Call to Order

1. Minutes of October 12, 2017................................................................. E. Benjamin Clyburn, MD

2. New Business ...................................................................................... Dr. Clyburn
   A. Telemedicine Curriculum ............................................................... James T. McElligott, MD, MSCR
   B. Residency Videos........................................................................... Allison R. Leggett
   C. Request for New Program Director (Endocrinology)
   D. Request for Temporary Increase (Psychiatry)
   E. Request for Permanent Increase (Neonatal)

3. ACGME Correspondence................................................................. Dr. Clyburn
   A. Approval of Temporary Increase (Critical Care [Pulmonary])
   B. Approval of Faculty (Thoracic Surgery)
   C. Removal of Participating Site (OB/GYN)

4. Quality Report .................................................................................. Elizabeth Mack, MD

5. Resident Representatives’ Report.................................................. Drs. Haulsee, Orabi, Siegel and Stem

6. VA Update ......................................................................................... Stephanie Myers

7. PC Update ........................................................................................ Melanie Pigott

8. Program Information
   A. Annual Program Evaluations (APE).............................................. Leonie Gordon, MD
      i. Pediatric Hematology/Oncology
      ii. Pediatric Emergency Medicine
      iii. Pediatrics
      iv. Dermatopathology
   B. Remediations: 4 residents in 4 programs
   C. Duty Hours

9. Old Business
   A. Request for Permanent Complement Increase (Neurology)

ANNOUNCEMENTS

Next GMEC Meeting
ALL PROGRAM DIRECTORS AND COORDINATORS are invited to attend.
Wednesday, December 13 ~ 1130 a.m. ~ 302 BSB

Please encourage any of your residents that may be interested in House Staff Council to attend the next meeting on Tuesday, November 14 at 6:00 p.m. in 419 CSB. Any resident/fellow is welcome to attend.

The next Chief Resident/Resident Representative meeting is
Wednesday, November 15 at 12 Noon in 349 BSB.
MEMBERS PRESENT: Batalis, Nick MD [Pathology]; Britten, Carolyn MD [Hem/Onc];
Bush, Jeff MD [Emergency Medicine]; Campbell, Ruth MD [Nephrology]; Clyburn, Ben
MD [Internal Medicine]; Cox, Lindsey MD [Urology]; Gordon, Leonie MD [Assoc. Dean
for GME]; Judge, Dan MD [Pediatric Cardiology]; Leddy, Lee MD [Orthopaedics] via
proxy; Lewis, Lee MD [Child and Adolescent Psychiatry] via proxy; Lewis, Madeleine MD
[Radiology] via proxy; Marchell, Richard MD [Dermatology]; Marshall, David MD
[Radiation Oncology (At large member)]; Memnito, Sarah MD [Med-Peds]; Meyer, Ted
MD, PhD [Otolaryngology]; Milano, Nick MD [Neurology]; Meyer, Stephanie [FMAC];
Nutaifis, Matt MD [Ophthalmology]; Pigott, Melanie [Emergency Medicine (PC)]; Siegel,
Mark MD [Pediatrics – HSC president]; Spiotta, Alex MD [Neurosurgery]; Stem,
Christopher MD [Pediatrics – resident]; Streck, Christian MD [Surgery]; Tavana, Lance
MD [Plastic Surgery – (At large Member)]; Willner, Ira MD [Gastroenterology];

MEMBERS ABSENT: Anderson, Bret MD [Interventional Radiology]; Armstrong, Milton
MD [Plastic Surgery (At large member)]; Barth, Kelly DO [Med-Psych]; Guldman, George
(GJ) MD [Anesthesiology]; Haulsee, Merle MD [Internal Medicine – resident]; Kantor, Ed
MD [Psychiatry]; Keith, Brad MD [Internal Medicine (At large member)]; Mack, Elizabeth
MD [Quality]; Orabi, Mohammed MD [Neurology – resident]; Pastis, Nick MD
[Pulmonary/Critical Care]; Savage, Ashlyn MD [OB/GYN]; Southgate, Mike MD
[Pediatrics]; Steed, Martin DDS [ Oral Surgery (At large member)]; Zyblewski, Sinai MD
[Pediatric Cardiology]

GME OFFICE: Rob Chisholm, Beth Jones, Ann Ronayne, Hung Vo, Angela Ybarra

GUESTS: Lori Roten (Pathology); Mindi Martin (Maternal Fetal) Olga Chajewski, MD
(Cytopathology); John Lazarchick, MD (Hematopathology); Terri Hayes (Rheum); Callie
Lalich, MD (Geriatric Psychiatry); Faye Hant, MD (Rheum)

TIME CALLED TO ORDER: 4:00 p.m.
TIME ADJOURNED: 5:05 p.m.
PRESIDING OFFICER: Dr. Ben Clyburn
RECORER: Ann Ronayne
LOCATION: 628 CSB

<table>
<thead>
<tr>
<th>AGENDA</th>
<th>DISCUSSIONS/CONCLUSIONS</th>
<th>RECOMMENDATIONS/ ACTIONS WHAT/WHEN</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call to Order</td>
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<tr>
<td>STANDING BUSINESS</td>
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<tr>
<td>MINUTES</td>
<td>The minutes from the September 14, 2017 meeting were reviewed.</td>
<td>The committee approved the minutes.</td>
<td>Dr. Clyburn</td>
</tr>
<tr>
<td>NEW BUSINESS</td>
<td></td>
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<tr>
<td>A. Handoff Policy</td>
<td>A. The Handoff Policy was presented again this month. There are too many policies within the bylaws and we are looking to combine them all. Drs. Schuerer, Mack and Clyburn convened to look at all the policies. They removed the acronym at the end of the current policy, as it doesn’t matter which acronym a program uses, just that they use something. Programs are expected to do the evaluation of handoffs - the new training requirements</td>
<td>The committee approved the updated policy. We will send this over to the VA as FYI.</td>
<td>Dr. Clyburn</td>
</tr>
<tr>
<td>B. Request for Temporary Complement Increase</td>
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<tr>
<td>C. Requests for</td>
<td></td>
<td>The committee approved the request.</td>
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require you to observe handoffs. CLER was very pleased with our handoff system. Even with all the emphasis on hand-offs, residents still identify them as the #1 concern.

B. Pulmonary and Critical Care is asking for a temporary increase so they can offer a one-year critical care program. They do not need to ask for RRC approval to offer this program if it is held in an ad hoc manner. If they were to do this every year, they would have to go to the RRC and ask for a new program.

C. Dan Judge, MD has been nominated to take over the Cardiology program. Dr. Ravi Veeraswamy has been nominated as Vascular Surgery program director. Dr. Baliga has also nominated Alicia Privette, MD to take over the Surgical Critical Care program. All three have been vetted by the GME Office.

D. Dr. Willner is asking for a new program in Transplant Hepatology. If a Gastro Fellow has completed 2 years, they can take Transplant Hepatology in the 3rd year. Because no additional funding is needed (other than application fees and subsequent annual fees), the hospital strategic manpower group approved funding.

E. The Annual Institutional Review (AIR) is required by the ACGME every year. We are putting together a subcommittee to review the information and put together a review for 17-18. If you are interested, please see Ann Ronayne.

F. Please make sure that you have a signed release form from residents or former residents prior to filling out verification requests.

G. Telemedicine has been named a Center of Excellence. There is funding available to formulate a curriculum for your residents. There are some groups that have already done this – stroke incorporates telemedicine very well. Internal Medicine piloted a four-hour online course for telemedicine. There is an opportunity to make a big difference, as there are very few published curriculums. This is especially relevant given the synergy with CLER and making a difference in health disparities.

H. Programs need to decide how long they want to keep programs archived, as the space is costing us money. The university has moved to Moodle classrooms and Panopto recordings.

I. The Accelerated Pathways Program graduates students early from Med School to begin residency earlier. There is currently a student who will graduate in October and begin his Ortho residency here at MUSC in November. There are two information sessions on this pathway, October 25 and November 1.

The committee approved the requests.
### ISSUES:

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<thead>
<tr>
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<tbody>
<tr>
<td>A.</td>
<td>Adding Participating Site (Surgery)</td>
</tr>
<tr>
<td>B.</td>
<td>Approval of ACFOR Resident</td>
</tr>
<tr>
<td>C.</td>
<td>Adding Faculty Members</td>
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<tr>
<td>D.</td>
<td>Temporary Increase Approval (Addiction Psych)</td>
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<tbody>
<tr>
<td>A.</td>
<td>Surgery has added Roper Hospital as a participating site. The committee acknowledged the correspondence.</td>
</tr>
<tr>
<td>B.</td>
<td>The Accelerated Pathway Program for Ortho is called the Accelerated Curriculum and Focused Orthopaedic Residency (ACFOR) and notes the following: The program is planned for up to two students to complete by the end of October and enter as a PGY 1 into the MUSC Ortho program, under a rotating surgical internship. They will then continue as a PGY1 in July in Ortho. A temporary complement increase is not needed for their 8-month internship. The ACGME is asking for follow up information.</td>
</tr>
<tr>
<td>C.</td>
<td>Vascular Surgery and Surgery are asking for approval to add faculty members to their programs. The ACGME approved the requests.</td>
</tr>
<tr>
<td>D.</td>
<td>The RRC approved the request for a temporary increase in resident complement from 3 to 4 effective July 1, 2019.</td>
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### RESIDENT REPRESENTATIVES’ REPORT

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<td></td>
<td>Dr. Siegel reported the HSC Happy Hour will be Tuesday, October 24. HSC is working on requesting the 18-19 salaries and will be in touch with Dr. Clyburn soon.</td>
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### VA UPDATE

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<td></td>
<td>Ms. Meyers introduced Rocky Lal, also with the education department at the VA. Over the last year, the VA approved an increase of 4.5 positions – 2 in Emergency Medicine, 1 psych, 1 critical care and .5 infectious diseases. With the additional resident spots, the VA has been approved as a 1A facility. The VA Quality Chief salary has been matched to the MUSC salary levels.</td>
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### HOSPITAL QUALITY REPORT

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<tr>
<td></td>
<td>There was no Quality Report.</td>
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### PROGRAM COORDINATOR REPORT

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<td></td>
<td>Ms. Pigott disclosed that increased communication between the PCs and PDs, in general, can be improved. PDs should have a standing meeting with their PCs, every week or two.</td>
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### PROGRAM INFORMATION

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<tbody>
<tr>
<td>A.</td>
<td>Annual Program Evaluations</td>
</tr>
<tr>
<td>i. Rheumatology</td>
<td></td>
</tr>
<tr>
<td>ii. Developmental &amp; Behavioral Peds</td>
<td></td>
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<tr>
<td>iii. Hematopathology</td>
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<td>iv. Cytopathology</td>
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<tr>
<td>v. Geriatric Psych</td>
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<tr>
<td>B. Remediations</td>
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<td>C. Duty Hours</td>
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<tr>
<td>A.</td>
<td>Rheumatology is in good standing, other than not having enough faculty fill out the ACGME survey. Especially noteworthy is the Carolina Fellows Directive, a collaborative effort between Duke, UNC, Emory and MUSC. Developmental and Behavioral Pediatrics is in fine shape. The program should be aware of the downward trend in educational content on the faculty survey. Hematopathology is in good standing – they had no fellow last academic year but have filled for 17-18. Cytopathology has a new program director, but is in fine shape. In a one-year program, it can be difficult to get resident scholarly activity, but surely your fellows teach or give presentations? Geriatric Psychiatry nationally is facing a lack of fellows. It is noted that they did not match for this academic year, but otherwise the program is in good standing.</td>
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<tr>
<td>B.</td>
<td>There are three residents in three programs currently on remediation. The GMEC approved the APE reports.</td>
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<td>Dr. Gordon</td>
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C. A reminder that the 80-hour rule has no leeway. RRCs will not look kindly toward any instances of violations going over the 80-hour workweek, not just those beyond what is averaged over 28 days. A report was included that detailed which programs had residents that worked more than an 80 hour work week. These included Hem Onc, OBGYN, Surgery, IM, Nephrology, Neurosurgery, Med Psych, Pediatric Cardiology, Thoracic Surgery and Vascular Surgery.

<table>
<thead>
<tr>
<th>OLD BUSINESS</th>
<th>There was no old business.</th>
<th>Dr. Clyburn</th>
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<thead>
<tr>
<th>ANNOUNCEMENTS</th>
<th>Next GMEC Meeting ~ Thursday, November 9 at 4:00 p.m. in 628 CSB</th>
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<tbody>
<tr>
<td></td>
<td>Please encourage any of your residents that may be interested in House Staff Council to attend the next meeting on Tuesday, November 14 at 6:00 p.m. in 419 CSB. Any resident/fellow is welcome to attend.</td>
</tr>
<tr>
<td></td>
<td>The next Chief Resident/Resident Representative meeting is Wednesday, October 18 at 6:00 a.m. in 419 CSB.</td>
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Approved at the TBD, 2017 GMEC meeting.
MEMORANDUM

October 30, 2017

TO: MUSC GMEC

RE: Appointment of New Program Director to Endocrinology Fellowship Training Program

I would like to nominate, Nicoleta D. Sora, MD, for the position of Program Director for the Endocrinology Fellowship training program. Dr. Sora will have authority and accountability for the operation of all components of the fellowship program. My recommendation of Dr. Sora for this position is because she has a strong commitment to graduate medical education and has 3 years experience in all facets of program leadership in the role of Associate Program Director.

Dr. Sora is currently an Assistant Professor in the Department of Medicine, Division of Endocrinology. She has been board certified through the American Board of Internal Medicine for a total of 5 years (Internal Medicine Certified since 2012 and Endocrinology Certified since 2013) and holds a MUSC medical staff appointment. Her South Carolina Medical License Number is 31459. Enclosed is Dr. Sora’s curriculum vitae.

I am recommending Dr. Sora for this appointment to begin on December 1, 2017. ACGME requirements indicate that the program director must intend to continue in his or her position for a length of time adequate to maintain the program’s stability. I acknowledge that Dr. Sora will need to maintain board certification for the duration of her appointment as Program Director.

I have reviewed the Program Requirements for the Endocrinology Fellowship training program which are posted on the ACGME website, and can assure the GMEC that Dr. Sora can comply with all requirements.

The Department of Medicine will ensure that the Program Director has sufficient financial and administrative support and protected time for her educational and administrative responsibilities to the program. As for ACGME requirements and MUSC funds flow, Dr. Sora will have a 25% reduction in CFTE in order to allow her to carry out the Endocrinology Fellowship administrative requirements. Dr. Sora will be protected at least 25% of her time and will receive 25% for this position.

I have discussed all the above with Dr. Sora. After approval by the GMEC, I understand the current program director needs to notify the ACGME electronically using their WebADS system.

Sincerely,

[Signature]

Don C. Rockey, MD
Professor and Chairman
Department of Medicine

cc: Dr. Nicoleta D. Sora
Enclosure: CV

"An equal opportunity employer, promoting workplace diversity."
Nicoleta Dorinela Sora, M.D.
Assistant Professor of Medicine
Curriculum Vitae

SCHOOL ADDRESS
Division of Endocrinology
Department of Medicine
College of Medicine
96 Jonathan Lucas Street, Room 938G, MSC 624
Charleston SC 29425
Work Email: sora@musc.edu
Work Phone: 843-792-2529
Home phone: 843-795-5205
House Email: nicolestora@yahoo.com
Cell Phone: (203) 209-5932

Marital/family information: Married
Citizenship/Visa Information: USA Green Card

LANGUAGES
- English, Romanian, Spanish

EDUCATION
<table>
<thead>
<tr>
<th>Year</th>
<th>Institution</th>
<th>Degree</th>
<th>Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>Liceul Teoretic Traian Doda</td>
<td>B.S.</td>
<td>Mathematics and Physics</td>
</tr>
<tr>
<td>1997</td>
<td>Victor Babes University of Medicine and Pharmacy</td>
<td>M.D.</td>
<td>Medicine</td>
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</table>

POSTDOCTORAL EDUCATION
<table>
<thead>
<tr>
<th>Year</th>
<th>Institution</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 - 2012</td>
<td>Medical University of South Carolina, Charleston, SC</td>
<td>Endocrinology Fellow, Advanced Training in Lipid and Obesity Metabolism</td>
</tr>
<tr>
<td>2009 - 2011</td>
<td>Medical University of South Carolina, Charleston, SC</td>
<td>Endocrinology Fellow</td>
</tr>
<tr>
<td>2006 - 2009</td>
<td>Saint Vincent’s Medical Center, Bridgeport, CT</td>
<td>Internal Medicine Resident</td>
</tr>
<tr>
<td>1998 - 1999</td>
<td>Timisoara Municipal Hospital, Romania</td>
<td>Medical Intern</td>
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LICENSURE AND CERTIFICATION
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<thead>
<tr>
<th>Year</th>
<th>Description</th>
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<tbody>
<tr>
<td>2012</td>
<td>Licensure - South Carolina Medical Board</td>
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<tr>
<td>2013</td>
<td>Certification - ABIM Endocrinology, Diabetes &amp; Metabolism Board</td>
</tr>
<tr>
<td>2012</td>
<td>Certification - American Board of Internal Medicine</td>
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FACULTY APPOINTMENTS
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<tr>
<th>Year</th>
<th>Institution</th>
<th>Role</th>
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<tbody>
<tr>
<td>2015 - Present</td>
<td>Medical University of South Carolina, Charleston, SC, Medicine, Division of Endocrinology</td>
<td>Associate Program Director, Endocrinology Fellowship Program</td>
</tr>
<tr>
<td>2015 - Present</td>
<td>Medical University of South Carolina, Medicine, Division of Endocrinology</td>
<td>Assistant Professor</td>
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<tr>
<td>2012 - 2015</td>
<td>Medical University of South Carolina, Medicine, Division of Endocrinology</td>
<td>Instructor</td>
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PROFESSIONAL EXPERIENCE
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<tr>
<th>Year</th>
<th>Title/Position</th>
<th>Institution/Organization</th>
<th>Comments</th>
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<tr>
<td>2015 - Present</td>
<td>Assistant Professor</td>
<td>Medical University of South Carolina, Charleston, SC</td>
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<tr>
<td>2012 - 2014</td>
<td>Instructor</td>
<td>Medical University of South Carolina, Charleston, SC</td>
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</tr>
<tr>
<td>2004 - 2015</td>
<td>Research Affiliate</td>
<td>Yale University, New Haven, CT</td>
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**PROFESSIONAL SOCIETIES/ASSOCIATIONS - NATIONAL**

<table>
<thead>
<tr>
<th>Year</th>
<th>Society/Association</th>
<th>Role</th>
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<tbody>
<tr>
<td>2011 - Present</td>
<td>National Lipid Association</td>
<td>Member</td>
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<tr>
<td>2009 - Present</td>
<td>American Association of Clinical Endocrinology</td>
<td>Member</td>
</tr>
<tr>
<td>2009 - Present</td>
<td>Endocrine Society</td>
<td>Member</td>
</tr>
<tr>
<td>2009 - Present</td>
<td>American Thyroid Association</td>
<td>Member</td>
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**JOURNAL ARTICLES REVIEWED**

<table>
<thead>
<tr>
<th>Year</th>
<th>Society/Association</th>
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<tbody>
<tr>
<td>2014</td>
<td>Acta Diabetologica</td>
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**CONTRACTS OR GRANTS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Funding Source</th>
<th>Agency Award Number</th>
<th>Amount Funded</th>
<th>PI/Co-PI</th>
<th>% Effort</th>
<th>Grant Title</th>
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<tbody>
<tr>
<td>2012 - 2014</td>
<td>Weight Watchers International</td>
<td>WWI-Diabetes Study</td>
<td>3,166,578</td>
<td>Collaborator</td>
<td>5</td>
<td>Effect of Glycemic Control and Weight of a Widely Available Weight Control Program Tailored for People with Type 2 Diabetes PI: Patrick O'Neill, PhD</td>
</tr>
<tr>
<td>2010 - Present</td>
<td>Novo Nordisk</td>
<td>EXK211-3748</td>
<td>407,575</td>
<td>Co-Investigator</td>
<td></td>
<td>LEADER, Multicenter, International, Double-Blind, Placebo-Controlled Trial to Determine Linagliptide Effects on Cardiovascular Events PI: Katherine Hermayer, MD</td>
</tr>
<tr>
<td>2010 - 2012</td>
<td>Eli Lilly</td>
<td>F3ZUS-10PZ</td>
<td>205,105</td>
<td>Co-Investigator</td>
<td></td>
<td>Randomized Clinical Trial Of Subcutaneous Analog Basal Bolus Therapy vs Sliding Scale Human Regular Insulin in the Hospital Management Of Hyperglycemia In Non-Critically Ill Patients without Known History of Diabetes PI: Katherine Hermayer , MD</td>
</tr>
<tr>
<td>2010 - 2011</td>
<td>Novo Nordisk</td>
<td>NN1250-3582</td>
<td>138,294</td>
<td>Co-Investigator</td>
<td></td>
<td>An Extension trial to NN1250-3582 comparing safety and efficacy of NN 1250 and insulin glargine, both with insulin aspart as meal-time insulin +OADs in type 2 diabetes. PI: Katherine Hermayer, MD</td>
</tr>
<tr>
<td>2009 - 2013</td>
<td>Sanofi-Aventis</td>
<td></td>
<td>179,116</td>
<td>Co-Investigator</td>
<td></td>
<td>Basal Bolus vs Basal Insulin Regimen For The Treatment of Hospitalized Patients with Type 2 Diabetes Mellitus: A randomized, open labeled, non-inferiority controlled study PI: Katherine Hermayer, MD</td>
</tr>
<tr>
<td>2009 - 2013</td>
<td>GSC</td>
<td>LPL100601</td>
<td>354,765</td>
<td>Co-Investigator</td>
<td></td>
<td>The stabilization of Atherosclerotic Plaque by Initiation of Darnpladiub Therapy. A clinical Outcomes Study of Darnpladiub vs Placebo in Subjects with Chronic Coronary Heart Disease to Compare the Incidence of Major Adverse Cardiovascular Events (MACE) PI: Maria Lopez-Virella, MD, PhD</td>
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**HONORS AND AWARDS**

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<tr>
<th>Year</th>
<th>Description</th>
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<tbody>
<tr>
<td>2013</td>
<td>Nominated &quot;Teacher of the Month&quot;, August 2013, Medical University of South Carolina</td>
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<tr>
<td>2012</td>
<td>Nominated &quot;Department of Medicine Excellence in Teaching Award&quot;, 2012, Medical University of South Carolina</td>
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<tr>
<td>2009</td>
<td>St. Louis de Marillac Award for Outstanding Service in exemplifying the philosophy, mission and values of St Vincent’s Medical Center, Bridgeport, Connecticut</td>
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<td>2008 - 2009</td>
<td>Humanitarian Award for Outstanding Community Service - St Vincent’s Medical Center, Bridgeport, Connecticut</td>
</tr>
<tr>
<td>2008 - 2009</td>
<td>Outstanding Ambulatory Senior Resident - St Vincent’s Medical Center, Bridgeport, Connecticut</td>
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<td>2008</td>
<td>St. Vincent’s Medical Center Science Symposium 1st place Award for oral presentation &quot;Effectiveness of screening or therapy for osteoporosis for women aged 65 years and older at St.Vincent’s Medical Center Family Health Center&quot;, Bridgeport, Connecticut</td>
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2006 - 2007  "Outstanding Intern of the Year", Saint Vincent's Medical Center, Bridgeport, Connecticut
1991 - 1997  National Scholarships for Meritorious Students, Romania

HOSPITAL COMMITTEES

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<tr>
<th>Year</th>
<th>Name of Committee</th>
<th>Role</th>
<th>Institution</th>
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<tr>
<td>2014 - Present</td>
<td>Multidisciplinary Graves Eye Disease Clinic</td>
<td>Member</td>
<td>Medical University of South Carolina</td>
</tr>
<tr>
<td>2013 - Present</td>
<td>Endocrinology Superuser for EPIC. Developed spreadsheet for inpatient endocrine consultations.</td>
<td>Member</td>
<td>Medical University of South Carolina</td>
</tr>
<tr>
<td>2012 - Present</td>
<td>Gatekeeper for Endocrine Referrals</td>
<td>Member</td>
<td>Medical University of South Carolina Endocrine Clinic</td>
</tr>
<tr>
<td>2012 - Present</td>
<td>Multidisciplinary Osteoporosis Clinic</td>
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UNIVERSITY COMMITTEES

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<tr>
<td>2014 - Present</td>
<td>Endocrinology Fellowship Program Evaluation Committee (PESC)</td>
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<td>2013 - Present</td>
<td>Endocrinology Fellowship Selection Committee</td>
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TEACHING EXPERIENCE/CURRICULUM DEVELOPMENT

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<tr>
<td>2014 - Present</td>
<td>Endocrinology Board Review Series - weekly session teaching endocrinology fellows, Medical University of South Carolina</td>
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<tr>
<td>2012 - Present</td>
<td>Teaching Endocrinology Fellows - Mentor for Endocrinology Rotation in Rutledge Tower Endocrinology Clinic/Attending for inpatient consult service, Medical University of South Carolina</td>
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<td>Teaching topics on diabetes, thyroid and adrenal disorders, a group of 3rd year Medical Students, during their &quot;Professor Rounds&quot; course, Medical University of South Carolina</td>
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<td>2012</td>
<td>Endocrine Lecture series for Internal medicine interns and residents, Medical University of South Carolina</td>
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<tr>
<td>2012 - Present</td>
<td>Teaching and supervision of Internal Medicine Interns, Residents and Fellows in Diabetes/Endocrinology- in inpatient consult service and outpatient clinic, Medical University of South Carolina</td>
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<td>2012 - Present</td>
<td>Teaching 3rd and 4th year Medical Students - Mentor for Diabetes and Endocrinology Rotation in Rutledge Tower Endocrinology Clinic/Attending for inpatient consult service, Medical University of South Carolina</td>
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<td>2010 - 2011</td>
<td>Precepting a group of 1st year Medical Students during their &quot;Fundamentals of Patient Care&quot; course, Medical University of South Carolina</td>
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TEACHING INTERESTS

- Thyroid pathology
- Lipid metabolism
- Obesity and its metabolic complications
- Bone disorders
- Diabetes mellitus

INVITED PRESENTATIONS

1. Adrenal Emergencies, MUSC Internal Medicine Noon Conference, September 2017
3. Medical Comorbidities in Obesity. 2017 Obesity Symposium, Medical University of South Carolina, Charleston, SC
5. Post-transplant complications - approach and management of solid endocrine and metabolic. The 2nd Annual Transplant Nephrology Symposium for Nephrologists, Primary Care and Other Health Care Professionals. October 1, 2016
8. Medical Comorbidities in Obesity. 2016 Obesity Symposium, Medical University of South Carolina, Charleston, SC
11. Adrenal Insufficiency. Endocrinology Grand Rounds, Medical University of South Carolina. August 2015.
12. Medical Comorbidities in Obesity. 2015 Obesity Symposium, Medical University of South Carolina, Charleston, SC
15. Obesity - Medical Comorbidities. Obesity Symposium Medical Students, Medical University of South Carolina, Charleston, SC. May 1, 2014.
16. Severe Insulin Resistance in Clinical Practice. Internal Medicine Grand Rounds, Medical University of South Carolina, Charleston, SC. May 6, 2014.
Based Medicine, Medical University of South Carolina, Charleston, SC. May 28, 2014.
24. Endocrinopathies and Effects on Glucose Metabolism (Panel presentation). Department of Medicine, Fifth Annual Diabetes Symposium, St. Vincent’s Medical Center, Bridgeport, CT. January 2008.
25. Effectiveness of Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older. Local Chapter of ACP Annual Meeting, Department of Medicine, St. Vincent’s Medical Center, Bridgeport, CT. January 2008.

POSTER PRESENTATIONS


PEER-REVIEWED PUBLICATIONS


FACTOR DEVELOPMENT

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<td>&quot;Developing a Career In Medical Education &quot;, Dr. D. McNell, Endocrine Society Annual Meeting 2014, Chicago, IL</td>
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<tr>
<td>2014</td>
<td>Endocrine Society Annual Meetings, Chicago, IL</td>
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<td>2014</td>
<td>&quot; Tales from the Promotion and Tenure Committee: An Insider's View and In Depth Analysis and What It Takes to Get Promoted&quot; Dr. G. Silvestri, MUSC</td>
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2013  Endocrine Society Annual Meetings, San Francisco, CA

COMMUNITY SERVICE

- Yale New Haven Hospital - Elder Horizons Program 2000 - 2003
Request for Change in Resident/Fellow Program Complement

☐ TEMPORARY  ☐ PERMANENT

Program Name: Psychiatry
Program Director: Edward Kantor
Program Coordinator: Liz Puca
Department Chair: Tom Uhde, MD
Specialty Program Director (if applicable): N /

# of positions requested: 2

FROM: 60 (# current complement) TO 62 (# requested complement):

Requested Effective Date: July 1, 2018
Effective End Date (if temporary): Dec 30, 2019

[Signature]

Program Director Signature/Date: Speciality Program Director Signature/Date:

[Signature] 10/11/2017

Program Director Signature/Date: Specialty Program Director Signature/Date:

Department Chair Signature/Date:

[Signature] 10/13/17

Requests to change a program’s resident/fellow complement need review and approval by:
1) Strategic Manpower Committee (only if hospital is to provide funding)
2) MUSC GMEC
3) ACGME/RRC

Requests to specific ACGME/RRC’s must not be made until after approval by the MUSC GMEC. Requests should be made in the WebADS system no longer than six months following GMEC approval. No resident or fellow should be hired or promised a position until there has been approval by each group noted above.

Please address all the questions/requirements on the next page in your request. Send completed requests to E. Benjamin Clyburn, MD (c/o GME Office, room 202 MUH, MSC 333) at least two weeks prior to the GMEC meeting date where you would like this item considered.

FOR GME OFFICE USE ONLY:

Date Received:
Approved by the GMEC:
Date approved in WEBADS:

Form approved by GMEC: 4/2011; 1/2014
Page 1 of 3
Request for Change in Resident/Fellow Program Complement
Rationale, Impact and Financing for Complement Change

Please answer the following questions.

1. How will additional positions be financed?
   - Please provide documentation.
     a. If the department will be funding the position(s), please submit a letter from the Chair indicating willingness to fully fund the position(s).
     b. If MUHA support is being requested, please complete the appropriate documentation to be submitted to and reviewed by the GME Strategic Manpower Committee

http://academicdepartments.musc.edu/gme/director_coordinator/internal/gme-strategic-manpower.html

The RJVMC has expanded funding support of psychiatry resident trainees consistently over the last 8 years from an initial 11 positions in 2008 to 18 positions currently (including 6 VACAA funded spots) The positions increase to a total of 19/60 (this is an increase from 18% to 31%) for AY 2018-19 with a recently approved new VACAA position. This, along with the grant renewal for our research training program (DART) in addictions, will provide additional and potentially alternative financial support. Additional MUHA service expansions will necessitate additional position funding from the medical center in the future.

1. Reason(s) for request to change the number of trainees in program:

This temporary increase is part of a longer term goal to balance trainees across our affiliate sites as funding for resident salaries and time demands shift disproportionately amongst affiliates. This specific temporary increase allows us to accommodate an additional off-cycle PG2 transfer resident (under in 2017-18) assuring we remain under cap into the next two years. It also helps to ensure adequate resident rotation time at MUSC as our funding on the VA side grows. Based on trainee estimations, we will potentially go over cap by .5 to 1.5 positions over the next two Academic Years. We are in the planning stages of a plan for a permanent increase in cap over the next 5 years. Although the funding exists for the expansion, the back-fill of resident time at MUSC is critical to both the institution and the program.

Adding additional residents to our core rotations will allow us to balance the number of trainees per service effectively to ensure an appropriate blend of experience- both required and desired. Recently we have struggled to maintain our older and more desirable model of pairing PG1 and II residents together on teams. This helps us implement an improvement plan which maintains flexibility of the training environment with a safe and credible learning environment. It also assists us in providing for resident well-being, placing educational goals and personal wellness in a priority position.

General psychiatry residents are allowed to transfer to child psychiatry (fast track), changing what was initially a 4 year categorical position to 3 years. This move often clarifies late in training, leaving us with an overall lower # of total residents. We have always been flexible with our own residents seeking to fast track to child/adolescent psychiatry. The base is further complicated as our combined training programs (Med/Psych and Psych/Neuro) have been successfully filling all positions in the match over the last few years (whose spots come from the core accredited programs) which though great educationally, moves trainees away from psychiatry related activities. The programs intermediate and long term planning goals are to
ensure an adequate # of accredited positions for the total complement of residents across the spectrum of 3 year (Fast track to child), 4 year (standard general), 5 year (Med/Psych) and 6 year (Psych/Neuro) training options, each with varied training needs and time allocation across specialties.

Our goal is to maintain a strong educationally centered CLE on rotations, and be able to continue to support resident wellness in the early years of training encouraging early exploration of emerging field-relevant activities.

2. What will be the impact of the change on the educational program? Please include both the positive and negative effects on the educational program in comparison to the current program size.

It will dramatically improve the clinical learning environment on our core required clinical rotations. Our mental health systems and research have expanded exponentially, creating incredible new opportunities in areas such as telehealth, primary care integration, public psychiatry, new outpatient psychotherapy exposure in evidence-based cognitive therapy variants, just to name a few. One of our own internal groups, the National Crime Victims Research and Treatment Center was just awarded an 18 million dollar grant and will be expanding their clinical operations over the next few years. I want to ensure we have the ability to take advantage of this and many other unique and highly desirable training environments.

At the same time, most core clinical rotations have increased service capacity. Though increasing learning opportunities, it has at times intruded into the flexibility of the clinical learning environment, stretching our ability to maintain reasonable clinical loads for trainees on several core services. We have thus far been able to balance and adjust teams to mitigate the effects but need additional tools as things continue to grow and change quickly.

Currently, we have many more general and specialty training opportunities than we can effectively assign residents to and still maintain the mentored support and learning environment we desire. Increasing the complement will allow us to take advantage of the growing relevant new opportunities, AND support and maintain the educational value of required rotations. As you know our program interfaces with two other departments—Internal Medicine and Neurology through the combined programs. In our case up to 8 of our 60 accredited positions may be allocated to combined training spots (along with 5 from Internal medicine and 3 from Neurology totaling 16). This leaves a net of 48–52 actual general psychiatry residents. By housing the combined program, these 16 trainees rotate on and off the core services adding additional variation and complexity to scheduling and rotation planning. This is more than made up by the enriched collaboration and expanded exposure across the other fields and the support to other clinical areas of the hospital. Because the programs are not individually accredited, and internally the positions are often noted as belonging to separate programs, it may appear that we are not using all of our current accredited spots, when in fact we are.

As described above in # 1, Psychiatry is fairly unique amongst the core specialties in that residents can elect to leave the general program after 3 years to begin child and adolescent psychiatry training (anywhere), adding additional variability to our PG4 year and our total complement, making the actual numbers quite variable from year to year. This along with our longitudinal outpatient training guidelines essentially eliminates planning for senior residents in block scheduling onto inpatient services in year 4.
3. What are the anticipated effects of your proposed program changes on other training programs at MUSC?

If anything, it would increase our **ability to expand into highly desirable collaborative care rotations and clinical services** - such as our HIV collaborative care clinic working with infectious diseases and our behavioral medicine clinic which supports many specialty departments such as GI and transplant. These are amazing opportunities that we are unable to access as effectively and consistently due to the core rotation spread and increased workloads. In the last 5 years we added a new resident rotation in Emergency Psychiatry (0-1), and expanded our trainees on our consult-liaison service (1-3) in the hospital at MUSC. Even so, the workload is catching up on trainee work-load balance. All of these interface directly on a day to day basis with other residents and clinical areas across the health system. Our on-call and Night float burden for trainees has increased significantly (~40% over five years). Our night float rotation case load specifically has grown dramatically in the last 2 years all in spite of program modifications aimed at balancing resident educational goals. The typical overnight new emergency consult requests have grown from 5-10 per resident to as high as 14-16, without additional hospital resources to offset the changes. These are intensive, high complexity patients in crisis often with comorbid medical and addiction problems and no psychosocial supports that require time and collaborative treatment. We need to provide the adequate time, supervision and support in order to maintain patient safety, trainee wellness and maintain a reasonable clinical learning environment. We continue to work with department and hospital leadership on protocols and alternative supplemental staffing, but the patient #s and complexity keeps increasing and it affects the trainees on the front lines significantly regardless.

4. How will the change affect the number of cases seen by the trainee?

**Highly positive.** Our case load in every area of operations is way above that of a typical psychiatry residency program, and at the present time I am exploring capping the number of cases residents are involved in as the clinical opportunities continue to grow, since the system continues to expect more clinically. Though our field does not specify an inpatient cap, we exceed the recommended guidelines by 50% at times.

It will actually expand the breadth of relevant field changing opportunities for more senior residents -like collaborative care, consult-liaison to other specialty medical services and stabilize the work-learning balance on our inpatient services and Night float rotation, which has at times become extreme.

Our ability to schedule effectively to ensure trainee wellness will improve dramatically with the additional trainees. There will also be benefits for many of our higher volume clinical services. More importantly, it is predicted to free up faculty time on these rotations, allowing them to again become more involved in teaching and mentoring, which improves the clinical learning environment.

5. If your RRC or American Board have requirements for a certain number of rotations, clinical experience, number of producers, cases, etc., will there be adequate experiences to meet RRC and Board requirements?

**Yes, without a doubt.** It will actually improve our ability to manage the experiential requirements consistently and more effectively from a resident training and patient safety perspective.
6. Assuming approval, what will the program look like for each year of training?
   • What will be added, deleted or moved?
   • Include a Block diagram by PGY year, for a model resident/fellow.

The **block diagrams and required rotations will not change much**, because of the added positions. It will allow us to improve resident experiences in basic program operations such as consistently allowing paired residents (PG 1 and 2 or 3 together) on large and busy inpatient, consult and ED psych teams, facilitate required vacation scheduling and time-off and ensure access to selective and elective opportunities in our many subspecialty areas. We expect to be able to take better advantage of new highly valued training tracks such as interventional psychiatry, addiction subspecialty, treatment, student mental health, women’s mental health, integrated care, telehealth and child/adolescent psychiatry to name a few. All of these areas align well with MUSC's strategic planning goals, and enhance our ability to integrate our educational strengths into clinical operations amongst other ICCE specialty areas. Collaborative and integrated-care are important field goals and appear highly relevant to other disciplines as well. It will also allow more flexibility in ensuring meaningful scholarly activity participation amongst the residents.

7. **Will there be additional or new training sites needed to accommodate the change in trainee complement?** If so:

   **No**, we currently have many more opportunities than residents across all of our sites. In fact due to external funding increases, we are having difficulty supporting MUSC core service goals as resident time follows funding.

8. **Is there adequate space and resources (offices, desks, computers, labs, etc...) to accommodate the change?** Please provide a summary of necessary resources.

   **Yes.** Much of the needed space exists in clinical sites that we already utilize and training often occurs longitudinally on a part-time basis. In addition, we utilize strong affiliates and have the opportunity to expand to additional rotations and sites, but are unable to access those resources and teaching/clinical opportunities due to resident numbers.

   We may need several additional laptops, or computing stations on inpatient units at IOP, in our resident education center, and potentially locker space or other low cost modifications. We may require adequate training director and coordinator time to manage the administration as the program expands which can be managed internally. Adding this # of residents does not change the required dollar support for program administration in the funds flow model.
Request for Change in Resident/Fellow Program Complement

☐ TEMPORARY X PERMANENT

Program Name: Neonatal-Perinatal Medicine

Program Director: David Annibale MD

Program Coordinator: Anita Thommes

Department Chair: Andy Atz MD

Specialty Program Director (if applicable):

# of positions requested: 1

FROM: 6 total per three year period (# current complement) TO 7 total
(# requested complement):

Requested Effective Date: 7/1/18

Effective End Date (if temporary):

10/24/17

Program Director Signature/Date: ____________________________

10/25/17

Department Chair Signature/Date: ____________________________

Specialty Program Director Signature/Date:
(if applicable)

Requests to change a program’s resident/fellow complement need review and approval by:
1) Strategic Manpower Committee (only if hospital is to provide funding)
2) MUSC GMEC
3) ACGME/RRC

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Please address all the questions/requirements on the next page in your request. Send completed requests to E. Benjamin Clyburn, MD (c/o GME Office, room 202 MUH, MSC 333) at least two weeks prior to the GMEC meeting date where you would like this item considered.

FOR GME OFFICE USE ONLY:

Date Received: ________________________________

Approved by the GMEC: ________________________________

Date approved in WEBADS: ________________________________

Form approved by GMEC: 4/2011; 1/2014

Page 1 of 3
Request for Change in Resident/Fellow Program Complement

Rationale, Impact and Financing for Complement Change

Please answer the following questions.

1. How will additional positions be financed?
   • Please provide documentation.
     a. If the department will be funding the position(s), please submit a letter from the Chair indicating willingness to fully fund the position(s).
     b. If MUHA support is being requested, please complete the appropriate documentation to be submitted to and reviewed by the GME Strategic Manpower Committee
        http://academicdepartments.musc.edu/gme/director_coordinator/internal/gme-strategic-manpower.html

1. Reason(s) for request to change the number of trainees in program:
The division is poised to increase clinical, QI, and scholarly options for fellow participation and education. Opportunities stem from expansion of scholarly and QI interests, expansion of the department, and recruitment of new faculty in neonatology. are listed below.
   a. Expanded research and scholarly opportunities with continued success and expansion of divisional research base. Research opportunities in developmental pulmonology have increased. Opportunities for collaboration with revitalized divisions of pediatric nephrology, pediatric pulmonology, and others have increased as the department has expanded.
   b. The division has added a faculty member interested in simulation and QI to supplement personnel already involved in scholarly work in those areas.
   c. The division has been involved in disparities research and interventions through translational research and state-wide QI initiatives. We are formalizing these efforts into a coordinated scholarly approach to disparities in perinatal care. This provides an additional internal option for fellow participation in research and QI.
   d. Expanding training opportunities with expansion of clinical services at SJCH
   e. To avoid suboptimal pattern of recruitment for 1 fellow every three year (current complement is 6: 1 third year, 2 second years and 3 first year fellows). Current pattern resulted from temporary increase to 7 fellows three years ago, resulting in recruitment of one fellow to return to complement of 6.

2. What will be the impact of the change on the educational program? Please include both the positive and negative effects on the educational program in comparison to the current program size.
The change will remove a suboptimal pattern of recruitment as described above. The entry of more than one fellow into training, especially from outside MUSC, will foster collegiality and the continued atmosphere of collaboration. Our program is proud of the work fellows do together – research projects with mutually beneficial collaboration through collaboration on QI initiatives to joint management to the presentation of educational conferences as small teams of educators. The only negative aspect of
expansion is the current space limitation in MUSC Children’s. We are hopeful and optimistic that that limitation will change with the opening of SJCH.

3. What are the anticipated effects of your proposed program changes on other training programs at MUSC?
There should be no impact on other programs. Indeed, we are unaware of any negative impact when, in recent years, we temporarily increased our complement of fellows to 7. Improved coverage at night and on weekends might be considered a positive impact. Fellow call schedules are based on the rotation the fellow is on during daytime hours. This pattern was developed to improve continuity of care while complying with ACGME duty hour regulations for fellows. As a result, there are uncovered nights. Increasing to 7 fellows will reduce (though not eliminate) such nights.

4. How will the change affect the number of cases seen by the trainee?
There should be no effect of a complement increase on the number of cases seen by individual fellows. Clinical schedules will not change (we have uncovered fellow months currently). Call schedules and number of rotations will not change.

5. If your RRC or American Board have requirements for a certain number of rotations, clinical experience, number of producers, cases, etc., will there be adequate experiences to meet RRC and Board requirements?
Our RRC requires 12 clinical months of service and a total of 33 months (excluding vacation/person or medical leave). We will easily comply with these requirements with the complement increase. Currently, fellows do 13 clinical months. Scholarly productivity is excellent.

6. Assuming approval, what will the program look like for each year of training?
- What will be added, deleted or moved? No changes are anticipated
- Include a Block diagram by PGY year, for a model resident/fellow.

7. Will there be additional or new training sites needed to accommodate the change in trainee complement? NO
If so:
- List the additional site(s).
- You will be required to provide completed Affiliation Agreement(s) before the start of the training.

8. Is there adequate space and resources (offices, desks, computers, labs, etc...) to accommodate the change? Please provide a summary of necessary resources. Yes. We had 7 fellows in the recent past. Although we will need to rearrange workspaces in the Division's office space, that will not be overly disruptive.
October 23, 2017

To Whom It May Concern:

The Department of Pediatrics has submitted a request for additional support of several GME trainee positions to the Strategic Planning Committee. This request included one position for fellowship training in Neonatal-Perinatal Medicine. Such a change would increase the total compliment of fellows in that 3-years training program from six to seven.

While we hope for approval from the committee, in the event the request is not approved, the Department will commit to funding of the additional Neonatal-Perinatal Medicine fellowship position.

Sincerely,

Andrew M. Atz, MD
Professor and Chairman
Department of Pediatrics
### Block Diagram 1: Year 1

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All years, all blocks: % outpatient refers to one day of high risk follow-up clinic per month except during NICU and Delivery Room rotations and vacation. Vacation may be taken during any research block (3 weeks). Electives include PICU (2 weeks required, 4 weeks max), Maternal Fetal Medicine (2 weeks required, 4 weeks max), Level II nursery, radiology, and genetics. Others may be developed on request if c/w program and trainee goals.
From: whart@acgme.org
Sent: Monday, October 23, 2017 12:52 PM
To: Pastis, Nicholas J.
Cc: Hay, Cameron; Ybarra, Angela; Ronayne, Ann; Clyburn, Ernest Benjamin;
whart@acgme.org
Subject: ACGME Temporary Complement Request Decision (Program [1564521067])

CAUTION: External

ACGME Temporary Complement Request Decision (Program [1564521067])

A Temporary complement change request has been approved for your program.

The Review Committee has included the following comments:
Thank you for the background information. The Committee supports this temporary increase to accommodate the two-fellows-at-the-VA experiment, and looks forward to reviewing the permanent increase request if your plan succeeds.
10/11/2017

Chadrick Denlinger, MD
Associate Professor, Program Director
Medical University of South Carolina
114 Doughty Street, Suite 283
MSC 295
Charleston, SC 29425

Dear Dr. Denlinger,

The Review Committee for Thoracic Surgery, functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education (ACGME), has reviewed the information submitted regarding the following program:

Thoracic surgery - Integrated
Medical University of South Carolina Program
Medical University of South Carolina College of Medicine
Charleston, SC

Program 4614521087

OTHER COMMENTS

The Executive Committee of the Thoracic Surgery Review Committee acknowledges the program's request, dated September 19, 2017, for review and consideration of the qualifications of Dr. Barry Gibney and Dr. Sanford Ziegler.

Upon review, the Executive Committee determined the qualifications of Dr. Gibney and Dr. Ziegler to be acceptable as supervising faculty in the program. The Committee has noted that Dr. Gibney and Dr. Ziegler are American Board of Thoracic Surgery eligible with the expectation for to be Board certified by June 2018.

This office must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by name and number as indicated above. Changes in participating sites and changes in leadership must be reported to the Review Committee using the ACGME Accreditation Data System.
10/10/2017

Ashlyn H Savage, MD, MSc
Associate Professor
Medical University of South Carolina
96 Jonathan Lucas St
Suite 634, PO Box 250619
Charleston, SC 29425

Dear Dr. Savage,

The Review Committee for Obstetrics and Gynecology, functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education (ACGME), has reviewed the information submitted regarding the following program:

Obstetrics and gynecology

Medical University of South Carolina Program
Medical University of South Carolina College of Medicine
Charleston, SC

Program 2204521270

OTHER COMMENTS

Based on the information provided in support of the request, the program has been granted approval to remove Trident Medical Center as a participating institution at the Medical University of South Carolina

This office must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by name and number as indicated above. Changes in participating sites and changes in leadership must be reported to the Review Committee using the ACGME Accreditation Data System.
<table>
<thead>
<tr>
<th>Program Name: Pediatric Hematology/Oncology</th>
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### Overall Attrition
- PD Change
- Faculty Attrition
- Resident Attrition
- Permanent Complement Changes

### Resident Survey
- Duty Hours
- Faculty
- Educational Content
- Evaluation
- Resources
- Patient Safety/Teamwork
- Overall Negative Opinion

### Faculty Survey
- Supervision & Teaching
- Educational Content
- Resources
- Patient Safety
- Teamwork

### Data Omission
- Failure to complete WEBADS annual update (on time)
- Failure to turn in APE materials

### Scholarly Activity
- Faculty
- Resident

### Omission
- Subspecialties

### MISC Indicators

### Action Plan

### QI/Patient Safety

### GME Stewardship

| N/A | 100% completed | 100% completed | N/A | N/A | N/A

Page 1 of 2
**Program Name:** Pediatric Hematology/Oncology

**Major Issue is board pass rates** - but good action plan to address this problem

**APE:**
- Board pass rate is below national average (5 year average)
- Program weakness on both fac and fellow survey: exposure to heme, board pass rates
- Addressing wellness
- Fellows presenting at nat’l conferences

**WEBADS**
- There are showers at MUSC
- Dr. Jarosak’s licensure is out of date
- You have one faculty member with no scholarly activity at all. Not even teaching a course?
- Resident scholarly activity is fine
- There is much more you could write for Q22 - the last question in WEBADS. Why don’t you incorporate many of the activities you describe in the APE form?

**Action plans**
- Appropriate to evaluation and survey concerns. evaluating outcome with redcap survey-goals?

**Surveys:**
- Lots of dips this year in many areas...issues addressed in AP
- Overall satisfaction with the program is down
- Faculty survey is fairly steady

**Concerns that fellows are used as residents as resident responsibilities decrease**

The committee recommends that the PD sit down with the DIO to discuss extra coverage for your patients. Maybe include the Peds PD in those talks
Program Name: Pediatric Emergency Medicine

Impressive Board Scores and Take Rate!
Both faculty and fellows mention lack of faculty at conferences - while this was in a previous action plan, it is not mentioned in the AP for this year. It should be incorporated

Faculty listing seems to be missing updated recertification years for Pediatrics. Don't they take them every 10 years?
What about for Peds EM?
Form listing specific pediatric faculty seems overly inclusive. For example: Do we have 12 pediatric urologists?

Excellent bounce back on ACGME resident survey in faculty, but watch the downward trend in educational content over the last two years

Action Plan is good, but it will be hard to determine fellow wellness
An absolute metric is needed for improving fellow satisfaction with electives - how will you measure this? How has it been measured before?
Program Name: Pediatrics

<table>
<thead>
<tr>
<th>Attraction</th>
<th>Scholarly Activity</th>
<th>Board Pass Rate</th>
<th>Resident Survey</th>
<th>Faculty Survey</th>
<th>Omission</th>
<th>Subspecialties</th>
<th>MISC Indicators</th>
<th>Action Plan</th>
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### Overall Attrition
- PD Change
- Faculty Attrition
- Resident Attrition
- Permanent Complement Changes

### Resident Survey
100% completed
- Duty Hours
- Faculty
- Educational Content [Highlighted]
- Evaluation
- Resources
- Patient Safety/Teamwork

### Faculty Survey
100% completed
- Supervision & Teaching
- Educational Content
- Resources
- Patient Safety
- Teamwork

### Data Omission
- Failure to complete WEBADS annual update (on time)
- Failure to turn in APE materials

### Scholarly Activity
- Faculty
- Resident

### Number of subspecialties with 3 or more indicators flagged
- TBD

### Involvement in QI/Pt Saf Projects
- TBD

### GME Stewardship
Program Name: Pediatrics

Action plan has not yet been presented to faculty.

I resident currently on remediation

Good Health disparities involvement of residents

167 PSII! Excellent reporting. No doubt because of the influence of Dr. Mack being in Pediatrics.

Evaluations are mentioned as a weakness. It may be too soon to see the effects from innovative PRIME-Plus for end is the service obligation too much?

You have a good handoff policy and we are concerned that the resident survey scored low on information lost during shift change or patient transfer.

US News rank it 9 out of > 50 programs in South

Excellent board pass rate 98% vs national norms

Would recommend creating a faculty development position in the department (or could be the program director) to ensure all faculty has access to faculty development materials and takes advantage.

Annual resident non ACGME review: areas of improvement. Service vs education with noon conferences, desire for formal resident wellness program, need for improved Resident and Faculty evaluations, too much computer interfacing vs direct patient care (This is a problem for ALL specialties).

Faculty non ACGME: Imbalance of inpatient vs outpatient care and emphasis on RVU generations effect on teaching.

Webads

Dr. Basco should have recertified again. Drs. Annibale, Atz recert certificate should have lapsed. Have they retaken the test or are they participating in MOC?

Emily Brennan has too many participation in local regional etc.-limit is 10

The program MUST get faculty to return evaluations in a timely manner. Less than 60% returning evals within two weeks is unacceptable

It will be interesting to see if this is attained to go to 80% as mentioned in the action plan

Resident survey

Low satisfied with feedback after assignments, program uses evaluations to improve

Also low in Transition care when fatigued, Education compromised by service

Faculty ACGME survey was stellar

Action Plan

Information is lost at handoffs – hopefully I pass will improve satisfaction

Feedback addressed with PRIME PLUS

  Action plan deals well with all of the areas of concern, will be very interesting how you implement the academic half day

  Very strong program overall with good scholarly activity for faculty and residents

Are you not doing any innovative work in Telehealth and Global Health that can be recognized?
Excellent boards pass and take rate
Strong faculty scholarly activity. Fellows SA is strong; not sure why participated in research is “no” for all when 2 of 3 have pub med publications.
Need to have a process in place to deal with fellow complaints about professionalism/mistreatment. (Question is not answered)
Excellent improvement in faculty survey response for ACGME survey
Charleston Pathology has sleeping rooms, a cafeteria and showers for the residents? Just checking to be sure
VAMC has all those things - should be checked
Trident Dermatology needs a secure area for residents
Remove Dr. Maize from faculty listing, as he only devotes 3 hours per week to the program (or boost him to 10 hours per week)
Bulleted items in Dr. Metcalf's CV should be fixed

New initiatives:
daily conferences with faculty and fellows
active role in teaching derm residents
Why are these not included in the action plan with measurable outcomes?
Current action plan item needs specific outcome number. Increase volume to what?

Why are only 2 spots currently filled? Approved for 3, and you indicate you have 3 enrolled, but the ACGME listing only shows 2

No surveys to review.
Request for Change in Resident/Fellow Program Complement

☐ TEMPORARY     ☒ PERMANENT

Program Name: Adult Neurology

Program Director: Nicholas Milano

Program Coordinator: Olivia Burch

Department Chair: Bruce Ovbiagele

Specialty Program Director (if applicable):

# of positions requested: 8

FROM: 24 (# current complement) TO 32 (# requested complement):

Requested Effective Date: 7/1/2018

Effective End Date (if temporary):

10/31/17

Program Director Signature/Date: ____________________________

11/1/17

Department Chair Signature/Date:

Specialty Program Director Signature/Date: ____________________________

Requests to change a program's resident/fellow complement need review and approval by:

1) Strategic Manpower Committee (only if hospital is to provide funding)
2) MUSC GMBC
3) ACGME/RRC

Requests to specific ACGME/RRC's must not be made until after approval by the MUSC GMBC. Requests should be made in the WebADS system no longer than six months following GMBC approval. No resident or fellow should be hired or promised a position until there has been approval by each group noted above.

Please address all the questions/requirements on the next page in your request. Send completed requests to Dr. Benjamin Clyburn, MD (c/o GME Office, room 202 MUH, MSC 333) at least two weeks prior to the GMBC meeting date where you would like this item considered.

FOR GME OFFICE USE ONLY:

Date Received: 11/1/17

Approved by the GMBC: ____________________________

Date approved in WEBADS: ____________________________
Request for Change in Resident/Fellow Program Complement
Rationale, Impact and Financing for Complement Change

Please answer the following questions.

1. How will additional positions be financed?
   - Please provide documentation.
     a. If the department will be funding the position(s), please submit a letter from the Chair indicating willingness to fully fund the position(s).
     b. If MUHA support is being requested, please complete the appropriate documentation to be submitted to and reviewed by the GME Strategic Manpower Committee
        http://academicdepartments.musc.edu/gme/director_coordinator/internal/gme-strategic-manpower.html

We have approval from the GME Strategic Manpower Committee for MUHA funding for 7 positions. The 8th position is funded by the VA Medical Center which we received approval for in June 2016.

1. Reason(s) for request to change the number of trainees in program:

   Neurology Today¹ and The Post and Courier² have recently reported on a study by Rao et al.³ which predicts that by 2025, South Carolina will have one of the 5 most severe shortages of neurologists in the United States, terming it a “Neurology Desert”. A previous study in 2012 by Dall et al.⁴ found that demand for Neurology services in South Carolina exceeded the supply by 120%.

   To meet this demand, over the last 4 years the Department of Neurology has added 15 faculty physicians with subspecialty Neurology expertise. This has created an increase in the number of educational experiences available to our residents. Unfortunately, during this same time period, our inpatient Neurology services have continued to expand. This has created a strain on our residency program worsening the balance between education and service, and ultimately leading to an ACGME site visit and citations. This can be illustrated by the ACGME resident survey. For the survey taken in January 2016, when asked if education was not compromised by service obligations, our program was only 15% compliant (National: 69%). We were able to raise our compliance to 57% in 2017 but this was accomplished through internal schedule adjustments and did not fix the underlying case volume problem. These schedule adjustments also took away from outpatient Neurology opportunities.

   Our inpatient Neurology services can be rich learning environments, but the high caseload can overwhelm the covering residents. With an increase in resident complement we will not only be able to increase the size of our inpatient teams, but also increase the number of outpatient experiences for our residents, taking advantage of our subspecialty outpatient faculty.
2. What will be the impact of the change on the educational program? Please include both the positive and negative effects on the educational program in comparison to the current program size.

We don’t foresee any negative effects to the educational program. Positive effects include increasing the number of outpatient neurology educational opportunities. The majority of practicing neurologists work in outpatient clinics. Thus, rotations in these subspecialties are vital to the resident experience. In addition, we plan to create an academic block for our senior (PGY3 and PGY4) residents. During this block, residents will have a choice between a research track and an education track. Residents on the research track will need to have a mentor and project approved prior to the rotation. Those on the education track will teach in the SIM lab, give medical student lectures, and give a presentation at the end of the block covering a clinical question of their choice.

3. What are the anticipated effects of your proposed program changes on other training programs at MUSC?

The first year of Neurology training requires 8 months of Internal Medicine (including one month of Emergency Medicine) and one month of Psychiatry. Increasing our complement will lead to an additional 2 residents requiring these rotations per year.

We currently have resident rotators from Internal Medicine and Psychiatry on our inpatient services. An increase in our resident complement will not change this. While our teams may be slightly larger, there are enough cases to cover this.

4. How will the change affect the number of cases seen by the trainee?

With an increase in resident complement, we plan to increase the size of our inpatient teams. While this will decrease the number of cases seen by each trainee, due to past caseload growth, our current trainees see more than the ideal number of cases from an educational perspective. An increase in complement will bring the number of cases seen down to the correct level.

All of our residents have their own weekly continuity clinic. An increase in resident complement will not affect this as each new resident will receive their own clinic.

5. If your RRC or American Board have requirements for a certain number of rotations, clinical experience, number of producers, cases, etc., will there be adequate experiences to meet RRC and Board requirements?

The Neurology RRC requires at least 6 months of Adult Clinical Inpatient Neurology and 6 months of Adult Clinical Outpatient Neurology. An increase in complement will not affect this.

6. Assuming approval, what will the program look like for each year of training?
   • What will be added, deleted or moved?
   • Include a Block diagram by PGY year, for a model resident/fellow.

See attached block diagrams. PGY1s are on a month schedule, while PGY2-4s are on a 4 week block schedule.
PG1: There will be no change from the current schedule. Residents complete 8 months of Internal Medicine (including Emergency Medicine), 3 months of Neurology, and a month of Psychiatry.

PGY2: Residents during this year are juniors on the inpatient services. They spend 2 blocks on the General Neurology Service and 2 blocks on Stroke Neurology. The also spend 2 blocks on VA Neurology service (a hybrid inpatient/outpatient rotation). In the first half of the year they are the junior resident at the VA and in the second half, they act as Senior Residents. Additional rotations include the NSICU, Pediatric Neurology Consults, an EEG reading rotation, Nightfloat, and Outpatient electives. The major change for the PGY2 schedule is a decrease in Nightfloat from 9 to 6 weeks, allowing for an increase to 2.5 blocks of outpatient elective time.

PGY3/4: Residents act as the senior resident on the inpatient services: General Neurology and Stroke. This has been decreased from 4 to 3 weeks for each year. With a complement change, PGY3s will spend 4 weeks as the senior resident of the Consult service, while PGY4s will spend 2 weeks. For our Emergency Neurology rotation, PGY3s will spend 2 weeks and PGY4s will spend 4 weeks. Both these rotations will be decreased from the current 4 weeks for each year. PGY3s will continue to spend one block as the senior of the VA Neurology service, but this rotation will be eliminated for PGY4s. There will be no change in the Pediatric Neurology rotations: 1 block for each year. Nightfloat will be decreased from 4 weeks to 3 weeks which along with the above changes allows for additional outpatient time. As mentioned above, a 3 week academic block will be created for both PGY3 and PGY4 residents, during which they may choose a research or education track. During the course of their training, our residents are required to complete at least one block of Behavioral Neurology, Epilepsy, Movement Disorders, Multiple Sclerosis, and Neuromuscular. Two of these selectives must be taken during each of the PGY3 and PGY4 years. This will then leave 4.5 blocks of electives during the PGY3 year, and 5.5 blocks of electives during the PGY4 year. All electives are approved by the program director and guided by the residents' strengths and weaknesses.

7. Will there be additional or new training sites needed to accommodate the change in trainee complement? If so:
   - List the additional site(s).
   - You will be required to provide completed Affiliation Agreement(s) before the start of the training.

   No additional training sites will be added.

8. Is there adequate space and resources (offices, desks, computers, labs, etc...) to accommodate the change? Please provide a summary of necessary resources.

   Yes, we currently have a large resident office on the 4th floor the Clinical Sciences Building. This includes 18 lockers (for PGY2-4 residents) and 10 computers. With an increase in complement, we will need to add 6 lockers and 1-2 computers.

   We have adequate outpatient clinic space to accommodate additional resident continuity clinics. Our department plans to move some of the Neurology Faculty clinics to MUSC's community sites to allow for the needed space.
## MUSC Neurology Proposed Block Diagram

### PGY1

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Notes:
- PGY1’s are on a month schedule, while other classes are on a 4 week block schedule

### PGY2

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Notes:  
- Total of 1.5 blocks (6 weeks of night float)
- During the course of training, all residents must complete at least one block of outpatient Behavioral Neurology, Epilepsy, Movement Disorders, MS, and Neuromuscular
- Outpatient/Elective options: behavioral neurology, movement disorders, epilepsy, neuromuscular, MS/headache, sleep medicine, outpatient stroke, mixed subspecialty clinics, NSICU, EEG, EMG, epilepsy monitoring unit, intraoperative monitoring, neuroradiology, transcranial dopplers, tele-neurology, neuropathology, neuro-otology, neuro-ophthalmology, outpatient pediatric neurology, research.

*Form approved by GMEC: 4/2011; 1/2014*  
*Page 5 of 7*
### PGY3

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Notes: -0.75 blocks of Gen Neuro, Stroke, Nightfloat, Academic. 0.5 blocks of Emergency Neurology.

- During the course of training, all residents must complete at least one block of outpatient Behavioral Neurology, Epilepsy, Movement Disorders, MS and Neuromuscular. Selective blocks must include one of these rotations.

- Outpatient/Elective options: behavioral neurology, movement disorders, epilepsy, neuromuscular, MS/headache, sleep medicine, outpatient stroke, mixed subspecialty clinics, NSICU, EEG, EMG, epilepsy monitoring unit, intraoperative monitoring, neuroradiology, transcranial dopplers, tele-neurology, neuropathology, neuro-otology, neuro-ophthalmology, outpatient pediatric neurology, research.
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<td>Rotation Name</td>
<td>Gen Neuro/Elective</td>
<td>Stroke/Elective</td>
<td>Neuro Consult/Elective</td>
<td>Emerg Neuro</td>
<td>Peds Out-Patient</td>
<td>Night Float/Elective</td>
<td>Academic/Elective</td>
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Notes: -0.75 blocks of Gen Neuro, Stroke, Nightfloat, Academic. 0.5 Blocks of Neuro Consults.

- During the course of training, all residents must complete at least one block of outpatient Behavioral Neurology, Epilepsy, Movement Disorders, MS and Neuromuscular. Selective blocks must include one of these rotations.

- Outpatient/Elective options: behavioral neurology, movement disorders, epilepsy, neuromuscular, MS/headache, sleep medicine, outpatient stroke, mixed subspecialty clinics, NSICU, EEG, EMG, epilepsy monitoring unit, intraoperative monitoring, neuroradiology, transcranial dopplers, tele-neurology, neuropathology, neuro-otology, neuro-ophthalmology, outpatient pediatric neurology, research

References
October 31st, 2017

Nicholas Milano, MD
Director, Neurology Residency

RE: Neurology Resident Complement Increase

Dear Dr. Milano,

The GME Strategic Manpower Committee met Wednesday, October 25th, 2017, to review your request. The following decision was made by the Committee:

- The Committee approves the request for the 7 new positions. The Committee would like the Department and the GME Office to explore partial Telehealth funding given the robust Telehealth Neurology services that MUSC offers. The Committee would also like the Department to monitor the impact that these new positions will have on New Patient Appointment Lag Days.

Please let do not hesitate to contact us with any questions or concerns.

Sincerely,

Daniel A. Handel, MD, MBA, MPH
Chief Medical Officer
MUSC Medical Center

CC: Bruce Ovbiagele, MD
David Chandler
Matt Wain
Ben Clyburn, MD
Gina Ramsey
Sarah Baskin
Lisa Goodlett
Beth Jones
Butler Stoudenmire

"An equal opportunity employer, promoting workplace diversity."
Department of Veterans Affairs

Memorandum

Date: October 7, 2016

From: Deputy Chief Academic Affiliations Officer (10A2D), VA Central Office, Washington, DC

Subj: Veterans Access, Choice, and Accountability Act (VACAA) GME Positions Round Three

To: Director (534/00), Network Director (10N7)

1. Thank you for submitting an application in response to the Request for Proposals (RFP) for the Graduate Medical Education (GME) Enhancement under the Veterans Access, Choice, and Accountability Act (VACAA) of 2014 which ended July 1, 2016.

2. The Office of Academic Affiliations (OAA) is pleased to announce that the Under Secretary for Health has approved 175.2 GME positions for this academic year.

3. Your facility has been approved for the follow positions:
   - Facility: Charleston VAMC
   - Location: Main Facility
   - Approved: 1
   - Specialty: Neurology
   - Affiliate: Medical University of South Carolina College of Medicine

4. The Base Allocations database is in the process of being updated to reflect these position approvals and to remove duplicate position requests. This will be completed shortly so that VISN prioritization of Base Allocation requests can proceed on schedule.

5. Please feel free to call Dr. Edward Bope at 614-388-7747 or edward.bope@va.gov or Mark Zunk at 804-875-5482 or mark.zunk@va.gov with any questions or if you wish to discuss your position award.

[Signature]

KAREN SANDERS, MD

cc: Chief Medical Officer
    Network Academic Affiliations Officer
    Chief of Staff
    ACOS/Education (or Designated Education Officer)