Call to Order

1. Minutes of August 10, 2017 ................................................................. Dave Marshall, MD

2. New Business ...................................................................................... Dr. Marshall
   A. Request for Temporary Increase (Addiction Psych)
   B. MUSC Handoff Policy – combining MUSC and GME policies
   C. Request for International Rotation (Emergency Medicine)

3. ACGME Correspondence ........................................................................ Dr. Marshall
   A. Approval of International Rotation (Radiology)
   B. Rescheduling of Site Visit until 2019 (Neuropathology)

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) .................................................. Dr. Marshall
      i. Vascular and Interventional Radiology
      ii. Nuclear Medicine
      iii. CT Anesthesia
      iv. Plastic Surgery
      v. Interventional Cardiology
   B. Remediations: 5 residents in 5 programs
   C. Duty Hours

9. Old Business

ANNOUNCEMENTS

Next GMEC Meeting ~ Thursday, October 12 at 4:00 p.m. in 628 CSB

Please encourage any of your residents that may be interested in House Staff Council to attend the next meeting on Tuesday, September 19th at 6:00 p.m. in 419 CSB. Any resident/fellow is welcome to attend.

The next Chief Resident/Resident Representative meeting is Wednesday, September 20th at Noon in 125 GAZES (please note room change).
August 10, 2017 GMEC MINUTES

MEMBERS PRESENT: Batalis, Nick MD [Pathology]; Bush, Jeff MD [Emergency Medicine]; Clyburn, Ben MD [Internal Medicine]; Gordon, Leonie MD [Assoc. Dean for GME]; Haulsee, Merle MD [Internal Medicine – resident]; Kantor, Ed MD [Psychiatry] via proxy; Leddy, Lee MD [Orthopaedics]; Lewis, Madeleine MD [Radiology]; Marchell, Richard MD [Dermatology] via proxy; Marshall, David MD [Radiation Oncology (At large member)]; Meyer, Ted MD, PhD [Otolaryngology]; Milano, Nick MD [Neurology]; Pigott, Melanie [Emergency Medicine (PC)]; Siegel, Mark MD [Pediatrics – HSC president] via proxy; Spiotta, Alex MD [Neurosurgery] via proxy; Willner, Ira MD [Gastroenterology]

MEMBERS ABSENT: Anderson, Bret MD [Interventional Radiology Integrated]; Armstrong, Milton MD [Plastic Surgery (At large member)]; Barth, Kelly DO [Med-Psych]; Britten, Carolyn MD [Hem/Onc]; Campbell, Ruth MD [Nephrology]; Cox, Lindsey MD [Urology]; Craig, Michael MD [Cardiovascular Disease]; Guldan, George (GJ) MD [Anesthesiology]; Keith, Brad MD [Internal Medicine (At large member)]; Lewis, Lee MD [Child and Adolescent Psychiatry]; Mack, Elizabeth MD [Quality]; Mennitto, Sarah MD [Med Peds]; Meyer, Stephanie [VAMC]; Nutaitis, Matt MD [Ophthalmology]; 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)]; Stem, Christopher MD [Pediatrics – resident]; Streck, Christian MD [Surgery]; Taverna, Lance MD [Plastic Surgery – At large Member]; Zyblewski, Sinai MD [Pediatric Cardiology]

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

GUESTS: Olga Chajewski, MD (Cytopath); Jack Yang, MD (Cytopath); Lori Roten (Pathology fellowships); Stephanie Whitener, MD (CC Anesthesia); David Annibale, MD (Neonatology); Anita Thommes (Neonatology)

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<tr>
<th>AGENDA</th>
<th>DISCUSSIONS/CONCLUSIONS</th>
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<td>STANDING BUSINESS</td>
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<td>MINUTES</td>
<td>The minutes from the July 13, 2017 meeting were reviewed.</td>
<td>The committee approved the minutes.</td>
<td>Dr. Clyburn</td>
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<td>NEW BUSINESS</td>
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<td>A. The Learning Environment</td>
<td>Angela Dempsey presented on the Learning Environment Committee. The LEC monitors the learning environment for students with evaluations of preceptors and courses. There is now more focus on addressing issues when they arise. Your residents will be reviewed if they are not a positive part of the learning environment, as evidenced by a series of evaluations. Hopefully, this will not be a punitive endeavor; rather, this should be seen as a corrective feedback mechanism.</td>
<td></td>
<td>Dr. Dempsey</td>
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<td>Committee Director</td>
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<td>B. GME Census Survey</td>
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| C. | Request for New Program Director (Cytopathology) | action through coaching.  
B. The AAMC National GME Census is open. The deadline is September 29. We have programs that did not complete this last year. This is an important data source that informs critical healthcare policy issues, such as training needs, GME funding, workforce projections, etc...  
C. Dr. Carroll is asking the committee to approve a request for a new fellowship director in Cytopathology. Dr. Chajewski has been vetted by the GME Office and while she does not have extensive experience, she meets the requirements. | The committee approved the request. |

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<th>ACGME CORRESPONDENCE/ISSUES:</th>
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<th>Dr. Clyburn</th>
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| A. Upcoming Site Visits (Palliative Care, Neuropathology, Thoracic Surgery and Ortho) | A. Site visits have been scheduled for Palliative Care, Neuropathology, Thoracic Surgery and Ortho. These are scheduled for late November.  
B. Dermatology has been approved for a temporary increase of one position.  
C. Dr. Lindsey Cox (Urology) and Dr. Leonie Gordon (Nuclear Medicine) have been approved as program directors in their respective programs. | The committee acknowledged the correspondence. | |

| RESIDENT REPRESENTATIVES’ REPORT | The residents report an increased awareness of wellness on behalf of all house staff. Is there institutional support for some of the components of the La Sierra project that Neurosurgery did this past year? Is there institutional support for a wellness lounge for house staff? Residents are anxiously awaiting the rollout of the cellphone policy, which is expected in the Fall. | Dr. Clyburn reported that the institution is bringing in a well-known wellness expert to come and speak to MUSC sometime in the next year. A wellness lounge would be something we could get on board with, if there was space available. | Drs. Jester and Haulsee |

| HOSPITAL UPDATE | There was no hospital update. | | |

<p>| VA UPDATE | There was no VA update. | Dr. Clyburn pointed out that MUSC currently has 102 | |</p>
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<tr>
<th>HOSPITAL QUALITY REPORT</th>
<th>There was no Quality Report.</th>
<th>total positions at the VA. The VA would like to see that number increased to 120-140, which would push it from a 1B facility to a 1A facility.</th>
<th>Melanie Pigott</th>
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<td>PROGRAM COORDINATOR REPORT</td>
<td>This is a new item for GMEC. The Program Coordinator representative will try to report on issues your PCs are facing. It’s reminded that PCs need continuing education – and program directors can be an advocate for that. If there is no program level PC association, they can go to an ACGME or an AHME conference. The issue of “super-coordinators” has surfaced. These are coordinators who do more than one program, with full devotion to the programs and no administrative/clinical support required. Whether through attrition or reassignment of duties, we intent to pilot this idea. This has led to the talk of centralizing coordinators through the GME Office, especially with the new funds flow model where the GME Office is paying for PC support. If we can’t bring PCs under the umbrella of GME, then maybe we could implement dual reporting, with GME weighing in on evaluations.</td>
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<td>PROGRAM INFORMATION</td>
<td>A. Interventional Cardiology, while having excellent board take and pass rates, has a few clerical issues that need attention. The action plan needs updating. Critical Care Anesthesia has a good program, although has a colorful report card. This is due mainly to the PD change and complement change, both of which are items the ACGME tracks. While not a trackable item, the APE committee is aware that many coordinators have been in this position over the last few years. Is a plan in place to retain a good PC? Neonatal Perinatal Medicine obviously put great thought and planning into this self-review. It is a very thorough and thoughtful review. The program is in excellent standing. Ophthalmology needs to incorporate a few more issues into the action plan and resubmit. Clinical Cardiac Electrophysiology used a minimalist approach to this annual self-study. This may be due to the Program Director taking full responsibility for the program; the coordinator can contribute with documentation and clerical areas. Child Abuse Pediatrics needs to deal with attrition issues before it recruits new fellows. They are dealing with faculty attrition and do not plan on recruiting until 2019. B. There are 5 residents in 5 programs currently on remediation. C. A reminder that the 80-hour rule has no leeway. RRCs will not look kindly</td>
<td>The GMEC approved the APE reports.</td>
<td>Dr. Gordon</td>
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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, Med Psych, Thoracic Surgery and Vascular Surgery.

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<td>Dr. Clyburn reminded the programs present that House Staff Council would like to have representation from each department at each HSC meeting. Please encourage your residents to attend these meeting.</td>
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| Next GMEC Meeting – Thursday, September 14th at 4:00 p.m. in 628 CSB  
Please encourage any of your residents that may be interested in House Staff Council to attend the next meeting on Tuesday, September 12th at 6:00 p.m. in 419 CSB. Any resident/fellow is welcome to attend.  
The next Chief Resident/Resident Representative meeting is Wednesday, August 16th at 6:00 a.m. in 419 CSB | Dr. Clyburn |

Approved at the TBD, 2017 GMEC meeting.
Request for Change in Resident/Fellow Program Complement

☑ TEMPORARY  ☐ PERMANENT

Program Name: Addiction Psychiatry Fellowship

Program Director: Tara Wright, MD

Program Coordinator: Amanda Wagner

Department Chair: Tom Uhde, MD

Specialty Program Director (if applicable):

# of positions requested: 4

FROM: 3 (# current complement) TO 4 (# requested complement):

Requested Effective Date: July 1, 2019

Effective End Date (if temporary): Sept 30, 2019

Program Director Signature/Date:  

Specialty Program Director Signature/Date: 8/30/17

Department Chair 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 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

There will be no change in the funding of positions. Due to a fellow being off cycle, there will be a
3 month overlap when she is completing her training; her GME funding will be unchanged.

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

We would like to offer a fellowship position to a current psychiatry resident who is off cycle due
to maternity leave. She will start fellowship October 1st, 2018 and would complete September
30, 2019. Assuming that we successfully recruit 3 fellows for the 2019 – 2020 academic year, there
will be a 3 month overlap where we would have 4 fellows in the program.

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.

Given that there is only a temporary 3 month overlap, we do not expect any significant impacts
on the educational program.

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

   None

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

   It will not affect the number of cases seen by the trainee.

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

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.

They clinical rotations for the 1 year addiction psychiatry fellowship will not change; there will be only be a 3 month off cycle delay for this particular fellow, but she will complete all clinical rotations as all other fellows do.

7. Will there be additional or new training sites needed to accommodate the change in trainee complement? If so:
   
   No
   
   • 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. I have spoken with the longitudinal supervisors and ensured that there is adequate office space to accommodate an additional fellow during this 3 month period.
MUSC GME Transitions of Care/Handoff Policy

Purpose:
To establish protocol and standards within MUSC Medical Center residency and fellowship programs that ensures the quality and safety of patient care when transfer of responsibility occurs due to shift changes or unexpected circumstances. Transfers of care have been associated with adverse clinical outcomes and improving handoffs is a national patient safety goal.

Definition:
A clinical handoff is the transfer of care and responsibility from the primary (outgoing) physician to the covering (incoming) physician. Handoff also occurs when a patient is changing services or teams. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another.

Policy:
Individual residency programs must design schedules and clinical assignments to maximize the learning experience for residents, respect duty hour requirements, and to optimize patient safety. This includes efforts to minimize transitions of care. Programs must ensure that all residents have received training on handoffs and transitions of care. All PGY1 residents are required to undergo formal training during GME orientation.

Procedure:
- Communication for handoff should be face-to-face interaction for verbal communication whenever possible. When face-to-face handoff not possible (e.g., home call), handoff should be verbal with both parties following along with the same handoff tool in the electronic health record (EHR). Solely written handoff with no verbal interaction is unacceptable.
- There should be no gap in coverage of patients by providers who have received handoff (i.e., team should not be covering who has not yet received handoff).
- Updated written or computerized information is to be shared as well. It is our expectation that each department program will use our institutional handoff site EHR tool, unless the program has developed an acceptable HIPAA-compliant alternative approved by GMEC. APF will inquire about handoff annually.
- Each program will have a faculty handoff champion responsible for oversight of supervised handoffs.
- The person receiving the handoff is expected to ask pertinent questions to clarify any unanswered questions.
- Handoffs should occur in a quiet place and be uninterrupted (office, call room, lounge) whenever possible.
- Clear accurate information needs to be handed off as well as all received back the next morning (“closing the loop”).
- Handoff communication should include:

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IMPROVING PATIENT HANDBOFFS THROUGH...

1– Identify (Name, MRN, Date of Admission, Code Status)
C– Chief Complaint or presenting symptoms
A– Active Problems List
T– Therapies and Interventions (planned for next 24 hours)
C– Clinical Trajectory and Condition (sick or not sick?) (Response to therapy and help the receiving caregiver anticipate problems)
H– Help Me: Encourage Questions and Dialogue
Global Health Rotation
MUSC Emergency Medicine

Rotation: OneWorld Health, Sebaco, Tola, and El Viejo, Nicaragua
MUSC mentors: Dr. Lacey MenklnSmith, Dr. Edward O’Bryan
Assistant Mentor: Dr. Tyler Winders
Uganda mentor: Dr. Godson Senyodo

Goals:
1. Gain experience and perspective on the delivery of medical care in a resource limited setting, specifically in Nicaragua
2. Gain first hand understanding of the public health issues in low and middle income countries and how they affect the delivery of care
3. Gain exposure to different cultural backgrounds and medical practices
4. Work alongside Nicaraguan clinicians, sharing scientific and clinical knowledge and skills

Objectives:

Upon completion of the elective the resident should be able to:
- Identify the challenges of providing medical care in a resource limited setting and techniques for managing those challenges
- Be familiar with the ways in which health disparities and public health policy affect the health of populations in low and middle-income countries
- Develop understanding and respect for a new culture and skills to practicing culturally competent medicine
- Be able to understand, critique and apply global health literature into evidence based practice

Resident duties:
1) Assist with the organization and running of outreach clinics with OneWorldHealth in rural Nicaragua
2) Provide urgent and primary care to adult and pediatric patients in outreach clinics, Monday through Friday during medical outreach weeks
3) Provide urgent and primary care to patients at a OneWorldHealth clinic, five days per week; Residents are expected to perform history and physical exam and establish a management strategy for clinic patients. They have the opportunity to perform procedures, for which they have been trained at MUSC.
4) Prepare a case-based learning case on a subject pertinent to the pathology experienced in Nicaragua (with typical clinical presentation, diagnosis and management.)
8/22/2017

Madeline Lewis, MD
Associate Professor
Medical University of South Carolina
Department of Radiology
96 Jonathan Lucas, MSC 323
Charleston, SC 29425-3230

Dear Dr. Lewis,

The Residency Review Committee for Radiology, 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:

Radiology-diagnostic

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

Program 4204521184

OTHER COMMENTS

The Review Committee has reviewed and approved the program's request to develop and implement a four-week International elective experience for qualified PGY-5 residents at Masindi Kitara Medical Center in Masindi, Uganda.

Please note, the program director is accountable for the educational value and safety of the residents' experience while participating in all international rotations.

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.
Sincerely,

Kate E. Hatlak

Kate Hatlak, MSEd
Associate Executive Director
Residency Review Committee for Radiology
312.755.7416
khatlak@acgme.org

CC:
Christopher Hannegan, MD
Ernest B. Clyburn, MD
Maria G. Matheus, MD

Participating Site(s):
Medical University of South Carolina College of Medicine
MUSC Medical Center
Ralph H Johnson VA Medical Center (Charleston)
8/15/2017

Cynthia Welsh, MD
Program Director
171 Ashley Avenue
Charleston, SC 29425

Dear Dr. Welsh,

This letter confirms information regarding the site visit of the residency program identified as:

Neuropathology

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

Program No.: 3154530001

A site visit by a field representative of the Accreditation Council had been scheduled as follows:

Date of Site Visit: 11/30/2017
Approximate Starting Time: 8:30am

David L. Larson, MD
414.881.6670
dlarson@acgme.org

At your request I have agreed to postpone this site visit and plan to reschedule it after 09/01/2016. You may expect to receive a new letter announcing the new site visit date after it has been scheduled.

By copy of this letter I will notify our site visitor that the site visit of this program has been postponed.
Sincerely,

[Signature]

Ingrid Philibert, PhD, MBA
Senior Vice President, Field Activities

CC List:

Ernest B Clyburn, MD
Lori A Roten
### Program Name: Vascular and Interventional Radiology

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<th>Resident Survey</th>
<th>Faculty Survey</th>
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<th>Subspecialties</th>
<th>MISC Indicators</th>
<th>Action Plan</th>
<th>QI/Patient Safety</th>
<th>GME Stewardship</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

#### Action Plan

#### Board Pass Rate

#### QI/Patient Safety
- Involvement in QI/Pt Saf Projects

#### GME Stewardship

#### Scholastic Activity
- Faculty
- Resident
Program Name: Vascular and Interventional Radiology

APE FORM
Why such a low take rate for the boards - great pass rate, but so few take it. How do you assess fellow performance if the board exam is not required?
Effective Teaching Methods is also taught by computer modules via MyQuest

WEBADS
MUSC has sleeping rooms, showers, and should have secure areas for your residents
Licensure information on Dr. Hannegan is out of date
the residents do not appear to have met the scholarly activities as you outlined them in the APE form. Not all participated in research or wrote book chapters
Good faculty scholarly activity

SURVEYS
Faculty scored below a 4.0 on faculty development on supervision - need to incorporate this into the Action Plan
Nice bounce back from the survey in 14-15. Still concerning trends have drops in almost all content areas - need to be aware of this

ACTION PLAN
None of the concerning trends/AFIs from the ACGME accreditation letter are addressed in the action plan.
The one area on the faculty survey below a 4 was not addressed on the action plan
Otherwise, good, measurable items on the action plan
Please address these issues and submit a new, updated plan no later than October 31st
<table>
<thead>
<tr>
<th>Overall</th>
<th>Resident Survey</th>
<th>Faculty Survey</th>
<th>Action Plan</th>
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<td>Attraction</td>
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<td>Board Pass Rate</td>
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<tr>
<td>PD Change</td>
<td>Duty Hours</td>
<td>Supervision &amp; Teaching</td>
<td>Involvement in QI/Pt Saf Projects</td>
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<tr>
<td>Faculty Attrition</td>
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<td>Educational Content</td>
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<td>Permanent Changes</td>
<td>Examination</td>
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<td>Resources</td>
<td>Teamwork</td>
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<tr>
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<td>Number of subspecialties with 3 or more indicators flagged</td>
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<th>Scholarly Activity</th>
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<td>Resident</td>
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Program Name: Nuclear Medicine
APE FORM
Noted that the program is "in flux." Would like to know more about why this is. How does this compare to other programs nationally? Will be interesting to see how this year progresses

Interesting that so few take the NM board. Your pass rate for those that do is excellent
Noted weakness is that lack of nuclear resident teaching experience to Radiology residents. State of flux of specialty since the introduction of hybrid imaging
Noted in the form that the PD is developing a wellness plan, but this should be added to the action plan

WEBADS
The three faculty only devote a total of 1 hour per week to research?
Shouldn't there be a recertification for Dr. Gordon for Nuc Med in 2016?
Shouldn't De Cecco have previous years of GME experience? He isn't a PGY1

VERY good scholarly activity for residents
Q2 isn't answered fully. How do you use Evalue to educate faculty on how to evaluate residents fairly?
Q4 is an honest answer, but must increase to 80-100%. This should be reflected in the action plan
Q19 asks what % of residents use the EMR to improve the health in a population of patients - yet you indicated you did no health disparity research in the APE form – wouldn't this lend itself to health population studies?

SURVEYS
The faculty feel that information is lost when transferring critical care - be aware of the dip from last year to this year

ACTION PLAN
The action plan as presented is good; as noted above, additions could be made
# 2017 APE Program Report Card

**Program Name:** Cardiothoracic Anesthesia

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**Overall Attrition**
- PD Change
- Faculty Attrition
- Resident Attrition
- Permanent Complement Changes

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

**Resident Survey**
- 100% completed
  - Duty Hours
  - Faculty
  - Educational Content
  - Evaluation
  - Resources
  - Patient Safety
  - Teamwork

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

**Number of subspecialties with 3 or more indicators flagged**

**Involvement in QI/Pt Saf Projects**

**Scholarly Activity**
- Faculty
- Resident

**Action Plan**

**Board Pass Rate**

**GME Stewardship**

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Program Name: Cardiothoracic Anesthesia

APE FORM
Excellent Board Pass Rates - is the national board pass rate really 100%?
The scholarly activity question is referencing the ACGME requirements - have you really met the requirements?
Do you track faculty development? This question was unanswered - but followed by the question that references % of core faculty involved in faculty development. You list this as 5%. 100% of your core faculty MUST be engaged in faculty development, and you must track this

WEBADS
Out of date licensure for Dr. Nelson
Why is it that you have four filled positions listed under number of positions? You have two actively enrolled for 17-18. Is this because you have two off-cycle?
Based on fellows completing the program - shouldn't you have Raj and Scharf listed
Q19 asks what % of residents use the EMR to improve the health in a population of patients - yet you indicated you did no health disparity research in the APE form -- wouldn't this lend itself to health population studies?
You have not fully answered Q22 - how are you addressing the improvement of mentoring?

SURVEYS
Excellent faculty surveys

ACTION PLAN
For 2017, you'd like to see a 10% increase in scores for both the internal and ACGME resident surveys for what specific questions?
You'd like to increase faculty satisfaction in regards to what area with at least a score of 4/5?
<table>
<thead>
<tr>
<th>Program Name: PLASTIC SURGERY</th>
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**Overall Attrition**
- PD Change
- Faculty Attrition
- Resident Attrition
- Permanent Complement Changes

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

**Resident Survey**
- 100% completed
  - Duty Hours
  - Faculty
  - Educational Content
  - Evaluation
  - Resources
  - Patient Safety/Teamwork

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

**Number of subspecialties with 3 or more indicators flagged**
- N/A

**Action Plan**

**Involvement in QI/Pt Saf Projects**

**GME Stewardship**

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Page 1 of 2
Effective Teaching Methods is also taught by computer modules in My Quest
What is a take rate of two for the boards? What percentage is this?
There should be a formal way to assess handoffs
All core faculty should be involved in faculty development-50% is not acceptable

Webads
There needs to be a secure area at Roper, Trident, O'Neil Plastic Surgery and MUSC East
Dr. Armstrong CV bibliography needs to be updated, as well as his licensure data
Faculty have very few publications — if Dr. Delaney has no activity at all, you might want to rethink him as a core member
How do you not know where Dr. Crane went to med school?
Why such a difference in your two first years in scholarly activity? One with none, and the other with many/much
The information on Dr. Charepoo seems incorrect - he transferred within MUSC to another plastics program? Not likely

Surveys
Faculty
Below national norm for faculty satisfied with personal performance feedback. Very nice survey overall
Patient Safety
Resident
Very good - nice upticks over the last three years

Action Plan
There are still some unresolved action items from last year’s action plan. I think lecture timing could be altered or perhaps use teleconferencing.
Not sure if sending residents to Duke micro flap course is necessary and where the funding will come from.

Residents commented to committee members that adding flexibility into the preceptorship model would be good
This minimizes our ability to participate in unique cases because we have to cover clinics or scrub routine cases
In addition, the residents mentioned the work load of the Pas and the shift of workload over to the residents. This is a work in progress and hopefully will work itself out in the near future
### Program Name: Interventional Cardiology

<table>
<thead>
<tr>
<th>Attrition</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>
<th>QI/Patient Safety</th>
<th>GME Stewardship</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
  - 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

#### Overall Negative Opinion
- Number of subspecialties with 3 or more indicators flagged
- N/A

#### Scholarly Activity
- Faculty
- Resident

#### Involvement in QI/Pt Saf Projects
- N/A

#### Action Plan
- Board Pass Rate

#### GME Stewardship
Date of self-study 1/1/18—is that correct? Should be 1/2020
The requirements have been updated since 2010. The PD and PC should take the time to read through the latest requirements
Excellent board pass and take rate.
The program needs a formal handoff criteria
The VA has shower facilities
It is out of date in many sections including CV of PD.
Faculty SA—excellent and varied.
Residents participate in teaching and research but have limited time to have publications seen to fruition.

Surveys: Consistently strong although small drops in mean trends. Should be monitored.

AP:
Need last year’s action plan with updates.
In-service exam requested by fellows—consider utilizing national resources from other programs so as not to create an entire test from scratch;
monitoring method will be grades
Research mentoring; method chosen could be fellow scholarly activity
Medical University of South Carolina - Sept. 13, 2017

Duty Hours Violations report (80 Hours Per Week - Averaged Over A Four-Week Period)

Reporting Period: 07/01/2017 through 06/30/2018 (365 days)

*Maximum hours: 320 hours in 28 days (4 week)*

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