ACPM Preventive Medicine Residency Directors’ Manual

A “Best Practices” Tool for Residency Programs in General Preventive Medicine, General preventive medicine/Public health, Occupational Medicine, and Aerospace Medicine

2002
Preventive Medicine Residency Directors’ Manual
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INTRODUCTION TO THE MANUAL (TAB A)

Dear Manual User,

The purpose of the Preventive Medicine Residencies Directors’ Manual is to provide an overview of requirements for preventive medicine residency programs and examples of “best practices” in a variety of topics, chosen as those essential to administering a preventive medicine residency. While every effort has been made to develop materials which meet the Accreditation Council for Graduate Medical Education’s (ACGME) Residency Review Committee’s (RRC) requirements for Preventive Medicine, we cannot guarantee that the use of this manual will result in a successful RRC site visit.* This manual is not endorsed by the ACGME.

The Manual includes examples on some topics, which may be used, modified, or rejected. All examples are located in appendices lettered to correspond to the tabs under which the requirements are located (i.e., requirements for affiliation agreements are located under Tab G, and examples of affiliation agreements are found in Appendix G). To facilitate the incorporation of these materials into individual residencies, downloadable information also will be posted on the American College of Preventive Medicine’s (ACPM’s) web site at www.acpm.org.

This document is a work in progress. We expect the Manual to improve considerably with time, through feedback, and subsequent gatherings of residency directors. Please send your suggestions, helpful documents, and additional materials to Jessica Cafarella, at jdc@acpm.org. We will gladly incorporate additional examples of “best practices.”

We thank all those who attended the Annual Preventive Medicine Residency Program Directors Workshops and contributed to the manual, especially: Kathleen Acree, Mary Applegate, Jessica Cafarella, Jeff Davis, Elizabeth Garland, Gary Goldbaum, Richard Jennings, Clifford Mitchell, Carol O’Neill, Sindy Paul, Beverly Taylor.

Please feel free to contact me (the past GME chair) at lhillbaird@aol.com, Gary Goldbaum, (the current GME chair) at Gary.Goldbaum@METROKC.GOV, or Jessica Cafarella (ACPM Graduate Medical Education Manager) at jdc@acpm.org

Sincerely,

Linda L. Hill, MD, MPH
ACPM GME Committee/Chair 1995-2001
ACPM Board West Regent 1995-2001

*This is otherwise known as a “disclaimer.”
ACCREDITATION 101: THE BASICS OF PREVENTIVE MEDICINE ACCREDITATION (TAB B)

What is the ACGME?

The Accreditation Council for Graduate Medical Education (ACGME) is a private professional organization responsible for the accreditation of nearly 7,800 residency education programs, including preventive medicine residencies. The ACGME's volume of accredited programs makes it one of the largest private accrediting agencies in the country, if not the world.

Stakeholders of the ACGME's accreditation process are residency programs, their sponsoring institutions, residents, medical students, the member boards of the American Board of Medical Specialties (ABMS), patients, payers, government, and the general public. Accreditation offers these stakeholders assurance that a given residency program and its sponsoring institutions meet an accepted set of educational standards. The ACGME accredits residency programs in 110 specialty and subspecialty areas of medicine, including all programs leading to primary Board certification by the 24 member boards of the ABMS, and completion of an ACGME-accredited residency program is a prerequisite for certification in a primary board.

For medical students graduating from medical school after January 1, 1984, completion of an ACGME-accredited subspecialty program is also required before an individual can sit for board certification in the majority of subspecialties, including preventive medicine.

The Accreditation Process

To develop and refine its accreditation standards and to review accredited programs for compliance with the standards, the ACGME relies on experts in the various medical specialties. Twenty-six specialty-specific committees, known as Residency Review Committees (RRCs), periodically revise the standards and review accredited programs in each specialty and its subspecialties. The process for periodically revising these standards includes solicitation of comment from interested parties and the public. The ACGME Board of Directors is ultimately responsible for standards revision and accreditation decisions. There is a separate Review Committee for the Transitional Year, a one-year program that prepares newly graduated physicians for entry into a specialty that accepts residents at the second residency year, and an Institutional Review Committee for the review of the more than 400 institutions that sponsor residency programs in two or more core specialties. The membership of the RRCs, the Transitional Year Review Committee, and the Institutional Review Committee is made up of physicians. Often, these are educators who have gained a reputation for expertise in residency education. Members of the RRC are appointed by their specialty boards, the American Medical Association, and their specialty societies.

To gain and maintain accreditation, residency programs are expected to comply with the accreditation standards for their discipline. In addition, institutions sponsoring residency programs are expected to adhere to a set of institutional requirements. Compliance with the ACGME's standards is measured through periodic review of all programs. Each year, the RRCs review nearly...
one-half of all accredited programs in their specialty. Some of these reviews involve a formal on-site visit to the program; the remaining reviews are based on documents each program provides to the ACGME. **On average, each accredited residency program is site visited every 3.7 years.** Sponsoring institutions are also site visited periodically. The interval between site visits ranges from one to five years, with a longer period indicating that the ACGME and RRCs are more confident about a program's or institution's ability to provide quality education.

All new residency programs begin by submitting an application, and go through a period of "provisional" accreditation. Programs that have demonstrated compliance with the accreditation standards receive full accreditation. If a program is found to have areas of non-compliance (deficiencies), the ACGME lists these as specific citations in its accreditation letter to the program and expects the program to come into compliance. The RRCs often monitor programs' progress in addressing deficiencies. If a program has significant deficiencies, it may be given a warning or be placed on probation. The intent is to alert the program and its sponsoring institution to the need to show improvement in the areas identified as deficient, or face more serious action by the ACGME.

Ultimately, programs that fail to comply with the standards have their accreditation withdrawn. It is rare that a program's accreditation is withdrawn because of failure to comply with a single standard, but this can occur for very serious deficiencies, termed "egregious violations of the accreditation standards." The ACGME's actions in establishing standards, and in withdrawing the accreditation of programs that fail to demonstrate compliance, have been affirmed by several court decisions.

A listing of all accredited programs and their accreditation status and time interval to their next site visit can be found on the ACGME Web site, www.acgme.org.

**The Accreditation Site Visit**

The formal periodic review of programs involves an on-site inspection, which is based on the Program Information Form (PIF), a comprehensive self-study document prepared by the program being reviewed. Each year approximately 2,000 programs are site visited by the members of the ACGME field staff, and around 150 programs are site visited by Specialist Site Visitors (SSVs). SSVs are volunteer experts who conduct a small number of site visits in their specialty during a given year. Members of the field staff are ACGME staff members. They are either physicians or individuals with a PhD or similar doctoral degree who are knowledgeable in the review of programs in all accredited specialties and subspecialties. In the ACGME's approach to accreditation, the site visitor is not the decision-maker regarding quality of a given educational program. Site visitors are fact-finders whose role is to verify and clarify the information provided in the PIF. The PIF and the site visitor's report form the basis of the RRC's review and accreditation decision.

Prior to the site visit, the site visitor (field staff or SSV) is expected to have reviewed the self-study document prepared by the program, along with the Program Requirements and the Institutional Requirements governing accredited residencies. The site visit consists of interviews with the program director, RAC members, members of the teaching faculty, residents, and often
administrators and other key personnel. Following the visit, the site visitor composes an objective narrative report of the information that he or she collected during the interviews. This document is factual and non-judgmental, and reports omissions or discrepancies between the PIF and the information collected during the interviews. Site visitors are prohibited from making recommendations and from interjecting personal opinion into reports. Their reports are intended to present information gathered at the visit, without any effort to sway the Residency Review Committee for or against the program. The site visitor may call attention to one or more points in the report to the RRC.

Site visitor reports are not released to the program unless the program is placed on probation. The RRC will then distribute the site visitor report (SVR) and PIF to two members of the RRC to review. These reviews are then presented at RRC meetings, and the RRC will make an accreditation decision with citations as appropriate. Letters are sent to the program director within six to eight weeks after the RRC meeting. The RRC may also request additional information through a progress report.
PROGRAM REQUIREMENTS FOR RESIDENCY EDUCATION IN PREVENTIVE MEDICINE\(^1\) (TAB C)

The requirements below were established by the Accreditation Council for Graduate Medical Education (ACGME) and must be followed by all accredited preventive medicine residency training programs.

I. Introduction
   A. Definition

Preventive Medicine is the specialty of medical practice that focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death. Preventive medicine specialists have core competencies in biostatistics, epidemiology, environmental and occupational medicine, planning and evaluation of health services, management of health care organizations, research into causes of disease and injury in population groups, and the practice of prevention in clinical medicine. They apply knowledge and skills gained from the medical, social, economic, and behavioral sciences. Preventive medicine has three specialty areas with common core knowledge, skills, and competencies that emphasize different populations, environments, or practice settings: aerospace medicine, occupational medicine, and public health and general preventive medicine.

1. Aerospace medicine focuses on the health of the operating crews and passengers of air and space vehicles, together with the support personnel who are required to operate such vehicles. Segments of this population often work and live in remote, isolated, and sometimes closed environments under conditions of physical and psychological stress.

2. Occupational medicine focuses on the health of workers including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures. Practitioners in this field diagnose, treat, and prevent morbid conditions caused by environmental exposures and stressors. They recognize that work and the environment in which work is performed can have favorable or adverse effects upon the health of workers as well as of other populations; that the nature or circumstances of work can be arranged to protect worker health; and that health and well-being at the workplace are promoted when workers' physical attributes or limitations are accommodated in job placement.

3. Public health and general preventive medicine focuses on promoting health, preventing disease, and managing the health of communities and defined

\(^1\) Documentation and performance measures are included to assist program directors in the development and administration of preventive medicine residency training programs. Documentation and performance measures are not program requirements.
populations. These practitioners combine population-based public health skills with knowledge of primary, secondary, and tertiary prevention-oriented clinical practice in a wide variety of settings.

B. Objectives and Components of the Residency Educational Process

The objective of preventive medicine is to develop in physicians the competencies requisite to the practice of preventive medicine in the recognized specialty areas. The main components of the residency educational process are:

1. definition of specific educational goals in terms of competencies, skills, and knowledge, expressed in behavioral, measurable terms;
2. assessment of the incoming resident relative to the specific educational goals;
3. design and provision of educational experiences through which specific educational goals may be achieved;
4. documentation of provision of educational experiences and the attainment of educational goals in terms of interim and overall outcome performance measures; and
5. use of periodic performance measures to determine the quality of the educational experience and the clinical competence of the individual resident, as well as the quality of the program.

C. Residency Structure

Residencies may be accredited for lengths of from 1 to 3 years, with the following general objectives associated with each period of accreditation:

1. Three years: attainment of basic general clinical competencies, the academic competencies in preventive medicine, and preventive medicine practice competencies
2. Two years: academic and practice competencies
3. One year: practice competencies

Programs accredited for more than 1 year may accept residents and are also accredited for any appropriate combination of shorter periods, eg, a program accredited for a 2-year training program may accept a resident with an MPH for a 1-year practicum experience.

Programs with a status of full accreditation may pursue combined training programs. Programs seeking to integrate preventive medicine training with other Accreditation Council for Graduate Medical Education (ACGME) - accredited training (combined programs) must meet all preventive medicine requirements. Programs must also meet all requirements as specified by both certifying boards of the integrated residencies.

II. Residency Design

A. General
1. Identification of specialty area: Residency programs must identify the specialty area of preventive medicine of the residency, the period of desired length of accreditation (1, 2, or 3 years), and the planned number of residents in each year.

   **Documentation Requirement:** The appropriate form must be completed and supplied in advance of a planned site visit.

   **Measure:** Accurately completed form.

2. Change in training period: The length of residency training for a particular resident may be extended by the program director if that resident needs additional training. If the extension is for only 6 months or less, the program director must notify the Residency Review Committee (RRC) of the extension and must describe the proposed curriculum for that resident and the measures taken to minimize the impact on other residents. Any changes in rotation schedules should be included in the notification. Approval must be obtained in advance from the RRC if the extension is greater than 6 months.

3. Educational goals overview: The program must prepare a written overview statement outlining the educational goals of the program with respect to knowledge, skills, and competencies to be acquired by residents during the training period. This statement must be distributed to residents and members of the teaching staff.

   **Documentation Requirement:** The written overview statement outlining the educational goals of the program with respect to knowledge, skills, and competencies of residents to be acquired during the training period must be supplied in advance of a planned site visit.

   **Measure:** Overview statement covers core and appropriate specialty area goals and competencies. Content is preventive medicine. Depth and breadth are commensurate with the selected specialty area. Indicates how the knowledge, skills, and competencies are to be met.

4. Program schedule: Prepare a written schedule of activities for each resident during the accredited length of the residency that demonstrates the provision of knowledge, skills, and competencies, including directly supervised clinical care, outlined in the educational goals. The residency program must specify a minimum set of competencies that each resident must acquire prior to completion of the program. This statement must be distributed to residents and members of the teaching staff.

   **Documentation Requirement:** The written schedule must be submitted in advance of a planned site visit.
Measure: The statement provides a coherent approach to provision of an overall resident experience that will create the opportunity for the resident to acquire the knowledge, skills, and core and specialty area competencies during the accredited length of the residency.

5. Resident support: Salaries and benefits of individual residents must comply with the institutional requirements for funding of residents.

6. Grievance process: The program must ensure that all training sites have a grievance process that is in compliance with the Institutional Requirements (Institutional Agreements and Conditions of Resident Employment). A written statement describing the grievance process for each training site must be available for review at the time of the site visit.

Documentation Requirement: Appropriate policies included in institutional agreements for all training sites.

Measure: Policies are accurate and comply with the Institutional Requirements.

B. Resident Qualifications

1. Entering the clinical phase: Residents entering the clinical phase must meet one of the eligibility requirements as outlined in the Institutional Requirements section II.A.1. In addition, residents must have completed steps I and II of the United States Medical Licensing Examination (USMLE) or, prior to 1996, its equivalent.

2. Entering either the academic or practicum phases: The entering resident must have completed training in an ACGME-accredited clinical year (12 months) with a minimum of 6 months of direct patient care. Direct patient care is the provision of preventive, diagnostic, and therapeutic interventions to patients.

3. Entering the practicum phase only:

   a. The entering resident must have completed an ACGME-accredited clinical year and have an MPH or other appropriate postgraduate degree. The MPH or other appropriate postgraduate degree must be accredited by the Council on Education in Public Health (CEPH) or other appropriate postgraduate accrediting body.

   b. If the resident has not been awarded an MPH or other appropriate postgraduate degree, then knowledge of each of the four core subjects - biostatistics, epidemiology, environmental and occupational health, and health services organization and administration - must have been obtained through at least 40 contact hours for each course in an academic setting.

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2 Hereinafter patient care is defined as the provision of preventive, diagnostic, and therapeutic intervention to patients.
The resident must complete the accredited MPH, or other appropriate postgraduate degree, prior to the end of the residency program.

c. The entering resident must have completed training in an ACGME-accredited clinical year (12 months) with a minimum of 6 months of direct patient care. Direct patient care is the provision of preventive, diagnostic and therapeutic interventions to patients.

**Documentation Requirement:** The program must maintain and make available for site visitor inspection a file for each resident (the resident file) that contains copies of certificates and academic institution records to document the specified requirements. Copies of these documents must be submitted to the RRC on request.

**Measure:** Resident files contain the appropriate documentation.

C. Program Director

1. Qualifications: The entire residency program must be under the supervision of one physician, the program director, who is certified by the American Board of Preventive Medicine (ABPM) in the appropriate specialty area of preventive medicine or has suitable qualifications and experience as determined by the RRC.

   The program director must have the following:

   a. Clinical, educational, and administrative experience
   b. License to practice medicine in the state where the institution that sponsors the program is located (Certain federal programs are exempted.)
   c. Appointment in good standing to the medical staff of an institution participating in the program

   **Documentation Requirement:** The curriculum vitae (CV) of the program director must be submitted in advance of a site visit, when program directors change, and on the request of the RRC.

   **Measure:** Documentation in the CV that the requirements are met.

2. Program director responsibilities: The program director is responsible for and must be able to demonstrate the provision of the following:

   a. Supervision of residents to achieve the objectives of the educational goals of the residency and educational plans of the residents.
   b. Counseling of residents in the academic phase in the selection of assignments, services, or elective courses that will assist the resident in achieving the skills and knowledge needed in the resident's practicum experiences and intended fields of practice in preventive medicine.
c. Selection of residents for appointment to the program in accordance with institutional and departmental policies and procedures.

d. Selection, development, and supervision of the faculty and other program personnel at each institution participating in the program.

e. Supervision of residents for applicable patient care and practicum experiences through explicit written descriptions of supervisory lines of responsibility. Patient care responsibilities include gradual assumption of clinical responsibility under direct supervision for a variety of clinical problems and preventive encounters. Such guidelines must be communicated to all members of the program staff. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.

f. Provision of information that describes the program's accreditation status, educational objectives, and structure to each applicant, or in the event of a major change to each resident.

g. Implementation of fair procedures, as established by the sponsoring institution, regarding academic discipline and resident complaints or grievances.

h. Review of the inter-institutional agreements with participating institutions annually and for scheduling updates as needed to ensure currency.

i. General administration of the program, including those activities related to the instruction, supervision, counseling, evaluation, and advancement of residents.

j. Maintenance of records related to program accreditation.

k. Preparation and submission of documentation required by the RRC.

**Documentation Requirement:** Written plans, policies, evaluations, and other applicable program communications (eg, letters, memos).

**Measure:** Program files contain the required documentation.

D. Faculty

1. Faculty qualifications and time commitment: Faculty and/or practicum supervisors must be assigned to provide the knowledge, skills, direct clinical supervision, and competencies as outlined in the educational goals of the program, and specific assignments must be indicated in each resident's educational plan. Faculty must have documented qualifications to provide the appropriate knowledge, skill, or competency to which they are assigned.

**Documentation Requirement:** A matrix must be provided showing faculty assignments to provide appropriate knowledge, skills, and competencies. CVs must demonstrate appropriate qualifications.
**Measure:** Program files contain matrices and CVs that document faculty qualifications appropriate to provide the knowledge, skill, or competency to which they are assigned.

2. **Faculty responsibilities**

   a. All members of the faculty must demonstrate a strong interest in the education of residents and support of the goals and objectives of the program through provision of appropriate knowledge, skills, direct clinical supervision, or competencies. Faculty must also demonstrate a commitment to their own continuing education and participation in scholarly activities.

   b. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the teaching staff. While not all members of a teaching staff must be investigators, the staff as a whole must demonstrate broad involvement in scholarly activity. This activity should include the following:

   1. Active participation of the teaching staff in discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.
   2. Participation in journal clubs and research conferences.
   3. Active participation in regional or national professional and scientific societies, particularly through presentation at the organizations' meetings and publication in their journals. Participation in research, particularly in projects that are funded following peer review and/or result in publication or presentations at regional and national scientific meetings.
   4. Offering of guidance and technical support (e.g., research design, statistical analysis) for residents involved in research.
   5. Provision of support for resident participation in scholarly activities.
   6. Active participation in the review of residents and of planning and review of the residency program.

   **Documentation Requirement:** Minutes of planning meetings; logs of journal club, rounds, or case conference attendance; membership on thesis committees; updated CVs for faculty and staff that document continuing education, meeting attendance, and publications.

   **Measure:** Program documents attesting to faculty contributions to program planning, review, and resident education.
E. Sponsoring Institution

The sponsoring institution must maintain office and laboratory space and access to computer facilities. A collection of basic reference texts and periodicals in preventive medicine and public health must be maintained. Residents must be provided with office facilities and support services during assigned duty hours. Funds must be provided for residents for travel to appropriate professional meetings.

**Documentation Requirement:** Facilities and support are documented at the time of the site visit.

**Measure:** Facilities and support are provided.

1. For programs offering training in basic clinical competencies: The institution's Graduate Medical Education Committee (GMEC) should approve the program. In addition to the preventive medicine residency, there must be at least one ACGME-accredited residency at the same institution that provides direct patient care.

   **Documentation Requirement:** The program has on file and available to the program director documentation of an ACGME-accredited residency program that provides direct patient care.

   **Measure:** The program has on file and available to the site visitor current documentation of approval of the clinical year by the institution's GMEC.

   **Measure:** Records documenting GMEC review and approval of clinical year.

2. For programs offering training in core preventive medicine knowledge (academic phase): Core preventive medicine knowledge is offered through a course of study leading to the degree of Master of Public Health or other appropriate postgraduate degree. The MPH or other appropriate postgraduate degree must be accredited by the CEPH or other appropriate postgraduate accrediting body. The sponsoring institution must provide an environment of inquiry and scholarship in which residents have structured research opportunities to participate in the development of new knowledge.

   **Documentation Requirement:** Accreditation documentation. A description of the sponsoring institution must include a statement of its research activities and how participation in these is available to the resident.

   **Measure:** Research opportunities are available to the resident. The accreditation is documented.

3. For programs offering training in competencies of preventive medicine practice (practicum phase):
a. Aerospace medicine

1. The year of acquisition of competencies in aerospace medicine practice must be accomplished in an institutional setting where operational aeromedical problems are routinely encountered and aerospace life support systems are under active study and development.
2. Laboratory facilities should be equipped to provide simulated environments in which the effects of and adaptation to extreme conditions of temperature, barometric pressure, acceleration, weightlessness, and psychological stress can be studied.

b. Occupational medicine: Acquisition of practice competencies in occupational medicine must be accomplished in institutions that provide comprehensive occupational health services to defined work groups, including regular and frequent presence in the work sites served.

c. Public health and general preventive medicine: The sponsoring institution may be an academically affiliated institution, an academically affiliated health care organization, or a government public health agency.

1. If the sponsoring institution is an academic institution or an academically affiliated health care organization, it should have resources for developing a comprehensive graduate program in preventive medicine. An affiliation must be established with a governmental public health agency to ensure appropriate public health practice and research opportunities.
2. If the sponsoring institution is a health agency, it should offer a comprehensive experience in community or public health. To ensure an appropriate didactic component, affiliations must be established with a medical school or a school of public health.

**Documentation Requirement:** Affiliation agreements are current and provided to the RRC and site visitor.

**Measure:** Appropriate affiliation agreements clearly documenting these requirements.

4. Support departments

The support departments of the sponsoring institutions, such as medical records and the medical library, must contribute to the education of residents in accordance with the Essentials of Accredited Residencies in Graduate Medical Education.
**Documentation Requirement:** The site visitor report must address the availability of medical records and medical reference materials.

**Measure:** Medical records and medical reference materials are available to the resident and faculty.

5. **JCAHO accreditation**

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) must accredit all participating hospitals.

**Documentation Requirement:** Programs must have on file and readily available for site visitor inspection a copy of current accreditation of all participating hospitals by JCAHO.

**Measure:** Required documents are current.

F. **Facilities and General Support**

The residency program and its affiliates must maintain adequate facilities, including office and laboratory space and access to computer facilities. Residents should have convenient access to the Internet and other online resources, and when available, the electronic medical information system of participating health care institutions.

A collection of basic reference texts and periodicals in preventive medicine and public health shall be maintained. Access to support services must be provided. Residents must be provided with adequate office facilities during assigned duty hours. All residents must be provided funds for travel to designated professional meetings.

**Documentation Requirement:** The program must supply in advance of a site visit a description of facilities and general support available to the resident.

**Measure:** The facilities and general support adequately support resident education.

G. **Library**

Residents must have ready access to medical reference materials, either at the institution where the residents are located or through arrangement with convenient nearby institutions. Library services should include the electronic retrieval of information from medical databases and an on-site reference librarian. There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.
**Documentation Requirement:** A description of availability of medical reference materials to residents must be supplied prior to a site visit.

**Measure:** the resident has the ability to access adequate medical reference materials, eg, reference texts and journal articles.

H. Participating Institutions and Training Sites

1. Individual phases or parts of the training program may be offered at participating institutions; the participating institutions must meet all requirements of the Institutional Requirements.

   The participating institution must provide experiences through which the appropriate knowledge, skills, and competency may be acquired consistent with the overall educational objectives of the residency.

   a. A faculty or staff member at each participating institution or training site must be designated to assume responsibility for the following:

      1. The day-to-day activities of the program at that institution.
      2. Supervision of residents to achieve the objectives of the educational goals of the residency and educational plans of the residents as appropriate to the participating institution.
      3. Direct supervision of residents to ensure applicable patient care and practicum experiences through explicit written descriptions of supervisory lines of responsibility. Such guidelines must be communicated to all members of the program staff. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.

   b. The responsible faculty or staff member and the residents assigned to the participating institution must coordinate all activities with the program director.

2. The reciprocal commitments of the residency program and the participating institutions must be explicit in a written agreement or contract, to include the following:

   a. The educational objectives of the affiliation experience, and the knowledge, skills, and competency experiences to be provided.
   b. The scope of the affiliation with placement locations noted.
   c. The resources, including space, support services, and clinical facilities of the affiliate, that will be available to the residents.
   d. The duties and responsibilities the residents will have in the affiliate.
e. The relationship that will exist between residents and staff of the residency program and the affiliate.

f. The supervisory relationship and identified supervisor, who shall be qualified by certification or equivalent experience in the area, as determined by the program director. There must be active participation by the residents at the affiliated site, and resident supervision on-site must be performed by a physician or appropriately qualified health professional. Supervisors must directly assess clinical development.

g. Procedures for academic discipline and handling of resident complaints or grievances.

Documentation Requirement: Copies of these written agreements or contracts must be provided to the RRC in advance of a site visit.

Measure: Written agreements or contracts demonstrate that each affiliated institution can provide a well-planned, relevant educational opportunity for the resident. The program director and the supervisor at the participating institution must sign these agreements.

III. Educational Objectives

A. Competencies, Skills, and Knowledge

1. The program director and teaching staff must prepare a list of specific competencies, skills, and knowledge that they are prepared to deliver to residents through the training program. Competency acquisition must be evaluated through the use of clearly defined performance indicators.

2. Residents in the same program may be in different "tracks" that have a different method or approach to training. Programs are encouraged to seek innovative ways to deliver and fund GME; however, the entire program will be assessed by the RRC—no tracks can be accredited separately.

Documentation Requirement: The program must submit a cross-referenced list of specific competencies, skills, and knowledge, including faculty assignments, available through the program. Performance indicators for the assessment of competency acquisition must be specified and tracked for each resident.

Measure: The content is preventive medicine. Depth and breadth are adequate and commensurate with the selected specialty area. Performance indicators are specified and documented for the competencies.

B. Educational Courses, Rotations, and Activities

The program director and teaching staff must prepare a matrix of educational courses, rotations, supervised clinical experiences, and other educational activities available through the residency
by which a resident will have the opportunity to acquire the specific competencies, skills, and knowledge. This matrix must be cross-referenced to the knowledge, skills, and competencies. Ongoing activities that provide an opportunity for group faculty-resident interaction, such as weekly didactic series, journal club, and grand rounds, are essential.

**Documentation Requirement:** A list of courses, rotations, and activities cross-referenced to the list of competencies, skills, and knowledge must demonstrate how educational objectives are met. Descriptions of each course, rotation, and activity must be submitted to the RRC prior to a site visit. The institution providing each course, rotation, or activity must be specified.

**Measure:** The cross-referenced list documents that the program provides courses, rotations, and activities corresponding to the program's knowledge, skills, and competencies list.

C. Incoming Resident Assessment

Each incoming resident must be assessed as to his/her knowledge, skills, and competencies in relationship to the educational goals for the residency program. This assessment may take the form of a self-assessment, an in-service exam, a structured interview, or other method that assesses knowledge, skills, and competencies. This assessment is used by the program director and faculty to guide the development of an individualized educational plan for each resident.

**Documentation Requirement:** The program must have a written assessment (self-assessment, in-service exam, structured interview, or other method) of incoming resident skills, knowledge, and competencies in the program files.

**Measure:** The assessment is specific to the educational objectives for the residency program and must be included in the educational plan for each resident.

D. Educational Plan

1. The residents, in collaboration with the program director and teaching staff, must prepare a written educational plan that directs the acquisition of a core set of competencies, skills, and knowledge appropriate to the objectives of individual residents, based on the residents' assessments. The educational plan will detail the courses, rotations, and activities to which they will be assigned to achieve the designated skills, knowledge, and competencies during their residencies.

**Documentation Requirement:** The program must have a written educational plan on file for each resident prior to a site visit.

**Measure:** The educational plan documents each resident's baseline skill, knowledge, and competency inventory; the resident's individual educational objectives; and the courses, rotations, and activities schedules that will provide the opportunity for each resident to meet the educational objectives.
2. The assigned activities must be organized into a structured schedule prior to each year of residency experience. A record of courses, rotations, and activities attended must be completed at the close of each year.

Residencies that offer 2- or 3-year programs may create schedules that concurrently integrate courses, rotations, and activities that incorporate the following criteria:

a. Adequate time is available to complete each objective.
b. The sequential acquisition of knowledge, skills, and competencies is clinical, academic/didactic, practicum.
c. The practicum experiences may be concurrent with academic experiences, but may not precede didactic experiences.
d. Resident hours on duty in a clinical setting shall be scheduled and monitored to avoid excessive stress and fatigue. Residents must have a keen sense of personal responsibility for continuing patient care and must recognize that their obligation to patients is not automatically discharged at any given hour of the day or any particular day of the week.
e. Resident care in the clinical setting must be directly supervised.
f. In no case should a resident go off duty until the proper care and welfare of patients have been addressed and, if applicable, until responsibilities to the community and public have been fulfilled.
g. Duty hours and night and weekend call for residents must reflect the responsibility for patients and provide for adequate patient care.
h. Residents must not be required regularly to perform excessively difficult or prolonged duties. When averaged over any 4-week period, residents should spend no more than 80 hours per week in all duties. Residents at all levels should, on average, have the opportunity to spend at least 1 day out of 7 free of hospital duties and should be on call no more often than every third night. There should be adequate opportunity to rest and sleep when on call for 24 hours or more. There should be adequate backup so that patient care is not jeopardized during or following assigned periods of duty. Patient care quality and education continuity must be ensured through assignment of progressive responsibility.

**Documentation Requirement:** The program must submit the educational plans for all current residents and the final completed schedules for residents who have completed the program since the prior site visit.

**Measure:** Resident schedules show progressive responsibility. Current residents: Documents the learning goals for an individual resident in terms of competencies, knowledge, and skills. Documents creation of a schedule that includes courses, rotations, and activities conducive to the accomplishment of the learning plan. Former residents: Documents completion of an educational program in preventive medicine.
E. General Clinical Competencies

The acquisition of basic clinical competencies will require an ACGME-accredited clinical year (12 months) with 6 months of direct patient care. The following competencies must be obtained by all residents by the time they graduate. (These competencies may also be acquired during academic and practicum training of the residency program and should be incorporated where applicable).

1. Patient Care: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2. Medical Knowledge: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
3. Practice Based Learning and Improvement: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
4. Interpersonal Skills and Communication: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates.
5. Professionalism: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6. Systems-based Practice: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

**Documentation Requirement:** Resident schedules and incoming resident assessment.

**Measure:** Resident schedules, incoming resident assessment, and program files document rotations and activities that verify a total of 12 months of clinical experience.

F. Academic Competencies—Preventive Medicine Knowledge Content Areas

1. Core knowledge content areas

The program must address in adequate depth and breadth the following competencies, skills, and knowledge that underlie the practice of preventive medicine:

   a. Health services administration
   b. Biostatistics
   c. Epidemiology
   d. Clinical preventive medicine
e. Behavioral aspects of health  

f. Environmental health

2. Aerospace medicine knowledge content areas:

a. History of aerospace medicine  
b. The flight environment  
c. Clinical aerospace medicine  
d. Operational aerospace medicine  
e. Management and administration

3. Occupational medicine knowledge content areas:

a. Disability management and work fitness  
b. Workplace health and surveillance  
c. Hazard recognition, evaluation, and control  
d. Clinical occupational medicine  
e. Regulations and government agencies  
f. Environmental health and risk assessment  
g. Health promotion and clinical prevention  
h. Management and administration  
i. Toxicology

4. Public health and general preventive medicine

The knowledge content areas for public health and general preventive medicine, while similar to those of the core content areas, emphasize more in-depth knowledge in each area.

a. Health services administration, public health practice, and managerial medicine  
b. Environmental health  
c. Biostatistics  
d. Epidemiology  
e. Clinical preventive medicine

**Documentation Requirement:** Resident schedules, resident academic records, rotation and course descriptions, academic transcripts.

**Measure:** The academic courses cover the knowledge areas listed above.

G. Preventive Medicine Competencies

The attainment of advanced preventive medicine practice competencies requires a sequence of continued learning and supervised application of the knowledge, skills, and attitudes of preventive medicine in the specialty area. The resident must assume progressive responsibility
for patients and/or the clinical and administrative management of populations or communities during the course of training.

The resident shall acquire the following core preventive medicine competencies:

1. Communication, program, and needs assessment
   a. Communicate clearly to multiple professional and lay target groups, in both written and oral presentations, the level of risk from hazards and the rationale for interventions
   b. Conduct program and needs assessments and prioritize activities using objective, measurable criteria such as epidemiological impact and cost-effectiveness

2. Computer applications relevant to preventive medicine: Residents shall be able to use computers for word processing, reference retrieval, statistical analysis, graphic display, database management, and communication.

3. Interpretation of relevant laws and regulations: Residents shall be able to identify and review relevant laws and regulations germane to the resident's specialty area and assignments.

4. Identification of ethical, social, and cultural issues relating to public health and preventive medicine contexts: Residents shall be able to recognize ethical, cultural, and social issues related to a particular issue and develop interventions and programs that acknowledge and appropriately address the issues.

5. Identification of organizational and decision-making processes: Residents shall be able to identify organizational decision-making structures, stakeholders, style, and processes.

6. Identification and coordination of resources to improve the community's health: Residents shall be able to assess program and community resources, develop a plan for appropriate resources, and integrate resources for program implementation.

7. Epidemiology and biostatistics, including the ability to:
   a. characterize the health of a community,
   b. design and conduct an epidemiological study,
   c. design and operate a surveillance system,
   d. select and conduct appropriate statistical analyses,
   e. design and conduct an outbreak or cluster investigation, and
   f. translate epidemiological findings into a recommendation for a specific intervention.
8. Management and administration, including the ability to:
   a. assess data and formulate policy for a given health issue,
   b. develop and implement a plan to address a specific health problem,
   c. conduct an evaluation or quality assessment based on process and outcome performance measures, and
   d. manage the human and financial resources for the operation of a program or project.

9. Clinical preventive medicine, including the ability to:
   a. develop, deliver, and implement, under supervision, appropriate clinical services for both individuals and populations and
   b. evaluate the effectiveness of clinical services for both individuals and populations.

10. Occupational and environmental health, including opportunities for residents to be able to assess and respond to individual and population risks for occupational and environmental disorders

   **Documentation Requirement:** Resident schedules, rotation descriptions, inter-institutional agreements.

   **Measure:** Adequate depth and breadth is provided.

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**H. Aerospace Medicine Competencies**

Specialty training for the physician in aerospace medicine must provide for the attainment of competencies relevant to the diagnosis, prevention, and treatment of disorders associated with the unique aerospace environments and with the adaptive systems designed to enhance performance and support life under such conditions.

1. Manage the health status of individuals working in all aspects of the aerospace environment
   a. Adequate supervised time in direct clinical care of aerospace medical problems must be provided to assure competency in managing aerospace and general medical problems in aerospace personnel.
   b. The resident is expected to develop and apply medical standards and grant exceptions and to facilitate prevention, early diagnosis, and treatment of health hazards.
   c. For programs with a training track in space medicine: The resident is expected to perform all activities of a crew surgeon for a space flight, develop and apply medical care standards and programs, evaluate the physiologic effects of spaceflight on crewmembers, and conduct and evaluate longitudinal studies on astronauts.
2. Promote aerospace passenger health, safety, and comfort: The resident is expected to acquire skills to educate passengers and physicians about the hazards of flight with certain medical conditions and to serve as passenger advocates to promote flight safety.

3. Facilitate optimum care of patients transported in the aerospace environment: The resident is expected to identify appropriate patients for aeromedical transport and to provide guidance for safe aeromedical transport of patients with common medical problems.

4. Apply human factors/ergonomic concepts to the aerospace environment: The resident will acquire skills to advise in the development of air and space flight equipment, biomedical equipment, and vehicles for flight and space flight; techniques for enhancing performance; and techniques of crew resource management.

5. Promote aerospace operational safety and mishap prevention: The resident will acquire skills to provide appropriate safety information and education and to conduct the medical aspects of any mishap investigation, including recommendations to prevent recurrences.

6. Interpret, integrate, and/or perform aeromedical research: The resident will acquire skills to effectively conduct aeromedical research into health, safety, human factors, and biomedical engineering aspects of the flight environment.

**Documentation Requirement:** Resident schedules, rotation descriptions, inter-institutional agreements.

**Measure:** Adequate depth and breadth is provided.

I. Occupational Medicine Competencies

Residents must be able to perform the following tasks.

1. Manage the health status of individuals who work in diverse work settings
   a. Adequate supervised time in direct clinical care of workers, from numerous employers and employed in more than one work setting, must be provided to ensure competency in mitigating and managing medical problems of workers.
   b. Residents must be able to assess safe/unsafe work practices and to safeguard employees and others, based on clinic and worksite experience.

2. Monitor/survey workforces and interpret monitoring/surveillance data for prevention of disease in workplaces and to enhance the health and productivity of workers: Active participation in several surveillance or monitoring programs, for different types of workforces, is required to learn principles of administration and
maintenance of practical workforce and environmental public health programs. Residents must plan at least one such program.

3. Manage worker insurance documentation and paperwork, for work-related injuries that may arise in numerous work settings: Residents should first learn worker insurance competencies under direct supervision of faculty and demonstrate competency to "open," direct, and "close" injury/illness cases.

4. Recognize outbreak events of public health significance, as they appear in clinical or consultation settings

   a. Residents should understand the concept of sentinel events, and know how to assemble/work with a team of fellow professionals who can evaluate and identify worksite public health causes of injury and illness.

   b. Residents must be able to recognize and evaluate potentially hazardous workplace and environmental conditions, and recommend controls or programs to reduce exposures, and to enhance the health and productivity of workers.

   c. Reliance on toxicologic and risk assessment principles in the evaluation of hazards must be demonstrated.

5. Report outcome findings of clinical and surveillance evaluations to affected workers as ethically required; advise management concerning summary (rather than individual) results or trends of public health significance.

   **Documentation Requirement:** Resident schedules, rotation descriptions, inter-institutional agreements.

   **Measure:** Competencies, skills and knowledge relevant to preventive intervention in the workplace are addressed in workplace settings. The resident has the opportunity to demonstrate constructive participation in comprehensive programs to prevent occupational injury and illness and maintain worker health. Clinic settings demonstrate bridging from clinical activities to effective preventive intervention in the workplace.

J. Public Health and General Preventive Medicine Competencies

Residents in public health and general preventive medicine must attain competencies in public health, clinical preventive medicine (as appropriate to the specific program), epidemiology, health administration, and managerial medicine.

1. Public health practice: At least 1 month must be spent in a rotation at a governmental public health agency and must include participation in at least one of the following essential public health services:

   a. Monitoring health status to identify community health problems
b. Diagnosing and investigating health problems and health hazards in the community
c. Informing and educating populations about health issues
d. Mobilizing community partnerships to identify and solve health problems
e. Developing policies and plans to support individual and community health efforts
f. Enforcing laws and regulations that protect health and ensure safety
g. Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable
h. Ensuring a competent public health and personal health care workforce
i. Evaluating the effectiveness, accessibility, and quality of personal and population-based health services
j. Conducting research for innovative solutions to health problems

2. Clinical preventive medicine
   a. Residents shall acquire an understanding of primary, secondary, and tertiary preventive approaches to individual and population-based disease prevention and health promotion.
   b. Residents shall be able to develop, implement, and evaluate the effectiveness of appropriate clinical preventive services for both individuals and populations.

3. Epidemiology
   Residents shall design and conduct health and clinical outcomes studies.

4. Health administration
   a. Residents shall design and use management information systems.
   b. Residents shall plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems.

*Documentation Requirement:* Resident schedules, rotation descriptions, inter-institutional agreements.

*Measure:* The resident demonstrates competency in public health agency administration and public health program planning and implementation, as well as managerial medicine competencies.

**IV. Evaluations**

The program director and faculty must annually evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and
administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the faculty, and the quality of supervision of residents.

A. Courses, Rotations, and Activities

1. Written method of evaluation. The program will evaluate in writing the provision of and individual resident participation in assigned courses, rotations, and activities. The method will evaluate achievement of competency, skill, and knowledge objectives from the perspectives of both the resident and the faculty.

   **Documentation Requirement:** The program will submit a written description prior to the site visit of the method by which the program director and the resident will document resident participation in assigned courses, rotations, and activities as well as acquisition of skills and knowledge and demonstration of competencies.

   **Measure:** Evaluation method provides for documentation by the supervisor and the resident of resident participation in learning experiences, the skills and knowledge acquired, and the competencies demonstrated.

2. Faculty and residents will use the evaluation method to evaluate the courses, rotations, and activities of each resident on at least a semiannual basis.

   **Documentation Requirement:** The program will maintain and make readily available to site visitors copies of evaluations by both the residents and the faculty of courses, rotations, and activities for the prior 5 years. Evaluation of residents in the academic phase will be the responsibility of the sponsoring institution and will include a transcript or equivalent document provided to each resident. The evaluations for each resident must be available for review by the individual resident.

   **Measure:** Documents for each resident for each experience that learning opportunities were provided, skills and knowledge were acquired, and competencies were demonstrated.

B. Summary Resident Evaluation

The program director, with participation of the faculty, shall evaluate resident progress toward educational goals in writing at least semiannually. Where progress toward educational goals deviates significantly from the educational plan, counseling or corrective actions must be documented.

Fair procedures, as established by the sponsoring institution, and in compliance with the ACGME Institutional Requirements regarding academic discipline and resident complaints or grievances, must be implemented.
Faculty should monitor resident stress, including mental or emotional conditions inhibiting performance or learning and drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.

The evaluations must be reviewed with the resident formally and in a timely manner. Where appropriate, interim evaluation is encouraged.

**Documentation Requirement:** These evaluations must be on file for the prior 5 years and readily available to the site visitor.

**Measure:** Documents that the resident has been supplied feedback on progress against plan on acquisition of knowledge, skills, and demonstration of competencies. Final evaluation documents completion of learning plan.

C. Program Evaluation

1. Residents

 Residents shall annually provide a confidential written evaluation of the educational program based on completion of a written questionnaire. This evaluation shall be provided to the program director. An additional confidential evaluation shall be provided to the chair of the residency advisory committee (RAC).

**Documentation Requirement:** Confidential written evaluations by each resident of the program must be maintained on file for the prior 5 years, be noted in the RAC minutes, and be readily available to the site visitor.

**Measure:** Documents that each resident has provided annual feedback to the program on the program structure, factors considered conducive to acquisition of skills and knowledge and demonstration of competencies, activities planned but not provided, and suggestions for program enhancement.

2. Faculty-Residency Advisory Committee

The RAC shall consist of faculty, external members, practicum supervisors, and at least one resident representative. A majority of the members must have their primary affiliation outside the sponsoring institution. Members must be certified in preventive medicine or knowledgeable about specialty training in preventive medicine. The RAC chair must be a physician. The program director must serve in an ex-officio capacity. The RAC must meet at least semiannually.

The mission of the RAC is to promote a residency training experience that is aligned with preventive medicine practice. The RAC, as an external body, complements the graduate medical education committee (GMEC), which serves to evaluate and support the residency from within the sponsoring institution.
The functions of the RAC are to advise and assist the program director to:

a. develop and update a written residency mission statement that describes goals and objectives;

b. develop educational experiences and practicum rotations;

c. provide new or emerging knowledge, skills, or competencies that may influence the content or conduct of preventive medicine education;

d. review the GMEC review of the residency program;

e. review confidential and written resident evaluations of the program and make recommendations for changes;

f. review the program director evaluation of individual residents; and

g. provide an annual report to the institution through the chair of the committee.

Documentation Requirement: Minutes document the functions of the RAC.

Measure: Minutes are available in the program files that document the activity of the RAC and faculty/member participation.

D. Resident Progression and Program Completion

The program director and faculty must document completion of courses, rotations, and activities and must certify that residents completing the program have fulfilled all established requirements of their educational plan. This final evaluation must be part of the resident's permanent record and must be maintained by the institution.

Although a person may have entered a practicum phase with an incomplete academic phase, that person may not be certified as having completed the practicum phase in the absence of a transcript certifying that all the requirements for the Master of Public Health or other appropriate postgraduate degree have been completed.

Documentation Requirement: This documentation must be readily available for site visitor review.

Measure: Documents status in and/or completion of the educational plan by each resident. Documents that a resident completing the practicum has achieved the planned competencies.

E. Resident Summary

The residency must maintain a database of all residents participating in the program and their professional status for 5 years.

1. The program must monitor the percentage of entering residents who take the certifying examination of the American Board of Preventive Medicine (ABPM).
A minimum of 50% of entering residents must take the certifying exam averaged over any 5-year period.

2. Of those residents taking the certifying examination, a minimum of 50% must pass the certifying examination averaged over any 5-year period.

**Documentation Requirement:** Prior to the site visit the program must provide documentation of the residents participating in the program, their professional status, the percentage taking the certifying examination, and the percentage passing the certifying examination.

**Measure:** 50% of entering residents must take the certifying examination of the ABPM, and of those taking the examination, 50% must pass.

F. Institutional Report of Program Director

The program director and the chair of the RAC must provide to the director of graduate medical education, or equivalent, at the institution an annual written report of the residency quality. The program director and the chair of the RAC must provide a written plan of corrective actions for any recommendations received from the director of graduate medical education.

**Documentation Requirement:** Reports and plans for corrective actions written since the prior site visit must be readily available to the site visitor.

**Measure:** Recommendations are acted upon by the residency program director.

PROGRAM INFORMATION FORMS, EFFECTIVE JULY 2001 (TAB D)

As explained under Tab A (The Basics of Preventive Medicine Accreditation), the Program Information Form (PIF) is a comprehensive self-study document prepared by each residency program. The PIF serves as the basis for the formal periodic review of programs and on-site inspection by the ACGME’s Preventive Medicine RRC.

Instructions for completing the Program Information Form

The following Program Information Forms are prepared for programs in all areas of specialization in Preventive Medicine: General Preventive Medicine/Public Health, Occupational Medicine, and Aerospace Medicine and for programs offering one or more of the three phases: Clinical, Academic, or Practicum. The minimum program length that can be accredited is the practicum phase.

Before completing the attached form, please review your Institutional Requirements (I.R.) effective and the Program Requirements (P.R.) for Preventive Medicine effective July 1, 2001. All residency programs surveyed after July 1, 2001 must use the following revised forms. Please be reminded that the program director is responsible for the accuracy of the submitted information.

APPLICATION FOR A NEW PROGRAM: Please mail four copies of this document, including appendices, to the Executive Director at the above address.

SURVEY OF A CURRENTLY ACCREDITED PROGRAM: Please mail one copy of this document, including appendices, to the site visitor at least two weeks before the site visit. Appendices should be clearly labeled and attached at the end of the program information form. Three additional copies should be held to permit corrections that may be required as the site visit proceeds. After the visit, three copies must be mailed to the Executive Director at the above address.

Additional instructions: Care has been taken to make these forms easier to use. For example, references to the Program Requirements have been added throughout to assist the writer (example, P.R. III. A.). If more space is required to respond to an item, insert additional pages as necessary. The information provided should be complete and concise. Do not include reprints, brochures, catalogs or lengthy CV’s. Please do not staple or bind the document. Secure with rubber bands. No revision to the form is permitted. The sequential order of the PIF must be retained; the program must complete an accurate table of contents.

Revised 3/01
### PROGRAM INFORMATION FORM

RESIDENCY REVIEW COMMITTEE FOR PREVENTIVE MEDICINE  
515 North State Street, Suite 2000, Chicago, Illinois  60610

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Check type of program and phase(s) for which accreditation is requested. (*Reference: Program Requirements IV.A.*)

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Attach as *Appendix A* the curriculum vitae for the program director.

* If the Program Director is not Board certified in Preventive Medicine, please attach an explanation of equivalent qualifications.
### Institutional Information

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**Instructions:** Attach all Institutional Affiliation Agreements as *Appendix B*. Include the respective institution number on each affiliation agreement.

* Attach accreditation letter as *Appendix C*.
### Institutional Information

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<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Responsible Official:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/ State/ZIP:</td>
<td>E-Mail</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>FAX:</td>
<td></td>
</tr>
</tbody>
</table>

#### NAME OF PARTICIPATING INSTITUTION (#6)

<table>
<thead>
<tr>
<th>JCAHO APPROVED: II.E.5</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Responsible Official:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
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<tr>
<td>City/ State/ZIP:</td>
<td>E-Mail</td>
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<tr>
<td>Phone:</td>
<td>FAX:</td>
<td></td>
</tr>
</tbody>
</table>

Instructions: Attach all Institutional Affiliation Agreements as Appendix B. Include the respective institution number on each affiliation agreement.

* Attach accreditation letter as Appendix C.
I. INTRODUCTION

Objectives and Components of the Residency Program

Provide a one-page description of the program and its concentration in aerospace medicine, occupational medicine, or public health and general preventive medicine. Describe the structure of the residency and its length. Describe general objectives associated with each phase of accreditation. Attach as Appendix D.

II. RESIDENCY DESIGN

<table>
<thead>
<tr>
<th>Number of Residents</th>
<th>Approved</th>
<th>Filled</th>
<th>Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical phase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic phase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practicum phase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concurrent a/p phases (only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMBINED RESIDENCY TRAINING: If program offers combined training, specify number of full time equivalents (FTE’s) at each level of training. These numbers should be included in the total identified above.

<table>
<thead>
<tr>
<th>TRAINING LEVEL</th>
<th>PGY-1</th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PG-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Medicine/ Specialty</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Preventive Medicine/ Specialty</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

39
## Educational Goals Overview

### GOALS AND OBJECTIVES

**II.A.3**

1. Is there a written statement of the goals and objectives of the program that is provided to the residents? Please attach as appendix E for review by the site visitor. | YES | NO |

2. Are the goals and objectives provided to faculty? | YES | NO |

3. Are there goals and objectives for each rotation? | YES | NO |

4. Are there goals and objectives for each year of training? | YES | NO |

5. Are all residents given a copy of the Preventive Medicine Program Requirements at the beginning of training? | YES | NO |

### II.A.4 Program Schedule

Attach an educational plan for each current resident; schedules for each current resident; and a final completed schedule for at least one resident who has completed the program since the last ACGME-site visit of the program as Appendix F.

### DUE PROCESS PROCEDURES

1. Is there a written due process procedure? A copy of the policy should be available for the site visitor. | YES | NO |

2. Do residents receive a copy of this procedure at the beginning of their training? | YES | NO |
II.B. 3 Practicum Phase

*Instructions:* The following items require a YES (Y) or NO (N) response. Attach a brief description or explanation where indicated. Be brief!

<table>
<thead>
<tr>
<th>PRACTICUM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has each resident admitted into the practicum completed an ACGME or RCPSC-accredited clinical year? If no, describe in detail and attach as Appendix G.</td>
<td>YES NO</td>
</tr>
<tr>
<td>2. Has each resident admitted to the practicum phase completed an MPH or other appropriate postgraduate degree? If no, explain how knowledge of each of the four core subjects is completed. <strong>Attach as appendix G.</strong></td>
<td>YES NO</td>
</tr>
</tbody>
</table>

Provide the following information for enrolled residents:

<table>
<thead>
<tr>
<th>NAME OF RESIDENT</th>
<th>YEAR IN PROGRAM</th>
<th>NAMES AND DATES OF MEDICAL SCHOOL</th>
<th>MPH OR EQUIVALENT DEGREE AND INSTITUTION</th>
<th>ACGME OR RCPSC CLINICAL YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
II. C. Program Director

Instructions: *The following items require a YES (Y) or NO (N) response. Attach a brief description or explanation where indicated. Be brief!*

<table>
<thead>
<tr>
<th>PROGRAM DIRECTOR QUALIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of Program Director:</td>
</tr>
<tr>
<td>2. Name of Assistant or Associate Program Director (if applicable):</td>
</tr>
<tr>
<td>3. Is the program director full-time in the sponsoring institution?</td>
</tr>
<tr>
<td>If not, what percent time in the institution?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROGRAM DIRECTOR RESPONSIBILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the program director responsible for selecting residents for appointment to the program?</td>
</tr>
<tr>
<td>2. Is information prepared by the program director and disseminated to residents covering the program’s accreditation status, educational objectives, and program structure?</td>
</tr>
<tr>
<td>3. Does the program have fair procedures, as established by the sponsoring institution, regarding academic discipline and resident complaints or grievances?</td>
</tr>
<tr>
<td>4. Are appropriate records related to program accreditation maintained?</td>
</tr>
</tbody>
</table>
### II.C. 2 SELECTION AND APPOINTMENT PROCESS

#### SELECTION PROCEDURES

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a selection committee to assist the Program Director in the appointment of residents? Briefly describe its composition (see note below):</td>
<td>YES</td>
</tr>
<tr>
<td>2. Is there a procedure for documenting the credentials of applicants, their past performance and professional integrity? Is this documentation always a part of the permanent training record? Briefly describe (see note below):</td>
<td>YES</td>
</tr>
<tr>
<td>3. Is there a documented procedure for evaluating and selecting applicants? Briefly describe (see note below):</td>
<td>YES</td>
</tr>
<tr>
<td>4. Are all applicants who are interviewed provided with a written description of:</td>
<td></td>
</tr>
<tr>
<td>a. The educational program?</td>
<td>YES</td>
</tr>
<tr>
<td>b. Financial compensation and policies regarding vacations and leaves (e.g., sickness, disability, maternity/paternity)?</td>
<td>YES</td>
</tr>
<tr>
<td>c. Liability, medical and disability coverage, including any important exceptions to coverage? Briefly describe (see note below):</td>
<td>YES</td>
</tr>
</tbody>
</table>

**NOTE:** Attach a written description for items 1, 2, 3 and 4c as appendix H.
Program Requirement II.D.

Faculty

1. Are faculty active participants in discussions, rounds, and conferences? Attach faculty C.V.’s as Appendix I.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

2. Are faculty available to offer guidance and technical support for residents involved in research?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

3. Are faculty available to supervise residents and monitor their progression through the program?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE II.D
CORE FACULTY AND STAFF*

<table>
<thead>
<tr>
<th>Faculty or Staff Name</th>
<th>ABPM Certification and Specialty</th>
<th>Other ABMS Specialty</th>
<th>Other Certification if Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

* Any faculty or staff who are directly responsible for teaching competencies in table III.A.

NOTE: Attach CV’s as Appendix I.
Program Requirement H.E

<table>
<thead>
<tr>
<th>SPONSORING INSTITUTION</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there at least one other ACGME-accredited residency at the same institution that provides direct patient care? If no, complete Appendix V, single program institution.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2. For the preventive medicine academic phase, is there a course of study leading to the Master of Public Health degree or other appropriate postgraduate degree?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3. For aerospace medicine, within the institutional setting is there an area where operational aeromedical problems are routinely encountered and aerospace life support systems are under active study and development?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4. For occupational medicine, within the institutional setting is there a comprehensive occupational health service?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5. For public health and general preventive medicine, within the institutional setting, is there an academically affiliated institution, an academically affiliated health care organization, or a government public health agency?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
Program Requirement II.F and II.G.

<table>
<thead>
<tr>
<th>LIBRARY FACILITIES</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is there a medical library readily available to the residents?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>b. Is this library available to the residents 24 hours/day, 7 days/week?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>c. Is there a librarian available?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>d. Is there computerized capability such as Medline, Medlar &amp; Index Medicus?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>e. Are inter-loan capabilities present?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>f. Are audio-visual materials available?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>g. Is there Internet access?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>h. Number of preventive medicine/behavioral science journals regularly received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and available electronically:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Number of other medical journals (e.g., pediatric, forensic) regularly received</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Briefly describe resources listed above, including access to the medical library, travel funds, computer access, office and lab space, attach as Appendix J.
## Program Requirement II.H.

<table>
<thead>
<tr>
<th>PARTICIPATING INSTITUTIONS</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is there a faculty or staff member designated at each participating institution responsible for resident supervision?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>b. Is there a signed affiliation agreement in place for each participating institution? (Appendix B)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>c. Does each agreement cover educational goals and objectives?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>d. Does each agreement cover scope of the affiliation?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>e. Does each agreement cover resources to support residents?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>f. Does each agreement cover duties and responsibilities of each resident?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>g. Does each agreement cover the relationship between residents and staff at the institution?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>h. Does each agreement cover a mechanism for evaluating residents?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>i. Does each agreement cover discipline and grievance procedures?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

*Note:* Program Requirement items c - i above can be in an affiliation agreement, letter of agreement and/or in a contract.
III. EDUCATIONAL OBJECTIVES

PROGRAM NARRATIVE DESCRIPTION

III.A RESIDENCY PROGRAM TEACHING STAFF

Instructions: Please match faculty and staff to the academic and/or practicum competencies they teach.

Please complete only those phases offered by the program.
NOTE: All programs must complete Core Preventive Medicine Section.

<table>
<thead>
<tr>
<th>Competency</th>
<th>List core faculty or staff who teach this competency*</th>
<th>Type: e.g. MPH Class work; Didactic or practicum experience</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Phase III.E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medical Knowledge</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Practice Based Learning and Improvement</td>
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<tr>
<td>Interpersonal Skills and Communication</td>
<td></td>
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<tr>
<td>Professionalism</td>
<td></td>
<td></td>
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<tr>
<td>Systems Based Practice</td>
<td></td>
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</tbody>
</table>

* Core faculty and staff should have details recorded in table II.D and a CV attached as Appendix I.
### Academic Competencies III.F

<table>
<thead>
<tr>
<th>Core Knowledge Content Areas</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Health Services Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Biostatistics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Epidemiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Clinical Preventive Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Behavioral Aspects of Health</td>
<td></td>
<td></td>
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<tr>
<td>F. Environmental Health</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Aerospace Medicine Knowledge Content Areas</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. History of Aerospace Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. The Flight Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Clinical Aerospace Medicine</td>
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<td></td>
</tr>
<tr>
<td>D. Operational Aerospace Medicine</td>
<td></td>
<td></td>
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<tr>
<td>E. Management and Administration</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupational Medicine Knowledge Content Areas</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Disability Management and work fitness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Workplace Health and Surveillance</td>
<td></td>
<td></td>
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<tr>
<td>C. Hazard Recognition, Evaluation, and Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Clinical Occupational Medicine</td>
<td></td>
<td></td>
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<tr>
<td>E. Regulations and Government Agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Environmental Health and Risk Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Health Promotion and Clinical Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Management and Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Toxicology</td>
<td></td>
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</tr>
</tbody>
</table>
### Public Health and General Preventive Medicine

**A. Health Services Administration, public health practice, and managerial medicine**

- B. Environmental Health
- C. Biostatistics
- D. Epidemiology
- E. Clinical Preventive Medicine

<table>
<thead>
<tr>
<th>Core Preventive Medicine III.G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication, program, and needs assessment</td>
</tr>
<tr>
<td>Computer applications relevant to preventive medicine</td>
</tr>
<tr>
<td>Interpretation of relevant laws and regulations</td>
</tr>
<tr>
<td>Identification of ethical, social, and cultural issues relating to public health and preventive medicine</td>
</tr>
<tr>
<td>Identification of organizational and decision-making processes</td>
</tr>
<tr>
<td>Identification and coordination of resources to improve the community’s health</td>
</tr>
<tr>
<td>Epidemiology and biostatistics</td>
</tr>
<tr>
<td>Management and administration</td>
</tr>
<tr>
<td>Clinical preventive medicine</td>
</tr>
<tr>
<td>Occupational and environmental health, including opportunities for residents to be able to assess and respond to individual and population risks for occupational and environmental disorders</td>
</tr>
</tbody>
</table>

### Aerospace Medicine III.H

- Manage the health status of individuals working in all aspects of the aerospace environment
<table>
<thead>
<tr>
<th>Promote aerospace passenger health, safety and comfort</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate optimum care of patients transported in the aerospace environment</td>
<td></td>
</tr>
<tr>
<td>Apply human factors/ergonomic concepts to the aerospace environment</td>
<td></td>
</tr>
<tr>
<td>Promote aerospace operational safety and mishap prevention</td>
<td></td>
</tr>
<tr>
<td>Interpret, integrate, and/or perform medical research</td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Medicine III.J</strong></td>
<td></td>
</tr>
<tr>
<td>Manage the health status of individuals who work in diverse settings</td>
<td></td>
</tr>
<tr>
<td>Monitor/survey workforces and interpret monitoring/surveillance data for prevention of disease in workplaces and to enhance the health and productivity of workers</td>
<td></td>
</tr>
<tr>
<td>Manage worker insurance documentation and paperwork, for work-related injuries that may arise in numerous work settings</td>
<td></td>
</tr>
<tr>
<td>Recognize outbreak events of public health significance, as they appear in clinical or consultation settings</td>
<td></td>
</tr>
<tr>
<td>Report outcome findings of clinical and surveillance evaluations to affected workers as ethically required; advise management concerning summary (rather than individual) results or trends of public health significance</td>
<td></td>
</tr>
<tr>
<td><strong>Public Health &amp; General Preventive Medicine III.J</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Public Health Practice

**A. Monitoring Health Status to Identify Community Health Problems**

B. Diagnosing and Investigating Health Problems and Health Hazards in the Community

C. Informing and Educating Populations About Health Issues

D. Mobilizing Community Partnerships to Identify and Solve Health Problems

E. Developing Policies and Plans to Support Individual and Community Health Efforts

F. Enforcing Laws and Regulations that Protect Health and Ensure Safety

G. Linking People to Needed Personal Health Services and Ensuring Provisions of Health Care when otherwise Unavailable

H. Ensuring a Competent Public Health and Personal Health Care Workforce

I. Evaluating the Effectiveness, Accessibility, and Quality of personal and population-based health services

J. Conducting Research for Innovative solutions to Health Problems

## Clinical Preventive Medicine

**A. Residents shall Acquire an understanding of primary, secondary, and tertiary preventive approaches to individual and population-based disease prevention and health promotion**

B. Residents shall be able to develop, implement, and evaluate the effectiveness of appropriate clinical preventive services for both individuals and populations.
<table>
<thead>
<tr>
<th>Epidemiology</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Residents shall design and conduct health and clinical outcomes studies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Administration</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Residents shall design and use management information systems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Residents shall plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please complete only those phases offered by the program.

NOTE: All programs must complete Core Preventive Medicine Section.
III.C Please describe the written resident assessment and attach as Appendix K.

III.D EDUCATIONAL PLAN

Attach an educational plan for each current resident; schedules for each current resident; and a final completed schedule for at least one resident who has completed the program since the last ACGME-site visit of the program as Appendix F.

III.E. GENERAL CLINICAL COMPETENCIES

Provide documentation to verify a total of 12 months of clinical experience covering the 6 general clinical competencies. Documentation should include resident schedules and incoming resident assessment. Describe for the 6 general competencies.

Clinical Phase

Complete the following section if accreditation of a clinical phase is requested. Include a detailed description for any clinical education occurring in cooperation with another service, such as internal medicine. In addition, (1) describe how preventive medicine residents are appointed, (2) the mechanism by which supervision is provided, and (3) the relationship between the program director and the individual responsible for the site at which the clinical experience is provided. If accreditation of a clinical phase is not requested, skip to III.F.

<table>
<thead>
<tr>
<th>Does the program offer a clinical phase? If yes, complete this section if there is an INPATIENT EXPERIENCE. Attach all narrative explanations as Appendix L.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of Participating Institution:</td>
</tr>
<tr>
<td>2. Is there an inpatient service? If yes, number of beds ____</td>
</tr>
<tr>
<td>3. What is the duration of the inpatient rotation?</td>
</tr>
<tr>
<td>4. Explain briefly the role of the resident (e.g., clinical service involvement, duties, etc.).</td>
</tr>
<tr>
<td>5. Is the resident supervised and evaluated by a designated faculty member? If yes, explain briefly.</td>
</tr>
<tr>
<td>6. Have goals and objectives for the inpatient rotation been developed? (Do not attach; have available for the site visitor)</td>
</tr>
<tr>
<td>7. Is the resident required to attend required educational conferences? (Have conference list and attendance records available for the site visitor.)</td>
</tr>
<tr>
<td>Is there an institutional policy regarding resident duty hours? Describe how this is monitored.</td>
</tr>
</tbody>
</table>
**Complete this section if there is an OUTPATIENT EXPERIENCE**

Attach all narrative explanations as Appendix L.

<p>| | | | | | | |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Name of Participating Institution:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Is there an outpatient rotation? If yes, list the approximate number of patients for which the resident is responsible: _____</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>What is the duration of the outpatient rotation?</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>4.</td>
<td>Explain briefly the role of the resident (e.g., clinical service involvement, duties, etc.)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5.</td>
<td>Is the resident supervised and evaluated by a designated faculty member? If yes, explain briefly.</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Have goals and objectives for the outpatient rotation been developed? (Do not attach; have available for the site visitor)</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Is the resident required to attend required educational conferences? (Have conference list and attendance records available for the site visitor.)</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Is there an institutional policy regarding resident duty hours? Describe how this is monitored.</td>
<td>YES</td>
<td>NO</td>
<td></td>
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</tr>
</tbody>
</table>
### III.F. ACADEMIC COMPETENCIES

Complete the following section if accreditation of an academic phase is requested. Skip to III.G. if accreditation of an academic phase is not requested.

Attach a narrative description of the academic phase as Appendix M.

Program Requirements

<table>
<thead>
<tr>
<th>ACADEMIC PHASE</th>
<th>Complete this section if there is an ACADEMIC PHASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and location of Participating Institution:</td>
<td></td>
</tr>
<tr>
<td>1. Is the academic program accredited? Attach the accreditation letter from the accrediting organization as Appendix C.</td>
<td>YES NO</td>
</tr>
<tr>
<td>2. Is there a required core course in biostatistics?</td>
<td>YES NO</td>
</tr>
<tr>
<td>3. Is there a required core course in epidemiology?</td>
<td>YES NO</td>
</tr>
<tr>
<td>4. Is there a required core course in health services organization and administration?</td>
<td>YES NO</td>
</tr>
<tr>
<td>5. Is there a required core course in environmental and occupational health?</td>
<td>YES NO</td>
</tr>
</tbody>
</table>
III.G. PREVENTIVE MEDICINE CORE COMPETENCIES

Complete the following section if accreditation of a practicum phase is requested.

Attach a description of how core competencies are taught in this program as Appendix N.

<table>
<thead>
<tr>
<th>PRACTICUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete this section for all programs for core preventive medicine competencies.</td>
</tr>
</tbody>
</table>

**Indicate in which of the following areas the program provides opportunities for residents to achieve the following objectives.** Explain briefly each area in which an opportunity does not exist.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communication, program, and needs assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Computer applications relevant to preventive medicine</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3. Interpretation of relevant laws and regulations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Identification of ethical, social, and cultural issues relating to public health and preventive medicine contexts</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5. Identification of organizational and decision-making processes</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>6. Identification and coordination of resources to improve the community’s health</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>7. Epidemiology and biostatistics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Management and administration</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>9. Clinical preventive medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Occupational and environmental health, including opportunities for residents to be able to assess and respond to individual and population risks for occupational and environmental disorders</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

11. If the sponsoring institution is not a public health agency, document how the minimum one-month experience in a public health agency is provided for each resident. The public health agency must be listed as a participating institution and an inter-institutional agreement must be attached. (Refer to the Program Requirements for Preventive Medicine/Public Health Program Requirements.)

12. If the sponsoring institution is a public health agency, the required didactic component must include affiliation with a medical school or school of public health. The academic institution must be listed as a participating institution and an inter-institutional agreement must be attached.
### III.H. AEROSPACE COMPETENCIES

**Practicum Phase**

**Instructions:** Complete this page if requesting the accreditation of a practicum phase for an aerospace medicine program. Discard this page if not requesting an accredited Aerospace Medicine practicum phase.

Please carefully complete this section by describing in detail the resident experience in the practicum. Attach as Appendix O.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Manage the health status of individuals working in all aspects of the aerospace environment</td>
</tr>
<tr>
<td>2.</td>
<td>Promote aerospace passenger health, safety, and comfort</td>
</tr>
<tr>
<td>3.</td>
<td>Facilitate optimum care of patients transported in the aerospace environment</td>
</tr>
<tr>
<td>4.</td>
<td>Apply human factors/ergonomic concepts to the aerospace environment</td>
</tr>
<tr>
<td>5.</td>
<td>Promote aerospace operational safety and mishap prevention</td>
</tr>
<tr>
<td>6.</td>
<td>Interpret, integrate, and/or perform aeromedical research</td>
</tr>
</tbody>
</table>
**PRACTICUM PHASE**  
**Aerospace Medicine**  
**Seminars and Conferences**

*Instructions:* List the conferences and seminars, journal clubs, specialty conferences, or similar educational sessions available for resident education. Indicate the frequency, e.g. weekly, monthly, etc., and whether conference attendance is required (R) or optional (O). Designate with an (*) those primarily for the program. Reference the Program Requirements for Aerospace Medicine, III H.

<table>
<thead>
<tr>
<th>CONFERENCE</th>
<th>R OR O</th>
<th>FREQUENCY</th>
<th>RESPONSIBLE PERSON/DEPARTMENT</th>
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</table>
### III. OCCUPATIONAL MEDICINE COMPETENCIES

**OCCUPATIONAL MEDICINE**

*Instructions*: Complete this page if requesting the accreditation of a practicum phase for an Occupational medicine program. Discard this page if not requesting an accredited Occupational Medicine practicum phase.

Please carefully complete this section by describing in detail the resident experience in the practicum. Attach as Appendix O.

<table>
<thead>
<tr>
<th>Topic</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Manage the health status of individuals who work in diverse work settings</td>
</tr>
<tr>
<td>2.</td>
<td>Monitor/survey workforce and interpret monitoring/surveillance data for prevention of disease in workplaces and to enhance the health and productivity of workers</td>
</tr>
<tr>
<td>3.</td>
<td>Manage worker insurance documentation and paperwork, for work-related injuries that may arise in numerous work settings</td>
</tr>
<tr>
<td>4.</td>
<td>Recognize outbreak events of public health significance, as they appear in clinical or consultation settings</td>
</tr>
<tr>
<td>5.</td>
<td>Report outcome findings of clinical and surveillance evaluations to affected workers as ethically required; advise management concerning summary (rather than individual) results or trends of public health significance</td>
</tr>
</tbody>
</table>

**NOTE**: The program must describe in detail how clinical supervision is provided to the residents.
Instructions: List the conferences and seminars, journal clubs, specialty conferences, or similar educational sessions available for resident education. Indicate the frequency, e.g. weekly, monthly, etc., and whether conference attendance is required (R) or optional (O). Designate with an (*) those primarily for the program. Reference the Program Requirements for Occupational Medicine III.I.

<table>
<thead>
<tr>
<th>CONFERENCE</th>
<th>R OR O</th>
<th>FREQUENCY</th>
<th>RESPONSIBLE PERSON/DEPARTMENT</th>
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</table>
## III.J. PUBLIC HEALTH AND GENERAL PREVENTIVE MEDICINE COMPETENCIES

*Instructions:* Complete this page if requesting the accreditation of a practicum phase for an public health and/or general preventive medicine program. Discard this page if not requesting an accredited Public Health and General Preventive Medicine practicum phase.

Please carefully complete this section be describing in detail the resident experience in practicum. Attach as Appendix O.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Public health practice</td>
</tr>
<tr>
<td>2.</td>
<td>Clinical preventive medicine</td>
</tr>
<tr>
<td>3.</td>
<td>Epidemiology</td>
</tr>
<tr>
<td>4.</td>
<td>Health Administration</td>
</tr>
</tbody>
</table>
PRACTICUM PHASE
Public Health and General Preventive Medicine

Seminars and Conferences

Instructions: List the conferences and seminars, journal clubs, specialty conferences, or similar educational sessions available for resident education. Indicate the frequency, e.g. weekly, monthly, and whether conference attendance is required (R) or optional (O). Designate with an (*) those primarily for the program. Reference the Program Requirements for Public Health/Preventive Medicine III.J.

<table>
<thead>
<tr>
<th>CONFERENCES</th>
<th>R OR O</th>
<th>FREQUENCY</th>
<th>RESPONSIBLE PERSON/DEPARTMENT</th>
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</tbody>
</table>

63
### IV. Evaluations

<table>
<thead>
<tr>
<th>EVALUATION OF RESIDENTS</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the program director maintain a file that documents the qualifications and progress of each resident? <strong>Provide a list of the contents of such a file to the site visitor.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are supervisory and other faculty written evaluations of the performance of residents obtained regularly and are they available in each resident's file?</td>
<td></td>
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</tr>
<tr>
<td>3. Are meetings with individual residents to discuss their evaluations and progress in the program conducted at least semi-annually</td>
<td></td>
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</tr>
<tr>
<td>4. Is a written summary of these meetings entered in the resident's training file?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Does the resident's file include copies of all evaluations of performance made in the course of training? Attach a blank evaluation form as Appendix P.</td>
<td></td>
<td></td>
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<tr>
<td>6. Do residents receive copies of these evaluations?</td>
<td></td>
<td></td>
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<tr>
<td>7. Are there methods by which the resident's performance in regard to issues involving clinical responsibilities, ethical behavior, and interpersonal relationships with staff and other residents are evaluated?</td>
<td></td>
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<tr>
<td>8. Are remedial plans and advancement criteria from one year of training to the next in place for those residents who do not perform satisfactorily?</td>
<td></td>
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<tr>
<td>9. Is there a written final evaluation for each resident who completes the program?</td>
<td></td>
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</tbody>
</table>

**Note:** Program files should contain all appropriate evaluations for review by the field staff during a site visit.

<table>
<thead>
<tr>
<th>EVALUATION OF FACULTY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a systematic confidential method for the evaluation of faculty performance by residents?</td>
<td></td>
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<tr>
<td>2. Is there a systematic method by which the program leadership regularly evaluates the faculty's contributions to the educational program?</td>
<td></td>
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</tr>
</tbody>
</table>
### Program Requirement IV.C.2

<table>
<thead>
<tr>
<th>Residency Advisory Committee (RAC)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a RAC for the Preventive Medicine training program?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Are there residents on the RAC?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Are teaching staff from each ACGME-approved affiliated subspecialty residency on the RAC?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does the RAC participate in program development?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Is the RAC responsible for program evaluation?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Is the RAC responsible for resident evaluation and/or advancement?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Is the RAC responsible for teacher and course evaluation and monitoring?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Is there a written description of the RAC and its responsibilities?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

### RESIDENCY ADVISORY COMMITTEE (RAC)

**Instructions:** Append the following requested information regarding the Residency Advisory Committee.

<table>
<thead>
<tr>
<th>Item</th>
<th>Attach as Appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A list of the Residency Advisory Committee members, which specifies the chair, ex-officio members, the institutional affiliation, and title of each member.</td>
<td>Q</td>
</tr>
<tr>
<td>2. The minutes of the two (2) most recent meetings of the RAC.</td>
<td>R</td>
</tr>
<tr>
<td>3. The mission statement for the RAC, which includes to whom the RAC reports within the sponsoring institution.</td>
<td>S</td>
</tr>
<tr>
<td>4. A copy of the most recent RAC report to the sponsoring institution.</td>
<td>T</td>
</tr>
<tr>
<td>5. The curriculum vitae for the chair of the RAC.</td>
<td>U</td>
</tr>
</tbody>
</table>
## EVALUATION OF PROGRAM

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the program director meet regularly with residents as a group to discuss the program and to resolve problems?</td>
<td></td>
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</tr>
<tr>
<td>2.</td>
<td>Has an internal review of the program been conducted by the institution’s Graduate Medical Education Committee, or an equivalent review for single-program institutions? Attach a description of the process as Appendix V. (Single program institutions complete Appendix W).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Does the program maintain ABPM Board performance data on graduates from the program?</td>
<td></td>
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<tr>
<td>4.</td>
<td>What percentage of entering residents has taken the ABPM examination in the past 5 years? PR IV.E.</td>
<td></td>
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<tr>
<td>5.</td>
<td>What percentage of those residents taking the ABPM certifying examination passed the ABPM exam in the most recent 5 years? PR IV.E.</td>
<td></td>
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</tr>
</tbody>
</table>

NOTE: 5 years should be counted since the receipt of the most recent ABPM report of resident certification.
Residents Completed Program

List of residents who completed all training for this specialty based on the academic year ending June 30, 200__

<table>
<thead>
<tr>
<th>Name</th>
<th>Actual Date of Completion</th>
<th>Date First Took First Stage of Board Exam-Passed on First Attempt (Y/N)</th>
<th>Date First Took Second Stage of Board Exam-Passed on First Attempt (Y/N)</th>
</tr>
</thead>
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</table>

List of residents who completed all training for this specialty based on the academic year ending June 30, 199__

<table>
<thead>
<tr>
<th>Name</th>
<th>Actual Date of Completion</th>
<th>Date First Took First Stage of Board Exam-Passed on First Attempt (Y/N)</th>
<th>Date First Took Second Stage of Board Exam-Passed on First Attempt (Y/N)</th>
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INFORMATION FURNISHED BY:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
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<th>Signature:</th>
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</table>

If someone other than the Program Director furnishes information, the Program Director must verify the accuracy of the information submitted.

Verified by the PROGRAM DIRECTOR:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
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Verified by CHAIR OF DEPARTMENT of Preventive Medicine or INSTITUTIONAL DIRECTOR:

<table>
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<th>Name:</th>
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<th>Signature:</th>
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</table>
Instructions: Provide a "biographical sketch" for all residency program teaching staff (Table II.D) who have a significant role in the teaching program. Use the "Biographical Data" form provided below.

<table>
<thead>
<tr>
<th>NAME:</th>
</tr>
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<tbody>
<tr>
<td>POSITION:</td>
</tr>
<tr>
<td>EDUCATIONAL SUMMARY:</td>
</tr>
<tr>
<td>RELEVANT PRIOR EXPERIENCE:</td>
</tr>
<tr>
<td>RESPONSIBILITIES/ACTIVITIES IN THIS RESIDENCY:</td>
</tr>
<tr>
<td>RESEARCH/SCHOLARLY INTERESTS: (See PR II.D.2.b.1-6)</td>
</tr>
<tr>
<td>LIST UP TO 10 RELEVANT PUBLICATIONS FOR THE LAST FIVE YEARS:</td>
</tr>
<tr>
<td>CERTIFICATION AND LICENSE(S):</td>
</tr>
</tbody>
</table>
# CURRICULUM VITAE
CHAIR, RESIDENCY ADVISORY COMMITTEE

<table>
<thead>
<tr>
<th>Name:</th>
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<tbody>
<tr>
<td>Present Position:</td>
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<tr>
<td>Address:</td>
<td>City/State/ZIP</td>
</tr>
<tr>
<td>Education including dates and degrees obtained:</td>
<td></td>
</tr>
<tr>
<td>Post graduate education including dates of residencies, etc:</td>
<td></td>
</tr>
<tr>
<td>Board Certification:</td>
<td></td>
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<tr>
<td>Licensure:</td>
<td></td>
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<tr>
<td>Significant professional appointments and activities:</td>
<td></td>
</tr>
</tbody>
</table>

Provide a brief statement regarding your responsibilities as Chair of the Residency Advisory Committee including the areas of expertise which you feel impact upon your ability to function effectively in this position:

| Publications: | Attach a list of publications for the last three years. |
REQUESTED APPENDICES

Instructions: Please insert all of the requested appendices at the end of the PIF in an appendix section.

Check

______ A Curriculum vitae of program director
______ B Institutional Affiliation Agreements
______ C Accreditation Letter for academic phase
______ D One page description of the program
______ E Written statement of goals and objectives for the program
______ F Resident Schedules and Educational Plans
______ G Explanation of non-ACGME accredited clinical year
______ H Narrative description of selection and appointment process.
______ I Faculty CV’s (use attached form)
______ J Description of library, computer, office resources
______ K Description of written resident assessment
______ L Narrative description of clinical phase
______ M Narrative description of academic phase
______ N Narrative description of core preventive medicine competencies
______ O Narrative description of specialty competencies
______ P Blank evaluation form
______ Q Residency advisory committee (RAC) members
______ R Residency advisory committee (RAC) minutes
______ S Residency advisory committee (RAC) mission statement
______ T Residency advisory committee (RAC) report to sponsoring institution
______ U Curriculum vitae of residency advisory committee (RAC) chair
______ V Internal Review of program
______ W Complete this appendix ONLY if a single-program institution
APPENDIX W

Single-Program Institutions

Single program institutions are conducted independent of the traditional organizational structure containing other ACGME-accredited residencies and resources for their oversight. This notwithstanding, all ACGME-accredited programs must comply with the ACGME Institutional Requirements. To demonstrate compliance, provide the following information.

1. Attach a letter indicating the commitment of the sponsoring institution, its governing body, the administration and the teaching staff to the residency and its pledge to provide the required financial and educational resources including access to adequate communication technologies and technological support to include at least computers and access to the internet. (Identify the designated institutional official who has the authority and responsibility for oversight and administration of the GME program/s and his/her position in the sponsoring institution’s administrative structure).

2. Provide a description of the method by which the sponsoring institution will monitor the residency/residencies to ensure that it has the resources to meet the Program Requirements. If regular internal reviews of the program’s educational quality and compliance with ACGME standards occur, please describe the process and indicate how residents are involved in regular program and faculty evaluation.

3. Summarize how the institution complies with Section 11, parts A & B of the ACGME institutional Requirements.

4. Summarize how the institution complies with Section 11, parts C & D of the ACGME Institutional Requirements (do not append the resident contract/agreement to the PIF but state when it is given to residents and have a copy available for verification by the site visitor on the day of the survey).

Provide a detailed description of the grievance (due process) procedure that is available to residents, including the composition of the committee and mechanisms for handling complaints and adverse actions including failure to reappoint.
## GETTING ORGANIZED: A SAMPLE TASK TIMELINE FOR RESIDENCY PROGRAMS (TAB E)

The following table lists residency director tasks on the left, and the recommended periodicity for these tasks on the right. The numbers below each task correspond to appropriate sections of the July 2001 RRC Program Requirements for Preventive Medicine (included in Tab C). Details on completion of the tasks are provided within appropriate sections throughout the manual, as noted.

<table>
<thead>
<tr>
<th>TASK</th>
<th>AT ENTRY</th>
<th>EVERY 6 MO.</th>
<th>EVERY YEAR</th>
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<tr>
<td>Intake paperwork</td>
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<tr>
<td>[II.B]</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Review of affiliation agreements</td>
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<td></td>
</tr>
<tr>
<td>[II.C.2h]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faculty meeting to review resources and curriculum</td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>[II.D.2]</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Intake assessment</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>[III.C]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Director evaluation of residents ³</td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>[IV.A.1,2; IV.B]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education plan: Narrative</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>[IV.A.1,2; IV.B]</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Timeline</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>[IV.A.1,2; IV.B]</td>
<td></td>
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<tr>
<td>Competencies</td>
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<td>X</td>
<td></td>
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<tr>
<td>[IV.A.1,2; IV.B]</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Academic evaluation (grades)</td>
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<tr>
<td>[IV.B]</td>
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<td></td>
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<tr>
<td>Residents evaluation of program</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>[IV.C.1; IV.C.2g]</td>
<td></td>
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<tr>
<td>RAC meetings</td>
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<td>X</td>
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<tr>
<td>[IV.C.2]</td>
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<tr>
<td>Annual report by RAC chair to GMEC</td>
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<td>X</td>
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<tr>
<td>[IV.C.2.g; IV.F]</td>
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<td></td>
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<tr>
<td>Pre Board counseling</td>
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<td>X</td>
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</table>

³ A final evaluation also should be performed upon completion of the program.
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ADMINISTRATIVE REQUIREMENTS (TAB F)

The ACGME RRC Program Requirements for Preventive Medicine, included under Tab C, include several administrative requirements. In order to meet such administrative requirements, residency programs may choose to develop a policy and procedures manual, as described below. The accompanying roman numerals refer to the section of the Program Requirements where the issue is addressed.

ENTRY DOCUMENTS

POLICY & PROCEDURES MANUAL

Each residency program should have a policy and procedure manual available for faculty, residents, and inspectors. At time of admission to a preventive medicine residency, all preventive medicine residents should be given a Policy and Procedures Manual (II.C.2) that includes the following, as applicable:

1. Admissions Criteria & Selection Process [II.C.2]
2. Graduation Criteria
3. Organization Chart
4. Goals & Objectives [II.A.3]
5. RAC Process & List of Members [IV.C.2]
6. Evaluation Policy [IV]
7. Supervision Policy [III.D.2]
8. Duty Hours & Moonlighting Policy [III.D.2]
9. Grievance Process, including sexual harassment [II.A.6]
10. Sample contract, which should also include the following policies:* [II.A.5]
   a. Financial support description
   b. Vacation policy
   c. Leave benefits
   d. Malpractice coverage
   e. Disability coverage
   f. Health insurance coverage
   g. Counseling options
   h. Length of employment
   i. Occupation protection issues (immunizations, TB screening, HIV exposure)
j. Resident Impairment Policy, including substance abuse
k. Policy for handling poor performance, including termination and non-renewal of contract policy.

*Typically also addressed by institutional requirements

**ORIENTATION BOOK OR SIMILAR MANUAL**

Programs also **must** provide incoming residents with an orientation book or similar manual that includes:

- a. accreditation status
- b. competencies grids
- c. evaluation schedules and forms [IV]

The orientation book or similar manual may also include these **optional** items:

- a. calendar of events
- b. didactic schedule
- c. contact numbers for faculty
- d. list of “ever-residents” and current residents, with contact numbers

**Samples of policies and procedures are provided in Appendix F.** Please note, however, that policies pertinent to the institutional requirements and not specific to preventive medicine may have already been developed by your sponsoring institution.

We strongly suggest that individual residency programs go through the program requirements and develop a checklist to make sure they are addressing all requirements.
AFFILIATION AGREEMENTS (TAB G)

The ACGME RRC Program Requirements for Preventive Medicine, included under Tab C, include the following requirements for affiliation agreements. The accompanying roman numerals refer to the section of the Program Requirements where the issue is addressed.

1. Affiliation agreement can be generic, non-resident specific. These agreements can be site specific, outlining competencies addressed at this site. Agreements must include the seven points outlined in the Program Requirements [II.2a-g]. If no changes have been made, these do not have to be renewed annually. However, program director should document review of affiliation agreements to assure they are current with a checklist or similar mechanism annually [II.C.2h].

2. Communication with training sites regarding competencies residents should achieve, resident-specific, can be done through addendums, letters, or other communication.

3. If agencies have contracts with a residency and the contracts cannot be modified (without involvement of lawyers, CEO, etc.), an additional affiliation agreement can be added between residency and preceptors.

4. Affiliation agreements must be included for all participating institutions used by the program (II.E.3.c.1,2):
   - GPM/PH: must include affiliation agreement with PHD and school of PH
   - OM: occupational medicine sites
   - ASM: aerospace medicine practice sites

Examples of affiliation agreements can be found in Appendix G. These examples include: 1) education and training guidelines for affiliated preventive medicine training sites; and 2) educational and training guidelines for affiliated occupational medicine training sites.
INCOMING RESIDENT ASSESSMENT [III.C] & IMPROVING BOARD PERFORMANCE [II.B.3] (TAB H)

The ACGME RRC Program Requirements for Preventive Medicine, included under Tab C, include the following requirements for incoming resident assessment and evaluating board performance. The accompanying roman numerals refer to the section of the Program Requirements where the issue is addressed.

Incoming Resident Assessment  [III.C]

As stated in the ACGME RRC Program Requirements for Preventive Medicine, “Each incoming resident must be assessed as to his/her knowledge, skills, and competencies in relationship to the educational goals for the residency program. This assessment may take the form of a self-assessment, an in-service exam, a structured interview, or other method that assesses knowledge, skills, and competencies. This assessment is used by the program director and faculty to guide the development of an individualized educational plan for each resident.”

**Documentation Requirement:** The program must have a written assessment (self-assessment, in-service exam, structured interview, or other method) of incoming resident skills, knowledge, and competencies in the program files.

**Measure:** The assessment is specific to the educational objectives for the residency program and must be included in the educational plan for each resident.

ACPM and residency directors recommend the following for incoming resident assessment:

- **In-service exam:** The American College of Preventive Medicine offers a Preventive Medicine In-service Examination each August that can be used for incoming resident assessment. The examination is designed for residents in all specialty areas of Preventive Medicine. The material covered in the exam relates to the core (morning) portion of the Board exam. The exam will enable residents and their directors to determine if there are specific areas where more study and experience are needed. It will enable residents to compare themselves with others at the same level nationally. Though it is not intended to be an examination preparation tool, it can be a gauge of how well residents are being trained and prepared for the content of the Board examination.

- **Review of prior training +/- experience with review of competency checklist:** This should be formalized with the use of the competencies. [III.A]

- **Assessment of resident goals**

**Techniques for Improving Board Performance**
ACPM and residency directors recommend the following for improving board performance:

- In-service exam (suggested minimal testing: Intake, before taking the board exam; maximal recommended testing: Intake, after first year, before taking the board exam)
- Board preparation didactics throughout residency
- Pre-graduation meeting to provide information, study guides, meeting with graduates who have taken boards, etc.
- Organize residents into study groups, seminars, or Board review seminars
- Use alumni to come in and present Board review material
- Arrange a weekly or periodic seminar on core topics
- Use the case-based seminar series developed by the CDC epidemiology program office. Each case consists of a series of 15-20 questions per case, and include questions on infectious disease, environmental health, mental health, and maternal and child health. In part, they are based on the ATSDR case studies.
- ACPM Review Course
- Program pays for Board exam fee (very optional)
CORE COMPETENCIES (TAB I)

In 1993, the American College of Preventive Medicine developed a set of competencies intended both to define the scope of the specialty of preventive medicine and to help guide and assess the effectiveness of residency training. The competencies were published in the *American Journal of Preventive Medicine* in an article that also provided guidance about using the competency framework for evaluating residents’ performance and assessing the quality of residency experiences (Lane DS, et al. “Performance Indicators for Assessing Competencies of Preventive Medicine Residents. *AJPM* 1995). Since that time, additional competencies have been developed to reflect the needs of the occupational and aerospace medicine specialists. These competencies have been published in their respective journals. The ACGME in recent years has become increasingly interested in competency-based education for residents in all fields, and it is in the process of adopting a competency-oriented approach to residency accreditation. In addition to specialty-specific competencies, the ACGME has developed a set of general competencies, addressing fundamental elements of medical practice.

In view of these changes on the national level, preventive medicine residency program directors need to integrate a competency focus into their training programs. In particular, they need to develop workable methods of assessing, documenting and monitoring residents’ accomplishment of the competencies. *The charts included in Appendix I* are based on the ACPM and ACGME competencies. They are designed to help PMR program directors, residents, and faculty advisors in structuring an individualized residency program and in tracking the resident’s progress.

Recommendations for using competency charts:

- Early in residency, the resident and advisor should use the evaluation chart to identify competencies that the resident already has achieved in previous training and/or professional positions. For example, a resident who has been an EIS officer will already have met many of the epidemiology and biostatistics competencies. The relevant past experiences should be noted on the chart; the advisor can initial those entries.

- After the initial assessment, the resident and advisor should use the planning chart to sketch out general plans for achieving each of the competencies. The resident should choose a broad range of practicum rotations in order to have opportunities to develop as many of the competencies as possible.

- During practicum rotations, the resident should record his/her progress in the evaluation chart, making note of specific experiences related to each competency (*see Appendix I*). Residents should define whether each skill was performed, observed, etc. The practicum supervisor can initial each entry to confirm the accuracy of the resident’s self-assessment and to attest to adequate performance.

- Throughout the residency, the resident should monitor his/her own progress in achieving the competencies as planned.
• Periodically during the residency – every 3-6 months – the resident should formally review the evaluation chart with the advisor and/or program director. This review will guide mid-course adjustments in the breadth and depth of the resident’s program if competencies were not achieved as intended. Failure to achieve competencies may happen when expected opportunities do not materialize, because unexpected opportunities arose changing the resident’s plans, or because the resident’s performance was inadequate.

• Periodic reviews of the evaluation chart also allow the resident and advisor to assess the intensity of the resident’s experiences. If too many of the competencies are checked off with only an “observed” level of involvement, the advisor should encourage the resident to take on greater responsibility for program activities and may need to discuss the issue with the practicum supervisor.

The advisor and program director can use the competency evaluation chart in writing reference letters and, with resident’s permission, may share the document with prospective employers to provide more detailed information about the resident’s experience.
ROTATIONS (TAB J)

Preventive medicine rotations vary widely across specialties. This manual does not propose to suggest restrictions to the variety each program might offer. We have attempted to provide some guidance, however, in choosing rotations.

Underlying Principles

- Practicum rotations serve at least three purposes:
  1. To achieve competencies specific to that institution
  2. To enhance resident skills and knowledge base
  3. To introduce career opportunities and promote career planning
  4. To promote the specialty of Preventive Medicine among potential employers

- Practicum rotations should be structured around competencies. They also may consider other benefits (such as career opportunities) of being exposed to certain sites.

Ultimate Objectives

To help all programs identify practicum opportunities and improve existing rotations, program directors should share through forums, the listserv, and the Residency Directors Workshop:

- Descriptions of their rotations, noting how the specific tasks or projects of each rotation address specific competencies; and

- Methods for documenting how well those tasks or projects are achieved in each rotation.

Minimum Requirements

The ACGME RRC Program Requirements for Preventive Medicine, included under Tab C, include the following requirements for rotations. The accompanying roman numerals refer to the section of the Program Requirements where the issue is addressed.

1. 1 month public health (PH/GPM ONLY) [III.J.1]

2. Didactics: details on number of hours of didactics required are not specified in the RRC requirements, but can be obtained from the ACGME “Frequently Asked Questions” website. [III.B]

3. Research

4. Rotations: specialty & competency driven

Suggestions for Rotations

General Preventive Medicine (GPM)/Public Health (PH):

1. Local, state, federal public health and health-related agencies
2. Health maintenance organizations (HMO)
3. Community health centers
4. Student health center
5. Military
6. University research centers
7. Veterans administration (VA) system
8. Private research centers
9. Centers for Disease Control & Prevention (CDC)
10. Sports medicine sites

Occupational Medicine:
1. OSHA
2. NIOSH
3. Industry
4. HMO
5. Military
6. Private occupational medicine facility
EVALUATION (TAB K)

The ACGME RRC Program Requirements for Preventive Medicine, included under Tab C, include the following requirements for evaluation [IV]. The accompanying roman numerals refer to the section of the Program Requirements where the issue is addressed.

<table>
<thead>
<tr>
<th>Type of Evaluation</th>
<th>Format</th>
<th>Corresponding ACGME RRC Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>6 12 18 24</td>
</tr>
<tr>
<td>Annual report by RAC chair to GMEC</td>
<td>Short report based on on last 2 RAC meetings identify problems and solutions</td>
<td>x</td>
</tr>
<tr>
<td>Residents evaluation of program to PD, RAC</td>
<td>Anonymous questionnaire (Example 1)</td>
<td>x x x</td>
</tr>
<tr>
<td>Residents evaluation of their preceptor</td>
<td>Questionnaire (Example 5)</td>
<td>Per practicum assignment</td>
</tr>
<tr>
<td>PD evaluation of resident (Example 2)</td>
<td>Written form portfolio and a final evaluation at completion of the residency</td>
<td>x x x x x</td>
</tr>
<tr>
<td>Preceptor evaluation of resident (Example 3)</td>
<td>Written form</td>
<td>Per practicum assignment</td>
</tr>
<tr>
<td>Academic evaluation of resident (grades OK)</td>
<td>Written transcripts</td>
<td>Per semester</td>
</tr>
<tr>
<td>Educational plan</td>
<td>Narrative</td>
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<tr>
<td>Educational plan</td>
<td>Timeline (Example 4)</td>
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<tr>
<td>Educational plan</td>
<td>Competencies</td>
<td>x or x Planning Evaluation doc</td>
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<tr>
<td>Graduate Database</td>
<td>Board performance</td>
<td></td>
</tr>
</tbody>
</table>

Examples of evaluation forms can be found in Appendix K.
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The ACGME RRC Program Requirements for Preventive Medicine, included under Tab C, include the following requirements for the Residency Advisory Committee and Graduate Medical Education Committee. The accompanying roman numerals refer to the section of the Program Requirements where the issue is addressed.

Residency Advisory Committee (RAC) [IV.C.2]

According to the 2001 ACGME RRC Preventive Medicine Program Requirements, each residency program must have a Residency Advisory Committee (RAC). The RAC should consist of faculty, external members, practicum supervisors, and at least one resident representative. A majority of the members must have their primary affiliation outside the sponsoring institution. Members must be certified in preventive medicine or knowledgeable about specialty training in preventive medicine. The RAC chair must be a physician. The program director must serve in an ex-officio capacity. The RAC must meet at least semiannually.

The mission of the RAC is to promote a residency training experience that is aligned with preventive medicine practice. The RAC, as an external body, complements the graduate medical education committee (GMEC), which serves to evaluate and support the residency from within the sponsoring institution.

The functions of the RAC are to advise and assist the program director to:

- develop and update a written residency mission statement that describes goals and objectives;
- develop educational experiences and practicum rotations;
- provide new or emerging knowledge, skills, or competencies that may influence the content or conduct of preventive medicine education;
- review the GMEC review of the residency program;
- review confidential and written resident evaluations of the program and make recommendations for changes;
- review the program director evaluation of individual residents; and
- provide an annual report to the institution through the chair of the committee.

The RAC must include the following components:

- Chair, who is a physician
- Faculty
- External Members
- Resident Representative
- Practicum Supervisors
- Members Must Be Certified in PM or Knowledgeable About PM Training
- Majority Of Members From Outside
- Residency Director Is Ex-Officio

Other individuals who may contribute to the RAC include:

- Other Residency Program Directors
The RAC must meet at least semiannually. The following are some helpful hints for holding successful RAC meetings:

- Select a convenient time & location (can rotate)
- Make it informative
- Make it Fun (graduation parties, etc.)
- Value-added free CME lecture
- More helpful hints
- Provide food and beverages
- Provide parking
- Allow members to feel they are contributing to graduate medical education

RAC meeting minutes must be used to document RAC function and should be maintained in files.

Graduate Medical Education Committee (GMEC) [IV.C.2]

The Graduate Medical Education Committee (GMEC) is a committee within a sponsoring institution that serves to evaluate and support all residency programs. It differs from the RAC in that the majority of GMEC members are from inside the institution.

The ACGME has charged the GMEC with following eight major responsibilities:

1. Establishment and implementation of policies that affect all residency programs regarding the quality of education and the work environment for residents in each program.

2. Establishment and maintenance of appropriate oversight of and liaison with program directors and assurance that program directors establish and maintain proper oversight of and liaison with appropriate personnel of other institutions participation in programs sponsored by the institution.

3. Conducting periodic Internal Reviews of each ACGME accredited Program by a panel of the GMEC, which should include faculty, resident, and administrators. The review must follow a written protocol approved by the GMEC.

4. Assurance that each residency program establishes and implements formal written criteria and processes for the selection, evaluation, promotion, and dismissal of residents in compliance with both the Institutional and relevant Program Requirements.

5. Assurance of an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation. This includes:

   (1) Provision of an organizational system for residents to communicate and exchange information on their working environment and their educational programs. This may be accomplished through a resident organization or other forums in which to address resident issues.
(2) A process by which individual residents can address concerns in a confidential and protected manner.
(3) Establishment and implementation of fair institutional policies and procedures for academic or other disciplinary actions taken against residents.
(4) Establishment and implementation of fair institutional policies and procedures for adjudication of resident complaints and grievances related to actions which could result in dismissal or could significantly threaten a resident's intended career development.

6. Collecting of intra-institutional information and making recommendations on the appropriate funding for resident positions, including benefits and support services.

7. Monitoring of the programs in establishing an appropriate work environment and the duty hours of residents.

8. Assurance that the residents' curriculum provides a regular review of ethical, socioeconomic, medical/legal, and cost-containment issues that affect GME and medical practice. The curriculum must also provide an appropriate introduction to communication skills and to research design, statistics, and critical review of the literature necessary for acquiring skills for lifelong learning. There must be appropriate resident participation in departmental scholarly activity as set forth in the applicable Program Requirements.

The GMEC must meet at least quarterly. Minutes must be kept and made available at the site visit.

Data that should be used in the GMEC review process include:

- Institutional and program requirements from “The Essentials of Accredited Residency Programs”
- ACGME Accreditation Letters
- Reports From Previous Program Internal Reviews
- Interviews With The Director, Faculty, Residents, & Appropriate Individuals Outside The Program

Documentation of the GMEC review should include the following:

- Recorded Mechanisms To Correct Identified Deficiencies
- Succinct Summaries Of The Review Are Required As Part Of The ACGME Institutional Review Document

PLEASE NOTE: Although Departmental Annual Reports Are Often Important Sources Of Information, They Do Not In Themselves Meet The Requirement For A Periodic Review.

In addition, the GMEC should assess the following to provide assurance of an environment without fear or intimidation:

- Resident Organization Or Other Forum To Address Resident Issues
- Process For Residents To Address Concerns In A Confidential, Protected Manner
- Establish & Implement Policies For Academic Or Other Disciplinary Action
- Establish & Implement Fair Policies To Adjudicate Resident Complaints & Grievances That Could Lead To Dismissal
PLEASE NOTE: Single program institutions are conducted independent of the traditional organizational structure containing other ACGME-accredited residencies and resources for their oversight. **Single program institutions are not required to have a GMEC.** This notwithstanding, all ACGME-accredited programs must comply with the ACGME Institutional Requirements. To demonstrate compliance, single program institutions must provide the following information.

1. Attach a letter indicating the commitment of the sponsoring institution, its governing body, the administration and the teaching staff to the residency and its pledge to provide the required financial and educational resources including access to adequate communication technologies and technological support to include at least computers and access to the internet. (Identify the designated institutional official who has the authority and responsibility for oversight and administration of the GME program/s and his/her position in the sponsoring institution’s administrative structure).

2. Provide a description of the method by which the sponsoring institution will monitor the residency/residencies to ensure that it has the resources to meet the Program Requirements. If regular internal reviews of the program’s educational quality and compliance with ACGME standards occur, please describe the process and indicate how residents are involved in regular program and faculty evaluation.

3. Summarize how the institution complies with Section 11, parts A & B of the ACGME institutional Requirements.

4. Summarize how the institution complies with Section 11, parts C & D of the ACGME Institutional Requirements (do not append the resident contract/agreement to the PIF but state when it is given to residents and have a copy available for verification by the site visitor on the day of the survey).

5. Provide a detailed description of the grievance (due process) procedure that is available to residents, including the composition of the committee and mechanisms for handling complaints and adverse actions including failure to reappoint.

**Examples of how the RAC and GMEC are organized at different preventive medicine residency programs can be found in Appendix L.**
OTHER USEFUL INFORMATION (TAB M)

Other Preventive Medicine Resources and Contact Information

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION
Suite 2000
515 North State Street
Chicago, IL 60610-4322
(312) 464-4920 (p)
(312) 464-4098 (f)
Website: www.acgme.org

AEROSPACE MEDICAL ASSOCIATION
320 South Henry Street
Alexandria, VA 22314-3579
Telephone: (703) 739-2240
Fax: (703) 739-9652
Website: www.asma.org

AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS
PMB #1720
P.O. Box 2430
Pensacola, FL
32513-2430
Website: www.aaphp.org

AMERICAN BOARD OF PREVENTIVE MEDICINE
330 South Wells Street, Suite 1018
Chicago, IL 60606
Telephone: (312) 939-ABPM [2276]
Facsimile: (312) 939-2218
General E-mail: abpm@abprevmed.org
Website: http://www.abprevmed.org

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE
1114 N. Arlington Heights Road
Arlington Heights, Illinois 60004
Telephone: 847/818-1800, Fax: 847/818-9266
General E-mail: acoeminfo@acoem.org
Website: www.acoem.org

AMERICAN COLLEGE OF PREVENTIVE MEDICINE
1307 New York Ave, NW Suite 200
Washington, DC 20005
(202) 466-2044 (p)
(202) 466-2662 (f)
General E-mail: info@acpm.org
Website: www.acpm.org

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH
1101 15th Street NW Suite 910
Washington DC 20005
Telephone: (202) 296-1099 Fax: (202) 296-1252
General E-mail: info@asph.org
Website: www.asph.org

ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE
1660 L Street, NW
Suite 208
Washington, DC 20036
(202) 463-0550 (p)
(202) 463-0555 (f)
General E-mail: Info@atpm.org
Website: www.atpm.org

RESIDENCY REVIEW COMMITTEE FOR PREVENTIVE MEDICINE
515 North State Street, Suite 2000
Chicago, Illinois 60610
(312) 464-4901
BENEFITS OF JOINING ACPM

Established in 1954, the American College of Preventive Medicine (ACPM) is the national professional society for physicians committed to disease prevention and health promotion. ACPM's 2,000 members are engaged in preventive medicine practice, teaching, and research. Many serve on ACPM committees and task forces and represent preventive medicine in national forums, contributing to the organization's role as a major national resource of expertise in disease prevention and health promotion.

All ACPM members receive the following benefits:

- **Publications** – *American Journal of Preventive Medicine (AJPM)*, the peer-reviewed journal, published eight times per year, features original articles and reviews. *ACPM News*, a quarterly newsletter, keeps you up to date on College events and projects. *ACPM HEADLINES*, the electronic newsletter highlights recent happenings at the College, developments in preventive medicine, and ACPM member activities.

- **Preventive Medicine** – the annual meeting for ACPM members and all physicians interested in preventive medicine. This meeting is held each February and concentrates on four primary issue areas: Public Health, Prevention Policy, E-Health/Informatics/Quality Improvement, and Clinical Preventive Medicine.

- **CME Opportunities – Including On-line CME!** In addition to the annual Preventive Medicine meeting, ACPM sponsors an annual preventive medicine review course. ACPM members receive a significant discount on course and meeting registrations. Many other CME modules are currently under development.

- **Advocacy** – ACPM actively and aggressively represents the interests of Preventive Medicine on Capitol Hill. From Preventive Medicine residency funding to patient safety to tobacco control, ACPM forcefully advocates for a strong profession and a healthy nation.

- **Networking** – ACPM provides significant networking opportunities such as at Preventive Medicine 2002, allowing members to meet with their colleagues throughout the country who face similar concerns and challenges and who can offer advice and counsel. ACPM has also developed a listserv to give active members an opportunity to exchange ideas and network on a daily basis. ACPM’s new mentoring program will help link younger ACPM members with experienced Preventive Medicine physicians.

- **JobFinder** – ACPM’s on-line job recruitment service for ACPM members. This service is destined to become the premiere employment service for Preventive Medicine physicians.

- **Partnerships** – ACPM is an important member of the ENACT tobacco control coalition, Partnership for Prevention, the AMA/APHA Medicine/Public Health Initiative and numerous other policy-oriented coalition and groups, focusing its efforts on enhancing support for population-based services and clinical preventive interventions.

- **Careers Initiative** – ACPM has launched a careers initiative to increase interest in career opportunities in preventive medicine. The initiative is supported by a network of medical school contacts and features brochures, a slide show, workshops, and other materials and activities.
• **Representation** – ACPM members represent the College and the field on numerous national scientific task forces, committees and coalitions, enhancing the visibility of preventive medicine in such areas as immunizations, domestic violence, high blood pressure, cholesterol, adolescent health, practice parameters, tuberculosis, women’s health and quality management.

• **Technology** – ACPM’s web site [www.acpm.org](http://www.acpm.org) includes information on member services, education programs and meetings, employment opportunities, legislative issues and residency programs.

• **Graduate Medical Education** – ACPM supports post-graduate preventive medicine training through publications, workshops and advocacy to expand residency-training funding and to develop the core competencies of preventive medicine.

• **Medem** – This e-health network makes preventive medicine information, as well as ACPM’s practice and public policies and other ACPM-developed content available through thousands of physician web sites nationwide. ACPM members will also be able to create their own personalized web sites free through Medem's "*Your Practice Online.*"
APPENDIX F – ADMINISTRATIVE REQUIREMENTS

Example #1 — Tulane University

POLICY ON RESIDENT ELIGIBILITY AND SELECTION

1. Resident Eligibility

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

a. Graduates of medical schools in the U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME).

b. Graduates of medical schools in the U.S. and Canada accredited by the American Osteopathic Association (AOA).

c. Graduates of medical schools outside the U.S. and Canada who meet both of the following qualifications:
   (1) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates, and;
   (2) Have a full and unrestricted license or a Graduate Education Temporary Permit (GETP) to practice medicine in the state of Louisiana.

d. Graduates of medical schools outside the U.S. who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

6. Resident Selection

a. Tulane University Graduate Medical Education Programs select from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to communicate are considered in the selection. These characteristics are accessed by means of the requirement for letter from the Dean of the Medical School of the candidate, letters of recommendation from faculty and others acquainted with the applicant and the day or more of interviews by faculty, residents and others in the program. The School of Medicine has as its policy to consider all candidates for graduate medical education regardless of race, sex, creed, nationality, or sexual orientation. Performance in medical school, personal letters of recommendation, achievements, humanistic qualities, and qualities thought important to the desired specialty will be used in the selection process.

b. Tulane University School of Medicine participates in the National Residency Matching Program (NRMP) in selecting residents for the following programs:
Anesthesiology, Dermatology, Internal Medicine, Medicine/Pediatrics, Medicine/Psychiatry, Obstetrics/Gynecology, Orthopaedics, Pathology, Pediatrics, Psychiatry, Radiology, General Surgery, Psychiatry/Neurology, and Transitional.

c. Specialty programs selecting residents from organized national matching programs other than NRMP are as follows:

Specialty/Subspecialty National Program
Neurology (Adult) NEMP (San Francisco)
Neurology (Child) NEMP (San Francisco)
Neurosurgery NSMP
Ophthalmology OMP (California)
Otolaryngology OLMP
Urology American Urology Assoc.
Sports Medicine Musculoskeletal Spin Match (NRMP)

STATEMENT OF POLICY ON
EQUAL OPPORTUNITY AND AFFIRMATIVE ACTION
INCLUDING VETERANS AND DISABLED INDIVIDUALS
(from the Office of the President of Tulane University)

Tulane University is an educational institution committed to affirmative action and equal employment opportunity, as stated in the Tulane University Mission statement, adopted by the Board of Administrators on April 30, 1992, which includes the following principle:

"Tulane is strongly committed to policies on non-discrimination and affirmative action in student admission and in employment."

To accomplish this goal, Tulane's admission and personnel actions, such as, but not limited to, recruitment, employment, compensation, and promotion do not discriminate on the basis of race, color, religion, sex, national/ethnic origin, age, citizenship, marital status, sexual orientation, disability, or veteran status.

Further, Tulane University is committed to a program of affirmative action that is in accordance with federal, state, local acts and regulations. Every good faith effort will be made in student admission and all levels of employment to advance individuals according to merit and avoid underutilization of qualified minorities, women, disabled and veteran individuals.

Students, applicants, and employees who wish to benefit under this Affirmative Action Program should identify themselves. Implementation and the day-to-day administration of this program is the responsibility of Mary L. Smith, Associate Vice President for Personnel Services and Equal Opportunity. For additional information or questions call 865-5280 or 587-7617.

By adopting the principles outlined in this statement, the Tulane University Board of Administrators reaffirms its commitment to quality education embracing the continuation of an
inclusive and culturally diverse campus community and enhancing mutual respect among our University community members. We continue to recognize our responsibility to prepare our students for active roles in a multi-cultural, multi-ethnic world. These are enduring goals of Tulane University, and we continue to encourage the work of those persons who are committed to multi-cultural and multi-ethnic participation in the university community.

Finally, the Board of Administrators reaffirms that quality education has always been and will continue to be the highest priority of this University, and that under this guiding principle the Board of Administrators will conscientiously adhere to the goals recited in this policy statement. Steps taken to implement this policy shall continue to follow the usual procedure of approval by the University Senate, with final approval by the Board of Administrators.

**POLICY ON RESIDENTS' DUTY HOURS**

Regardless of where affiliated rotations are offered, duty hours and on-call time periods must not be excessive for the residents of Tulane University. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the Institutional and Program Requirements that apply to each program. Residents generally should work, on an average over a four-week period, no more than 80 hours total per week; should be on call no more than one 36-hour period in three days; should work no longer than 36 hours consecutively; and should be off duty at least one day in seven. This also includes all moonlighting hours. Exceptions to these standards must be justified by written educational policies, and reviewed by the IGMEAC.

The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations in any participating institution affiliated with Tulane Graduate Medical Education Programs. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. However, when patient care responsibilities are especially difficult or prolonged, programs must ensure that residents are provided appropriate backup support.

**POLICY ON MOONLIGHTING**

Residents who wish to engage in the practice of medicine outside of their formal training program must have the explicit written approval of their Program Director or Chair following the institutional principles established for duty hours. All residents who engage in moonlighting activities must be fully licensed to practice medicine; have state and federal (DEA) license to prescribe; and must carry individual malpractice insurance coverage.

All licenses and insurance coverage provided by Tulane University, School of Medicine or by its affiliated teaching hospitals for purposes of graduate medical education cannot be used for purposes of moonlighting.
RESIDENTS’ PARTICIPATION AND REPRESENTATION ON INSTITUTIONAL COMMITTEES AND COUNSELS WHOSE ACTIONS EFFECT EDUCATION AND PATIENT CARE

Residents must have appropriate representation on institutional committees and counsels whose actions effect their education and/or patient care. Residents must be aware of and participate as appropriate in institutional programs and medical staff activities. They must be knowledgeable about and adhere to established practices, procedures, and policies of each institution participating in the educational experiences and activities of their training program. During their course of training, each resident should participate in one or more of the following institutional committees:

Tulane University Hospital & Clinic Medical Staff Committees:
- Surveillance/Continuum Care of Patient
- Patient Rights/Ethics Management of Information
- Assessment Environment of Care
- Management of H.R. Cancer

Tulane University Hospital & Clinic, Quality Improvement Counsel, Hospital Committee
Institutional Graduate Medical Education Advisory Committee, Tulane Medical School
Medical Center of Louisiana at New Orleans Standing Committees:
- Executive Clinical Quality Management
- Medical Records Cancer
- Infection Control Transfusions
- Pharmacy & Therapeutics

Resident Review and Advisory Committee, VA Medical Center, New Orleans, as well as Quality Assurance and other similar established institutional committees as they occur in all affiliated training institutions.

POLICY ON SUPERVISION AND EVALUATION OF RESIDENTS

The purpose of this memorandum is to establish the Tulane University School of Medicine (TUSM) policy for the supervision of resident performance, including the method of documenting such supervision. It is the policy of TUSM that all residents be given the required level of supervision in all aspects of their training and that this supervision will be documented in the medical record.

Within all participating institutions, each service/section which participates in training residents will designate a Program Coordinator with the concurrence of the sponsoring Tulane Medical School Program Director. The Program Coordinator may also be the Program Director.

The Program Director is responsible for the quality of the overall affiliated education and training program discipline and for ensuring that the program is in compliance with the policies of the respective accrediting and/or certifying body(ies) (RRC’s). The Program Coordinator is responsible for the quality of educational experiences provided within the section/service and is
responsible for ensuring that the resident is aware of and adheres to established practices, procedures, and policies of the institution. The Program Coordinator will:

• Periodically assess the staff practitioner’s discharge of supervisory responsibilities from evaluations and interviews with residents, other practitioners and other members of the health care team.

• Work with the Program Director to structure training programs consistent with the requirements of the accrediting bodies and the affiliated medical schools.

• Ensure that residents attend required rounds, lectures, seminars, and other educational venues and scholarly activities required in order to fulfill the curriculum goals and objectives of their residency program.

• Provide for all residents entering their first rotation to participate in an orientation to institutional policies, procedures, and the role of residents within each affiliated institution's health care system.

• Provide residents the opportunity to participate on committees where decisions are made that affect resident activities (Quality Assurance, Utilization Review, Ethics, GME Program Committees, and Medical Staff Activities).

Proper supervision of residents is expected in all areas of all affiliated institutions to assure consistently high standards of patient care. It is a cardinal principle that overall responsibility for the treatment of each patient lies with the staff practitioner to whom the patient is assigned and who supervises the resident physician. All inpatients and outpatients will have one staff practitioner listed as the physician in charge of the patient’s medical treatment. The name of this staff practitioner will be clearly designated on each patient's medical record.

A Medical Staff member will be involved in patient treatment to the degree necessary to assure consistently high standards of patient care. This staff practitioner will be responsible for, and must be familiar with, the care provided to the patient. The staff practitioner is expected to fulfill this responsibility, at a minimum, in the following manner:

• Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, the experience and judgment of the resident being supervised and within the scope of the approved clinical privileges of the staff practitioner. Documentation of this supervision will be via progress note, or countersignature of, or reflected within, the resident’s progress note at a frequency appropriate to the patient's condition, according to each affiliated institution's requirements.

• Meet the patient early in the course of care and document, in a progress note, concurrence with the resident's initial diagnosis and treatment plan. At a minimum, the progress note must state such concurrence and be properly signed and dated.
• Participate in attending rounds. Participation in rounds provides the presence of the staff practitioner for patients care and for appropriate supervision to residents. A variety of face-to-face interactions such as chart rounds, X-ray review sessions, pre-op reviews, or informal patient discussions also fulfill this requirement.

• Assure that all technically complex diagnostic and therapeutic procedures which carry a significant risk to the patient are: medically indicated, fully explained to and understood by the patient to meet informed consent criteria, properly executed, correctly interpreted, and evaluated for appropriateness, effectiveness and required follow-up. Evidence of this assurance should be documented.

• Assure that a high-risk or technically complex treatment modality (such as anti-arrhythmia medications, chemotherapy, radiation therapy, electroconvulsive therapy, and the withholding/withdrawal of life-sustaining treatment) is: the appropriate therapy, properly prescribed/ordered, properly initiated or executed, and monitored as appropriate. Evidence of this assurance should be documented.

• Direct appropriate modifications of care as indicated in response to significant changes in diagnosis or patient status. Evidence of this assurance should be documented.

**Graduated Levels of Responsibility:**

The Program Coordinator will be responsible for developing a personal program with each resident which assures continued growth and guidance from teaching staff. As part of their training program, residents will be given progressive responsibility for the care of the patient. A resident may act as a teacher assistant to less experienced residents. Assignment of the level of responsibility must be commensurate with their acquisition of knowledge and development of compassion, judgment and skill, and consistent with safe and effective patient care and with the requirements of accrediting agencies.

Based on a locally developed process of assessing a resident's knowledge, skill, experience and judgment, residents will be assigned graduated levels of responsibility to perform procedures or conduct activities without a supervisor directly present, and/or act as a teaching assistant to less experienced residents. The determination of a resident's ability to accept responsibility for performing procedures or activities without a supervisor directly present and/or act as a teaching assistant will be based on documented evidence of the resident's clinical experience, judgment, knowledge and technical skill.

**Supervision of Residents Performing Invasive Procedures or Surgical Operations:**

The inherent risks associated with all types of surgery and invasive procedures require that staff practitioners provide appropriate levels of supervision of all residents performing such procedures.

Staff practitioners supervising residents will review the indications for the performance of each procedure which should be documented by a written notation in the patient’s medical
record stating their concurrence with both the performance and with the interpretation of the results and complications, if any.

Residents must have the approval of a staff practitioner prior to surgery or an invasive procedure and so document in the patient’s medical record. Staff practitioners will closely supervise the work-up of patients, scheduling of cases, assignment of case priorities, the preoperative preparation, and the intra-operative and postoperative care of surgical patients and patients undergoing invasive procedures. This supervision must be reflected in progress notes made by staff practitioners at appropriate times in the course of each patient’s hospitalization. The surgical/invasive procedure schedule will be approved by the appropriate clinical service chief, or his/her designee.

As residents advance in their education and training, they may be given progressively increasing levels of responsibility. The degree of responsibility will depend upon the individual's general aptitude, demonstrated competence, prior experience with similar procedures, the complexity and degree of the risks involved in the anticipated surgical/invasive procedure. An important aspect of a resident’s learning experience is the opportunity of a senior resident to supervise more junior residents. As a general rule, senior residents, when acting in the role of a teaching assistant to less experienced residents, may supervise the performance of surgical/invasive procedures of lesser or more routine complexity. This, however, does not release the staff practitioner's responsibility for the oversight of the patient's care.

Documentation of a resident’s assigned level of responsibility will be filed in the resident's record and will include: a specific statement identifying the evidence on which such a determination is made; the types of diagnostic or therapeutic procedures the resident may perform and those for which the resident may act as a teaching assistant; and the concurrence of the service chief.

When a resident is acting as a teaching assistant, the staff practitioner remains responsible for the quality of care of the patient, providing supervision and meeting medical recorded documentation requirements as defined within this policy.

**Evaluation of Residents and Supervisors:**

Each resident will be evaluated on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior and overall ability to manage the care of a patient. Evaluations will occur in accordance with their specific RRC requirements, or at the end of each resident's rotation, every 6 months, whichever is more frequent. This written evaluation will be discussed with the resident and made available to all of the resident’s supervisors.

If at any time a resident’s performance is judged to be detrimental to the care of a patient(s), action will be taken immediately to assure the safety of the patient(s). The program coordinator will promptly provide written notification to the affiliate program director or Department/division chairperson of the resident's unacceptable performance or conduct.
Each resident will complete a formal written evaluation of the educational experience in the training program and of the staff practitioner, addressing the provision of clinical supervision (e.g., availability, responsiveness, depth of interaction and knowledge gained). The evaluations will be reviewed by the program coordinator and integrated into discussions with staff practitioners. The program coordinator will share the evaluations with the staff practitioner’s supervisor and other appropriate individuals with a legitimate need to know. Confidential written evaluations will be completed at the end of the resident's rotation or every six months, whichever is more frequent. The program coordinator will strive to create an atmosphere which assists residents in being comfortable completing evaluations of staff and assures the anonymity of the residents. All written evaluations of residents and staff practitioners will be kept on file in the offices of the service chief as well as the program director, and will be used to provide continued quality improvement to the program.

ACGME Guidelines for Resident Evaluations:

The new Essentials from the ACGME clearly states that each residency training program "maintain a permanent record of evaluation for each resident and have it accessible to the resident and other authorized personnel." Recent query on the interpretation of this statement has led to the following decisions:

1. Indeed it is illegal to keep a resident from seeing his/her evaluations, but the program director can control the way those files are made available to the resident i.e., the resident may see the file only in the company of a designated person. The files should be made available to the resident at the end of every evaluation period, be it monthly or quarterly, but the evaluation should be used as an educational tool so that the resident can benefit as soon as possible from any constructive criticism offered in his/her evaluation. Timely addressing of problems with the resident will probably benefit the resident and the program.

2. The ACGME states that resident evaluations "should be available" to the reviewer at the next institutional review. At that time, they will want to be able to go to every Department and look at the resident evaluations. In order to make sure that evaluations are being kept up to date, IGMEAC will do periodic reviews to determine the availability and completeness of residents' evaluation files.

Access to Evaluations:

Resident files should be treated as any other student file. They are open to the resident to review and should be considered confidential and limited to those who have a legitimate need to know within the institution.

ACADEMIC AND PROFESSIONAL REMEDIATION POLICY

Substandard disciplinary and/or academic performance is determined by each Department. Corrective action for minor academic deficiencies or disciplinary offenses which do not warrant
remediation as defined below, shall be determined and administered by each Department. Corrective action may include oral or written counseling or any other action deemed appropriate by the Department under the circumstances. Corrective action for such minor deficiencies and/or offenses are not subject to appeal.

**Probation**

Residents may be placed on probation for, among other things, issuance of a warning or reprimand; or imposition of a remedial program. Remediation refers to an attempt to correct deficiencies which if left uncorrected may lead to a non-reappointment or disciplinary action.

In the event a Resident’s performance, at any time, is determined by the Resident Program Director to require remediation, the Resident Program Director shall notify the Resident in writing of the need for remediation. A remediation plan will be developed that outlines the terms of remediation and the length of the remediation process. Failure of the Resident to comply with the remediation plan may result in termination or non-renewal of the Resident’s appointment.

A Resident who is dissatisfied with a departmental decision to issue a warning or reprimand, impose a remedial program or impose probation may appeal that decision to the Department Head informally by meeting with the Department Head and discussing the basis of the Resident’s dissatisfaction within ten (10) working days of receiving notice of the departmental action.

**Termination And Other Adverse Action**

A Resident may be dismissed or other adverse action may be taken for cause, including but not limited to:

i) unsatisfactory academic or clinical performance;
ii) failure to comply with the policies, rules, and regulations of the Residency Training Program or University or other facilities where the Resident is trained;
iii) revocation or suspension of license;
iv) violation of federal and/or state laws, regulations, or ordinances;
v) acts of moral turpitude;
vi) insubordination;
vii) conduct that is detrimental to patient care; and
viii) unprofessional conduct.

The Residency Training Program may take any of the following adverse actions:

i) issue a warning or reprimand;
ii) impose terms of remediation or a requirement for additional training, consultation or treatment;
iii) institute, continue, or modify an existing summary suspension of a Resident’s appointment;
iv) terminate, limit or suspend a Resident’s appointment or privileges;
v) non-renewal of a Resident’s appointment;
vi) dismiss a Resident from the Training Program;
vii) or any other action that the Residency Training Program deems is appropriate under the circumstances.

Adverse actions for dismissal, termination, or non-renewal that were not proceeded by a period of probation or remediation require additional justification, in writing, to the Resident and copied to the Associate Dean for GME.

NON-RENEWAL OF RESIDENT TRAINING

A decision not to renew a Resident's participation in the training program must be made prior to April 1 of each year. Sufficient information should be available by that date to each training program for purposes of evaluating each resident for purposes of renewing their participation in their training with the following exception:

1. A Resident, who may be on probation with written defined goals and objectives which have been previously shared with the Resident, may be notified in writing on April 1 that the decision of non-renewal is pending completion of objective criteria that must be achieved prior to the end of the training year in order to renew the Resident's participation in the training program. It must be made clear to the resident that failure to achieve the criteria established will result in a non-renewal of participation in the training program.

2. If it is felt that there is insufficient information to make a decision about renewal 90 days before, the Resident should be notified in writing and given objective criteria that must be accomplished prior to the end of the training year in order to renew the Resident's participation in the training program. It should be made clear to the resident that failure to achieve the criteria established will result in a non-renewal of participation in the training program.

3. If financial exigencies of the Department require that the number of Residents in that Department be reduced, the affected Residents should be notified as soon as possible after a decision has been made reducing the number of allotted positions.

There is nothing in this policy that would prohibit a Department from terminating, for cause, a Resident subsequent to the April 1 date.

GRIEVANCE PROCEDURE
OFFICE OF POSTGRADUATE MEDICAL EDUCATION
TULANE UNIVERSITY SCHOOL OF MEDICINE

The residency training programs of the Tulane Affiliated Hospitals and the Office of Postgraduate Medical Education of the Tulane University School of Medicine recognize that Residents enrolled in their training programs have certain rights and responsibilities. The policies and procedures outlined below shall provide the proper elements of a Grievance procedure within the context of the residency training programs.
The Tulane University School of Medicine and Affiliated Hospitals encourage the participation of Residents in decisions involving their educational process and learning environment. Normally, such participation occurs in formal and informal interaction with the faculty and attending staff. When misunderstandings, disagreements or complaints give rise to dissatisfaction on the part of the Resident, the following procedures will be available for clarification and settlement of the issues involved.

Grievance procedures are available to all officially registered Medical School Residents who allege that they have been treated improperly by their Departments, including, but not limited to, suspension, probation, dismissal or non-renewal of their participation in the training program. Any Resident who is alleging discrimination based upon race, sex, color, religion, national/ethnic origin, age or handicap should also notify the Affirmative Action Office at the time he/she files a Grievance. The Affirmative Action Officer will participate as mediator and advisor in any cases involving complaints about possible violations of affirmative action/equal employment opportunity in the Medical School. As part of monitoring responsibility of that office, the Affirmative Action Officer will keep in the Affirmative Action Office detailed written records of all transactions during a grievance case.

1. DEFINITIONS For purposes of this Agreement, the following terms shall be defined as follows:

1.1 Departmental Chairman — Chairman of the Department from which the Grievant is seeking redress. In most situations it will be the Chairman of the Department in which the Grievant holds a residency slot. However, in those circumstances in which a resident is rotating through another Department and the grievance relates to such rotation, the applicable Chairman will be from the latter Department. It shall also include the designated or acting representative.

1.2 Dean — Dean of the School of Medicine. It shall also include the designated or acting representative.

1.3 HHC — Housestaff Hearing Committee.

1.4 HAB — Housestaff Appeal Board.

1.5 Shall — The term shall is mandatory.

1.6 May — The term may is permissive but not mandatory.

1.7 Time Frames — when any time frame is used, such as 30 days, it shall mean consecutive days and not working days unless otherwise noted.

1.8 Working Days — Shall mean Monday through Friday except for University recognized holidays.

1.9 All notices of findings to Grievant and Chairman shall be delivered by hand with
a signed acknowledgment or by certified mail.

2. GRIEVANCE

2.1 Grievances shall not be limited to, but should generally involve, personal, patient care, or training environment matters.

2.2 Prior to the submission of a written grievance, it is incumbent on the Resident to exhaust all means of resolving the matter regularly available within his/her Department. This should include discussion of the issues with any involved faculty, as well as with the Departmental Chairman.

2.3 If the matter cannot be resolved as directed in preceding paragraph 2.2, the Resident shall then submit his/her grievance in writing signed by the grievant and with specific details of its basis to his/her Chairman's Office for forwarding to the Housestaff Hearing Committee.

2.4 The grievance should specify not only the action that the Resident feels is inappropriate but should also specify what corrective action the Resident feels should be taken.

2.5 The grievance shall be submitted within 30 days of the alleged action of which the Resident is seeking a review. If not submitted within the 30-day time frame, the Resident is deemed to have waived his/her right to a grievance hearing.

2.6 The grievance shall be submitted to the Chairman's Office and forwarded within three (3) days to the Departmental HHC.

3. HOUSESTAFF HEARING COMMITTEE

3.1 The HHC shall consist of three (3) Housestaff and two (2) attending physicians. The Housestaff representative shall be elected by a majority of the housestaff in the Department and shall have been in the Graduate Education Program of the Department for at least one year. The Chairman of the Department shall appoint the two (2) attending physicians from the Departmental full-time faculty. The senior faculty member shall serve as Chairman of the HHC. These five members shall be appointed/elected annually in each Department and should be done after July 1 of each year.

3.2 In the event an appointed faculty or elected resident is unable to serve for a particular grievance hearing because of involvement in the complaint or is otherwise unavailable, an alternate will be chosen by the same procedure. In the event it is a small Department and no alternates are available from the faculty or the Housestaff, the Chairman shall appoint a faculty member or Housestaff, whichever is needed, from another clinical Department HHC, with the concurrence of the Chairman of the other Department.
3.3 The Housestaff Hearing Committee shall, within thirty (30) days from the receipt of the Resident's written complaint, conduct a hearing.
a. The HHC may continue the hearing on subsequent dates until it determines all relevant matters have been discussed by the Committee.
b. Prior to making its final recommendations, the HHC may endeavor to arrange a compromise suitable to both parties.
c. The hearing shall not be taped, but a summary of the evidence and testimony presented will be made by the Chairman of the HHC.
d. Both parties shall have the right to a fair hearing, and shall have the right to call and examine or cross-examine witnesses, to introduce written evidence, and to rebut any testimony or written evidence produced. The Chairman of the HHC shall rule on the admissibility of any evidence. The Rules of Evidence are not applicable.
e. Following the end of receiving all the evidence, the HHC shall make findings and recommendations. All matters for decision by the HHC shall be decided by simple majority vote. In the event of less than unanimous decision, a minority report may also be submitted.
f. The findings and recommendations of the HHC, along with any minority report, shall be forward to the Dean within three (3) working days, with a copy to the Grievant, and the Chairman of the Department.

7. APPEAL OF HHC FINDINGS

4.1 If either the Resident or the Chairman of the Department is dissatisfied with the recommendations of the HHC, the dissatisfied party shall have fourteen (14) days following the receipt of such recommendations to submit an appeal to the Office of the Dean of the HHC findings and recommendations. Failure to submit an appeal within the fourteen (14) days shall constitute a waiver of the right of appeal and the findings and recommendations of the HHC shall be final.

4.2 If the grievance concerned is either a suspension, a dismissal or a non-renewal of participation in the training program, the appeal is directed to the Housestaff Appeals Board through the Dean's Office.

4.3 If the grievance concerns any other matter, the appeal is to the Dean.

4.4 The appeal shall be in writing and shall specify the reason for the appeal as well as the specific items of disagreement with the findings and recommendations of the HHC.

8. APPEAL TO THE DEAN

5.1 Within fourteen (14) days of receipt of an appeal, the Dean shall meet with the Grievant and the Chairman. Either party may submit any new evidence that is relevant. The Dean will forward his findings to the grievant and the Chairman
within seven (7) days following the meeting.

5.2 The decision of the Dean is final.

9. APPEAL TO THE HOUSESTAFF APPEALS BOARD

6.1 Appeals involving suspension, dismissal or non-renewal of the participation in the training program shall be submitted to the Office of the Dean for review by the Housestaff Appeals Board. Upon receipt of an appeal request, the Dean's Office will notify the Chairman of the HAB to commence a hearing.

6.2 The HAB of the School of Medicine shall consist of three (3) standing faculty members and two (2) additional ad hoc faculty members from the resident's field. The three (3) standing members shall be appointed by the Dean of the School of Medicine prior to July 1 of each year, and shall serve a one-year term. The standing members will include at least one (1) faculty member from Medicine, Pediatrics or a related field and one (1) member from Surgery or a related field. These members may be either full-time or part-time clinical faculty. The Chairman, non-voting member shall be from the General Counsel's Office in the Medical School.

6.3 The two (2) ad hoc members are appointed for only the specific case under appeal. One (1) ad hoc member shall be nominated by the Departmental Chairman, and one (1) by the resident. These nominations shall be made to the Chairman of the HAB.

6.4 Either party may challenge the inclusion of any individual member of the HAB by submitting to the Chairman of the HAB his/her objections in writing. The Chairman of the HAB shall disqualify a member only upon showing that the member could not sit fairly and impartially. A replacement shall be selected in the same manner as was the disqualified member.

6.5 Within thirty (30) days after the HAB has been fully constituted, the Chairman of the HAB shall schedule a hearing. Postponements and extensions of the time beyond the dates expressly permitted by these procedures may be requested by either party, but shall be authorized by the Chairman of the HAB only on showing a good cause.

6.6 The grievant and the Departmental Chairman shall each be sent written notice of the hearing from the HAB. This notice shall inform both parties of the time and location of the hearing.

6.7 Under no circumstances shall the hearing be conducted without the presence of both the resident requesting the hearing and the Chairman of the Department without the expressed written waiver of both parties. The hearings shall be confidential and only those persons whose presence is approved by the Chairman of the HAB shall be admitted. Neither party may have an attorney
represent him at the hearing, although the resident may have an attorney present, but said attorney may not examine any witnesses or address the Committee. The Chairman of the HAB has the authority to exclude any individual other than the HAB members and the parties from the hearing.

6.8 At least five (5) days prior to the hearing, each party shall present to the Chairman of the HAB, with a copy to the other party, a list of the possible witnesses to be called and documentary evidence to be produced. Failure to comply with this procedure shall bar the party from calling witnesses or producing documentary evidence, except for good cause shown.

6.9 Although appearance of witnesses cannot be guaranteed, the University shall make all reasonable efforts to have all witnesses available, and shall not prevent a person from testifying because of employment or academic obligations.

6.10 The Chairman of the HAB shall act to ensure that all participants have a reasonable opportunity to be heard, that all relevant oral and documentary evidence be presented, and that decorum is maintained. He/she shall be entitled to determine the order of procedure during the hearing.

6.11 The hearing board may adjourn and reconvene the hearing at the convenience of the parties without special notice.

6.12 Both parties shall have the right to call and examine or cross-examine witnesses, to introduce evidence and to rebut any testimony or written evidence presented. Written evidence is admitted at the discretion of the Chairman of the HAB. The rules of evidence are not applicable.

6.13 The HAB hearing may be taped at the discretion of the Chairman of the HAB. A verbatim transcript will not be produced, but a summary of the testimony and the evidence presented will be made a part of the Committee report. The Chairman of the HAB, at his/her discretion, may permit or require a verbatim transcript.

6.14 Within thirty (30) days of the close of the HAB hearing, the HAB shall submit a written majority report, and if necessary a written minority report, to the Dean of the School of Medicine and to both parties. The majority report shall contain the findings and recommendations of the HAB.

6.15 All matters for decision by the HAB shall be upon majority vote of the HAB.

6.16 Either party may appeal the findings and recommendations of the HAB to the Dean. Said appeal must be filed in writing within seven (7) days of receipt of the HAB report. Failure to file an appeal within the time frame waives any right to said appeal. If the matter is appealed by either party, the Dean will review the HAB report, along with any other documentary evidence that either party may
wish to submit, and render a final decision within seven (7) days of receipt of the appeal. The Dean, at his option, may conduct a hearing in which both parties must be present.

6.17 The decision of the Dean shall be final.

POLICY ON SEXUAL HARASSMENT  
(from the Office of the President of Tulane University)

Tulane University is an educational institution committed to providing an environment of study and work free from sexual harassment. Sexual harassment, as per the attached EEOC (Equal Employment Opportunity Commission) Guidelines, is an affront to human dignity and is fundamentally at odds with the values of this University.

Tulane has never tolerated sexual harassment by members of the University community, and I am taking this opportunity to reaffirm our dedication to providing an environment that is fair, humane, and responsible.

I hope that occurrences of sexual harassment at Tulane are exceedingly rare. However, individuals who believe themselves to be victims of sexual harassment should report such situations to Tulane’s Office of Equal Opportunity at 865-5280 or 587-7617, their department chair, dean, or supervisor. Any retaliation, verbal or otherwise, taken against individuals for filing or cooperating in an investigation of a sexual harassment complaint constitutes an unlawful practice and a violation of this policy.

Individuals need not lodge a formal grievance or make a written complaint in order to seek counseling from any of the above persons or offices. However, the Office of Equal Opportunity must be informed, by the University official contacted, of the alleged harassment and of any action taken.

RESIDENTS' ASSISTANCE PROGRAM  
(504) 588-1591

A. Policy

It is the policy of Tulane University School of Medicine to ensure that the highest quality physicians are practicing medicine in the hospitals and clinic. The Residents' Assistance Program is intended for the identification and treatment of resident physicians with psychiatric problems and resident physicians who are impaired, in efforts to reduce public risk, as well as restore the physician to health and effective practice.

B. Procedure

1. An impaired resident physician means a physician involved in training or research, licensed to practice medicine in the State of Louisiana who is unable to
practice medicine with reasonable skill and safety to patients because of a mental disorder, physical illness, and/or excessive use or abuse of drugs, including alcohol.

2. Whenever there is a reasonable belief that a resident physician is practicing while under impairment, the Residents' Assistance Coordinator should be notified immediately.

3. Upon such notification, the Coordinator will conduct a preliminary investigation, and if he/she finds a reasonable belief that such an impairment exists, he/she will report such information to the appropriate Departmental Chairman and the Associate Dean for Graduate Medical Education.

4. The resident will automatically be temporarily suspended by the Departmental Chairman from his/her training program until evaluation of the case is complete. During these proceedings, the resident will have complete access to the due process procedure as detailed in the Complaint Procedure Office of Postgraduate Medical Education, Tulane University School of Medicine.

5. In conjunction with the suspension, the Residents' Assistance Coordinator will notify the Impaired Physicians Program of the Orleans Parish Medical Society.

6. At a minimum, if it is determined that the resident physician should not be terminated permanently from the residency program, a physician suspended due to chemical and/or alcohol impairment will be required to successfully complete a rehabilitation program approved by the Residents' Assistance Coordinator and the Impaired Physicians Program of the Orleans Parish Medical Society. The Residents' Assistance Coordinator will document compliance in the rehabilitation program with the treating physician of the impaired resident physician while the resident physician is in a rehabilitation program.

7. If the resident physician fails to comply with the rehabilitation program, he/she is automatically terminated from residency training and a notice to that effect will be placed in his/her permanent record and the appropriate state and national bodies will be notified.

8. Upon completion of a rehabilitation program, the resident physician may be required by the Residents' Assistance Coordinator, the treating physician or the Impaired Physician Program of the Orleans Parish Medical Society to enter an aftercare program. Aftercare treatment programs will be approved by the Residents' Assistance Coordinator, the treating physician, and the Impaired Physicians Program of the Orleans Parish Medical Society. The Residents' Assistance Coordinator will be responsible for documentation of compliance in following the details of the aftercare program.

9. The Associate Dean of Graduate Medical Education and the appropriate
Departmental Chairman are to be notified when the resident physician could be considered for reestablishment of his/her residency training and credentials are determined by the treating physician, the Impaired Physicians Committee of the Orleans Parish Medical Society and the Residents' Assistance Coordinator. If the resident physician is in aftercare when reestablishment of training and credentials is granted, the Departmental Chairman is required to make time available in the resident physician's schedule to allow total participation in the aftercare program. This scheduling will be done in such a way as to maintain maximum confidentiality. The Residents' Assistance Coordinator will continue to be responsible for documentation of compliance in following details of the aftercare program.

10. If the resident physician fails to comply with aftercare, he/she is automatically terminated from residency training.

11. The Residents' Assistance Coordinator will notify the Department Chairman and Associate Dean for Graduate Medical Education when a resident has completed the aftercare program.

12. If, after successful completion of the aftercare program, the resident subsequently redevelops a chemical or alcohol impairment, termination from residency will be recommended unless there are extenuating circumstances. The final decision shall rest with the Associate Dean for Graduate Medical Education at the Tulane University School of Medicine.

13. The impaired physicians' program of the state to which the resident is moving will be notified by the Residents' Assistance Coordinator if a resident physician is involved in inpatient or aftercare treatment at the time the resident is completing this residency training.

**LEAVE OF ABSENCE**

A Leave of Absence may be granted only with written permission of the Department Chair and/or Residency Program Director. Such leave may necessarily prolong the duration of residency training according to each specialty's Board requirements, and the requirements unique to programs at Tulane University. In all cases, the number of total months required to complete program requirements for graduation is to be determined by the Department Chair and/or Program Director.

**MILITARY LEAVE**

Eligible employees who are members of the National Guard, Naval Militia or of a reserve component of the United States military forces and who are required to undergo annual field or periodic weekend training or active duty training shall be granted a leave of absence for such period as provided by regulation or emergency situation. The employee shall be entitled to full
pay for a period of two weeks per year. This pay will be the difference between his/her regular salary and the money received from National Guard or other reserve unit. Any such hours granted will be in addition to the employee's regular vacation hours. Any remaining military obligation will be granted without pay or, if the employee wishes, he/she may use accumulated vacation time. Armory drills or multiple training assemblies do not qualify for short-term military leave with or without pay.

If you enter the Armed Forces of the United States while an employee of the University, you will have certain re-employment rights, as required by Federal law, after completing your military service. Contact the Personnel Department for details.

SICK LEAVE POLICY

A period of sick leave of two weeks is allowed per resident per year. If a resident calls in sick, it is the prerogative of the Program Director to ask for a doctor's excuse from the resident. Each resident/fellow must be aware that each particular specialty allows only a certain amount of absence from training per year. Absence beyond that designated time—be it for vacation or sick leave—will extend their time in training.

There can be no accrual of sick leave from one year to the next; i.e., two weeks maximum sick leave are allowed per year.

LEAVE TIME ALLOWED BY SPECIALTY BOARDS WITHOUT MAKE UP*

Allergy and Immunology Discretion of program director
Anesthesiology 20 working days/year
Colon and Rectal Surgery No specific policy
Dermatology 6 weeks/year
Emergency Medicine 6 weeks/year
Family Practice 30 days/year (includes vacation & sick leave)
Internal Medicine 6 weeks for pregnancy and an additional 1 month for vacation time delayed starts & illness.
Neurological Surgery No specific policy
Nuclear Medicine 6 weeks/year
Obstetrics and Gynecology 6 weeks/year
Ophthalmology 1 month/year
Orthopaedic Surgery 6 weeks/year
Otolaryngology 6 weeks/year
Pathology 2 weeks/year
Pediatrics 3 months during residency
Physical Medicine and Rehabilitation 6 weeks/year
Plastic Surgery 4 weeks/year
Preventive Medicine 4 weeks/year
Psychiatry and Neurology 1 month/year
Radiology 6 weeks/year
Surgery 4 weeks/year
Thoracic Surgery Discretion of program director (unofficially
4 weeks/year)
Urology Discretion of program director
*Amount of leave noted includes vacation time

PARENTAL LEAVE POLICY FOR
TULANE RESIDENTS AND FELLOWS
MATERNITY LEAVE

Maternity leave will be granted upon request to all pregnant residents. Maternity leave will be leave with pay for a period of up to six weeks. This time represents vacation and sick leave. All or a portion of the six weeks may be requested. Maternity leave greater than six weeks duration, except in cases of illness of mother or infant, will require approval by the Chairman and is unfunded. Benefits will be provided during the six weeks of maternity leave. Benefits may be continued beyond six weeks at the resident's expense. Funding for maternity leave will be prorated by the hospitals to which the particular resident rotates during the same training year, and will be reported to the Office of Graduate Education by the Program Director.

The resident must notify the Department Chairman, giving him/her a four month notice that she is pregnant, a plan to begin maternity leave and when she plans to return to work. Duration of leave should not exceed that period of time defined by the resident's specialty board as a leave of absence for which time need not be made up. Upon return to work the resident will be reinstated without loss of training status, provided that her return is on the date previously approved by her Chairman.

If leave is requested for more than six weeks due to medical reasons, approval for return to the training program will be at the discretion of the Department Chairman. A doctor's certificate verifying the condition of the resident may be requested. In those cases where a resident must make up time missed due to medical reasons in order to fulfill board requirements, the resident will be paid for all hours worked and the institution will continue benefit coverage during that time.

All schedule accommodations shall be made, with the Chairman's approval, with reference to the needs of both the resident and also the Department (including other residents) so that the requirements of training as stipulated by the specialty board may be met.

ADOPTION

If a female resident requests leave in order to adopt a child, she too is entitled to paid leave similar to that of maternity leave described above. The resident must discuss the impending adoption with the Departmental Chairman in as much advance as possible and the program should make every effort to allow the resident the same leave time as provided in maternity leave if the resident should request it.
Paternity leave of up to one month will be granted to any father during the first month after delivery or adoption of a child. Such leave should also be requested in as much advance as possible. Paternity leave will be paid and should be made up of vacation and/or sick leave; additional leave would have to be made up by extending residency training. The institution would pay salary and benefits for any extension of training if indeed the father's extra leave was considered necessary (i.e., illness of newborn or spouse). The program should also attempt to allow any father to have minimal call around the time of delivery of his child and no call while he is on leave.

BEREAVEMENT

If there is a death in the immediate family, a leave of absence will be granted. This leave shall not exceed three working days for a funeral which is held within a 300-mile radius of New Orleans and shall not exceed five working days for a funeral outside this radius. If additional time is required, accrued vacation may be used. For purposes of this policy, immediate family is defined as the resident's mother, father, sister, brother, children, grandparents, grandchildren, spouse and parents of spouse. A Chairman or Program Director may request verification of the death and location of the funeral prior to approving payment for this leave.

VACATION POLICY

Policy

Resident I 3 weeks
Resident II and above 4 weeks

Procedure

• Vacation requests should be submitted to the Chief Resident.
• Vacation requests should be submitted as far in advance as possible and must be submitted according to Department-specific procedures.
• Vacation is usually given on a first-come, first-serve basis.
• It is the responsibility of the vacationing Resident to make sure that his/her responsibilities are covered by an appropriate substitute and that the program director is aware of such substitutions.
• Preference for vacation, in most programs, is given to senior residents and fellows.
• Vacations are taken with Departmental approval.

For Department-specific vacation procedures, contact the chief resident.

TULANE UNIVERSITY SCHOOL OF MEDICINE
RESIDENT EDUCATIONAL LEAVE POLICY

A. Policy
It is the policy of Tulane University School of Medicine to ensure that the residents in training at Tulane University School of Medicine are allowed to attend and to participate in educational and scientific meetings that would contribute to the medical education of the resident physician.

B. Procedure

1. Each resident may be granted five (5) working days per year of educational leave for the purpose of attending or participating in educational or scientific meetings that would contribute to the medical education of the resident physician.

2. Permission for and approval of the leave must be granted in writing by the Departmental Chairman or his/her designee.

3. The Departmental Chairman or his/her designee will be responsible for notification of the medical education official of the institution at which the resident is stationed during the period of the leave.

4. The Departmental Chairman or his/her designee will be responsible for notifying the medical education official of the institution at which the resident is stationed the name of the individual(s) who will assume the clinical responsibilities for the resident taking leave while on leave.

5. In those cases in which a resident is stationed at an affiliated institution during the time of the leave, the arrangements for coverage must be satisfactory to the program coordinator at the affiliated institution.

6. Any conflict or disagreement related to resident educational leave may be referred to the Dean or his designee.

This policy does not address expenses or reimbursement of expenses as a part of education leave.

**IMMUNIZATION PROCEDURES**

Our residents are at high risk for developing infectious diseases from the patients they treat. Also, in some cases, infected Residents are a potential hazard to their patients and their colleagues. Most of these infections can be prevented through routine vaccination at the time of entry into our program.

Recommendations

1. Hepatitis B. Any Resident who has not received a series of three hepatitis B injections during medical school should have a baseline titer. Hepatitis B vaccine should be offered to any Resident with a negative titer. There is evidence to suggest that titers wane after approximately five years after the series; therefore, these individuals should also obtain a
titer and a booster injection if indicated. Prior vaccination in the gluteus muscle has also been associated with inadequate response to the vaccine, and a titer should be obtained on individuals giving that history.

2. Tetanus/Diphtheria (TD). A TD should be administered to Residents not receiving a booster within ten years.

3. Influenza. Flu shots should be provided electively to Residents each fall.

4. Mumps, Measles, Rubella (MMR). Proof of receiving 2 MMR injections should be obtained. If proof is not available, titers should be obtained on females, and vaccine should be administered if indicated following screening for pregnancy. Males may be offered the vaccine without a titer, at the discretion of the employee health physician or their primary care physician.

5. Varicella. Any Resident without known history of chicken pox should receive a FAMA test. Vaccination should then be offered, particularly for residents entering pediatrics training (females should first be screened with a pregnancy test).

6. Hepatitis A. No CDC recommendations exist at the present time. However, a vaccine has been developed which is thought to be safe and effective, and may eventually be routinely offered to health care workers at risk for exposure to hepatitis A.

**Tuberculin testing**
A routine PPD test should be placed on each Resident at entry, unless the Resident has a history of prior positive tuberculin reactivity. Routine annual PPD testing should be done thereafter. More frequent testing may be indicated for Residents at high risk for TB exposure (examples might include pulmonary and infectious diseases fellows). A baseline radiograph should be obtained on any Resident with a positive PPD (or history of positive PPD) at baseline.

**HIV testing**
HIV testing is not routinely currently offered to health care workers at the time of employment. However, individuals seeking testing (because of a perception of being at risk) should be offered the test at baseline. Also, any Resident exposed by injury during his/her training should be referred to employee health for counseling, HIV testing and evaluation for treatment with AZT.

**Other testing**
Most health care workers receive a baseline complete blood count and urinalysis. Screening for syphilis with an RPR is no longer routinely offered, but should be provided to individuals with prior exposure.

Recommendations for baseline testing of health care workers for hepatitis C do not exist, however, testing may become routine if a vaccine is developed.
OCCUPATIONAL EXPOSURE INFORMATION

In the event of an occupational exposure to blood or body fluids (i.e., needlestick), scrub the wound for 5 minutes with betadine, hibiclens or soap. If there is a splash of blood or body fluids to the eye, then it should be irrigated for 5 minutes with water or normal saline.

REPORT IMMEDIATELY FOR MEDICAL TREATMENT AT THE ASSIGNED CLINICAL INSTITUTION WHERE THE INCIDENT OCCURRED.

IF INJURY OCCURS AT TULANE (TUHC): Report to the Employee Health/Occupational Medicine Clinic, 5th Floor, TMC, (586-3831 or 586-3986), Monday-Friday, 7:30 a.m. to 4 p.m. or to the Emergency Room (588-5711) after 4 p.m. on weekdays and on weekends. Complete a "Report of Occupational Injury" form.

IF INJURY OCCURS AT MCLNO OR UNIVERSITY HOSPITAL: Report to the Employee Health Department located at MCLNO Hospital (568-3159), 6:30 a.m.-3:30 p.m., Monday-Friday, or after hours to the Emergency Room at MCLNO or University Hospital. Complete an "Incident Report" form.

IF INJURY OCCURS AT VETERANS ADMINISTRATION HOSPITAL: Report to Employee Health (568-0811, ext 3851), or after hours to the Emergency Room. Complete the "Employee Accident" forms 2126/CA-1.

REPORT INJURY TO PROGRAM DIRECTOR.

PROFESSIONAL LIABILITY COVERAGE

While you are a Tulane Resident and/or Fellow, you are included in the Self-Insurance Trust Program that Tulane has for professional liability. Under the following circumstances, this coverage is secondary to coverage that is otherwise provided.

1. While on rotation at MCLNO Hospital, you are provided coverage through the State Malpractice Program. This is statutory coverage that provides that health care providers, including house staff who treat patients at any of the state institutions, are personally immune from liability. The state is obligated to provide the defense for any Resident and/or Fellow so named and is also responsible for any judgments that may arise from any claim.

2. Veterans Administration Rotation. Those Residents on rotation within the VA system are considered covered under the Federal Tort Claims Act and therefore would be immune from any personal liability. In those situations, the federal government is obligated to provide the cost of defense and the satisfaction of any judgments and/or settlements.

3. Residents on rotation to facilitates outside the state of Louisiana. The primary coverage would be determined pursuant to the affiliation agreement between Tulane and the affiliating institution.
Other than the above three exceptions, the Residents and Fellows would have primary coverage by the Tulane program. Under the Tulane coverage, the first $100,000 is covered by Tulane, the remaining $400,000 (up to the statutory limit of $500,000) is provided through the Patients’ Compensation Fund. As a safety net in case the statutory cap is removed, the Tulane Self-Insurance Trust program provides an additional $900,000 coverage. The coverage provided by Tulane through its Self-Insurance Trust and to the Patients’ Compensation Fund is an occurrence-based policy and provides no tail exposure for Residents and Fellows.

**Tulane does not provide any coverage for moonlighting activities of a Resident.**

Any questions about the above coverage can be addressed to the Director of Risk Management for Tulane University. The number is 587-7510 or 865-5653.

**BEEPERS**

All Tulane Residents will be provided with beepers for use during their training as clinical residents or fellows. They will be responsible for returning assigned beepers at the completion or termination of training. The Office of Graduate Medical Education will provide Departments and sections with an adequate number of beepers. Distribution will be accomplished through Department program directors and coordinators. Residents may retain the same beepers throughout their period of training within a program.

Radiofone charges the office of Graduate Medical Education a $50 fee for each lost beeper. Beginning October 15, 1998, the departments/sections will be responsible for the cost of replacing lost beepers. At the request of the department/section, the office of Graduate Medical Education will process an IT for reimbursement of these fees and obtain the replacements.

**ARREST POLICY**

To provide quality service to the students, residents and fellows of Tulane University Medical Center, a detailed plan should be in place in the event that one of the students, residents or fellows should be arrested. *The Tulane University Medical Center Police Department will make reasonable efforts to help in arranging for release of that individual but there may be occasions for reasons beyond the control of Tulane University Medical Center Police Department that efforts to secure the release cannot be arranged.* Normally the release will be accomplished by contacting persons who have parole powers designated by state law. There are times when the seriousness of the crime may be such when this cannot be accomplished. The proposed plan for future cases would be as follows:

1. The person arrested or an acquaintance must notify the Tulane University Medical Center Police Department at 588-5531. The information needed will be the name of the individual arrested, if the individual is a student, resident or fellow, the program he/she is in, such as surgery or medicine; also a listing of the charges and the jail or parish prison at which the individual is being detained.

2. The Crime Prevention Coordinator or his/her designate shall either be called or paged by
the Tulane University Medical Center Police Department. The Crime Prevention Coordinator will have a listing of persons with parole powers. A call will be placed by the Crime Prevention Coordinator to that individual, and that person will be provided with the necessary information to help in obtaining the release.

3. In the event that the seriousness of the crime is beyond the scope of parole powers, a call will be place to the University’s Attorney-at-Law, or a designate. This office will then provide legal counsel to that person as to his/her rights or to an appropriate bail agency unless that individual chooses to obtain other counsel which is his/her option.

4. The Crime Prevention Coordinator will then notify the respective section head, such as the Associate Dean for Graduate Medical Education, the Chair of the Department, or the Program Director. A report of what has occurred will be provided with as much information as possible.

5. Should the individual arrested be in need of transportation from the jail or parish prison, the Crime Prevention Coordinator will arrange for transportation to either the medical center or his/her residence.

6. Once the individual is returned to his/her residence, a confidential report will be compiled and forwarded to the appropriate section head.

7. The arrested individual will also be provided with the office number of a University attorney, should that individual wish to find out answers to any legal questions. The arrested individual is not obligated to accept the assistance of the Tulane University Medical Center Police Department, Tulane University School of Medicine or any representatives of the University. The individual is also free to contact any lawyer of his/her choice or make other arrangements for release.

8. In the event that a signature bond is imposed (a signature bond guarantees the appearance of the individual), it will not be the responsibility of the Tulane University Medical Center Police or its representative to sign the bond. A friend, faculty member, program coordinator or other responsible person can sign the bond, which will secure the release of the individual. The person signing the bond personally guarantees that the arrested person will make all court appearances.
APPENDIX G – AFFILIATION AGREEMENTS

Example #1

EDUCATIONAL AND TRAINING GUIDELINES FOR AFFILIATED PREVENTIVE MEDICINE/OCCUPATIONAL MEDICINE TRAINING SITES

PRACTICUM TRAINING SITE: ______________________

ELECTIVE ______________________ REQUIRED _______

This document represents an affiliation agreement between the Preventive Medicine Residency Program at ________________________________________________________________ (Parent Institution) and the above named practicum training site/facility. This affiliation agreement outlines the general educational and training guidelines pertaining to rotation of preventive medicine residents at this site. Residents assigned to this facility under this affiliation agreement are licensed physicians in the State of _______________ and are currently enrolled in an accredited preventive medicine residency program.

Optional: Resident stipend and benefits as well as malpractice liability coverage and workers’ compensation coverage are fully provided by the resident’s parent program. The above named practicum training site/facility has agreed to engage in supervising residents without an expectation of additional compensation for teaching. The site and the preceptors at the site have agreed to voluntarily participate in teaching.

1. The participating institution must provide experiences through which the appropriate knowledge, skills, and competencies may be acquired consistent with the overall educational objectives of the residency.
   a. Faculty or staff member responsible for the resident _______________________,
      is responsible for:
      (Type name and license number here)

      1. The day-to-day activities of the program at the site
      2. Supervision of the residents to achieve the objectives of the educational goals of the residency and educational plans of the residents as appropriate to the participating institution
      3. Direct supervision of residents to ensure applicable patient care and practicum experiences through explicit written descriptions of supervisory lines of responsibility (attach written descriptions to this document). Such guidance must be communicated to all members of the program staff. Resident must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.

   b. The responsible faculty or staff member and the resident assigned to the participating institution must coordinate all activities with the program director.
2. The reciprocal commitments of the residency program and the participating institutions must be explicit in a written agreement or contract and include the following;
   a. Educational objectives

   1. If possible, during their rotation, residents will obtain experience in and/or have opportunity to participate in the following competencies as listed below:

      ____ Specify:
      ____ Specify:
      ____ Specify:
      ____ Other projects and activities as appropriate.

   2. Other--site-specific competencies for ____________________________________________ (Name of Site)

      ____ Specify:
      ____ Specify:
      ____ Specify:
      ____ Other:

   b. The scope of the affiliation with placement locations

      Suggestions
      Only one resident will rotate at the practicum facility at any given time. During the period that the resident is assigned to this site under this agreement:

      1. He/She will rotate with the facility _____ for ____ (days) (half-days) per week over a longitudinal period spanning the course of their practicum training.
         _____ for a _____ block of time.

      2. He/She is expected to be productively involved in duties which occupy the normal working hours of the site. Resident duty hours and on-call time periods must not be excessive and should focus on the needs of patients and
their continuity of care, the needs of the practicum site, and the educational needs of the resident.

3. Should special opportunities or travel be involved, the normal duty hours may be reasonably extended.

4. Activities external to the training site may be required by the Preventive Medicine Residency Program Director with the concurrence of the site Preceptor. Such activities may include weekly and special conferences, didactic lectures, and other special educational offerings.

5. Official designated holidays, vacation, sickness and other leave requests of the resident’s Parent Institution will be honored.

6. The dates of actual rotation will be mutually agreed upon by the site Preceptor, the resident, and the Program Director in advance of the rotation.

c. The resources, including space, services, and clinical facilities of the affiliate, that will be available to all residents (describe)

d. The duties and responsibilities of the resident at the affiliate (describe)

Example:

At all times during resident assignment to the practicum facility, the resident’s Parent Institution shall be solely responsible during the course of their work for their medical conduct, their technical expertise, their diagnosis and treatment of patients, and their overall performance of their job duties. Dress and appearance are expected to be both professional and appropriate to the work site.

e. The relationship that will exist between residents and staff of the residency program and affiliate (describe)

f. The supervisory relationship and identified supervisor (qualified by certification or experience) (describe)

g. Procedures for academic discipline and handling of resident complaints or grievances (describe)

Additional/ Optional Language:
Some programs are required to include specific language such as:

To the extent authorized under the laws of the State of ______________, the resident’s Parent Institution shall hold the practicum institution harmless from liability resulting from the Parent Institution’s acts or omissions within the terms
of this agreement provided, however, the resident’s Parent Institution shall not hold the practicum institution harmless from any claims, demands, or causes of action arising in favor of any person or entity resulting directly or indirectly from negligence (whether sole, joint, concurring or otherwise) of the practicum institution or its officers, agents, representatives or employees, or any person or entity not subject to the Parent Institution’s supervision or control.

**Supervision and Terms of Agreement.**

The resident will receive direct supervision from a preceptor assigned by the rotation site (Preceptor) who is: ___ the current facility physician.

___ other (specify): ________________________.

The resident will communicate with the Preventive Medicine Residency Program Director on a biweekly basis (every two weeks) during the rotation, or at another frequency approved by the RRC.

The resident will have opportunity for active and meaningful participation in site activities with the gradual assumption of increased clinical and/or administrative responsibility leading to the mature and independent practice of preventive medicine.

Adequate work space will be provided at the practicum site and the resident may have support from clerical and other personnel as appropriate at the site, along with access to computer facilities when available. Clinic or office space will be made available as appropriate for the resident to see and visit privately with patients and employees.

This agreement is effective upon the date of execution and will continue in effect indefinitely until otherwise altered, modified, or replaced. The agreement will be reviewed annually.

Either party may terminate this agreement upon 60 days written notice to the other party.

3. **Confidentiality.**

a. All residents shall treat employee medical records and communications as confidential records in accordance with Federal and State laws, and company issued bulletins and policies issued on the subject.

b. It is expected that the resident’s Parent Institution will have access to medical records prepared by residents for an indefinite period of time in order to defend itself against any actual or pending litigation.
c. It is appreciated that in order to optimize the educational process, the resident may become aware of sensitive matters affecting both individuals and the practicum institution. Certain information might be of a proprietary nature or could place the company in legal jeopardy should it become public. Consequently, the resident will treat all information with the same caution and concern as in dealing with medically confidential issues.

4. **Evaluations.**

a. The responsible site Preceptor will provide an evaluation of the resident in accordance with the Preventive Medicine Residency Policies and Procedures of the resident’s Parent Institution, and review this evaluation with the resident.

b. Residents will also complete an evaluation of the training site experience in accordance with these Policies and Procedures.

5. **Signatures.**

This affiliation agreement is entered into on the _____________________.

(Day) (Month) (Year)

For ________________________________ (Parent Program):

_______________________________

Name:  
Program Director, Preventive Medicine Residency

For: (site)  

_______________________________

Name: Date
Title:
## APPENDIX I – CORE COMPETENCIES

### COMPETENCY EVALUATION

**GENERAL CLINICAL COMPETENCIES**

(may be met by documenting that incoming residents have successfully completed rotations and activities comprising at least 12 months of clinical experience)

* Key: I = Independent; P = Participated; O = Observed

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>ACTIVITY</th>
<th>LEVEL*</th>
<th>DATE</th>
<th>TYPE OF EVALUATION</th>
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<tbody>
<tr>
<td>1. Patient care</td>
<td>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</td>
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<tr>
<td>2. Medical knowledge</td>
<td>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological, social-behavioral) sciences and the application of this knowledge to patient care.</td>
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<tr>
<td>3. Practice-based learning</td>
<td>Investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.</td>
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<td>4. Interpersonal skills and communication</td>
<td>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and professional associates.</td>
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<tr>
<td>5. Professionalism</td>
<td>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.</td>
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<tr>
<td>6. Systems-based practice</td>
<td>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.</td>
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4 Other possible columns include: 1) Assessment of performance (Exc/Satisf/Unsatis); and 2) Initials of the evaluator.
## COMPETENCY EVALUATION

### CORE PREVENTIVE MEDICINE COMPETENCIES

* Key: \(I\) = Independent; \(P\) = Participated; \(O\) = Observed

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<tr>
<th>COMPETENCY</th>
<th>ACTIVITY</th>
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<th>TYPE OF EVALUATION</th>
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<tbody>
<tr>
<td>1. Communication, program, and needs assessment</td>
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<tr>
<td>a. Communicate clearly to professional target groups, in both written and oral presentations, the levels of risk from hazards and the rationale for interventions.</td>
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<td>I P O</td>
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<tr>
<td>-- Communicate clearly to lay target groups, in both written and oral presentations, the levels of risk from hazards and the rationale for interventions.</td>
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<tr>
<td>b. Conduct program and needs assessments.</td>
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<td>-- Prioritize activities using objective, measurable criteria such as epidemiological impact and cost-effectiveness.</td>
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<td>I P O</td>
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<tr>
<td>2. Computer applications relevant to preventive medicine</td>
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<tr>
<td>Use computers for word processing, reference retrieval, statistical analysis, graphic display, database management, and communication.</td>
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<td></td>
<td></td>
<td>I P O</td>
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<tr>
<td>3. Interpretation of relevant laws and regulations</td>
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<tr>
<td>Identify and review relevant laws and regulations germane to the specialty area and specific assignments.</td>
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<tr>
<td>4. Identification of ethical, social, and cultural issues</td>
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<tr>
<td>Recognize ethical, cultural, and social issues related to a particular issue and develop interventions and programs that acknowledge and appropriately address the issues.</td>
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</table>
5. Identification of organizational & decisions-making processes

| Identify organizational decisions-making structures, stakeholders, style, and processes. | I | P | O | I | P | O |

6. Identification and coordination of resources to improve community's health

| Assess program and community resources, develop a plan for appropriate resources, and integrate resources for program implementation. | I | P | O | I | P | O |

7. Epidemiology and biostatistics

| a. Characterized the health of a community | I | P | O | I | P | O |
| b. Design and conduct an epidemiological study | I | P | O | I | P | O |
| c. Design and operate a surveillance system | I | P | O | I | P | O |
| d. Select and conduct appropriate statistical analyses | I | P | O | I | P | O |
| e. Design and conduct an outbreak or cluster investigation | I | P | O | I | P | O |
| f. Translate epidemiological findings into a recommendation for a specific intervention | I | P | O | I | P | O |
8. Management and administration

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<tbody>
<tr>
<td>a.</td>
<td>Assess data and formulate policy for a given health issue</td>
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<td>b.</td>
<td>Develop and implement a plan to address a specific health problem</td>
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<td>c.</td>
<td>Conduct an evaluation or quality assessment based on process and outcome performance measures</td>
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<tr>
<td>d.</td>
<td>Manage the human and financial resources for the operation of a program or project</td>
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9. Clinical preventive medicine

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<tbody>
<tr>
<td>a.</td>
<td>Develop, deliver, and implement, under supervision, appropriate clinical services for both individuals and populations</td>
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<td>IPO</td>
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<tr>
<td>b.</td>
<td>Evaluate the effectiveness of clinical services for both individuals and populations</td>
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10. Occupational and environmental health

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<tr>
<td>Assess and respond to individual and population risks for occupational and environmental disorders</td>
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<td>IPO</td>
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</tbody>
</table>
## COMPETENCY EVALUATION

### AEROSPACE MEDICINE COMPETENCIES

* Key: **I** = Independent; **P** = Participated; **O** = Observed

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<tr>
<th>COMPETENCY</th>
<th>ACTIVITY</th>
<th>LEVEL</th>
<th>DATE</th>
<th>TYPE OF EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Manage the health status of individuals working in all aspects of the aerospace environment</td>
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<tr>
<td>a.</td>
<td>Demonstrate competency in managing aerospace and general medical problems in aerospace personnel</td>
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<tr>
<td>b.</td>
<td>Develop and apply medical standards and grant exceptions to facilitate prevention, early diagnosis, and treatment of health hazards</td>
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<tr>
<td>c.</td>
<td>Space medicine: Perform all activities of a crew surgeon for a space flight</td>
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<tr>
<td></td>
<td>-- develop and apply medical care standards and programs</td>
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<td></td>
<td>-- evaluate the physiologic effects of spaceflight on crew members</td>
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<td></td>
<td>-- conduct and evaluate longitudinal studies on astronauts</td>
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<tr>
<td>2.</td>
<td>Promote aerospace passenger health, safety, and comfort</td>
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<td></td>
<td>Educate passengers and physicians about the hazards of flight with certain medical conditions and to serve as passenger advocates to promote flight safety</td>
<td><strong>I</strong></td>
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<tr>
<td>3.</td>
<td>Facilitate optimum care of patients transported in the aerospace environment</td>
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<tr>
<td></td>
<td>Identify appropriate patients for aeromedical transport and provide guidance for safe aeromedical transport of patients with common medical problems</td>
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</tbody>
</table>
4. Apply human factors/ergonomic concepts of the aerospace environment

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<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>Advise in the development of air and space flight equipment, biomedical equipment, and vehicles for flight and space flight</td>
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<tr>
<td>-- techniques for enhancing performance</td>
<td>I P O</td>
<td>I P O</td>
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<tr>
<td>-- techniques of crew resource management</td>
<td>I P O</td>
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</table>

5. Promote aerospace operational safety and mishap prevention

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<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>Provide appropriate safety information and education</td>
<td>I P O</td>
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<tr>
<td>-- conduct the medical aspects of any mishap investigation, including recommendations to prevent recurrences</td>
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</table>

6. Interpret, integrate, and/or perform aeromedical research

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<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>Effectively conduct aeromedical research into health, safety, human factors, and biomedical engineering aspects of the flight environment</td>
<td>I P O</td>
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</tbody>
</table>
**COMPETENCY EVALUATION**

**OCCUPATIONAL MEDICINE COMPETENCIES**

* Key: I = Independent; P = Participated; O = Observed

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>ACTIVITY</th>
<th>LEVEL*</th>
<th>DATE</th>
<th>TYPE OF EVALUATION</th>
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</thead>
<tbody>
<tr>
<td>1. Manage the health status of individuals who work in diverse work settings</td>
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<tr>
<td>a. Demonstrate competency in mitigating and managing medical problems of workers</td>
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<tr>
<td>b. Assess safe/unsafe work practices and safeguard employees and others, based on clinic and worksite experience</td>
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<td>2. Monitor/survey workforces and interpret monitoring/surveillance data for prevention of disease in workplaces and to enhance the health and productivity of workers</td>
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<td>Through active participation in several surveillance/monitoring programs, for different types of workforces, learn principles of administration and maintenance of practical workforce and environmental public health programs</td>
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<tr>
<td>-- Plan at least one such surveillance/monitoring program</td>
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<td>3. Manage worker insurance documentation and paperwork, for work-related injuries and illnesses</td>
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<td>Demonstrate competency to “open,” direct, and “close” injury/illness cases</td>
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<tr>
<td>4. Recognize outbreak events of public health significance, as they appear in clinical or consultation settings</td>
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<tr>
<td>a. Understand the concept of sentinel events, and know how to assemble/work with a team of fellow professionals who can evaluate and identify worksite public health causes of injury and illness</td>
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<td>b. Recognize and evaluate potentially hazardous workplace and environmental conditions</td>
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<tr>
<td>-- Recommend controls or programs to reduce exposures and to enhance the health and productivity of workers</td>
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<td>I</td>
<td>P</td>
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<td></td>
<td>IPO</td>
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<tr>
<td>c. Demonstrate reliance on</td>
<td>IPO</td>
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<tr>
<td>toxicologic and risk assessment principles in the evaluation of hazards</td>
<td>IPO</td>
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<tr>
<td>5. Ethics and communication</td>
<td>IPO</td>
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<tr>
<td>Report outcome findings of</td>
<td>IPO</td>
<td></td>
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<tr>
<td>clinical and surveillance</td>
<td>IPO</td>
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<tr>
<td>evaluations to affected</td>
<td>IPO</td>
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<tr>
<td>workers as ethically required</td>
<td>IPO</td>
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<tr>
<td>Advise management concerning</td>
<td>IPO</td>
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<tr>
<td>summary (rather than individual) results or trends of public health significance</td>
<td>IPO</td>
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</tr>
</tbody>
</table>
# COMPETENCY EVALUATION

## PUBLIC HEALTH & GENERAL PREVENTIVE MEDICINE COMPETENCIES

* Key: **I** = Independent; **P** = Participated; **O** = Observed

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>ACTIVITY</th>
<th>LEVEL*</th>
<th>DATE</th>
<th>TYPE OF EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Public health practice -- spend at least one month in a rotation at a government public health agency gaining competency in at least one of the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Monitoring health status to identify community health problems</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>b. Diagnosing and investigation of health problems and health hazards in the community</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>c. Informing and educating populations about health issues</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>d. Mobilizing community partnerships to identify and solve health problems</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>e. Developing policies and plans to support individual and community health efforts</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>f. Enforcing laws and regulations that protect health and ensure safety</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>g. Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>h. Ensuring a competent public health and personal health care workforce</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>i. Evaluating the effectiveness, accessibility, and quality of personal and population-based health services</td>
<td></td>
<td><strong>I</strong></td>
<td><strong>P</strong></td>
<td><strong>O</strong></td>
</tr>
<tr>
<td>j.  Conducting research for innovative solutions to health problems</td>
<td>IPO</td>
<td>IPO</td>
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<tr>
<td>2. Clinical preventive medicine</td>
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<tr>
<td>a. Demonstrate understanding of primary, secondary, and tertiary preventive approaches to individual and population-based disease prevention and health promotion</td>
<td>IPO</td>
<td>IPO</td>
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</tr>
<tr>
<td>b. Develop, implement, and evaluate the effectiveness of appropriate clinical preventive services for both individuals and populations</td>
<td>IPO</td>
<td>IPO</td>
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<tr>
<td>3. Epidemiology</td>
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<tr>
<td>Design and conduct health and clinical outcomes studies</td>
<td>IPO</td>
<td>IPO</td>
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<tr>
<td>4. Health administration</td>
<td></td>
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<tr>
<td>a. Design and use management information systems</td>
<td>IPO</td>
<td>IPO</td>
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<tr>
<td>b. Plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems</td>
<td>IPO</td>
<td>IPO</td>
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</tbody>
</table>
APPENDIX K – EVALUATIONS

Example #1

Sample 1

ADMINISTRATIVE FACULTY ADVISOR FORM
(to be completed by resident)

Date: ______________________________

<table>
<thead>
<tr>
<th>Rating Scale</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Avg.</th>
<th>Good</th>
<th>Very Good</th>
<th>N/A</th>
</tr>
</thead>
</table>

Residency Director:
1. Accessibility 1 2 3 4 5 6
2. Interest in advising 1 2 3 4 5 6
3. Flexibility 1 2 3 4 5 6
4. Quality of advice 1 2 3 4 5 6

5. What could the Residency Director have done differently to enhance your residency experience?

________________________________________________________________________

________________________________________________________________________

6. Other comments:

________________________________________________________________________

________________________________________________________________________

Other Faculty:
7. Accessibility 1 2 3 4 5 6
8. Interest in advising 1 2 3 4 5 6
9. Flexibility 1 2 3 4 5 6
10. Quality of advice 1 2 3 4 5 6

11. What could the other faculty have done differently to enhance your residency experience?

________________________________________________________________________

________________________________________________________________________

12. Other comments:
Residency Coordinator:
13. Accessibility  1 2 3 4 5 6
14. Interest in advising  1 2 3 4 5 6
15. Flexibility  1 2 3 4 5 6
16. Quality of advice  1 2 3 4 5 6

17. What could the residency coordinator have done differently to enhance your residency experience?

18. Other comments:

General Program Considerations:
19. Please list what you think the major strengths of the General Preventive Medicine Residency are:

20. Please list what you think the major weaknesses of the General Preventive Medicine Residency are:

21. General comments, suggestions, etc.
## RESIDENT EVALUATION BY PROGRAM DIRECTOR

<table>
<thead>
<tr>
<th>Resident</th>
<th>Month of Evaluation: 2 6 12 18 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluator</td>
<td>Date ____________________________</td>
</tr>
<tr>
<td>Practicum Location</td>
<td>____________________________</td>
</tr>
<tr>
<td>Time Period Covered</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

### MPH/Research

<table>
<thead>
<tr>
<th>Thesis progress</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of research</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Class work</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

### Didactic

<table>
<thead>
<tr>
<th>Participation</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of presentations</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

### Practicum

<table>
<thead>
<tr>
<th>Competency in area of practicum</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of preventive medicine to practicum</td>
<td>1 2 3 4 5</td>
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</table>

### Public Health

<table>
<thead>
<tr>
<th>Introduction (Planned/Completed)</th>
<th>1 2 3 4 5</th>
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</thead>
<tbody>
<tr>
<td>Sacramento (Planned/Completed)</td>
<td>1 2 3 4 5</td>
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</tbody>
</table>
3-week project (Planned/Completed)

Applicability of public health experience to preventive medicine goals

Underserved

Project (Planned/Completed)

Quality of work

Overall

Preventive Medicine competencies

Integration of Preventive Medicine

Community Activities

Residency Progress Report complete (date)

Preceptor Evaluation complete (date)

Evaluator

Date

Resident

Date
Sample 3

PRECEPTOR EVALUATION OF RESIDENT

Resident______________________________  Month of Evaluation: 6  12  18  24
Preceptor______________________________  Date______________________________
Practicum location__________________________________________________________
Time period covered by this evaluation  From____________  To______________

Resident duties______________________________________________________________

_______________________________________________________________

Process evaluation (attendance, compliance with institutional rules)______________

_______________________________________________________________

Quality of work (understanding of scope, thoroughness, follow-through, work with minimal supervision

_______________________________________________________________

Areas of particular strength_______________________________________________

_______________________________________________________________

Areas needing improvement_______________________________________________

_______________________________________________________________

General program feedback_______________________________________________
### ACTIVITY TIMELINE

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>PGY2 Fall</th>
<th>PGY2 Spring</th>
<th>PGY3 Fall</th>
<th>PGY3 Spring</th>
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</thead>
<tbody>
<tr>
<td>Academic</td>
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<tr>
<td>Research</td>
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<tr>
<td>Didactics</td>
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<tr>
<td>Public Health</td>
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<tr>
<td>Rotations</td>
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<tr>
<td>Electives</td>
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<tr>
<td>Other Program Specific Requirements</td>
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</tbody>
</table>
APPENDIX L – RAC & GMEC SERVICES

Example #1 - New Jersey Department of Health and Senior Services
(Prepared by Sindy M. Paul, M.D., M.P.H. and Martin T. Zanna, M.D., M.P.H.)

This document is organized according to the ACGME requirements for the RAC and GMEC (see Tab L). Throughout the document, the ACGME requirements are listed first, and they are followed by examples of “best practices” in the preventive medicine program at the New Jersey Department of Health and Senior Services (examples are written in blue). Helpful hints for running a RAC and GMEC also are included below.

Residency Advisory Committee (RAC)

RAC Membership

- Chair = Physician
  - Chair, Board Certified in PH
- Faculty
  - All Faculty Members Are On The RAC
- External Members
  - 14 From A Variety of Organizations
- Practicum Supervisors
  - All Practicum Supervisors Are On RAC
- Members Must Be Certified in PM or Knowledgeable About PM Training
  - 12 Board Certified in a PM Specialty, Rest = Knowledgeable
- Majority Of Members From Outside
  - 14/25 (~60%) Are Outside NJDHSS
- Residency Director Is Ex-Officio
  - Residency Director Is Ex-Officio

Helpful Hints For RAC Membership

- Other Residency Program Directors
- MPH Program Director
- Industrial Hygienist (Occupational Residencies)
- Industry e.g., Pharmaceutical Companies, Trade Unions
- Don’t Yield To “Political Appointees”

Frequency of Meetings

- The RAC Must Meet At Least Semiannually
  - Our RAC Meets Quarterly
Helpful Hints For Attendance at RAC Meetings

- Convenient Time & Location (Can Rotate)
- Make It Informative
- Make It Fun (Graduation Parties Etc)
- Value Added Free CME Lecture
- More Helpful Hints
- Provide Food And Beverages
- Provide Parking
- Members Should Feel That They Are Contributing To Graduate Medical Education

Mission of the RAC

- The Mission Of The RAC Is To Promote A Residency Training Experience That Is Aligned With PM
  - The Mission Statement Is Included In The Annual RAC Report To Administration
- The RAC Complements The GMEC Which Evaluates and Supports The Residency From Within The Institution

RAC Functions To Advise And Assist The Residency Director

- Develop & Update A Written Residency Mission Statement That Describes Goals and Objectives
  - Reviewed Annually By The RAC
- Develop Educational Experiences and Practicum Rotations
  - Reviews Resident Schedules
  - Each Resident Presents Their Experience At Each RAC Meeting
- Provide New Or Emerging Knowledge, Skills Or Competencies That May Influence The Content Or Conduct Of PM Education
  - Presentation on Web Based GME
- Review The GMEC Review Of The Residency
  - The Annual GMEC Review Is Distributed & Discussed At The RAC
- Review Confidential And Written Resident Evaluations And Recommend Changes
  - The Annual Written Report To The RAC Chair From Each Resident Is Reviewed
- Changes Recommended Included:
  - Shortening a Block Rotation (Policy)
  - Adding Year-Long Longitudinal Rotations - Continuing Office Of The Commissioner
  - Add EMS Block Rotation
- Review The Program Director Evaluation Of Individual Residents
  - The Residency Director Provides a Verbal Progress Report At Each RAC Meeting
- Provide An Annual Report To The Institution Through The Chair
  - The Chair Provides A Written Annual Report To The Deputy Commissioner

**Documentation Required & How It’s Measured**

- RAC Minutes Document RAC Function And Are Maintained In Files
  - Minutes Are Kept From Each RAC Meeting, Distributed To RAC Members, & Kept On File By Chair And Director
  - RAC Activity and Faculty/Member Participation Are Noted In The Minutes
  - An Attendance List Is Maintained
  - Distance Participation By Phone
  - Exploring Teleconference Potential

**Graduate Medical Education Committee (GMEC)**

**Mission of the GMEC**

- The GMEC Monitors And Advises On Graduate Medical Education
- Helpful Hints For Attendance
  - Same Hints As The RAC

**Frequency of GMEC Meetings**

- The GMEC Must Meet At Least Quarterly
  - The GMEC Meets At Least Quarterly
- Minutes Must Be Kept And Available At The Site Visit
  - Minutes Are Kept And Available At The Site Visit

**An Example of GMEC Voting Membership**

- Residents Nominated By Their Peers
  - All Our Residents Are On The GMEC
- Appropriate Residency Directors
  - The Residency Director Is On The GMEC
- Other Faculty Members
  - All Faculty Members Are On The GMEC
- Accountable Institutional Official/ Designee
  - Institutional Official On GMEC

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GMEC Responsibilities

- Establishment & Implementation of Policies Affecting Educational Quality & Work Environmental For All Residents
  - The Policy Manual Is Reviewed Annually
- Establish & Maintain Oversight & Liaison With Residency Program Directors & Personnel From Other Institutions
  - Director and Personnel on RAC & GMEC - Constant Communication With Director
- Regular Review Of Residency Programs For ACGME & Institutional Requirement Compliance Between Site Visits
- The Review Committee Must Include Faculty, Residents, & Administrators From Within & Outside The Dept. In Which The Residency Exists +/- External Reviewers
- Follow Written GMEC Approved Protocol
- An Annual Review Is Conducted
- A Written GMEC Approved Policy Is Followed (New Jersey Example Attached)
- The Review Committee Members Include:
  - Faculty
  - Residents
  - An Administrator
  - An External Reviewer
- Educational Objectives of Each Program
- Adequacy Of Available Educational & Financial Resources To Meet These Objectives
- Effectiveness Of Each Program In Meeting Its Objectives
- Effectiveness of Addressing ACGME Citations & Previous Deficiencies Noted In Internal Reviews
- The Educational Objectives Are Reviewed
- Adequacy of Resources Is Reviewed Including A Survey Of Salaries/Tuition Reimbursement In Other Programs
- Effectiveness In Meeting Objectives: Continuously Monitor Resident’s Progress
- No Citations At Last Site Visit, But Address Needs Noted In The Faculty, Resident, & Residency Director Reviews

How the GMEC Establishes & Implements Policies

- Formal Written Criteria & Processes For:
  - Resident Selection
  - Resident Evaluation
  - Resident Promotion
  - Resident Dismissal
- Policies Need To Comply With ACGME & Institutional Requirements
- Reviewed By GMEC Annually
- Informed At Meeting Selection & Promotion

Data To Be Used In The GMEC Review Process

- Institutional & Program Requirements From The Essentials of Accredited Residency Programs
- ACGME Accreditation Letters
- Reports From Previous Program Internal Reviews
- Interviews With The Director, Faculty, Residents, & Appropriate Individuals Outside The Program
  - These Data Sources Are Specified In The Policy
  - These Data Sources Are Used
  - GMEC Chair Conducts The Interviews

Documentation Of The GMEC Review

- Documentation Includes Recorded Mechanisms To Correct Identified Deficiencies
  - This Is Included In The Report: Attend Conferences & Distance Based Learning
- Succinct Summaries Of The Review Are Required As Part Of The ACGME Institutional Review Document
  - These Are Supplied As Requested

Caveat!

- Although Departmental Annual Reports Are Often Important Sources Of Information, They Do Not In Themselves Meet The Requirement For A Periodic Review
  - The Chair Of The GMEC Does Both An Annual report And An Annual Review
  - These Are Separate Processes That Result In Separate Documents With Differing Content

Assurance of An Environment Without Fear Or Intimidation

- Resident Organization Or Other Forum To Address Resident Issues
  - Affirmative Action Officer On GMEC
  - Policies Developed & Implemented Include Mechanisms For Grievances
  - Informal Communication With Chair Or GMEC Members
- Process For Residents To Address Concerns In A Confidential, Protected Manner
  - Affirmative Action Officer On GMEC
  - Policies Developed For Grievances
  - Informal Discussion With Chair Or GMEC Member
  - Residents = Union Members
• Establish & Implement Policies For Academic Or Other Disciplinary Action
  - Residents = Union Members
  - State Employees: Rights, Privileges, & Due Process Guaranteed By Union Contract & State Policies
  - Can Go Through Many Steps Including Administrative Law Court

• Establish & Implement Fair Policies To Adjudicate Resident Complaints & Grievances That Could Lead To Dismissal  -Residents = Union Employees
  - Rights, Privileges, & Due Process Guaranteed By Union Contract & State Policies
  - Can Go Through Many Steps Including Administrative Law Court

GMEC Role In Funding Recommendations

• Collect Intra-institutional Information & Make Recommendations On Appropriate Funding
  - Salary Schedule Dependent On Union Contract
  - GMEC Recommended & Residency Implemented Increased Funding To Attend In-State & Out-Of-State Conferences

Monitor Work Environment & Duty Hours

• Monitor Work Environment & Duty Hours  -All Residents Work 35 Hours/Week Per Union Contract
  - Leave Time Per Union Contract
  - No Nights Or Weekends Scheduled
  - Duty Hours Documented On Time Sheets
  - GMEC Has Recommended Minimal Requirements For Work Space E.G., Office Space, Computer, Soft-Ware Packages

GMEC Assurances Regarding Curriculum

• Assure That The Resident’s Curriculum Includes Socioeconomic, Ethical, Medical/Legal, And Cost-Containment Issues
  - GMEC Chair Interviews Each Resident
  - GMEC Chair Interviews Faculty
  - GMEC Chair Interviews Director
  - GMEC Reviews Academic Courses And Practicum Rotations

• The Curriculum Must Include Communication Skills, Research Design, Statistics, & Critical review Of The Literature
  - GMEC Chair Interviews Faculty, Residents, and Residency Director
  - GMEC Reviews The Academic & Practicum Schedules
  - Meetings Include Discussions, Presentation Of Resident Research, Presentations/Papers