance inadequacy indicates a need for action stronger than a verbal warning. The written warning should note the unacceptable conduct or action that caused the warning, as well as the program's improvement expectations. The written warning must be signed by the resident and a copy given to him/her. A copy must be placed in the resident's academic file.

Probation:

A Department Chair or Program Director may place on probation a resident who is unable to meet the academic expectations of the training program (failing to progress at the expected pace), who experiences a serious lapse in complying with the responsibilities of the program, or for other serious misconduct and/or performance problems. A Department Chair or Program Director should notify the Associate Dean for Graduate Medical Education or his/her designee before placing a resident on probation.

Probation is usually the second step of a series of disciplinary actions for a resident. Usually a resident will have one or more counseling sessions or receive a verbal or written warning about his/her deficiency prior to being placed on probation. In placing the resident on probation the Chair or Program Director should:

- Review the policies and expectations of the program;
- Identify the area of deficiency;
- Identify the improvement(s) that must be achieved during the probation period;
- Identify the length of the probationary period; and
- Inform the resident what action(s) may be taken if the stated improvements are not met in the established time frame.

A resident will receive this probation notification in writing. Copies of the probation notice will be placed in the residents' academic file and in his/her administrative file located in the Office of Graduate Medical Education. A probation period occurring during training will be noted in all letters of reference.

Suspension:

The Dean of the School of Medicine or his designee, the department Chair, and Program Director have the authority to suspend a resident for the most serious violations of policies, rules, laws and misconduct, performance problems, and/or recurring administrative lapses such as violations of medical records requirements. Prior to suspending a resident from the training program, the department Chair or Program Director must notify the Associate Dean for Graduate Medical Education or his/her designee. In addition, the Program Director will inform the OGME, in writing, of the cause for suspension, the length of suspension, whether the time lost while on suspension will be added to the resident's training requirements at the conclusion of his/her program, and any other pertinent information.

When suspending a resident, the Program Director or his/her designee must inform the resident, in writing, of the following:

- An action(s) that precipitated the decision to suspend the resident;
- The length of the suspension;
- The fact that the resident will not be paid while on suspension;
- The fact that the suspension will NOT be counted toward the completion of the training time required to be eligible for board examination(s);
- An indication of what the resident may/may not do while on suspension (for example, no moonlighting);
- The program's expectations for the resident upon his/her return from suspension.

Copies of the suspension notice will be placed in the resident's academic file and in his/her administrative file located in the Office of Graduate Medical Education. Suspensions will be noted in all letters of references.

Termination:

If a residency appointment is terminated during the appointment period, the terminated resident may appeal the decision by following the procedures outlined in Section 33, "Hearing and Appellate Review Procedures for Termination of a Resident."

Emory University Pediatric Rheumatology Fellowship Training Program Policy on Grievance and Due Process

It is the policy of the Emory University Pediatric Rheumatology Fellowship Training Program to follow the guidelines set forth by Emory University School of Medicine. This policy will be reviewed and updated accordingly.

The School of Medicine, GMEC and the Division of Rheumatology support fair policies regarding grievances and the due process. Fellows are encouraged to approach the Program Director and/or Assistant Program Director with any disputes or complaints regarding the fellowship training program and also those disputes or complaints which cannot be resolved between two fellows, a fellow and a resident/student, or a fellow and an attending. A fellow who has an unresolved significant dispute or complaint with the residency training program, the training program director, or other faculty members may grieve the dispute or complaint in the manner described in the GME House staff Policies and Orientation handbook. Fellows will be notified by pager and email when and if these procedures change and will be referred to the specific site in the Manual.

Please refer to the GME website at www.med.emory.edu/GME for the House Staff Policies and Procedures Manual, Sections 7, 33 and 34 for a full discussion of these procedures.

Counseling and Support Services

When a resident needs private counseling or professional assistance to address an issue which is, or may affect his/her ability to live or work fully and productively, assistance is available through the Faculty Staff Assistance Program (FSAP) at the main office location at the Emory Wellness Center, or any of the following satellite offices: Orr Bldg.-Emory University Hospital Midtown (EUHM), Steiner Bldg.- Grady campus and Cox Hall next to Emory University Hospital. To schedule an appointment please call the main number at 404.727.4328. The FSAP facilitates the ability of its clients to discover options and manage resources that enhance health, productivity, and behavior. FSAP services are available to residents at no charge. Immediate family members who play a significant role in the life of a resident may also receive services.

A change in productivity, attendance, or behavior is often the first indicator of the need for help. The FSAP offers confidential and professional consulting, brief counseling, education, and referral services covering areas such as:

- Marital, family, or relationship issues
- Health and wellness
- Abuse of alcohol or other drugs
- Financial obligations
- Anger management and Lateral Violence
- Addictive disorders
- Stress and depression
- Childcare and parenting issues
- Career concerns
- Eldercare
- Work systems and quality of work life
- Critical incident stress debriefing (processing traumatic events) When a resident takes the initiative to call or visit, the FSAP can help the resident:
 - Discover and manage available options and resources
 - Sort through a problem or concern and identify the core issues
 - Develop a plan for dealing with identified issues

- Obtain professional assistance to complete the plan

FSAP is available 24 hours per day, 7 days per week for residents who are in crisis and need assistance during off hours. To reach a counselor on call, residents can call the main number for FSAP at 404.727.4328. Press option "2" to reach the answering service who will page the appropriate counselor.

Disaster Policy

It is the policy of GMEC at Emory University School of Medicine to establish the procedures to be followed to provide administrative support for the residency training programs and residents/fellows subsequent to an event or series of events that cause a significant interruption in the provision of patient care, as mandated by the ACGME's Policies and Procedures.

A disaster is defined as an event or set of events causing a significant alteration to the residency/fellowship experience at one or more residents/fellowship programs.

ACGME DECLARATION OF A DISASTER:

When warranted, the ACGME Chief Executive Officer, with consultation of the ACGME Executive Committee and the Chair of the Institutional Review Committee, will make a declaration of a disaster. A notice of such will be posted on the ACGME website with information relating to ACGME respond to the disaster.

PROCEDURE:

After the declaration of a disaster, the Associate Dean for GME/DIO and other leadership will always provide continuing support to all involved residents using the following procedures:

-The DIO or designee will meet with each Program Director and appropriate university and/or hospital officials to determine the ability of the programs to continue to provide adequate educational experiences for residents and fellows.

-Insofar as a program/institution cannot provide at least an adequate educational experience for each of its residents/fellows because of a disaster, the DIO and Program Directors will proceed to:

A. Arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows, or

B. Assists the residents in permanent transfers to other programs/institutions, i.e., enrolling in other ACGME-accredited programs in which they can continue their education.

Program Directors are to use a previously developed contact list of potential sites for residential placement. The Program Director and DIO are jointly responsible for maintaining ongoing communication with the GMEC throughout the placement process.

If more than one program/institution is available for temporary or permanent transfer of a particular resident, the preferences of each resident must be considered. Programs must make the keep/transfer decision expeditiously so as to maximize the likelihood that each resident/fellow will complete the year in a timely fashion.

The DIO or designee will contact the ACGME Institutional Review Committee Executive Director within ten days after declaration of the disaster to discuss the due date for submission of plans for program reconfigurations and resident transfers to the ACGME.

The DIO will then provide initial and ongoing communication to university/hospital officials and all affected Program Directors.

Each Program Director and or the DIO will determine/confirm the location of all residents; determine the means for ongoing communication with each; and notify emergency contacts of any resident who is injured or cannot be located.

As soon as arrangements for temporary or permanent transfers have been confirmed, but no less than 10 days after declaration of the disaster, the Program Director or designee will notify each resident.

The DIO will access information on the ACGME website to provide Program Directors with assistance in communicating and document resident transfers, program reconfigurations, and changing participating sites.

Communication with ACGME:

On its website, the ACGME will provide phone numbers and email addresses for emergency and other communication with the ACGME from disaster affected institutions and programs. The DIO shall ensure that each Program Director and resident is provided with information annually about this emergency communication availability.

In general:

The DIO will call or email the Institutional Review Committee Executive Director with information and/or requests for information.

Program Directors will call or email the appropriate Review Committee Executive Director with information and/or requests for information.

Residents call or email the appropriate Review Committee Executive Director with information and/or requests for information, if they are unable to reach their Program Director or DIO.

EXTREME EMERGENT SITUATION

The extreme emergent situation is defined as a local event (such as a hospital-declared disaster for an epidemic) that affects resident education or the work environment but does not rise to the level of an ACGME-declared disaster as defined in the ACGME Policies and Procedures.

DECLARATION OF AN EXTREME EMERGENT SITUATION:

Declaration of an extreme emergent situation may be initiated by a Program Director or by the DIO. Declaration of a qualifying local disaster is made by the DIO, in collaboration with the hospital CEO, the COO, the CMO, affected Program Directors, and Department Chairs. When possible, an emergency meeting of the GMEC – conducted in person, through a conference call, or through web-conferencing – shall be convened for discussion and decision-making as appropriate.

PROCEDURE:

After declaration of an extreme emergent situation:

The Program Director of each affected residency/fellowship program shall meet with the DIO and other university/hospital officials, as appropriate, to determine the clinical duties, schedules, and alternate coverage arrangements for each residency program sponsored by the Institution. ACGME's guidelines for development of those plans should be implemented, including:

Residents and fellows must be expected to perform according to the professional expectations of them as physicians, taking into account their degree of competence, level of training, and context of the specific situation. Residents who are fully licensed in this state may be able to provide patient care independent of supervision in the event of an extreme emergent situation, as further defined by the applicable medical staff bylaws.

Residents are also trainees/students. Residents/fellows should not be first-line responders without consideration of their level of training and competence; the scope of their individual license, if any; and/or beyond the limits of their self-confidence in their own abilities.

Program Directors will remain in contact with the DIO about implementation of the plans to address the situation, and additional resources as needed.

The DIO will call the ACGME IRC Executive Director if (and, only if) the extreme emergent situation causes serious, extended disruption that might affect the Institution/Program's ability to remain in substantial compliance with ACGME requirements. The ACGME IRC will alert the respective RRC. If notice is provided to the ACGME, the DIO will notify the ACGME IRC ED when the extreme emergent situation has been resolved.

The DIO and GMEC will meet with affected Program Directors to establish monitoring to ensure the continued safety of residents and patients through the duration of the situation; to determine that the situation has been resolved; and to assess additional actions to be taken (if any) to restore full compliance with each affected resident's completion of the educational program requirements.

Important Contacts

Current House Staff and HSO

About the House Staff Organization

The House staff Organization (HSO) is the designated organization which represents all residents and fellows in graduate medical education training programs at Emory University School of Medicine and Affiliated Hospitals. The Organization is available to seek resolutions to issues that cannot be resolved within the training program, and will present and advocate House staff concerns to appropriate Graduate Medical Education, University, Hospital administrators, and other related parties.

Additionally, we coordinate with the graduate medical education office on advocacy, social, and other activities. House staff organization is a strong advocate on behalf of the residents and fellows on salary and benefit issues. All residents and fellows are automatic members of the HSO and are all welcome at all HSO meetings.

Medical Education Contact Information

- Office of Medical Education and Student Affairs - (404) 727-5655
- Office of Admissions - (404) 727-5660
- Office of Clinical Education & Visiting Students - (404) 778-1372
- Emory University School of Medicine - 1648 Pierce Drive, Atlanta, GA 30322
- Woodruff Health Sciences Center, 1440 Clifton Road, NE, Atlanta, GA 30322

Websites

- ACGME – WWW.ACGME.ORG
- AETNA – WWW.aetna.com
- American Medical Colleges – WWW.AAMC.ORG
- Children’s Healthcare of Atlanta – www.choa.org
- Emory Parking Office – <http://www.epcs.emory.edu/park>
- Educational Commission for Foreign Medical Graduates – WWW.ECFMG.ORG
- Emory GME – <http://www.med.emory.edu/GME/>
- Employee Health – <http://www.ehso.emory.edu/Forms/ImmunizationHistory.pdf>
- Georgia Medical State Board – WWW.MEDICALBOARD.STATE.GA.US
- Grady Parking Office – <http://gradyhealthsystem.org>
- Housing – <http://housing.emory.edu>
- IT information – <http://it.emory.edu>
- New Innovations (GME Database) – WWW.NEW-INNOV.COM/SUITE
- Payroll – <https://www.finance.emory.edu>; <https://psofthr.cc.emory.edu>
- Residency Match Program – WWW.NRMP.ORG
- Risk Management/Liability – <http://www.emory.edu/oris/faqs.htm>

I _____ was given an electronic copy of the **Rheumatology Fellowship Handbook & Curriculum**. It is my responsibility to review and become familiar with all rotations and policies and procedures. I also was informed that the Handbook & Curriculum is also available in New Innovations. I also understand that any revisions will be communicated electronically.

Signature

Date