**Morehouse**

**School**

**of**

**Medicine**

720 Westview Drive, SW

Atlanta, Georgia 30310

**Public Health and Preventive Medicine Residency Program**



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**Program Requirements and Policies Manual**

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# *Glossary of Terms*

* **ACGME**—Accreditation Council for Graduate Medical Education
* **CCC**—Clinical Competency Committee
* **RAC/PEC**—Residency Advisory Committee/Program Evaluation Committee
* **RRC**—Residency Review Committee
* **GME**—Graduate Medical Education
* **GMEC**—Graduate Medical Education Committee
* **AIR**—Annual Institutional Review
* **APR**—Annual Program Review
* **APE**—Annual Program Evaluation
* **CLER**—Clinical Learning Environment Review
* **NAS**—Next Accreditation System

**Morehouse School of Medicine**

**Public Health and General Preventive Medicine Residency**

# *Overview*

The Morehouse School of Medicine (MSM) Residency Program in Public Health and General Preventive Medicine is a two-year accredited program that offers residents the opportunity to integrate a practicum with academic work towards the degree of Master of Public Health. Residents spend a total of two years completing the integrated academic and practicum year requirements at Morehouse School of Medicine.

Its mission is to train qualified physicians to promote healthy behavior and prevent disease, injury, and premature death. The program teaches residents to understand the health risks associated with social, cultural, and behavioral factors; identify and address health needs in individuals and populations; understand and address the impact of health disparities among racial and ethnic groups; and recognize and eliminate behaviors that lead to injury and death.

# *Mission*

Our mission is to train qualified physicians to promote healthy behavior and prevent disease, injury, and premature death. The program teaches residents to understand the health risks associated with social, cultural, and behavioral factors; identify and address health needs in individuals and populations; understand and address the impact of health disparities among racial and ethnic groups; and recognize and eliminate behaviors that lead to injury and death.

The Morehouse program offers residents coordinated didactic and practical experience through the preventive medicine expertise of the faculty and staff of the MSM Department of Community Health and Preventive Medicine and the broad range of activities of the DHR-Division of Public Health as well as other local and federal health agencies.

# *Program Aims*

* To teach residents to identify and address health needs in diverse individuals and populations.
* To teach residents to understand and address the impact of health disparities among racial and ethnic groups.
* To produce excellent, independent practitioners who will be leaders in public health practice, academic medicine, and clinical preventive medicine.

# *Program Structure*

The MSM residency program is a two-year program that offers residents the opportunity to integrate a practicum with academic work towards the degree of Master of Public Health. Residents spend a total of two years completing the intermeshed academic and practicum year requirements at Morehouse School of Medicine. Both the academic and practicum programs have been designed with enough scheduling flexibility to accommodate dual enrollment of residents. These experiences are designed for residents to achieve competence in the preventive medicine milestones.

After completing their academic and practicum years, residents can realistically expect to find employment in public health at the federal, state, or county levels. Other feasible career opportunities include serving as a public health researcher, a medical director of a health center, or an academician or consultant.

Funding for these positions is provided through a physician training award from the American Cancer Society. Other program support comes from the Georgia Board for Physician Workforce and institutional funds.

# *Accreditation*

The Morehouse School of Medicine Public Health and Preventive Medicine Residency Program is fully accredited by the Accreditation Council for Graduate Medical Education. The letter describing the accreditation is on file in the program office.

## Resident Eligibility, Selection, and Appointment

4. **RESIDENT/FELLOW ELIGIBILITY CRITERIA**:

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) Institutional Requirements Section IV.A. Institutional GME Policies and Procedures – Resident/Fellow Recruitment, and the ACGME Common Program Requirements – Resident/Fellow Appointments/Eligibility/Transfers – section III.A-C. Sponsoring Institutions are required to have written policies and procedures for resident/fellow recruitment and must monitor each of its ACGME accredited programs for compliance.

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

4.1. graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or,

4.2. graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or,

4.3. graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:

4.3.1. holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or,

4.3.2. holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty-/subspecialty program; or,

4.3.3. has graduated from a medical school outside the United States and has completed a Fifth Pathway program provided by an LCME-accredited medical school.

4.4. An applicant invited to interview for a resident/fellow position must be informed in writing or by electronic means, of the most current terms, conditions, and benefits of appointment to the ACGME-accredited program.

4.4.1. Information must include financial support; vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents.

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

4.6. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.

4.6.1. Residency programs must receive verification of each resident’s level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from prior training program upon matriculation.

4.7. A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.

4.8. Resident Eligibility Exceptions per ACGME specialty review committees. See specialty-specific requirements.

5. FELLOW APPOINTMENTS - ELIGIBILITY CRITERIA

5.1. Each ACGME Review Committee to choose one of the following: (please review the specialty specific eligibility criteria)

5.1.1. Option 1: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)- accredited residency program located in Canada.

5.1.1.1. Fellowship programs must receive verification of each entering fellow’s level of competence in the required field, upon matriculation, using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program.

5.1.2. Option 2: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program or an AOA-approved residency program.

**5.1.2.1. Fellowship programs must receive verification of each entering fellow’s level of competence in the required field, upon matriculation, using ACGME Milestones evaluations from the core residency program**

**5.2. Fellow Eligibility Exceptions per ACGME specialty review committees. See subspecialty-specific requirements.**

**3.4.** Programs must include the following **GME Programs’ Technical Standards and Essential Functions for Appointment and Promotion information**:

**3.4.1. Introduction**

**3.4.1.1.** Medicine is an intellectually, physically, and psychologically demanding profession. All phases of medical education require knowledge, attitudes, skills and behaviors necessary for the practice of medicine and throughout a professional career. Those abilities that residents must possess to practice safely are reflected in the technical standards that follow. These technical standards/essential functions are to be understood as requirements for training in all Morehouse School of Medicine residencies and are not to be construed as competencies for practice in any given specialty.

**3.4.1.2.** Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.

**3.4.1.3.** Residents in Graduate Medical Education programs must be able to meet these minimum standards with or without reasonable accommodation (*see* Section III).

**3.4.2. Standards—Observation**

**3.4.2.1.** Observation requires the functional use of vision, hearing, and somatic sensations. Residents must be able to observe demonstrations and participate in procedures as required.

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

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

**3.4.3. Standards—Communication**

**3.4.3.1.** Communication includes speech, language, reading, writing, and computer literacy.

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

**3.4.4. Standards—Motor**

**3.4.4.1.** Residents must possess sufficient motor function to elicit information from the patient examination by palpation, auscultation, tapping, and other diagnostic maneuvers.

**3.4.4.2.** Residents must also be able to execute motor movements reasonably required for routine and emergency care and treatment of patients.

**3.4.5. Standards—Intellectual: Conceptual, Integrative, and Quantitative Abilities**

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

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

**3.4.6. Standards—Behavioral and Social Attributes**

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

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

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

**3.4.6.4.** Residents must also be able to work effectively and collaboratively as team members.

**3.4.6.5.** As a component of their education and training, residents must demonstrate ethical behavior consistent with professional values and standards.

**3.4.7. Standards—Reasonable Accommodation**

Morehouse School of Medicine (MSM) is committed to providing equal access to employment and educational opportunities for all individuals, including persons with disabilities. MSM recognizes that individuals with disabilities may need reasonable accommodations to have equally effective opportunities to participate in or benefit from educational programs, services, and activities, and to have equal employment opportunities. MSM shall adhere to all applicable federal and state laws, regulations, and guidelines with respect to providing reasonable accommodations, including academic adjustments, as necessary to afford equal employment opportunity and equal access to programs for qualified persons with disabilities.

**3.4.7.1.** MSM will make a reasonable accommodation available to any qualified individual with a disability who requests an accommodation. A reasonable accommodation is designed to assist an employee or applicant in the performance of the essential functions of his or her job or MSM’s application requirements.

**3.4.7.2.** Accommodations are made on a case-by-case basis. MSM will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in each situation. Complete information is found on the MSM Human Resources Office of Disability Services web page at http://www.msm.edu/Administration/HumanResources/disabilityservices/index.php

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

*\*It is important to note that the MSM enrollment of non-eligible residents may be cause for withdrawal of residency program accreditation*.

**3.4.8. Title IX Compliance**

**3.4.8.1.** The residency education environment shall be free of undue harassment, confrontation, and coercion because of one’s gender, cultural and religious beliefs, other individual traits, and status or standing.

**3.4.8.2.** Therefore, in compliance with the Title IX of the Education Amendments of 1972, Morehouse School of Medicine (MSM) does not discriminate on the basis of sex in its education programs and activities, and is required under Title IX and the implementing regulations not to discriminate in such a manner. The prohibited sex discrimination covers sexual misconduct including, but not limited to, sexual harassment and sexual violence, and extends to employment in and admission to such programs and activities.

**3.4.8.3.** Also in compliance with federal law, including Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act (and ADAAA amendments), it is the policy of MSM that discrimination against any person or group of persons on the basis of race, color, national origin, religion, gender, sexual orientation, marital status, ancestry, genetic information, age, disability, veteran or military status, or any other legally protected characteristic is specifically prohibited.

**3.4.8.4.** MSM also prohibits retaliation against members of the MSM community who raise concerns about or report incidents of discrimination based on legally protected characteristics. The following persons have been designated to handle inquiries about and reports made under MSM’s Sex/Gender Nondiscrimination and Sexual Harassment policy.

Marla Thompson, Title IX Coordinator, Direct Dial (404) 752-1871,

Fax (404) 752-1639 Email: mthompson@msm.edu

Morehouse School of Medicine, 720 Westview Drive, SW Harris Building,

Atlanta, GA 30310

**IV. RESIDENT ELIGIBILITY:**

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) “Institutional Requirements” of the “Essentials of Accredited Residencies in Graduate Medical Education.” Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

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

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

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

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

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

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

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

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

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

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

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

**V. SCREENING AND SELECTION CRITERIA:**

**5.1.** Available MSM resident positions are dependent upon the following criteria:

* The current number of residency program positions authorized by the Accreditation Council for Graduate Medical Education (ACGME)
* The space available in the post graduate year
* Funding and faculty resources available to support the education of residents according to the “educational requirements” of the specialty program

**5.2.** In order for any applicant to be eligible for appointment to a MSM residency program, the following requirements shall be met along with the eligibility criteria stated in paragraph IV above:

**5.2.1.** All MSM residency programs shall participate in the National Resident Matching Program (NRMP) for PGY-1 level resident positions. All parties participating in the match shall contractually be subject to the rules of the NRMP. This includes MSM, its residency programs, and applicants. Match violations will not be tolerated.

**5.2.2.** All applicants to MSM residency programs shall do so through the Electronic Residency Application Service (ERAS). This service shall be used to screen needed information on all applicants. All applicants shall request that three (3) letters of professional or academic references current as of at least 18 months, be sent to the residency program administration.

**5.2.3.** Any program requests for an official adjustment to the program’s “authorized” resident complement shall be evaluated and approved by the GMEC through the Designated Institutional Official (DIO) prior to submission to the ACGME Residency Review Committee (RRC).

**5.2.4.** Programs may establish additional selection criteria (e.g.: determine specific minimum scores for the USMLE). Specific criteria must be published for applicants to review as part of the required program-level policy on Eligibility and Selection.

**5.2.5.** Residency program directors and their Residency Advisory Committees shall have program standards to review MSM residency program applications in order to ensure equal access to the program. Eligible resident applicants shall be selected and appointed only according to ACGME, NRMP, and MSM’s requirements and policies.

**5.2.6.** Applicants from United States or Canadian accredited medical schools shall request that an original copy of a letter of recommendation or verification from the dean of the medical school be sent to the program administration.

**5.2.7.** Selectees from an LCME- or AOA-accredited United States medical school shall provide proof of graduation or pending “on-time” graduation. They shall request that official transcripts, diplomas, or “on-time” letters be sent to the program.

**5.2.8.** Selectees shall provide official proof of passing both USMLE Step 1 and USMLE Step 2 (CK and CS) before they are eligible to begin their appointment in MSM Residency Programs.

**5.2.9.** Residents are considered transfer residents under several conditions including moving from one program to another within the same or different sponsoring institution and when entering a PGY-2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the match (e.g.: accepted to both programs right out of medical school). Before accepting a transfer resident, the program director of the “receiving program” must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current program director.

**5.2.10.** The term “transfer resident” and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program. However, MSM Residency Programs shall identify all residents who would begin the residency program and would have to continue beyond the “Initial Residency Period.” \*The Initial Residency Period is the length of time required to complete a general residency program (e.g.: Internal Medicine—3 years; Psychiatry—4 years).

**5.2.11.** The State of Georgia and MSM consider any time spent in a residency program as time that must be declared by the applicant when applying for a Temporary Resident Postgraduate Training Permit. This time is applicable whether the applicant completed the period of residency or not. A letter of explanation/verification is required by the applicant and the past residency program director.

**5.2.12.** Applicants who have not graduated from a United States or Canadian accredited medical school shall request certification of completion (by seal) by an official of the medical school. If the medical school is not in the United States, such official letters shall be in English and/or have a certified or notarized English translation of the content.

**5.2.13.** A current (stamped indefinite) certificate from the Educational Commission on Foreign Medical School Graduates (ECFMG) must also be submitted with ERAS documents. Initial ECFMG Certificates should not be pending when applicants are reporting to a residency program. Failure to obtain an ECFMG Certificate by the start date of the resident appointment will void both NRMP and MSM resident agreements.

**5.2.14.** Program directors must ensure that IMG candidates are eligible for J1-Visa sponsorship before ranking these candidates in NRMP.

**5.2.15.** All selectees shall complete an MSM Non-Faculty Employment Application. The Human Resources Department is available for assistance.

**5.2.16.** Upon selection, all academic and employment documents referenced within this section and other documents requested by the residency program must be presented to the program administrator in their original form.

**5.2.16.1.** As a part of credentials authentication, documents shall be screened for authenticity and must be void of alterations.

**5.2.16.2.** Program administrators shall screen for signatures, seals, notarization, and other official stamps as being original.

**5.3.** An Applicant invited to interview for a resident position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment. Information that is provided must include: financial support; vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability, and other insurance accessible to residents/fellows and their eligible dependents.

**5.3.1.** Personal interviews of applicants shall be conducted by at least two (2) faculty members assigned to the program. These interviews should be documented for the residency program files and be retained for the period determined by MSM management policies. These interviews also become a permanent part of a selected applicant’s file.

**5.3.1.1.** If telephone interviews are performed, the same standards and documentation criteria must be used to record the interview.

**5.3.1.2.** In MSM programs, the applicant’s credentials and the faculty interview summary are formally presented to the Residency Program Advisory Committee (RAC) or equivalent.

**5.3.2.** A faculty consensus is formed on the selections for entry into the NRMP Rank Order Listing or for departmental selection for those positions not placed in the match (i.e.: PGY-2). Final disposition for applicant selection and ranking is done by the residency program director and/or department chairperson.

VI. Non-Immigrant Applicants to Residency Programs – please see detailed information in the current version of the GME policy manual at <http://www.msm.edu/Education/GME/index.php>

# Program Components

### Practicum

The practicum component of the Morehouse Residency Program in Public Health and General Preventive Medicine is comprised of seven rotations and weekly half-day clinical assignments. Five of the eight rotations correspond to the five major component areas of preventive medicine and are required of all residents regardless of degree status:

* Epidemiology/Biostatistics
* Health administration,
* Environmental and Occupational health
* Clinical Preventive Medicine
* Longitudinal Social/Cultural/behavioral aspects of medicine.
* Special Studies
* Major Area of Concentration
* The Special Studies and Major Area of Concentration electives allow residents to acquire additional knowledge and skills in one of the five component areas of public health.

The following rotations are available to residents who enter the program with the MPH degree:

* Clinical Preventive Medicine II
* Special Studies II
* Major Area of Concentration II

The above rotations allow for an individualized program while ensuring that each resident encounters a core of basic learning opportunities. In some areas, residents help to develop competencies as part of the learning experience.

### Clinical Activities

Resident engage in direct patient care throughout the resident during the weekly clinic assignments and through the completion of the Clinical Preventive Medicine and Occupational Medicine Rotations (see the above rotation list). Although the ACGME requires preventive medicine residents to complete a minimum of 320 hours of direct patient care each year, the PH/PM Residency Program requires ongoing clinical activities for the maintenance of patient care skills.

### Didactics

Residents are required to participate in weekly didactic sessions that provide additional instruction in public health and preventive medicine. The didactic sessions also provide residents the opportunity to engage with program faculty, guest lecturers, students, and peers. The didactic sessions include the following subject areas:

* Epidemiology
* Clinical Preventive Medicine
* Preventive Medicine Board Review
* Integrative Medicine
* Professional Development
* Community-based Participatory Research
* Journal Club
* Other special topics

Residents are required to attend all sessions, unless excused. Residents must participate in minimum of 80% of sessions each year.

### Academic

Residents must complete the Master of Public Health Program for board eligibility in preventive medicine. The MPH degree is provided through the Morehouse School of Medicine Master of Public Health (MPH) Program. This program trains public health professionals in the public health theory that supports the social mission of MSM. The MPH Program was established in 1995 to address the increasing shortage of underrepresented minorities in leadership positions in the field of public health. The Program was accredited initially in 1999 by the Council on Education for Public Health making it the first accredited MPH Program at an HBCU. Residents in this program complete the ACGME preventive medicine academic requirements through matriculation in the MSM MPH program. Their progress is this program is monitored by the Residency Program Director and the Associate Residency Program Director.

Below is a list of course to be completed by PH/PM residents.

* Fundamentals of Public Health
* Research Methods
* \*Cancer Epidemiology
* \*Intro to Cancer Prevention & Control
* Health Program Planning & Evaluation
* Public Health Practice Leadership Seminars
* Biostatistics
* Health Administration, Management and Policy
* Social and Behavioral Aspects of Public Health
* Epidemiology
* \*\*Financial Management for Healthcare Professionals
* Introduction to Environmental Health
* \*\*Advanced Epidemiology
* \*\*Advanced Biostatistics
* \*\*Clinical Preventive Medicine for Healthcare Professionals
* \*\*Environmental Risk Hazard and Control
* \*Courses Required for Cancer Prevention & Control Track
* \*\*Courses/Content required by ACGME/Program

**In addition to the above courses, residents must complete the MPH**

* Practicum (Residency Rotation (s) counted
* Culminating Experience (Thesis Project)

# PH/PM Residency Staff and Faculty Roles

## Residency Program Staff

**Residency Program Director**

The Residency Program Director monitors the day-to-day operation of the residency program, evaluates and monitors all resident educational activities, identifies teaching faculty, ensures the effectiveness of the training curriculum, oversees the program budget, and maintains accreditation standards. The program director also secures program funding and identifies training sites.

**Association Residency Program Director**

The Associate Residency Program Director participates in the day-to-day operation of the residency program along with the Residency Program Director. Additionally, Associate Residency Program Director participates in curriculum development, maintains accreditation standards, advises residents and participates in the resident selection process.

**Program Manager**

The program manager manages the daily operational activities of the residency program and coordinates training activities at various affiliated institutions. The program also develops and manages the program budget as well as manage all the program grants. The program manager ensures that the residents complete all required administrative tasks, including evaluation completion, duty hour logging, and milestones documentation. The program manager also ensures that residents’ training records are updated and maintained.

The program manager is responsible for completing documentation for internal and external entities (e.g., MSM Graduate Medical Examination [GME] office, the Accreditation Council for Graduate Medical Education, and various funding agencies). The program manager develops and disseminates the monthly clinic and didactic schedules. The program manager plans the resident recruitment activities and all program meetings, retreats, and special events.

**Program Assistant**

The program assistant provides administrative support to the program director, associate program director, and the residency program manager. The residency program assistant provides professional and prompt completion of data entry, expense requests, travel support, program documentation, and meeting logistics. The program assistant also supports residents and faculty in the use of the New Innovations Residency Management System.

## PH/PM Residency Core Faculty & Research Interests

**Dr. Sonja Hutchins,** Residency Program Director and Faculty Advisor

**Professional/Research Interests**: Epidemiology, Immunizations, Graduate Medical Education, and Public Health Research

**Dr. Beverly Taylor,** Chair &Associate Residency Director and Faculty Advisor

**Professional/Research Interests**: Graduate Medical Education, Community-Based Research, and Cancer Prevention

**Dr. Alex Crosby,** Adjunct Faculty and Epidemiology Faculty Advisor**;** Epidemiology Seminar Series & Journal Club Advisor

**Professional/Research Interests**: Epidemiology, Suicide Prevention, Child Maltreatment, Intimate Partner Violence, Interpersonal Violence, and Injury Prevention

**Dr. Alma Jones** – Faculty Coordinator, Clinical Preventive Medicine Lecture Series

**Professional/Research Interests**: Undergraduate Medical Education and Rural Health

**Dr. Sherry Crump** – Longitudinal Social/Cultural/Behavioral Rotation Advisor

**Professional/Research Interests**: Graduate Medical Education and Community-Based Participatory Research

**Dr. Jennifer Rooke** – Preventive Medicine Board Review Advisor and

Risk Assessment & Management Course Director

**Professional/Research Interests**: Integrative Medicine, Plant-Based Nutrition, Lifestyle Medicine, and Occupational & Environmental Health

**Dr. Lee Caplan**–Resident Research Advisor & Cancer Prevention & Control Track Advisor

**Professional/Research Interests**: Cancer Epidemiology and Research

**Dr. Ruby Thomas** –Integrative Medicine Faculty Coordinator & Course Director, Clinical Preventive Medicine Course

**Professional/Research Interests**: Adolescent Health and Integrative Medicine

# *Roles and Responsibilities of MSM PH/PM Residents*

## Resident Responsibilities and Agreements

As employees of the Morehouse School of Medicine, residents complete the relevant MSM employment and onboarding documents. As trainees in the Public Health and Preventive Medicine Residency Program, residents agree to the following:

* **Active participation in residency training program**

Residents agree to participate actively in the MSM Residency Program, **acknowledging that benefits from training will be directly proportional to individual effort**. Residents will take responsibility for keeping their academic advisor and practicum preceptor informed of progress in the program/rotation and for seeking assistance and advice as needed.

* **Adherence to academic and administrative policies**

Residents agree to comply with the program’s academic and administrative policies, including those related to attendance, reports, documentation of learning, and self-assessment. For more information concerning Morehouse School of Medicine residency policies, please see the Graduate Medical Education Policies and Procedures at <http://www.msm.edu/Education/GME/Documents/2016-17MSMGMEPolicyManual5.26.16.pdf> (also see notebook).

* **Fulfillment of all responsibilities related to the MPH degree**

Residents integrating coursework toward the MPH degree in their residency training agree to assume responsibility for fulfilling all requirements of the academic program as well as the practicum and for ensuring that faculty and staff assigned to the residency program are kept informed of their progress and commitments.

The following statements of responsibilities more fully detail these expectations.

* Actively participate in the orientation program at the beginning of the first year of residency and continuing resident orientation activities each year.
* Actively participate in weekly seminars, Grand Rounds, presentations and discussions held for residents during the academic year. (Residents will be allowed three absences per academic year excluding CME, vacation time, and sick time.) **Any resident more than fifteen (15) minutes late to a weekly didactic session will be documented as absent.**
* Conduct and present results of approved field research projects.
* Submit semiannual reports including milestone and competencies completion to the Residency Program Director and advisor that reflect resident’s progress toward achieving mastery of the competencies. These will help the preceptor in completing the rotation evaluation and the Advisory Committee in conducting its annual evaluation.
* Seek advice and assistance as needed from the program director, associate residency program director, chief resident, or senior resident and program advisor in fulfilling any of the previously listed responsibilities.
* Evaluate both the academic and practical components of the entire residency program by completing the annual ACGME Resident Survey, the MSM Graduate Medical Education Resident Survey, and the Graduating Resident Exit Survey.
* Scholarly Activities (All residents must submit at least 1 abstract in the 2nd year, participate in Resident Research Day, participate in the Annual Public Health Summit; Journal Club).
* Maintain Learning Portfolio (includes learning activities and milestones documentation).

## Practicum Objectives:

* Actively participate in the orientation program at the beginning of the first year of residency and continuing resident orientation activities each year.
* Actively participate in weekly seminars, Grand Rounds, presentations and discussions held for residents during the academic year. (Residents will be allowed three absences per academic year excluding CME, vacation time, and sick time.) **Any resident more than fifteen (15) minutes late to a weekly seminar will be documented as absent.**
* Participate fully in practicum rotations.
* Complete a learning contract at the beginning of each rotation and submit it to the program office.
* Complete all assignments and administrative duties in a timely manner.
* Conduct and present results of approved field research projects.

**Specific practicum objectives can be found in the competency-based learning objectives and milestones.**

## Academic Objectives:

* Maintain good academic standing and fulfill all requirements of the degree program (MPH).
* Actively participate in school activities, including seminars, required courses, and teaching opportunities.
* Seek advice and assistance from the designated preceptor in planning both academic and rotation experiences.

## Patient Safety

Per ACGME requirements, the program, its faculty and residents must actively participate in patient safety systems and contribute to a culture of safety. The program must have a structure that promotes safe, interprofessional, team-based care. Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.

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

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

* know their responsibilities in reporting patient safety events at the clinical site;
* know how to report patient safety events, including near misses, at the clinical site;
* be provided with summary information of their institution’s patient safety reports.
* Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.

Resident Education and Experience in Disclosure of Adverse Events

* Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.
* All residents must receive training in how to disclose adverse events to patients and families.
* Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.

**Quality Improvement**

* Education in Quality Improvement - A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary for health care professionals to achieve quality improvement goals.
  + Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.
* Quality Metrics - Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.
  + Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.
* Engagement in Quality Improvement Activities - Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.
  + Residents must have the opportunity to participate in interprofessional quality improvement activities.
    - This should include activities aimed at reducing health care disparities.

The PH/PM Residency Program provides a curriculum that teaches residents the principles and practices of patient safety and quality improvement (PS/QI). The curriculum’s objectives are as follows:

1. Discuss the historical background of Patient Safety/Quality Improvement
2. Define the principles of Patient Safety/Quality Improvement
3. Define PS/QI problems specific to Public Health and Preventive Medicine
4. Demonstrate the ability to apply PS/QI principles in a community or public health setting.
5. Formulate a Quality Improvement project or participate in a project that is already in progress
6. Demonstrate behaviors associated with effective teamwork and interpersonal and communication skills

# PH/PM Residency Program Wellness

The MSM PHPM Residency Program understands its responsibility, in partnership with the Sponsoring Institution, to address resident well-being must include:

*“VI.C.1.a)efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)*

*VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being;*

*VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members;”*

To mitigate resident burnout and to promote resident wellness, the program’s current initiatives include providing formal (via the annual program orientation and resident tip sheet) and informal guidance on managing the multiple activities of the program. Providing this guidance is important because the residents have to manage multiple activities and deadlines in the academic, clinical, and practicum components of the program. Additionally, the program provides faculty mentoring and administrative support to residents, conducts an annual health and wellness retreat for residents and core faculty, provides faculty and resident education on fatigue and sleep deprivation, and encourages a healthy lifestyle among residents. This includes encouraging residents to take vacation time, participate in professional development activities, and practice healthy habits (ex. healthy nutrition, fitness, sleep hygiene, and meditation). The program also provides healthy meals during didactic and nutritious snacks in the residents' office.

Resident will also be informed of the available mental health services within and outside of the institution, encouraging residents to report impairment, depression, or burnout in themselves or their colleagues to the program, and making clearer to the residents the importance of their training and work as physicians so that they find satisfaction and meaning in their work.

# Tips for Managing Program Responsibilities

* Consolidate all calendars (e.g. residency monthly calendars, outlook notices, etc. to include all due dates
* Prioritize tasks based on time commitment and due dates.
* Develop Daily & Weekly Schedules to include

Rotation activities

MPH Class sessions

Clinic assignments

Longitudinal rotation activities

Didactics

Administrative meetings (e.g. committees, residency interviews, etc.)

Other MPH Program activities

Deadlines & Deliverables

* Also, use the MPH Program semester course schedule to fill in residency program activities (e.g. clinic sessions, rotations, board preparation time, etc.).
* Schedule time each work day to read and respond to emails and to log duty hours
* Develop a monthly board preparation schedule (a minimum of 4 hours/month).
* When possible, parlay professional interests into rotation assignments, class assignments, or your thesis project.
* Seek assistance and coaching.
  + Meet w/ Program Advisor quarterly to discuss milestones progress and any academic concerns
  + Share any concerns with program administration as they arise
* Schedule time each week to complete the following administrative tasks (we suggest Fridays following didactics)

Didactic evaluations

Milestones documentation

* Update your CV at the end of each semester/rotation.
* Be mindful to include adequate rest, nutrition, and emotional and spiritual enrichment every day.
* Don’t forget to schedule vacation leave. As a reminder, leave will not be granted during special program/GME events.

# Program Goals & Objective by PGY Level

Because the PH/PM Resident Program is completed in an integrative fashion, there are no specific curriculum objectives by PGY level. Please see the below progression policies for promotion requirements.

# Public Health and Preventive Medicine Progression Policy

**Resident must adequately demonstrate progression in the completion of all components of preventive medicine specialty training.**

The following statements of responsibilities more fully detail resident progression.

## Year One

By the end of the first year, residents should have completed the following program components:

* Completion of at least 30 credit hours in the MPH Program with a minimum grade of “B.”
* Successful completion of **at least two rotations** as evidenced by evaluation feedback.
* Successful completion of **at least two months (320 hours)** of direct patient care activities.
* Successful participation in program didactics, conferences, and other meetings.
* **Active** participation in the longitudinal community health project.
* Submission of community health project reports as determined by the program director.
* Adherence to all the policies and procedures outlined in the:
  + Public Health and Preventive Medicine Residency Program Manual
  + Morehouse School of Medicine Graduate Medical Education Policy Manual
  + Morehouse School of Medicine Institutional Policies
  + Morehouse School of Medicine Student Handbook, and
  + Any affiliate/participating site institutional policies and procedures
* Demonstration of professional and ethical conduct (this includes prompt arrival/completion of all educational, clinical, administrative, and service activities and documentation).

## Year Two

By the end of the second year, residents should have completed the following program components:

* Completion of at least 16 credit hours in the MPH Program with a minimum grade of “B.” These credits must include the completion and approval of the Culminating Experience (Thesis Project).
* Successful completion of **at least six** rotations as evidenced by evaluation feedback.
* Successful completion of **at least two months (320 hours)** of direct patient care activities.
* Successful participation in program didactics, conferences, and other meetings.
* Active participation in the longitudinal community health project.
* Submission of community health project reports as determined by the program director.
* Participate in scholarly activities as described below.
* Adherence to all the policies and procedures outlined in the:
  + Public Health and Preventive Medicine Residency Program Manual
  + Morehouse School of Medicine Graduate Medical Education Policy Manual
  + Morehouse School of Medicine Institutional Policies
  + Morehouse School of Medicine Student Handbook, and
  + Any affiliate/participating site institutional policies and procedures
* Demonstration of professional and ethical conduct (this includes prompt arrival/completion of all educational, clinical, administrative, and service activities and documentation).

### Graduation Eligibility

Residents who have not met all of the above requirements are ineligible to graduate from the program.

## Scholarly Activities

The program provides opportunities for residents to develop research skills that improve their knowledge and application of patient/population care. All residents in the PH/PM Residency Program are required to engage in scholarly activities in several ways:

* Submit at least 1 abstract to a state, regional, or national specialty conference in the 2nd year of training.
* Present (oral or poster presentation) at the MSM Resident Research Day during each year of the program.
* Present (oral or poster presentation) at the Annual Dr. Daniel S. Blumenthal Public Health Summit during each year of the program.
* Present in Journal Club as scheduled.

Residents are also encouraged to seek other opportunities for scholarly activities as approved by the program. All activities **must** be documented in the New Innovations Residency Management System and in the semiannual milestones reports.

## MSM Resident Promotion Policy

1. **PURPOSE:**
   1. The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition).
   2. The resident will be prepared to undertake independent medical practice upon the successful completion of a residency program and shall have completed requirements to obtain a physician’s license and prepare for certification by a specialty board.
2. **SCOPE:**

All MSM administrators, faculty, staff, residents, and accredited participating affiliates shall understand and support this policy and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.

1. **POLICY:** 
   1. Residency education prepares physicians for independent practice in a medical specialty. The resident is expected to progressively increase his or her level of proficiency in order to advance within a residency program.
   2. MSM’s focus is on the resident’s acquisition and development of pertinent skills and behaviors with the intent of providing a competent practicing physician to the community.
   3. Appointments are made on a yearly basis with the expectation of continuation within the one-year appointment and of reappointment yearly throughout the duration of the residency period.
2. **RESIDENCY PROGRAM PROMOTION:**
   1. Program Responsibilities
      1. The resident will receive periodic, scheduled, written evaluations of his or her performance, progress, and competence in the program specialty as outlined in the MSM Evaluation Policy.
      2. Residents must be familiar with ACGME-RRC and MSM educational requirements to successfully complete the residency program.
      3. This should begin on the first day of matriculation.
      4. At a minimum, residents must be given the following information by the residency program and/or the GME office:

* A copy of the MSM Graduate Medical Education (GME) General Information Policy
* A Residency Program Handbook (or equivalent) outlining at a minimum:
  + The residency program goals, objectives, and expectations
  + The ACGME Specialty Program Requirements
  + The six general competencies designed within the curriculum of the program
  + Clinical rotations and/or other education modules with specific goals, objectives, and expected outcomes
  + Schedules of assignments to support rotations
  + The educational supervisory hierarchy within the program, rotations, and education affiliates
  + The residency program evaluation system
  1. Promotion Requirements
     1. In order for a resident to complete an MSM residency education program, he or she must successfully meet the following standards in addition to any program-specific requirements:
        1. The resident must exhibit clinical and academic performance and competence consistent with the curricular standards and the level of training undergone.
        2. The resident must satisfactorily complete all assigned rotations, as supported by evaluation documentation, in each Post Graduate Year (PGY).
        3. The program director must certify that the resident has fulfilled all criteria, including the program-specific criteria, to move to the next level in the program.
        4. The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities that can be objectively measured in an academic and/or clinical environment.
        5. The resident must achieve a satisfactory score on the in-service examinations along with other program-specific criteria required in order to advance. ACGME-RRC Program Requirements provide the outline of standards for advancement.
     2. Upon the resident’s successful completion of the criteria listed above, the residency program director will certify the completion by placing the semi-annual evaluations and the promotion documentation into the resident’s portfolio indicating that the resident has successfully met the specialty requirements for promotion to the next educational level. If this is a graduating resident, the program director should place the Final Summative Assessment in the resident’s portfolio.
  2. Process and Timeline for Promotional Decisions
     1. Normal promotion decisions are made no later than the fourth month of the appointment. Reappointment agreements are prepared based on the residency Clinical Competency Committee and program director’s recommendation for promotion.
     2. When a resident will not be promoted to the next level of training, the program will provide the resident with a written notice of intent no later than four months prior to the end of the resident’s current appointment agreement. If the primary reason for non-promotion occurs within the last four months of the appointment agreement period, the program will give as much written notice as circumstances reasonably allow.
     3. If the resident’s appointment agreement is not going to be renewed, the residency program must notify the resident in writing no later than four months prior to the end of the resident’s current contract. If the decision for non-renewal is made during the last four months of the contract period, the residency program must give the resident as much written notice as possible prior to the end of the appointment agreement expiration.
     4. For more information concerning adverse events, refer to the Adverse Academic Decisions and Due Process Policy.

# *Other Program Features*

## Records Management

MSM resident files are maintained at Morehouse School of Medicine or online on the New Innovations Residency Management system. They contain relevant inter-institutional agreements, resident records, program records, advisory committee minutes, and evaluations.

## Resident Benefits

As employees of Morehouse School of Medicine, residents are entitled to the fringe benefit package provided to employees. This package includes health, life, and disability insurance. Health insurance for dependents is available with payment of an employee premium. Malpractice insurance for MSM residency-related activities is also provided by Morehouse School of Medicine.

Medical care is available at discounted fees through Morehouse Medical Associates. The employee insurance plan can also be used to cover services through other health care providers.

## Public Health and Preventive Medicine Program Benefits

In addition to the benefits described above, the Public Health and Preventive Medicine Residency Programs offers the following benefits to all residents in good standing based on the availability of funds:

* All tuition and fees for the Master of Public Health degree
* Board review support
* Attendance at specialty conferences
* A tablet or laptop computer

# Program Policies and Procedures

The PHPM program follows and complies with all policy and procedures of MSM Human Resources and Graduate Medical Education. Please review the GME policy manual available on the main GME website at <http://www.msm.edu/Education/GME/index.php> The following are PHPM program specific policies and procedures.

## Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

(1) compassion, integrity, and respect for others; (Outcome)

(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

(3) respect for patient privacy and autonomy; (Outcome)

(4) accountability to patients, society and the profession; and, (Outcome)

(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual

orientation.

**Source: ACGME Program Requirements for Graduate Medical Education in Preventive Medicine Common Requirements Professionalism**

Residents in the PH/PM Residency Program must adhere to a professional code of conduct as described below.

### PH/PM Residency Professionalism Contract

(Adapted from the Internal Medicine Residency Naval Medical Center San Diego)

The goals of the residency program are to provide residents with experiences in the specialty of preventive medicine to achieve excellence to practice independently without supervision. As a resident physician, I recognize that I am in a noble profession where humanistic qualities foster the formation of patient/community/physician relationships. These qualities include integrity, respect, compassion, professional responsibility, personal accountability, courtesy, sensitivity to patient needs for comfort and encouragement, and professional attitude and behavior towards colleagues, faculty, staff, and students.

The purpose of having a professionalism contract for residents is to remind you of the high professionalism expectations of a physician. In addition, this contract reinforces that all residents are evaluated in the professionalism competency based on their behavior in all components of the training program. Professionalism is a broad competency that affects your success in all ACGME competencies.

*In signing this contract, I agree to adhere to the professionalism expectations as outlined below, and I understand the potential for severe consequences for unprofessional behavior. Consequences may include, but are not limited to the following:*

* + - Probation/continued probation
    - Non-promotion to the next PGY level
    - Repeat of a rotation or other education block module
    - Non-renewal of residency appointment agreement
    - Dismissal from the residency program

Residents in the Public Health and Preventive Medicine Residency Program must adhere to the professionalism policies mandated by the MSM Office of Graduate Medical Education as outlined below.

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## Professionalism Policy

(Resident Code of Conduct, Dress Code, and Social Media Guidelines)

1. **PURPOSE:**
   1. Residents are responsible for fulfilling all obligations that the GME Office, hospitals, and residency programs deem necessary for them to begin and continue duties as a resident, including but not limited to:
      1. Attending orientations, receiving appropriate testing and follow-up, if necessary, for communicable diseases, fittings for appropriate safety equipment, necessary training and badging procedures (all of which may be prior to appointment start date)
      2. Completing required GME, hospital and program administrative functions in a timely fashion and before deadlines such as medical records, mandatory on-line training modules, and surveys or other communications
   2. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff.
   3. All GME program directors and faculty are responsible for educating, monitoring, and providing exemplary examples of professionalism to residents.
   4. Refer to the MSM GME *Policy and Procedures Manual* regarding confidential professionalism reporting systems and resources.
2. **SCOPE:**
   1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.
   2. Each program must have a program-level professionalism policy which describes how the program provides professionalism education to residents. The program director will ensure that all program policies relating to professionalism are distributed to residents and faculty. A copy of the program policy on professionalism must be included in the official program manual and provided to each resident upon matriculation into the program.
3. **POLICY:**
   1. **Professionalism**—Residents and faculty members must demonstrate an understanding of their personal role in the:
      1. Provision of patient- and family-centered care
      2. Safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events
      3. Assurance of their fitness for work, including:
         1. Management of their time before, during, and after clinical assignments; and
         2. Recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team
      4. Commitment to lifelong learning
      5. Monitoring of their patient care performance improvement indicators; and
      6. Accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data
   2. **Professionalism—Code of Conduct**

Residents are responsible for demonstrating and abiding by the following professionalism principles and guidelines.

* + 1. Physicians must develop habits of conduct that are perceived by patients and peers as signs of trust. Every physician must demonstrate sensitivity, compassion, integrity, respect, and professionalism, and must maintain patient confidentiality and privacy.
    2. A patient’s dignity and respect must always be maintained.
    3. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.
    4. Residents are responsible for completing hospital, program, and GME educational and administrative assignments by given deadlines that include:
* Timely completion of evaluations and program documentation;
* Logging of duty hours, cases, procedures, and experiences; and
* Promptly arriving for educational, administrative, and service activities.
  + 1. A medical professional consistently demonstrates respect for patients by his or her performance, behavior, attitude, and appearance.
    2. Commitment to carrying out professional responsibilities and an adherence to ethical principles are reflected in the following expected behaviors:
* Respect patient privacy and confidentiality.
* Knock on the door before entering a patient’s room.
* Appropriately drape a patient during an examination.
* Do not discuss patient information in public areas, including elevators and cafeterias.
* Keep noise levels low, especially when patients are sleeping.
  + 1. Respect patients’ autonomy and the right of a patient and a family to be involved in care decisions.
       1. Introduce oneself to the patient and his or her family members and explain their role in the patient’s care.
       2. Wear name tags that clearly identify names and roles.
       3. Take time to ensure patient and family understanding and informed consent of medical decisions and progress.
    2. Respect the sanctity of the healing relationship.
       1. Exhibit compassion, integrity, and respect for others.
       2. Ensure continuity of care when a patient is discharged from a hospital by documenting who will provide that care and informing the patient of how that caregiver can be reached.
       3. Respond promptly to phone messages, pages, e-mail, and other correspondence.
       4. Provide reliable coverage through colleagues when not available.
       5. Maintain and promote physician/patient boundaries.
    3. Respect individual patient concerns and perceptions.
       1. Comply with accepted standards of dress as defined by each hospital.
       2. Arrive promptly for patient appointments.
       3. Remain sensitive and responsive to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
    4. Respect the systems in place to improve quality and safety of patient care.
       1. Complete all mandated on-line tutorials and public health measures (e.g.: TB skin testing) within designated timeframe.
       2. Report all adverse events within a timely fashion.
       3. Improve systems and quality of care through critical self-examination of care patterns.
    5. A professional consistently demonstrates respect for peers and co-workers.
       1. Respect for colleagues is demonstrated by maintaining effective communication.
       2. Inform primary care providers of patient’s admission, the hospital content and discharge plans.
       3. Provide consulting physicians all data needed to provide a consultation.
       4. Maintain legible and up-to-date medical records, including dictating discharge summaries within approved hospital guidelines.
       5. Inform all members of the care team, including non-physician professionals, of patient plans and progress.
       6. Provide continued verbal and written communication to referring physicians.
       7. Understand a referring physician’s needs and concerns about his or her patients.
       8. Provide all appropriate supervision needed for those one is supervising, by informing and involving supervising faculty of any changes in patient status, and by providing informed and safe handoffs to colleagues who provide patient coverage.
       9. Acknowledge, promote, and maintain the dignity and respect of all healthcare providers.
    6. Respect for diversity of opinion, gender, and ethnicity in the workplace.
       1. Maintain a work environment that is free of harassment of any sort.
       2. Incorporate the opinions of all health professionals involved in the care of a patient.
       3. Encourage team-based care.
       4. In addition, professionals are held accountable to specialty-specific board and/or society codes of medical professionalism.
  1. **Professionalism—Dress Code**

Residents must adhere to the following code elements to reflect a professional appearance in the clinical work environment; residents are also held accountable to relevant individual hospital/site and MSM institution policies.

* + 1. **Identification**: Unaltered ID badges must be worn and remain visible at all times. If the badge is displayed on lanyard, it should be a break-away variety.
    2. **White Coats**: A long white coat that specifies the physician’s name and department should be worn.
    3. Personal Hygiene:
       1. Hair must be kept clean and well groomed. Hair color or style may not be extreme. Long hair must be contained as so to not drape or fall into work area.
       2. Facial hair must be neat, clean, and well-trimmed.
       3. Fingernails must be kept clean and of appropriate length.
       4. Scent of fragrance or tobacco should be limited/minimized.
    4. **Shoes/footwear**: Must be clean, in good repair, and of a professional style appropriate to work performed. No open-toed shoes may be worn. Shoes must have fully enclosed heels or secured with a heel strap for safety purposes.
    5. **Jewelry**: Must not interfere with job performance or safety.
    6. **Inappropriate/not permitted**: Pins, buttons, jewelry, emblems, or insignia bearing a political, controversial, inflammatory, or provocative message may not be worn.
    7. **Tattoos**: Every effort must be made to cover visible tattoos.
    8. **Clothing**: Must reflect a professional image, including: dress-type pants and collared shirts; skirt and dress length must be appropriate; clothing should cover back, shoulders, and midriff; modest neckline (no cleavage).
    9. **Scrubs**: Residents may wear scrubs in any clinical situation where appropriate. When not in a work area, a white coat should be worn over scrubs.
  1. **Professionalism: Social Media Guidelines** 
     1. Because social media blurs the line between personal voice and institutional voice, these guidelines were created to clarify how best to protect personal and professional reputations when participating.
     2. In both professional and institutional roles, employees need to adopt a common sense approach and follow the same behavioral standards as they would in real life, and are responsible for anything they post to social media sites either professionally or personally.
     3. For these purposes, “social media” includes but is not limited to social networking sites, collaborative projects such as wikis, blogs, and microblogs, content communities, and virtual communities.
     4. Best practices for all social media sites, including personal sites follow:
        1. **Think before posting**—There is no such thing as privacy in the social media world. Before you publish a post, consider how it would reflect on you, your department/unit, and on the institution.

Search engine databases store posts years after they were published, so posts could be found even if they were deleted; and comments may be forwarded or copied.

* + - 1. **Be accurate**—Verify your information for accuracy, spelling, and grammatical errors before posting. If an error or omission ends up being posted, post a correction as quickly as possible.
      2. **Be respectful**—The goal of social media is to engage your audience in conversation. At times, that comes in the form of opposing ideas. Consider how to respond or disengage in a way that will not alienate, harm, or provoke.
      3. **Remember your audience**—Though you may have a target audience, be aware that anything posted on your social media account is also available to the public at large, including prospective students, current students, staff, faculty, and peers.
      4. **Be a valuable member**—Contribute valuable insights in your posts and comments. Self-promoting behavior is viewed negatively and can lead to you being banned from a website or group you are trying to participate in.
      5. **Ensure your accounts’ security**—A compromised account is an open door for malicious entities to post inappropriate or even illegal material as though it were from you. If you administer a hospital/school/college/department/unit social media account, be sure to use a different password than for your personal accounts. Follow best practices in selecting and protecting your university account passwords.
    1. Guidelines for all social media sites, including personal sites
       1. **Protect confidential and proprietary information**—Do not post confidential information about MSM, students, faculty, staff, patients, or alumni; nor should you post information that is proprietary to an entity other than yourself.
       2. Employees must follow all applicable Federal privacy requirements for written and visual content, such as FERPA and HIPAA. Failure to do so comes at the risk of disciplinary action and/or termination.
       3. **Respect copyright and fair use**—When posting, be aware of the copyright and intellectual property rights of others and of the university. Refer to MSM system policies on copyright and intellectual property for more information/guidance.
       4. **Do not imply MSM endorsement**—The logo, word mark, iconography, or other imagery shall not be used on personal social media channels. Similarly, the MSM name shall not be used to promote a product, cause, or political party/candidate.

### PH/PM Residency Professionalism Contract

(Adapted from the Internal Medicine Residency Naval Medical Center San Diego)

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, will exercise good judgment, integrity and behavior both inside and outside the workplace to include, but not limited to the following:

I will accept primary responsibility for the delivery of care to all assigned patients, and will accept responsibility for the complete turn-over of those patients when I am going off duty, regardless of the institution I am working at. This commitment to patients and the medical profession may at times go beyond my own self-interest.

I will do more than just my job, including being available to offer assistance as needed to patients, their families, my colleagues, the clinic, and clinic staff.

I will willingly accept guidance, criticism, and evaluation from those with more experience and use this information to improve my practice and my behavior. I will recognize that I am not perfect, but will reflect on how I can improve.

I will conduct myself ethically and professionally and keep my position as a physician in the care of patients and in relationships between myself and other members of the medical staff. I will avoid unduly familiar relationships in the workplace.

I will conduct myself ethically and professionally and keep my position as a physician in relationships between myself and members of rotation staff, my assigned community, and the MPH Program. I will avoid unduly familiar relationships in these settings.

I will develop and participate in a personal program of self-study and professional growth. In doing so, I recognize that my program has a defined academic schedule, and I will attend, at a minimum, 80% of all scheduled didactic sessions. I will arrive promptly to didactic sessions, and, I will not text, sext, surf the internet, or act in any inappropriate manner that is disrespectful to those who are working to educate me.

I will demonstrate intellectual honesty and professional integrity in both clinical/population health practice and academic endeavors. I will not plagiarize presentations, and will provide credit/acknowledgement when I adopt or use the work of another as part of a presentation or didactic lecture. I will not knowingly copy or duplicate the patient care documentation of another physician or provider nor represent it as my own. I will comply with all HIPAA regulations, and not access medical records of individuals for whom I am not providing healthcare.

I will always relate the truth when engaging with patients, faculty, staff, and students. I will never lie.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Director:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Adverse Academic Decisions and Due Process Policy

1. **PURPOSE**:
   1. Morehouse School of Medicine (MSM) shall provide residents with an educational environment that MSM believes is fair and balanced.
   2. This policy outlines the procedures which govern adverse academic decisions and due process procedures relating to residents and fellows during their appointment periods at Morehouse School of Medicine regardless of when the resident or fellow matriculated.
   3. Actions addressed within this policy shall be based on an evaluation and review system tailored to the specialty in which the resident is matriculating.
2. **SCOPE**:
   1. All MSM administrators, faculty, staff, residents, and administrators at participating affiliates shall comply with this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.
   2. Residents shall be given a copy of this Adverse Academic Decisions and Due Process policy at the beginning of their training.
3. **DEFINITIONS**:
   1. **Academic Deficiency**
      1. A resident’s academic performance is deemed deficient if performance **does not meet/does not satisfy** the program and/or specialty standards.
      2. Evidence of academic deficiency for a resident can include, but is not limited to:
         1. Having an insufficient fund of medical knowledge
         2. Inability to use medical knowledge effectively
         3. Lack of technical skills based on the resident’s level of training
         4. Lack of professionalism, including timely completion of administrative functions such as medical records, duty hours, and case logging
         5. Unsatisfactory written evaluation(s)
         6. Failure to perform assigned duties
         7. Unsatisfactory performance based on program faculty’s observation
         8. Any other deficiency that affects the resident’s academic performance
   2. **Opportunity to Cure** occurs when a resident is provided the opportunity to correct an academic deficiency and corrects the academic deficiency to the satisfaction of the faculty, program director, department chairperson, and Clinical Competency Committee of the program in which the resident is enrolled.
   3. **Day**—a calendar business day 8:30 am–5:00 pm, Monday-Friday; weekends and MSM-recognized holidays excluded
   4. **Corrective Action**
      1. Written formal action taken to address a resident’s academic, professional, and/or behavioral deficiencies and any misconduct
      2. Typically, “corrective action” includes/may include probation which can result in disciplinary action such as suspension, non-promotion, non-renewal of residency appointment agreement, dismissal, or termination pursuant to the due process guidelines outlined in this policy or in other appropriate MSM policies.
      3. Corrective action does not include a written or verbal notice of academic deficiency.
   5. **Disciplinary Action**—suspension, non-promotion, non-renewal of residency appointment agreement
   6. **Dismissal**—the immediate and permanent removal of the resident from the educational program for failing to maintain academic and/or other professional standards required to progress in or complete the program. This includes conduct described in section 4.2 of this policy.
   7. **Due Process**
      1. For matters involving academic deficiency(ies) in resident performance, due process involves:
         1. Providing notice to the resident of the deficient performance issue(s);
         2. Offering the resident a reasonable opportunity to cure the academic deficiency; and
         3. Engaging in a reasonable decision-making process to determine the appropriate course of action to take regarding whether to impose corrective action.
   8. **GME**—Graduate Medical Education
   9. **GME Office**—Graduate Medical Education Office of Morehouse School of Medicine
   10. **Mail**—to place a notice or other document in the United States mail or other courier or delivery service
       1. Notices mailed via first class mail, postage prepaid, unless returned to sender by the United States Postal Service or other courier or delivery service, are presumed to have been received three (3) days after mailing.
       2. Unless otherwise indicated, it is not necessary in order to comply with the notice requirements in this policy to hand-deliver the notice or use certified or registered mail. However, such methods of delivery, when documented, will verify actual notice. It is the resident’s responsibility to ensure that his or her program and the GME office possess the resident’s most current mailing address.
       3. E-mail Notification—Morehouse School of Medicine e-mail addresses (@msm.edu) are the official e-mail communication for all employees including residents. E-mailing information to the resident’s official MSM e-mail address is sufficient to meet MSM’s notification and mail obligations except where otherwise indicated. Residents are responsible for ensuring that they check and are receiving e-mail communication.
   11. **Meeting**
       1. The appeals process outlined in this policy provides a resident an opportunity to present evidence and arguments related to why he or she believes the decision by the program director, department chairperson, or Clinical Competency Committee to take action for non-renewal or dismissal is unwarranted.
       2. It is also the opportunity for the program director, department chairperson, or Clinical Competency Committee to provide information supporting its decision(s) regarding the resident.
   12. **Misconduct**
       1. Misconduct involves violations of standards, policies, laws, and regulations that affect professional and ethical standards of a physician in training.
       2. These violations constitute a breach of the MSM Resident Training Agreement.
   13. **Non-Renewal of Appointment**—if the residency program determines that a resident’s performance is not meeting the academic or professional standards of MSM, the program, the ACGME program requirements, the GME requirements, or the specialty board requirements, the resident will not be reappointed for the next academic year.
       1. Reappointment in a residency program is not automatic.
       2. The program may decide to not reappoint a resident, at its sole discretion.
   14. **Non-Promotion**
       1. Resident annual appointments are for a maximum of 12 months, year to year.
       2. A delay in being promoted to the next level is an academic action used in limited situations. These limited situations include, but are not limited to, instances where a resident has an overall unsatisfactory performance during the academic year or fails to meet any promotion criteria as outlined by the program.
   15. **Notice of Deficiency**—the residency program director may issue a written warning to the resident to give notice that academic deficiencies exist that are not yet severe enough to require a formal corrective action plan or disciplinary action, but that do require the resident to take immediate action to cure the academic deficiency. It is at the program director’s discretion as to whether a written remediation will be required.
   16. **CCC**—Clinical Competency Committee reviews all resident evaluations at least semi-annually; prepares and ensures the reporting of Milestones evaluations of each resident semi-annually to ACGME; and advises the program director regarding resident progress, including promotion, remediation, or dismissal.
   17. **Probation**—a residency program may use corrective action when a resident’s violations include but are not limited to:
       1. Providing inappropriate patient care;
       2. Lacking professionalism in the education and work environment;
       3. Failure to cure notice of academic deficiency or other corrective action;
       4. Negatively impacting healthcare team functioning; or
       5. Causing residency program dysfunction.
   18. **Remediation**
       1. Remediation cannot be used as a stand-alone action and must be used as a tool to correct a Notice of Academic Deficiency or probation and assists in strengthening resident performance when the normal course of faculty feedback and advisement is not resulting in a resident’s improved performance.
       2. Remediation allows the resident to correct an academic deficiency(ies) that would adversely affect the resident’s progress in the program.
   19. **Suspension**
       1. Suspension is the act of temporarily removing a resident from all program activities for a period of time because the resident’s performance or conduct does not appear to provide delivery of quality patient care, or is not consistent with the best interest of the patients or other medical staff.
       2. While a faculty member, program director, chairperson, clinical coordinator, or administrative director, or other professional staff of an affiliate may remove a resident from clinical responsibility or program activities, only the program director makes the determination to suspend the resident and the length (e.g.: days) of the resident’s suspension.
       3. Depending on circumstances, a resident may not be paid while on suspension. The program director determines whether a resident will be paid or not paid.
   20. **Reportable Adverse Actions**—probation, suspension, non-renewal, and dismissal may be reportable actions by the program/MSM for state licensing, training verifications, and hospital/insurance credentialing depending upon the state and entity.
4. **POLICY**:
   1. When a resident fails to achieve the standards set forth by the program, decisions must be made with regard to notice of academic deficiency, probation, suspension, non-promotion, non-renewal of residency appointment agreement, and in some cases, dismissal. MSM is not required to impose progressive corrective action, but may determine the appropriate course of action to take regarding its residents depending on the unique circumstances of a given issue.
   2. Residents engaging in conduct violating the policies, rules, bylaws, or regulations of MSM or its educational affiliates, or local, state, and federal laws regarding the practice of medicine and the standards for a physician in training may, depending on the nature of the offense, be dismissed.
      1. Such misconduct will be considered a breach of the Resident Appointment Agreement or Reappointment Agreement.
      2. In such instances, the Graduate Medical Education Office and Human Resources Department may be involved in the process of evaluating the violation.
   3. A resident who exhibits unethical or other serious behaviors that do not conform to achieving the skills required for the practice of medicine may be summarily dismissed.
5. **PROCEDURES**:
   1. If any clinical supervisor deems a resident’s academic or professional performance to be less than satisfactory, the residency program director will require the resident to take actions to cure the deficiencies.
   2. **Notice of Academic Deficiency**
      1. The residency program director may issue a Notice of Academic Deficiency to a resident to give notice that academic deficiencies exist that are not yet severe enough to require corrective action, disciplinary action, or other adverse actions but that do require the resident to take immediate action to cure the academic deficiency.
      2. This notice may be concerning both progress in the program and the quality of performance.
      3. Residents will be provided reasonable opportunity to cure the deficiency(ies) with the expectation that the resident’s academic performance will be improved and consistently maintained.
      4. It is the responsibility of the resident, using necessary resources, including advisor, faculty, PDs, chairperson, etc., to cure the deficiency(ies).
      5. The residency program director will notify the GME director in writing of all notices of deficiency(ies) within five (5) calendar days of the program director’s decision.
   3. **Probation**
      1. A residency program may use this corrective action when a resident’s actions are associated with:
         1. Providing inappropriate patient care;
         2. Lacking professionalism in the education and work environments;
         3. Negatively impacting healthcare team functioning; or
         4. Failure to comply with MSM, GME, and/or program standards, policies, and guidelines.
         5. Causing residency program dysfunction.
      2. Probation can be used as an option when a resident fails to cure a notice of academic deficiency or other corrective action.
      3. The program director must notify and consult with the GME DIO and/or director before issuing a probation letter to a resident.
         1. A probation letter must be organized by ACGME core competencies and detail the violations and academic deficiencies.
         2. A probationary period must have a definite beginning and ending date and be designed to specifically require a resident to correct identified deficiencies through remediation.
         3. The length of the probationary period will depend on the nature of the particular infraction and be determined by the program director. However, the program director should set a timed expectation of when improvement should be attained. The duration will allow the resident reasonable time to correct the violations and deficiencies.
         4. A probation period cannot exceed six (6) months in duration and residents cannot be placed on probation for the same infraction/violation for longer than 12 consecutive months (i.e.: maximum of two (2) probationary periods).
      4. Probation decisions shall not be subject to the formal appeals process.
      5. While on probation, a resident is not in good standing.
      6. Remediation must be used as a tool for probation. Developing a viable remediation plan consists of the following actions:
         1. The resident must be informed that the remediation is not a punishment, but a positive step and an opportunity to improve performance by resolving the deficiency.
         2. The resident may be required to make up time in the residency if the remediation cannot be incorporated into normal activities and completed during the current residency year.
         3. The resident must prepare a written remediation plan, with the express approval of the program director as to form and implementation. The program director may require the participation of the resident’s advisor in this process.
            1. The plan shall clearly identify deficiencies and expectations for reversing the deficiencies, organized by ACGME core competencies.
            2. It is the responsibility of the resident to take actions to meet all standards, and to take the initiative to make improvements as necessary.
      7. All residents placed on probation are required to meet with the Director for Graduate Medical Education.
      8. If the deficiency(ies) persist during the probationary period and are not cured, the residency program director may initiate further corrective or disciplinary action including but not limited to: continuation of probation with or without non-promotion, non-renewal of residency appointment agreement, or dismissal.
      9. The program director must notify and consult with the GME DIO and/or director before initiating further corrective or disciplinary action.
         1. If the reasons for non-promotion, non-renewal of appointment, or dismissal occur within the last four (4) months of the resident’s appointment year, the program will provide the resident reasonable notice of the reasons for the decision as circumstances reasonably allow.
         2. The decision of the program director will be communicated to the resident and to the Office of Graduate Medical Education.
         3. The residency program director will notify the resident in writing of non-promotion, non-renewal of appointment, or dismissal decisions.
   4. **Suspension** 
      1. Suspension shall be used as an immediate disciplinary action because of a resident’s misconduct. Suspension is typically mandated when it is in the best interest of the patients [patient care] or professional medical staff that the resident be removed from the workplace.
      2. A resident may be placed on paid or unpaid suspension at any time for certain violations in the workplace.
      3. A resident may be removed from clinical responsibility or program activities by a faculty member, program director, department chairperson, clinical coordinator, or administrative director of an affiliate. At his or her sole discretion, that individual can remove the resident if he or she determines that one of the following types of circumstances exist:
         1. The resident poses a direct detriment to patient welfare.
         2. Concerns arise that the immediate presence of the resident is causing dysfunction to the residency program, its affiliates, or other staff members.
         3. Other extraordinary circumstances arise that would warrant immediate removal from the educational environment.
      4. All acts of removal from clinical responsibility or program activities shall be documented by the initiating supervisor or administrator and submitted to the program director in writing within 48 hours of the incident/occurrence, explaining the reason for the resident’s removal and the potential for harm.
      5. After receiving written documentation of the incident/occurrence, the program director has up to five (5) days to determine if a resident will be suspended.
      6. Only the program director has authority to suspend a resident from the program and decide the length of time of the suspension, regardless of individual hospital or affiliate policies and definitions of suspension.
      7. The program director must notify and consult with the GME DIO and/or director before suspending a resident.
      8. After a period of suspension is served, further corrective or disciplinary action is required.
         1. The program director shall review the situation and determine what further disciplinary action is required.
         2. Possible actions to be taken by the program director regarding a suspended resident may be to:
            1. Return the resident to normal duty with a Notice of Academic Deficiency;
            2. Place the resident on probation; or
            3. Initiate the resident’s dismissal from the program.
   5. **Failure to Cure Academic Deficiency**—if a resident fails to cure academic deficiencies through an approved corrective action, formal corrective action plan (remediation), probation, or other forms of academic support, the program director may take an action, including but not limited to, one or more of the following actions:
      1. Probation/continued probation
      2. Non-promotion to the next PGY level
      3. Repeat of a rotation or other education block module
      4. Non-renewal of residency appointment agreement
      5. Dismissal from the residency program
   6. The resident shall have the right to appeal only the following disciplinary actions:
      1. Dismissal or termination from the residency program
      2. Non-renewal of the resident’s appointment
   7. **Appeal Procedures—Program and Department** 
      1. All notices of dismissal from the residency program or a non-renewal of the resident’s appointment shall be delivered to the resident’s home address by priority mail and e-mail. A copy may also be given to the resident on site, at the program’s sole discretion.
      2. If the resident intends to appeal the decision, he or she should communicate intent to do so in writing to the program director within seven (7) days upon receipt of the letter that identifies the decision.
      3. The program director will notify the department chairperson who then convenes the departmental appeal committee.
         1. The Departmental Appeal Committee shall consist of a minimum of three (3) faculty members and one (1) administrative person (usually the residency program manager) who functions as a facilitator and manages scheduling, communication, and administrative functions of the committee. The Committee will select one of the three faculty members as lead to complete the written recommendation on behalf of the committee.
         2. A Departmental Appeal Committee will meet to review the resident’s training documents and hear directly from the resident and program director regarding the matter.
         3. The Appeal Committee will notify the resident and program director of the meeting date, time, place, and committee members’ names and titles.
         4. The program director must submit a written summary letter and timeline of events for the committee to review at least 24 hours before the scheduled meeting.
         5. The resident may submit written documentation to the committee to review and must do so at least 24 hours before the scheduled meeting.
         6. The resident may bring an advocate, such as a faculty member, staff member, or other resident.
         7. Legal counsel is not permitted to attend the appeal because the process is an academic appeal.
         8. Appeal meetings may not be recorded.
         9. Ttends discretion with MSM, GME and/or program standards, policieshe Department Appeal Committee reserves the right to determine the manner in which the meetings with the resident and program director will be conducted.
      4. The Departmental Appeal Committee will present its written recommendation to the program director within seven (7) days of the end of the appeal meeting. The program director will then forward the resident’s training documents, all information concerning the dismissal/termination/nonrenewal, written appeal recommendation, and any other pertinent information to the chairperson.
      5. The department chairperson will review all materials and make the final departmental decision within seven (7) days of receipt of materials.
      6. The department chairperson will communicate the final written departmental decision to the program director.
      7. The program director will then communicate the decision by written letter to the resident via mail and e-mail. This should occur within ten (10) days of the final decision.
   8. **Appeal to the Dean**
      1. The resident may appeal the decision of the department chair.
      2. If the resident is unsuccessful in his or her appeal to the chairperson, he or she may submit a written request to the dean for a review of due process involved in the program’s decision of dismissal/termination/non-renewal of appointment.
      3. A request for appeal to the dean must be submitted in writing within seven (7) days of the notification of the final departmental decision.
      4. The appeal must be submitted to both the dean and the program director.
      5. The dean shall instruct the GME office to convene an Institutional Appeal Committee to review the case and provide an advisory opinion as to whether the residency program afforded the resident due process in its decision to dismiss or to not renew the resident’s appointment. This review is that of program protocol and documentation in the case. MSM’s Designated Institutional Officer, or his or her designee, shall chair the institutional appeal committee.
         1. The Institutional Appeal Committee shall consist of the DIO, two (2) faculty members, and one (1) administrative person, usually the GME Director, who functions as a facilitator and manages scheduling, communication, and administrative functions of the committee.
         2. The Institutional Appeal Committee will meet to review the resident’s training documents and hear directly from the resident and program director regarding the matter.
         3. The Institutional Appeal Committee will notify the resident and program director of the meeting date, time, place, and committee members’ names and titles.
         4. The program director shall provide the training documents and record of the departmental appeal proceedings.

The program director must also provide a written summary letter and timeline of events for the committee to review at least 24 hours before the scheduled meeting.

* + - 1. The Institutional Appeal Committee shall give the resident an opportunity to present written and/or verbal evidence to dispute the allegations that led to the disciplinary action.

The resident may submit written documentation to the committee to review and must do so at least 24 hours before the scheduled meeting.

* + - 1. The resident may bring an advocate, such as a faculty member, staff member, or other resident.
      2. Legal counsel is not permitted to attend the appeal because the process is an academic appeal.
      3. Recording of meeting(s) and/or proceedings is prohibited.
    1. The institutional appeals committee chair will submit a written report of the findings to the dean who will make the final determination regarding the status of the resident.
    2. The final written determination by the dean may be:
       1. That the resident is returned to the residency program without penalty.
       2. Recommendation for dismissal, termination, or non-renewal of appointment stands.
       3. Other as deemed appropriate by the dean.
    3. If a recommendation for dismissal/termination/non-renewal is confirmed, the resident is removed from the payroll effective the day of the dean’s decision.

## Public Health and Preventive Medicine Resident Leave Request Procedures (Partial)

1. **POLICY:**
   1. Residents must submit leave requests via e-mail to the Residency Program Manager and the CH/PM time keeper at least ten (10) business days prior to planned leave.
   2. Once approved, all leave requests must be entered into the Kronos system **prior** to the leave date.
   3. In the case of illness or an emergency, the resident must notify the residency program manager, preceptor, and class instructor of the absence as soon as possible.
   4. Leave will not be granted during mandated residency events, such as orientation, residency retreats, annual GME activities, and the program’s annual luncheon.
2. **COMPENSATED LEAVE TYPES:**
   1. Resident Vacation Leave: Residents are allotted 15 days compensated Vacation Leave per academic year (from July 1 through June 30).
      1. Vacation Leave may not be carried forward from year-to-year (accrued).
      2. Vacation leave shall not be subject to an accumulated “pay out” upon the completion of the program, transfer from the program, or upon a resident’s involuntary termination from the program.
   2. Sick Leave: Compensated Sick Leave is 15 days per year. This time can be taken for illness for the resident or for the care of an “immediate” family member.
      1. Sick leave is not accrued from year to year.
      2. Available sick leave, 15 days maximum, and/or available vacation leave, 15 days maximum, may be used to provide paid leave in situations requiring time off for the purpose of caring for oneself or an immediate family member due to serious health conditions.
   3. Administrative Leave: granted at the discretion of the program director, may not exceed ten (10) days per twelve-month period. Residents should be advised that some Medical Boards count educational leave as time away from training and may require an extension of their training dates.
   4. Holiday Leave: time off for a holiday is based on a resident’s rotation assignment. When rotating on a clinic or service that closes due to a holiday, the resident may take that time off as paid holiday leave with approval of the program director.
   5. Family and Medical Leave: MSM provides job-protected family and medical leave to eligible residents. Contact the MSM Human Resources department for most current information regarding FML.
3. **SHORT TERM DISABILITY:**
   1. Short-term disability (STD) is an MSM employee paid benefit offered to regular full-time employees and part-time employees who are eligible for benefits. The benefits are administered by an insurance carrier which provides income continuation to employees who are unable to work for up to twenty-six (26) weeks due to a non-work related illness or injury that prevents the performance of normal duties of their position.
   2. Eligible employees must enroll for the STD program within thirty (30) days of employment. If the employee does not enroll within thirty (30) days of eligibility and would like coverage at a later date, the employee must provide evidence of insurability to gain coverage subject to approval by the insurance carrier.
   3. There is a required fourteen (14) day benefit elimination period during which an employee must use any available accrued sick and/or vacation leave.
      1. If an employee continues to be determined disabled after the benefit elimination period, the insurance carrier will pay sixty percent (60%) of his or her weekly salary, until a decision is made that the employee is no longer disabled, or the employee’s claim transitions to Long-Term Disability.
      2. The maximum benefit period for STD is twenty-six (26) weeks. The benefit period could be shorter as determined by medical documentation submitted.
      3. For additional information, refer to MSM’s Short Term Disability Policy (HR 6.01).

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1. **LEAVE OF ABSENCE WITHOUT PAY:**
   1. Leave required beyond available compensated sick and/or vacation leave will be uncompensated Leave Without Pay (LWOP).
      1. Requests for LWOP shall be submitted in writing to the residency program director and reviewed by the Human Resources Department for disposition and approval no less than 30 days in advance of the start of any planned leave. The request shall identify the reason for the leave and the duration.
      2. LWOP, when approved, shall not exceed six (6) months in duration. If LWOP does extend beyond six (6) months in duration, the resident must reapply to the residency program.
   2. MSM’s Human Resources Department shall advise both the resident and the residency program director on applicable policies and procedures. All applicable categories of compensated leave must be exhausted prior to a resident being granted LWOP. Residents shall consult with the HR Manager for Leave Management prior to taking LWOP.
2. **OTHER LEAVE TYPES:**

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

1. **RETURN TO DUTY:**
   1. For leave due to parental or serious health conditions of the resident or a family member, a physician's written “Release to Return to Duty” or equivalent is required with the date the resident is expected to return to resume his or her residency. This information is submitted to the Human Resources Department (HRD).
   2. When applicable, the residency program director will record in writing the adjusted date required for completion of the PGY or the program because of Extended Resident Leave. One copy is placed in the resident’s educational file and a copy is submitted to the Office of Graduate Medical Education (GME) to process the appropriate Personnel Action.
2. **PROGRAM LEAVE LIMITATIONS:**
   1. Leave away from the residency program includes the total of all leave categories taken within an academic year. This includes uncompensated Federal Family and Medical Leave or other Leave without Pay (LWOP).
   2. All leave is subject to the requirements of the individual medical specialty boards and the ACGME-RRC regarding the completion of the program. It is the responsibility of each residency program director to determine the effect of absence from training for any reason on the individual’s educational program and, if necessary, to establish make-up requirements that meet the Board requirements for the specialty. Always review the current certification application eligibility requirements at the specialty board website.

# Resident Learning and Working Environment Policy

1. **PURPOSE**:
   1. Graduate Medical Education (GME) is an integral part of the Morehouse School of Medicine (MSM) medical education program. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients.
   2. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions.
   3. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence.
2. **SCOPE:**
   1. All MSM administrators, faculty, staff, residents, and administrators at participating training affiliates shall understand and support these and all other policies and procedures that govern both GME programs and resident appointments at MSM.
   2. Each resident will receive a copy of this Resident Learning and Working Environment Policy.
3. **POLICY:**
   1. Per ACGME Learning and Working Environment requirements, residency education must occur in the context of a learning and working environment that emphasizes the following principles:

* Excellence in the safety and quality of care rendered to patients by residents today
* Excellence in the safety and quality of care rendered to patients by today’s residents in their future practice
* Excellence in professionalism through faculty modeling of:
  + The effacement of self-interest in a humanistic environment that supports the professional development of physicians
  + The joy of curiosity, problem-solving, intellectual rigor, and discovery
* Commitment to the well-being of the students, residents, faculty members, and all members of the healthcare team
  1. Patient Safety
     1. **Culture of safety** is defined as a culture of safety which requires continuous identification of vulnerabilities and a willingness to deal with them transparently.
     2. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety to identify areas for improvement.
        1. The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.
        2. The program must have a structure that promotes safe, inter-professional, team-based care.
     3. Education on Patient Safety

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

* + 1. Patient Safety Events
       1. Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program.
       2. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.
       3. Residents, fellows, faculty members, and other clinical staff members must:
          1. Know their responsibilities in reporting patient safety events at the clinical site;
          2. Know how to report patient safety events, including near misses, at the clinical site;
          3. Be provided with summary information of their institution’s patient safety reports
       4. Residents must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.
    2. Resident education and experience in disclosure of adverse events
       1. Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events.
       2. This is an important skill for faculty physicians to model, and for residents to develop and apply.
          1. All residents must receive training in how to disclose adverse events to patients and families.
          2. Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.
  1. Quality Improvement
     1. Education in Quality Improvement is a cohesive model of healthcare which includes quality-related goals, tools, and techniques that are necessary for healthcare professionals to achieve quality improvement goals.

Residents must receive training and experience in quality improvement processes, including an understanding of healthcare disparities.

* + 1. Quality Metrics refers to access to data which is essential to prioritizing activities for care improvement and for evaluating success of improvement efforts.

Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.

* + 1. Engagement in Quality Improvement Activities—Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.
       1. Residents must have the opportunity to participate in inter-professional quality improvement activities.
       2. This should include activities aimed at reducing healthcare disparities.
  1. Clinical Experience and Education (formerly duty hours)
     1. Programs, in partnership with their sponsoring institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.
     2. Maximum hours of clinical and educational work per week

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

* + 1. Mandatory time free of clinical work and education
       1. The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
       2. Residents should have eight hours off between scheduled clinical work and education periods.
       3. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.
       4. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
       5. Residents must be scheduled for a minimum of one (1) day in seven (7) free of clinical work and required education (when averaged over four (4) weeks). At-home call cannot be assigned on these free days.
    2. Maximum clinical work and education period length
       1. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
       2. Up to four (4) hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care and/or resident education.
       3. Additional patient care responsibilities must not be assigned to a resident during this time.
    3. Clinical and Educational Work Hour Exceptions
       1. In rare circumstances, after handing off all other responsibilities, a resident, on her or his own initiative, may elect to remain or return to the clinical site in the following circumstances:
          1. To continue to provide care to a single severely ill or unstable patient;
          2. To provide humanistic attention to the needs of a patient or family; or
          3. To attend unique educational events.
       2. These additional hours of care or education will be counted toward the 80-hour weekly limit.
  1. A review committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.
     1. In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures.
     2. Prior to submitting the request to the review committee, the program director must obtain approval from the sponsoring institution’s GMEC and DIO.
  2. **Moonlighting Policy and Procedure**

ACGME defines Moonlighting as: “Voluntary, compensated, medically-related work performed beyond a resident’s or fellow’s clinical experience and education hours and additional to the work required for successful completion of the program.

* + - 1. External moonlighting: Voluntary, compensated, medically-related work performed outside the site where the resident or fellow is in training and any of its related participating sites.
      2. Internal moonlighting: Voluntary, compensated, medically-related work performed within the site where the resident or fellow is in training or at any of its related participating sites.
      3. Moonlighting at MSM must be in accordance with the following guidelines:

PGY-1 residents are not permitted to moonlight.

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

Moonlighting must be approved in writing by the program director and designated institutional official (DIO)

Time spent by residents/fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour Maximum Weekly Hour Limit.

Each resident/fellow requesting entry into such activities shall have a State of Georgia physician’s license.

Residents/fellows must complete the Moonlighting Request Form and sign the “Professional Liability Coverage” statement available from the GME office. Examples of these follow this policy. of understanding as part of the Resident Appointment Agreement entered with the program and upon the approval of a request to moonlight. A sample of this statement follows the professionalism policy in this policy manual.

* 1. Professional liability coverage provided by MSM does not cover any clinical activities not assigned to the resident/fellow by the residency/fellowship program.
  2. Moonlighting activities shall not be credited as being part of the program structure or curriculum.
  3. MSM shall not be responsible for these extracurricular activities. The **resident/fellow must secure liability coverage for these outside activities from the respective institutions or through his or her own resources.**

**Professional Liability Coverage – Moonlighting Request**

**This letter shall be completed upon appointment to a Morehouse School of Medicine Residency Program and at any time a Resident/Fellow enters into moonlighting activities.**

**This is to certify that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am a Resident/Fellow Physician at Morehouse School of Medicine. As a Physician in training, I understand that all professional activities that are sanctioned by Morehouse School of Medicine related to or a part of the Residency/Fellowship Education Program, are covered by the following professional liability coverage:**

**$1 million per/occurrence and; $3 million annual aggregate; and;**

**Tail coverage for all incidents that occur during my tenure as a Resident/Fellow in accordance with the above.**

**In addition, I understand that the above professional liability insurance coverage does not apply to professional activities in which I become involved outside of the MSM Residency/Fellowship Program, and that upon written approval by the residency/fellowship program director to moonlight, I am personally responsible for becoming licensed and securing adequate coverage for these outside activities from the respective institutions or through my own resources.**

**In addition, all these activities shall be recorded and reported to the residency program director for evaluation and approval.**

**Resident/Fellow signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Four of Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* 1. In-House Night Float
     1. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
     2. The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the review committee.
  2. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

* 1. At-Home Call

Time spent on patient care activities by residents on at-home call must count towards the 80-hour maximum weekly hour limit.

* + 1. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of clinical work and education, when averaged over four (4) weeks.
    2. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
    3. Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

1. **MSM GMEC CLINICAL WORK AND EDUCATION OVERSIGHT PROCEDURE:**

It is the goal of the Graduate Medical Education Committee (GMEC) and affiliated hospitals that the institution will have no duty hour violations.

* 1. Institutional GMEC Clinical Work and Education Monitoring Process
     1. The Program Annual Review Process
        1. The GMEC is responsible for conducting an annual review of all programs.
        2. As part of the process, the GME Office will review and document each program’s clinical work and education compliance status including review of programs’ learning and work environment policies and procedures.
        3. The GME Office will monitor, track, and report compliance for all programs to the GMEC on a monthly basis.
     2. ACGME Resident Survey
        1. Residents are surveyed by the ACGME every year between January and April.
        2. Programs found to be noncompliant with the ACGME duty hours will be required to submit a corrective action plan to GMEC.
  2. Program-Level Oversight and Monitoring for Compliance with clinical work and education requirements
     1. Program Clinical Work and Education Policy
        1. All programs must demonstrate compliance with ACGME clinical work and education requirements.
        2. Programs must develop and maintain a policy on clinical work and education.
        3. Program directors must submit the following items annually into the New Innovations system for GME review:
           1. The program’s schedules reflecting daily work hours and compliance with all clinical work and education requirements
           2. The program’s clinical work and education monitoring policy and process which must:
* Meet the educational objectives and patient care responsibilities of the training program and
* Comply with specialty-specific program requirements, the Common Program Requirements, the ACGME clinical work and education standards, and the Institutional GME clinical work and education policy
  + - * 1. In addition, the program policy must address:
* How the program monitors duty hours, according to MSM institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements
* How the program monitors the demands of at-home call and adjusts schedules as necessary to mitigate excessive service demands and/or fatigue, if applicable
* How the program monitors fatigue, and how the program will adjust schedules as necessary to mitigate excessive service demands and/or fatigue
* How the program monitors the need for and ensures the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged
* If the program allows moonlighting; if moonlighting is allowed, the policy must comply with and reference the MSM GME Moonlighting Guidelines
* If the program allows call trading; if so, document how the program oversees to ensure compliance with clinical work and education requirements
* Mechanisms used by the program to ensure that residents log their duty hours in New Innovations
  + - 1. Program directors must complete weekly/monthly duty hour review periods in the New Innovations system and provide oversight comment(s) for any violation. (See document: Duty Hour Oversight—Program Level for step-by-step instructions.)
      2. Follow-up and resolution of identified problems are the responsibility of the program director and the department.
      3. An action plan must be created for any violation that includes identifying reasons for the violation(s) and how the program will resolve the issue(s) to prevent future violations.

Clinical Work and Education Policy

Residents are fully subject to the clinical work and education policy regulations put forward by the ACGME. Specifically, residents may work no more than 80 hours/week averaged over a four (4) week period, must have at least one (1) day in seven off (averaged), should have 10 hours off but must have at least eight (8) hours off in between work periods. Refer to the GME policy manual for detailed information about the Clinical Work and Education Policy at

<http://www.msm.edu/Education/GME/Documents/2016-17MSMGMEPolicyManual5.26.16.pdf>.

ACGME guidelines, designate duty hours as the following:

* Any time spent in any clinical activities
* Any time spent in any educational activities, including rotations, courses, lectures, didactics, conferences (both local and national), workshops, and seminars
* Any time spent in any administrative activities including meetings, program retreats, residency interviews, and evaluation meetings
* Any MSM-mandated service activities such as health fairs and health education/health promotion activities
* Any outside professional activities (i.e. moonlighting)

## Program Monitoring and Oversight of Duty Hour Compliance Procedures

Residents must document all of the above activities, in addition to all leave, in the New Innovations Residency Management System **at least five (5) days each week**. Duty hour logging will be monitored by the program and the Office of Graduate Medicine Education. Activities not included in duty hour reporting include the following:

* Commuting
* Studying

Failure to log duty hours as instructed will result in a verbal reprimand at the first offense and in written evaluations; subsequent offenses will result in failure to progress to the next level of training/completion (see “Public Health and Preventive Medicine Residency Program Progression Policy”).

## Moonlighting

The policies listed below are taken from the full MSM Moonlighting Policy. Moonlighting at MSM must be in accordance with the following guidelines:

**3.7.6.1.** PGY-1 residents are not permitted to moonlight.

**3.7.6.2.** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

**3.7.6.3.** Moonlighting must be approved in writing by the program director.

**3.7.6.4.** Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

**3.7.6.5.** Each resident requesting entry into such activities shall have a State of Georgia physician’s license.

**3.7.6.6.** The resident must sign a “Professional Liability Coverage” statement of understanding as part of the Resident Appointment Agreement entered into with the program and also upon the approval of a request to moonlight. A sample of this statement is attached to the policy in the full MSM Moonlighting Policy.

**3.7.6.7.** It must be understood that professional liability coverage provide by MSM does not cover any clinical activities not assigned to the resident by the residency program. Moonlighting activities shall not be credited as being part of the program structure or curriculum.

**3.7.6.8.** MSM shall not be responsible for these extracurricular activities. The resident must secure liability coverage for these outside activities from the respective institutions or through his or her own resources.

## PH/PM Residency Moonlighting Request Procedures

Residents in the PH/PM Residency Program are not permitted to moonlight during the first six (6) months of training. Residents who seek to moonlight after that period of time must obtain a written statement of permission from the program director; that statement of permission is then included in the resident’s file. The resident must also provide a statement from the practice verifying the provision of liability coverage for this activity. The resident’s performance will be monitored for the effect of these activities. Any adverse effects may lead to withdrawal of permission to moonlight. The program directors will closely monitor all moonlighting activities.

Residents must be scheduled for a minimum of one (1) day free of duty every week (when averaged over four (4) weeks). At-home call cannot be assigned on these free days. The following policies are taken from the full MSM Moonlighting Policy:

**3.7.8. Maximum Duty Period Length**

**3.7.8.1.** Duty periods of PGY-1 residents must not exceed 16 hours in duration.

**3.7.8.2.** Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m. is strongly suggested (by ACGME).

**3.7.8.2.1.** It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four (4) hours.

**3.7.8.2.2.** Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

## Resident Learning and Working Environment Policy

The following policies are taken from the full MSM Resident Learning and Working Environment Policy:

**3.7.8.2.3**. In unusual circumstances, residents on their own initiative may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:

a) Appropriately hand over the care of all other patients to the team responsible for their continuing care

b) Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

**3.7.9. Minimum Time Off between Scheduled Duty Periods (exceptions must be recorded)**

**3.7.9.1.** PGY-1 residents *should* have 10 hours, and *must* have eight (8) hours free of duty between scheduled duty periods.

**3.7.9.2.** Intermediate-level residents (as defined by the Review Committee) *should* have 10 hours free of duty, and *must* have eight (8) hours between scheduled duty periods. They *must* have at least 14 hours free of duty after 24 hours of in-house duty.

**3.7.9.3.** Residents in the final years of education (as defined by the Review Committee) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

**3.7.9.3.1.** This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards.

**3.7.9.3.2.** While it is desirable that residents in their final years of education have eight (8) hours free of duty between scheduled duty periods, there may be circumstances (as defined by the Review Committee) when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

**3.7.9.3.3.** Circumstances of return-to-hospital activities with fewer than eight (8) hours away from the hospital by residents in their final years of education must be monitored by the program director.

**3.7.10. Maximum Frequency of In-House Night Float**

Residents must not be scheduled for more than six (6) consecutive nights of night float. The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee. Refer to the MSM-GME Night Float protocol.

**3.7.11. Maximum In-House On-Call Frequency**

PGY-2 residents and above must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

**3.7.12. At-Home Call**

**3.7.12.1.** Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

**3.7.12.2.** Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”



**GRADUATE MEDICAL EDUCATION**

**Moonlighting Approval Request form**

**Moonlighting Criteria**

1. PGY 2 or higher (PGY 1 residents may not moonlight)
2. J1-Visa sponsored residents may not moonlight
3. A full Georgia Physician’s license is required
4. Resident/Fellow must have “good standing” status in the program
5. Residents/fellows must log all internal and external moonlighting hours which count toward the ACGME duty hours
6. Moonlighting must occur within the state of Georgia

**To be completed by the Resident/Fellow:**

Program Name: Academic Year:

Resident/Fellow Name: PGY Level:

Georgia Medical License #: Expiration Date:

Name of Malpractice Carrier: Malpractice policy #:

Name of Moonlighting Site/Organization:

Address: City: Zip Code:

Moonlighting Supervisor Name: Phone number:

Date Moonlighting Starts: Date Moonlighting Ends:

Moonlighting Activities:

Maximum hours per week: Number of weeks:

Check One:

\_\_\_\_\_\_\_External moonlighting: Voluntary, compensated, medically-related work performed **outside** the site of your training and any of its related participating sites.

\_\_\_\_\_\_\_Internal moonlighting: Voluntary, compensated, medically-related work performed **within** the site of your training or at any of its related participating sites.

**Resident/Fellow Acknowledgement of Moonlighting Policy and Procedures**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ attest that I meet and will comply with the moonlighting criteria. I understand that moonlighting activities are not credited toward my current training program requirements. I understand that I cannot moonlight during regular program work hours. I agree to submit another moonlighting approval form if there are any changes in location, activity, hours, supervisor, etc.

I understand that violation of the GME moonlighting policy is a breach of the Resident/Fellow Appointment Agreement and may lead to corrective action. I attest that the moonlighting activity is outside of the course and scope of my approved training program.

I understand that Morehouse School of Medicine assumes no responsibility for my actions as relate to this activity. I will also inform the organization that is employing me and will make no representation which might lead that organization or its patients to believe otherwise. While employed in this activity, I will not use or wear any items which identify me as affiliated with Morehouse School of Medicine, nor will I permit the moonlighting organization to represent me as such.

I give my program director permission to contact this moonlighting employer to obtain moonlighting hours for auditing purposes.

I am not paid by the military or on a J1-visa.

By signing below, I attest and agree to all the above statements:

Resident/Fellow Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by the Program Director:**

I attest that the resident is in good standing and meets all the moonlighting criteria. Moonlighting time does not conflict with the training program schedule. Moonlighting duties/procedures are outside the course and scope of the training program. I agree to monitor this resident for work hour compliance and the effect of this moonlighting activity on overall performance. My approval will be withdrawn if adverse effects are noted.

Approved\_\_\_\_\_\_\_ Not Approved\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Director Signature Date

**Associate Dean and Designated Institutional Official (DIO) or Designee:**

Approved\_\_\_\_\_\_\_ Not Approved\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yolanda Wimberly, MD Date

## Sleep Deprivation and Fatigue Policy

1. **PURPOSE:**
   1. The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition).
   2. Resident education and patient care management can be greatly inhibited by resident sleepiness and fatigue.
2. **SCOPE:** 
   1. This policy is in direct response to requirements of the Accreditation Council on Graduate Medical Education (ACGME) pertaining to residents’ fatigue and is designed to ensure the safety of patients as well as to protect the residents’ learning environment.
   2. This policy is in addition to any policy established by MSM and its affiliate institutions regarding sleep deprivation and fatigue.
3. **DEFINITION OF FATIGUE:**
   1. Fatigue is a feeling of weariness, tiredness, or lack of energy. Fatigue can impair a physician’s judgment, attention, and reaction time which can lead to medical errors, thus compromising patient safety.
   2. There are many signs and symptoms that would provide insight to one’s impairment based on sleepiness. Clinical signs include:

* Moodiness
* Depression
* Irritability
* Apathy
* Impoverished speech
* Flattened affect
* Impaired memory
* Confusion
* Difficulty focusing on tasks
* Sedentary nodding off during conferences or while driving
* Repeatedly checking work and medical errors

1. **POLICY:**

MSM faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply the following programs and procedures to prevent and counteract potential associated negative effects on patient care and learning. These programs and procedures are designed to:

* Raise faculty and residents’ awareness of the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care.
* Provide faculty and residents with tools for recognizing when they are at risk.
* Identify strategies for faculty and residents to use that will minimize the effects of fatigue (in addition to getting more sleep).
* Help identify and manage impaired residents.

1. **INDIVIDUAL RESPONSIBILITY:** 
   1. Resident’s Responsibilities in Identifying and Counteracting Fatigue
      1. The resident will be educated on the hazards of sleep deprivation and fatigue in the workplace and in their personal lives (motor vehicle accidents).
      2. The resident is expected to adopt habits that will provide him or her with adequate sleep in order to perform the daily activities required by the program.
      3. Duty Hours should be strictly adhered to. In the event that the resident is too sleepy to drive home at the end of a work period, he or she should be encouraged to use another form of transportation (taxicab) or take a nap prior to leaving the training site.
   2. Faculty Responsibilities in Identifying and Counteracting Fatigue:
      1. Faculty will be educated on the hazards of sleep deprivation and fatigue in the workplace and in the provision of care to patients.
      2. Faculty members will be able to determine if residents are sleep deprived and will make the appropriate recommendations to the resident that will correct this problem.
      3. The faculty will learn to accept the limitations on the role of the resident under the Duty Hour mandates and will not penalize the resident as being lazy or disinterested when the resident leaves a work assignment “on time.”

## PH/PM Residency Program Procedures

The PH/PM Residency Program will provide all faculty members and residents information and instruction on recognizing the signs of fatigue and sleep deprivation via an annual didactic session and during the annual program health and wellness retreat. These sessions will cover alertness management, fatigue mitigation processes, as well as how to adopt these processes to avoid potential negative effects on patient care and learning. Additionally, residents in the PH/PM Residency Program are not assigned a call schedule, with most residency activities taking place during business hours.

This is accomplished by orientation sessions sponsored by GME and a department-sponsored session early in the academic year. This information is then posted on New Innovations for easy reference.

To ensure that patient care is not compromised if a resident or faculty member must apply fatigue mitigation techniques while on scheduled duty, residents should contact the chief medical resident or the resident’s faculty supervisor so that appropriate coverage can be obtained to ensure continuity of patient care. The PH/PM Residency Program and its affiliates ensure that adequate sleep facilities are available to residents and/or safe transportation options are available for residents requesting assistance due to fatigue because of time spent on duty.

# Resident Counseling

Short termcounselingis available from MSM Counseling Services (404-752-1789). MSM has an **Employee Assistance Program** (EAP) available for residents as a self-referral, program-referral or for family assistance. Residents are briefed on these programs during in-coming orientation to include the Drug Awareness Program, resident impairment issues, and family counseling. More information regarding these programs is available in the respective residency program office or the Human Resources Department, (404) 752-1600.

## Public Health and Preventive Medicine Resident Concern and Complaint Process

To ensure that residents are able to raise concerns, complaints, and provide feedback without intimidation or retaliation, and in a confidential manner as appropriate, the following options and resources are available and communicated to residents and faculty annually.

**Step One**

Discuss the concern or complaint with your chief resident, advisor, preceptor, program manager, associate program director and/or program director as appropriate.

**Step Two**

If the concern or complaint involves the program director and/or cannot be addressed in step one, residents have the option of discussing issues with the department chair or service chief of a specific hospital as appropriate.

**Step Three**

If you are not able to resolve your concern or complaint within your program, the following resources are available:

* For issues involving program concerns, training matters or work environment, residents can contact the Graduate Medical Education director, (404) 752-1011 or tsamuels@msm.edu.
* For problems involving interpersonal issues, the Resident Association president or president elect may be a comfortable option to discuss confidential informal issues apart and separate from the resident’s parent department.
* Residents can provide anonymous feedback/concerns/complaints to any department at Morehouse School of Medicine by completing the online GME Feedback form athttp://fs10.formsite.com/bbanks/form33/index.html. Comments are anonymous and cannot be traced back to individuals.
* Personal follow-up regarding how feedback/concerns/complaints have been addressed by departments and/or GME will be provided only if residents elect to include their name and contact information in the comments field.
* MSM Compliance Hotline—**1-888-756-1364** is an anonymous and confidential mechanism for reporting unethical, noncompliant and/or illegal activity. Call the Compliance Hotline to report any concern that could threaten or create a loss to the MSM community including:
  + Harassment—sexual, racial, disability, religious, retaliation
  + Environment Health & Safety—biological, laboratory, radiation, laser, occupational, chemical and waste management safety issues.
  + Other reporting purposes:
    - Misuse of resources, time, or property assets
    - Accounting, audit and internal control matters
    - Falsification of records
    - Theft, bribes, and kickbacks

Refer to the online version of the MSM GME Policy Manual <https://www.msm.edu/Education/GME/Documents/MSMGMEPolicyManual.pdf> at for detailed information regarding the Adverse Academic Decisions and Due Process Policy.

## Resident Participation in Program Policy Development

One resident, appointed by the residency director, participates on the Residency Advisory Committee for a term of one year. He or she is responsible for contributing residents’ perspective to decisions about policy and for communicating Advisory Committee decisions to fellow residents. Residents also participate in program development through engaged participation in the evaluation process.

## Orientation

The practicum year begins with an orientation and is planned by the residency director, program faculty and staff.

The objectives of orientation:

* To familiarize residents with the goals, methods, and resources of the MSM PH/PM Residency Program
* To introduce residents to the faculty and staff with whom they will have primary contact
* To familiarize residents with the facilities of MSM and affiliated organizations

Supervision and Accountability Policy

1. **PURPOSE**:

The purpose of this policy is to ensure that the Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) comply with ACGME supervision requirements and that the programs meet the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and the specialty program goals and objectives. The resident physician is expected to progressively increase his or her level of proficiency with the provision of predetermined levels of supervision.

1. **SCOPE:**

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

1. **POLICY:**
   1. Supervision in the setting of graduate medical education has the following goals:
      1. Ensuring the provision of safe and effective care to the individual patient;
      2. Ensuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine;
      3. Establishing a foundation for continued professional growth
   2. Each patient must have an identifiable, appropriately-credentialed, and privileged Attending physician (or licensed independent practitioner) who is responsible and accountable for the patient’s care. This information must be available to residents, faculty members, other members of the healthcare team, and patients.
   3. Residents and faculty members must inform patients of their respective roles in each patient’s care when providing direct patient care.
   4. All residents working in clinical settings must be supervised by a licensed physician. The supervising physician must hold a regular faculty or adjunct faculty appointment from the Morehouse School of Medicine. For clinical rotations occurring outside of Georgia the supervising physician must be approved by the residency program director.
   5. The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident’s level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.
      1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
      2. The program director must evaluate each resident’s abilities based on specific criteria guided by the Milestones.
      3. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and delegate him or her the appropriate level of patient care authority and responsibility. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of the residents.
      4. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
      5. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty members.
      6. Each resident must know the limits of his or her scope of authority, and the circumstances under which he or she is permitted to act with conditional independence. Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available.
2. **LEVELS OF SUPERVISION:**
   1. To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classifications of supervision:
      1. **Direct Supervision**: The supervising physician is physically present with the resident and patient.
      2. **Indirect Supervision with direct supervision immediately available**: The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.
      3. **Indirect Supervision with direct supervision available**: The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.
      4. **Oversight**: The supervising physician is available to provide review of procedures and encounters with feedback provided after care is delivered.
   2. Each program must specify in writing the type and level of supervision required for each level of the program.
      1. Levels of supervision must be consistent with the Joint Commission regulations for supervision of trainees, “graduated job responsibilities/job descriptions.”
      2. The required type and level of supervision for residents performing invasive procedures must be clearly delineated.
      3. The Joint Commission Standards for GME Supervision include:
         1. “Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff.
         2. The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant’s progressive involvement and independence in specific patient care activities.
         3. Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner.”
3. **SUPERVISION OF PROCEDURAL COMPETENCY:**
   1. Residents shall obtain competence in their field to be able to treat and manage patients in a qualified manner.
   2. This competence shall be evaluated and documented as to success and qualifications. The following protocol is used for administration of certifying residents’ procedural competency.
      1. Residents must be instructed and evaluated in procedural techniques by a licensed independent practitioner (LIP) who is certified as competent to independently perform that procedure or who has been credentialed by the medical staff office to perform that procedure.
      2. The Attending or program director is responsible for assessing procedural competency based on direct observation and/or identifying the number of procedures which must be completed successfully to grant proficiency.
      3. The program director for each training program will be responsible for maintaining an updated list of residents who have been certified as competent to perform procedures independent of direct supervision. This list must be available to Nursing in order to assist them in developing a physician resource listing.
      4. The program director must also develop a method for surveillance of continued competency after it is initially granted.
      5. The ability to obtain and document informed consent is an essential component of procedural competency. The supervising LIP must also supervise and attest to the trainee’s competence in obtaining and documenting informed consent.
      6. Until a resident trainee is judged competent in obtaining informed consent, he or she may only obtain informed consent while supervised by an individual with credentials in that procedure.
4. **GME PROGRAM SUPERVISION PROCEDURES AND PROCESSES:**
   1. Each program will maintain current call schedules with accurate information enabling residents at all times to obtain timely access and support from a supervising faculty member.
   2. Verification of required levels of supervision for invasive procedures will be reviewed as part of the Annual Program Review process. Programs must advise the Associate Dean for GME, in writing, of proposed changes in previously approved levels of supervision for invasive procedures.
   3. The GMEC Committee must approve requests for significant changes in levels of supervision.
   4. The program director will ensure that all program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on supervision must be included in the official Program Manual and provided to each resident upon matriculation into the program.
   5. The GME Office provides a Program Supervision Policy Template and Example for programs to utilize.
5. **CLINICAL RESPONSIBILITIES:**

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.

1. **TEAMWORK:**

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in the specialty and larger health system.

# Resident Supervision – update

## PH/PM Residency Program Supervision Procedures

Supervision may be provided by the supervising faculty member, a more advanced licensed practitioner, fellow, or more senior resident, either in the institution, or by means of telephonic and/or electronic modalities; or in some cases, post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

### Supervision of At-Home Call

Residents only have at-home call and clinical faculty are immediately available by phone, providing indirect supervision with direct supervision available.

**Process**

The program maintains current call schedules with accurate information enabling residents at all times to obtain timely access and support from a supervising faculty member. The program director will ensure that all program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on supervision is included in the official Program Manual and provided to each resident upon matriculation into the program.

**Progressive Authority and Responsibility, Conditional Independence, Supervisory Role in Patient Care**

The recommended level of supervision is specified in each rotation’s goals and objectives. It is the responsibility of the program director and supervising clinician to determine the progressive authority and responsibility, conditional independence, and a supervisory role in patient care to be delegated to each resident.

* At the beginning of each clinical rotation, the supervising clinician will directly observe each resident’s interaction with multiple patients. Supervising clinicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. It is the responsibility of the supervising clinician to delegate progressive authority and responsibility to each resident as appropriate.
* Each resident is responsible for knowing the limits of his or her scope of authority and the circumstances under which he or she is permitted to act with conditional independence, and for acting within these limits and circumstances.

**Guidelines for When Residents Must Communicate with the Attending**

In the clinical setting, the residencies ensure there will be sufficient and appropriate attending-resident communication to provide the highest quality of patient care and enough supervision for an excellent educational experience. While specific levels of supervision are described above, the supervisor and resident have a mutual responsibility to recognize the need for and implement increased communication and supervision under the following circumstances:

* A significant deterioration in clinical status of a patient;
* Any patient with a high-risk condition (e.g., critically ill);
* Uncertainty regarding the diagnosis;
* Uncertainty regarding the proposed clinical management of the patient;
* Patients requiring interventions that entail significant risk.

**Graduated Levels of Responsibility for Preventive Medicine Residents**

The following table lists the minimum level of supervision required for resident procedures.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **General Preventive Medicine and Public Health** | | | | | | | |
|  | Direct Supervision: Faculty Present | Indirect Supervision with Direct Supervision Immediately Available: Faculty in Area | Indirect Supervision with Direct Supervision Available: Faculty by Phone | | Indirect Supervisionwith Direct Supervision Available: Senior Resident by Phone | | Oversight: Faculty Available to Provide Review and Feedback |
| Level of Supervision | 1 | 2 | 3 | | 4 | | 5 |
|  | | | | | | | |
| Procedures | | | | Minimum Level of Supervision: Year 1 | | Minimum Level of Supervision: Year 2 | |
| Perform preventive medicine history and physical examination for patients seen on this service | | | | 3 | | 5 | |
| Treat and manage patient on this service | | | | 3 | | 5 | |
| Make referrals and request consultations | | | | 3 | | 5 | |
| Provide consultations within the scope of his or her privileges | | | | 3 | | 5 | |
| Use all skills normally learned during medical school | | | | 3 | | 5 | |
| Render any care in a life-threatening emergency | | | | 3 | | 5 | |
| Supervise allied health professionals on this service | | | | 3 | | 5 | |
| Practice of population health care | | | | 5 | | 5 | |
| For Year 1 residents, supervising physicians (or their designees) are to be available by phone at all times during direct patient care, but may supervise population health care through oversight. In keeping with appropriate and measured increasing independence as practitioner, and commensurate with the resident level of skill and experience, Year 2 residents may be supervised through faculty oversight. | | | | | | | |

The supervision of residents over the continuum of the program occurs on several levels.

1. Advisor/Mentor: Each resident is provided with an advisor at the beginning of the program. Residents are to meet with the advisor on a quarterly basis to establish a professional relationship. The resident’s progress will be reviewed by the advisor on a quarterly basis through the Critical Incidents Evaluation.
2. Onsite supervision: Each rotation site has an onsite supervisor/preceptor who is responsible for the overall educational experience of the resident. The onsite supervisor and the resident develop the learning contract at the beginning of the rotation. The supervisor will evaluate the resident at the end of the rotation for compliance with the six core competencies as well as the rotation competencies.
3. Responsibilities for patient/community care is evaluated through the community- based assignment. This experience is evaluated by the Community Medicine Project rotation supervisor, who is also the residency program director. Management of the patient /community is tracked through monthly updates during the Friday seminars. Progression of responsibility for the care of the community follows the continuum of community diagnosis/community engagement. Residents will assess the community, review findings with community leaders, prioritize the health needs, and develop, implement, and evaluate the intervention. The faculty supervisor initiates contact with the community and assists the resident with the interaction between the resident and the community and with the activities of the community throughout the assignment. Monthly updates with all residents allows for the opportunity for the resident to share experience with each other and collaborate on projects.
4. Supervision of residents during the clinical experience at the Veterans Administration Community Based Clinic is done by the on-site supervisor. The supervision addresses the project that the resident is assigned to, collaboration with the healthcare team on the project, and interaction with the veteran population of patients.
5. Supervision of residents during the clinical experience at the Community Advanced Practice Nurses Clinic is done by the on-site supervisor. The supervision addresses collaboration with the healthcare team at the clinic and interaction with the population of patients.

# Supervision Policy

The Public Health & General Preventive Medicine Residency follows the Morehouse School of Medicine GME Supervision Policy, which can be found at in the ***MSM Graduate Medical Education Policy Manual, 2018-2019***

To ensure oversight of resident supervision and graded authority and responsibility, the program follows the ACGME classification of supervision (CPR VI.D.3):

* Direct Supervision: The supervising physician is physically present with the resident and patient.
* Indirect Supervision: With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
* With Direct Supervision Available: The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
* Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Program Supervision Policy

Supervision may be provided by the supervising faculty member, a more advanced licensed practitioner, fellow, or more senior resident, either in the institution, or by means of telephonic and/or electronic modalities; or in some cases, post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

Supervision of At-Home Call:

Residents only have at-home call and attendings are immediately available by phone, providing indirect supervision with direct supervision available.

Process

The program maintains current schedules with accurate information enabling residents at all times to obtain timely access and support from a supervising faculty member. The Program Director will ensure that all program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on supervision is included in the official Program Manual and provided to each resident upon matriculation into the program.

Progressive Authority & Responsibility, Conditional Independence, Supervisory Role in Patient Care

The recommended level of supervision is specified in each rotation’s goals and objectives. It is the responsibility of the program director and supervising clinician to determine the progressive authority and responsibility, conditional independence, and a supervisory role in patient care to be delegated to each resident.

1. At the beginning of each clinical rotation, the supervising clinician will directly observe each resident’s interaction with multiple patients. Supervising clinicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. It is the responsibility of the supervising clinician to delegate progressive authority and responsibility to each resident as appropriate.
2. Each resident is responsible for knowing the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence, and for acting within these limits and circumstances.

Guidelines for When Residents Must Communicate with the Attending

In the clinical setting, the residencies ensure there will be sufficient and appropriate attending-resident communication to provide the highest quality of patient care and enough supervision for an excellent educational experience. While specific levels of supervision are described above, the supervisor and resident have a mutual responsibility to recognize the need for and implement increased communication and supervision under the following circumstances:

a) A significant deterioration in clinical status of a patient;

b) Any patient with a high-risk condition (e.g., critically ill);

c) Uncertainty regarding the diagnosis;

d) Uncertainty regarding the proposed clinical management of the patient;

e) Patients requiring interventions that entail significant risk.

Graduated Levels of Responsibility for Preventive Medicine Residents

The following table lists the minimum level of supervision required for resident procedures.

Patient Hand-off—Transitions of Care Policy

1. **PURPOSE:**

The purpose of this policy is to define a safe process to convey important information about a patient’s care when transferring care responsibility from one physician to another.

1. **BACKGROUND:**
   1. In the course of patient care, it is often necessary to transfer responsibility for a patient’s care from one physician to another. Hand-off refers to the orderly transmittal of information, face to face, that occurs when transitions in the care of the patient are occurring.
   2. Proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during that shift. In summary, the primary objective of a hand-off is to provide complete and accurate information about a patient’s clinical status, including current condition and recent and anticipated treatment. The information communicated during a hand-off must be complete and accurate to ensure safe and effective continuity of care.
2. **SCOPE:**

These procedures apply to all MSM physicians who are teachers/supervisors or learners in a clinical environment and have responsibility for patient care in that environment.

1. **POLICY:**
   1. **Transitions of Care**—Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.
   2. Programs and clinical sites must maintain and communicate schedules of Attending physicians and residents currently responsible for care.
   3. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in ACGME Common Program Requirement VI.C.2 (Resident Well-Being), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.
   4. Programs must ensure that residents are competent in communicating with team members in the hand-off process.
   5. Programs in partnership with their sponsoring institutions must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety.
      1. Hand-offs must follow a standardized approach and include the opportunity to ask and respond to questions.
      2. A hand-off is a verbal and/or written communication which provides information to facilitate continuity of care. A hand-off or “report” occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:

* Move to a new unit
* Transport to or from a different area of the hospital for care (e.g.: diagnostic/treatment area)
* Assignment to a different physician temporarily   
  (e.g.: overnight/weekend coverage) or longer (e.g.: rotation change)
* Discharge to another institution or facility
  + 1. Each of the situations above requires a structured hand-off with appropriate communication.

1. **CHARACTERISTICS OF A HIGH QUALITY HAND-OFF:** 
   1. Hand-offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.
   2. Hand-offs include up-to-date information regarding the patient’s care, treatment and services, condition, and any recent or anticipated changes.
   3. Interruptions during hand-offs should be limited in order to minimize the possibility that information would fail to be conveyed or would be forgotten.
   4. Hand-offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.
2. **HAND-OFF PROCEDURES:**
   1. Hand-off procedures will be conducted in conjunction with (not be limited to) the following physician events:

* Shift changes
* Meal breaks
* Rest breaks
* Changes in on-call status
* When contacting another physician when there is a change in the patient’s condition
* Transfer of patient from one care setting to another
  1. Hand-off procedures and information transfer forms and guidelines for physicians are developed and implemented by each service according to the needs of that service. The hand-off forms or guidelines may be in either paper or electronic format, and must include clinical information agreed upon by physicians on that service, as being integral to the provision of safe and effective patient care for that patient population.
  2. Each service will develop and implement a hand-off process that is in keeping with the shift or rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.
  3. Each service hand-off process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.
  4. Each hand-off process must be conducted discreetly and free of interruptions to ensure a proper transfer.
  5. Each hand-off process must include at minimum a senior resident or Attending physician.
  6. A resident physician must not leave the hospital until a face-to-face hand-off has occurred with the Attending physician or senior resident that is coming onto the service. Telephonic hand-off is not acceptable.

1. **STRUCTURED HAND-OFF:**
   1. Within each service, hand-offs will be conducted in a consistent manner, using a standardized hand-off form or structured guideline.
   2. Hand-offs, whether verbal or written, should include, at minimum, specific information listed below (as applicable):

* Patient name, location, age/date of birth
* Patient diagnosis/problems, impression
* Important prior medical history
* DNR status and advance directives
* Identified allergies
* Medications, fluids, diet
* Important current labs, vitals, cultures
* Past and planned significant procedures
* Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
* Plan for the next 24+ hours
* Pending tests and studies which require follow up
* Important items planned between now and discharge

1. **FORMATTED PROCEDURE:**
   1. A receiving physician shall:
      1. Thoroughly review a written hand-off form or receive a verbal hand-off and take notes.
      2. Resolve any unclear issues with the transferring physician prior to acceptance of a patient.
   2. In addition, the SBAR can be used to deliver or receive the information:

* **Situation**: What is the problem?
* **Background**: Pertinent information to problem at hand
* **Assessment**: Clinical staff’s assessment
* **Recommendation**: What do you want done and/or think needs to be done?
  1. The following document is a suggested format for programs to document information with a sign-out process.

**A SAMPLE FORMAT**

**Shift Date: / / Shift Time (24 hour):**

By my signature below, I acknowledge that the following events have occurred:

1. Interactive communications allowed for the opportunity for questioning between the giver and receiver about patient information.
2. Up-to-date information regarding the patient’s care, treatment and services, condition, and any recent or anticipated changes was communicated.
3. A process for verification of the received information, including repeat-back or read-back, as appropriate, was used.
4. An opportunity was given for the receiver of the hand-off information to review relevant patient historical information, which may include previous care, and/or treatment and services.
5. Interruptions during hand-offs were limited in order to minimize the possibility that information would fail to be conveyed, not be heard, or forgotten.

Receiving Resident’s Name and Signature Date/Time

Departing Resident’s Name and Signature Date/Time

## PH/PM Residency Program Procedures

The PH/PM Residency Program will provide faculty and residents instruction on how to complete an effective handoff during an annual didactic session. PH/PM residents only manage patients in outpatient settings; therefore handoff training will focus on these circumstances. This session will cover the importance of effective transitions of care in a patient safety context, components of a high quality handoff, the protocol to initiate and complete a handoff. Residents will be required to have an annual assessment of handoff protocol according to the Structured Hand-Off checklist below.

1. **STRUCTURED HAND-OFF CHECKLIST**:
   1. Within each service, hand-offs will be conducted in a consistent manner, using a standardized hand-off form or structured guideline.
   2. Hand-offs, whether verbal or written, should include, at minimum, specific information listed below (as applicable):
2. Patient name, location, age/date of birth
3. Patient diagnosis/problems, impression
4. Important prior medical history
5. Identified allergies
6. Medications, fluids, diet
7. Important current labs, vitals, cultures
8. Past and planned significant procedures
9. Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
10. Plan for the next 24+ hours
11. Pending tests and studies which require follow up
12. Important items planned between now and discharge

## Evaluation of Residents, Faculty, and Programs Policy

# PURPOSE:

# The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition); and that MSM GME (the sponsor), residency programs, residents, fellows, and faculty, and training programs are evaluated as prescribed required in the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common, and Specialty/subspecialty specific Program Requirements.

# SCOPE:

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

# All MSM residency and fellowship programs must:

# Have a program-level evaluation policy and procedures for assessment and evaluation of residents, fellows, faculty, and program that are compliant with ACGME Common and Specialty Specific Requirements.

# Utilize the New Innovations System for all required evaluation components.

# The GME Office will monitor all evaluation components, set up, and completion rates and provide programs with a minimum of quarterly delinquent/compliance reports.

# RESIDENT/FELLOW EVALUATION OF RESIDENTS – Feedback and Evaluation:

# Faculty Evaluation of Residents and Fellows

# Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment

# Evaluation must be documented at the completion of the assignment

# For block rotations more than three months in duration, evaluation must be documented at least every three months.

# Continuity clinic and other longitudinal experiences in the context of other clinical responsibilities, must be evaluated at least every three months and at completion

# Clinical Competency Committee (CCC)

# The program director must appoint the A Clinical Competency Committee must be appointed by the program director.

# At a minimum the Clinical Competency Committee must include be composed of three (3) members of the program faculty, at least one of whom is a core faculty member.

# Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program’s residents/fellows. Others eligible for appointment to the committee include faculty from other programs and non-physician members of the healthcare team.

# The Clinical Competency Committee must: There must be a written description of the responsibilities of the Clinical Competency Committee that includes

# measuring/assessing the progress of each resident in collaboration with the program director by:

# Reviewing all resident/fellow evaluations at least semi-annually. Determine each resident’s/fellow’s progress on achievement of the specialty-specific Milestones Preparing Milestones evaluations of each resident/fellow semi-annually and ensuring that the evaluations are reported to ACGME

# Meet prior to the resident’s/fellow’s semi-annual evaluations and advise the program director regarding each resident’s/fellow’s progress. Advising the program director regarding resident progress, including promotion, remediation, and dismissal

# RESIDENT/FELLOW ASSESSMENT AND EVALUATION:

# Evaluation concerning performance and progression in the residency program shall be provided to the resident throughout the duration of the program. Assessments and evaluations will measure performance against curricular standards.

# One activity within a residency program is to identify deficiencies in a resident’s academic performance. This requires ongoing monitoring for early detection, before

# serious problems arise. The requirement is to provide the resident with notice of deficiencies and the opportunity to cure.

# The resident will be provided with a variety of supervisors, including clinical supervisors, resident trainers, and faculty advisors, with whom to discuss professional and personal concerns.

# Besides personal discussions, the resident will receive routine verbal feedback and periodic written evaluations on his or her performance and progress in the program. These measurements should highlight both positive performance and deficiencies.

# There must be an opportunity to review evaluations with supervisors and to attach a written response, preferably in the form of reflection and planning for improvement.

# At the end of each rotation, the resident will have an ACGME, competency-based, global assessment of performance for the period of assignment.

# The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation within 14 days of completion of the rotation/assignment.

# Evaluations must be immediately available for review by the resident. Resident notification of completed evaluations should be set up in New Innovations by requiring that residents sign off electronically on the evaluation.

# In addition to the global assessment evaluation by faculty members, multisource methods and evaluators will be used to provide an overall assessment of the resident’s competence and professionalism.

# The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones and must use multiple methods and evaluators to include:

# Narrative evaluations by faculty members and non-faculty evaluators

# Other professional staff member evaluations

# Clinical competency examinations

# In-service examinations

# Oral examinations

# Medical record reviews

# Peer evaluations

# Resident self-assessments

# Patient satisfaction surveys

# Direct observation evaluation

# 4.8.1 This information must be provided to the CCC for its synthesis of progressive resident/fellow performance and improvement toward unsupervised practice.

# Use multiple assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; progressive resident performance improvement appropriate to educational level must be documented.

# Non-cognitive skills and behaviors are observed and measured as an integral part of the evaluation process. Professionalism must be demonstrated, including the possession of a positive attitude and behavior along with moral and ethical qualities that can be objectively measured in an academic/clinical environment.

# A resident will be assigned supervisory and teaching responsibilities for medical students and junior residents as they progress through the program.

# Residents will be evaluated on both clinical and didactic performance by faculty, other residents, and medical students.

# Semi-Annual Evaluation—At least twice in each Post-Graduate Year, the residency/fellowship director or their designee, with input from the Clinical Competency Committee, must:

# Meet with and review with provide each resident/fellow their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones with a documented performance evaluation summary that incorporates input from the Clinical Competency Committee.

# Assist residents/fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and

# Develop plans for residents/fellows failing to progress, following institutional policies and procedures.

# Resident Progression Evaluation – At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program. Programs will need to implement annual evaluation. Residents must be evaluated annually on their readiness to progress to the next level of training.

# Documentation of these meetings, supervisory conferences, results of all resident evaluations, and examinations will remain in the resident’s permanent educational file and be accessible for review by the resident/fellow.

# Final Summative Evaluation (end of residency/fellowship)

# The program director must provide a summative final evaluation for each resident/fellow upon completion of the program.

# The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as one of the tools to ensure that residents and fellows are able to engage in autonomous practice core professional activities without supervision upon completion of the program.

# The final evaluation must:

# Become part of the resident’s/fellow’s permanent record maintained by the program with oversight of institution, and must be accessible for review by the resident/fellow in accordance with institutional policy;

# Document the resident’s performance during the final period of education; and,

# Verify that the resident/fellow has demonstrated sufficient competence the knowledge, skills, and behaviors necessary to enter autonomous practice without direct supervision. Programs will need to change in letter templates – tms

# Consider recommendations from the CCC

# Be shared with the resident/fellow upon completion of the program.

# **FACULTY EVALUATION OF FACULTY**:

# Faculty evaluations are performed annually by department chairs, in accordance with the faculty bylaws.

# The program director must have a process to evaluate each faculty member’s performance as it relates to the educational program at least annually and include a review of the faculty member’s clinical teaching abilities, commitment to engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance knowledge, professionalism, and scholarly activities.

# This evaluation must include written, anonymous, and confidential evaluations by the residents and fellows.

# Programs must not allow faculty members to view these individual evaluations by residents/fellows. These evaluations of faculty must be aggregated and made anonymous and provided to faculty members annually in a summary report. This summary may be released as necessary, with program director review and approval in instances where evaluations are required for faculty promotions.

# In order to maintain confidentiality of faculty performance evaluations, small programs with four or fewer residents/fellows may use one of the following:

# Generalize and group residents’ comments to avoid identifying specific resident feedback.

# Aggregate faculty performance evaluations across multiple academic years.

# Residents/Fellows must be given the opportunity to submit, at a minimum, annual written, anonymous, and confidential evaluations of faculty members.

# Program directors must maintain continuous and ongoing monitoring of faculty performance. This may include automated alerts regarding low evaluation scores on end-of-rotation evaluations by residents, regular surveillance of end-of-rotation evaluations, and regular verbal communication with residents regarding their experiences.

# Department chairs should be notified by the program director when faculty receive unsatisfactory evaluation scores. Faculty performance must be reviewed and discussed during the annual faculty evaluation review process conducted by the chair or division.

# Faculty members must receive feedback on their evaluations at least annually

# Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.

# **EVALUATION OF PROGRAM EVALUATION AND IMPROVEMENT**:

# Program directors must appoint the Program Evaluation Committee (PEC) to conduct and document the Annual Program Evaluation as part of the program’s continuous improvement process.

# The PEC must be composed of at least two core faculty members, at least one of whom is a core faculty member, and should include at least one resident/fellow.

# There must be a written description of the PEC responsibilities to must include:

# Acting as an advisor to the program director, through program oversight

# Review of the program’s self-determined goals and progress toward meeting them

# Guiding ongoing program improvement, including development of new goals, based upon outcomes

# Review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program’s mission and aims.

# Planning, developing, implementing, and evaluating educational activities of the program;

# Reviewing and making recommendation for revision of competency-based curriculum goals and objectives;

# Addressing areas of non-compliance with ACGME standards; and

# Reviewing the program at least annually using evaluation of faculty, residents, and others as specified below.

# The PEC should consider the following elements in its assessment of the program: The program, through the PEC, must annually document formal, systematic evaluation of the curriculum and render a written Annual Program Evaluation (APE) report. The program must monitor and track:

# Curriculum

# Outcomes from prior APEs

# ACGME LONs including citations, areas for improvement, and comments

# Quality and safety of patient care

# Aggregate resident and faculty:

# Well-being

# Recruitment and retention

# Workforce diversity

# Engagement in PSQI

# Scholarly activity

# ACGME Resident and Faculty Surveys and

# Written evaluations of the program (annual GME survey)

# Aggregate resident

# Achievement of the Milestones

# In-training examinations

# Board pass and certification rates

# Graduate performance

# Aggregate faculty

# Evaluation

# Professional development

# The PEC must evaluate the program’s mission and aims, strengths, areas for improvement, and threats

# The annual review, including the action plan must:

# Be distributed to and discussed with the members of the teaching faculty and the residents/fellows

# Be submitted to the DIO

# The program must complete a Self-Study prior to its 10-year accreditation site visit

# A summary of the self-study must be submitted to the DIO

# ACGME Board Pass Rate Requirements – Section V.C.3

# The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

# V.C.3.a - For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program’s aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

# V.C.3.b - For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program’s aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

# V.C.3.c - For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program’s aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

# V.C.3.d - For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program’s aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.

# V.C.3.e - For each of the exams referenced in V.C.3.a-d, any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.

# V.C.3.f - Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.

# Resident performance;

# Faculty development;

# Graduate performance, including board certification examination results;

# Program quality; and

# Progress on the previous year’s action plan(s).

# The program must also:

# Provide faculty and residents annual opportunities to provide confidential written evaluative input;

# Use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.

# The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above as well as delineate how they will be measured and monitored.

# The action plan should be reviewed and approved by the teaching faculty and documented in the meeting minutes.

# Program Evaluation Procedure

# In order to maintain confidentiality of resident and faculty evaluation of program, the GME office provides facilitation and support by generating a standard program evaluation survey delivered to faculty and residents by the GME office.

# Results are aggregated and available to the program to review during the annual program evaluation meeting.

# PH/PM Residency Program Evaluation Procedures

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 performance of members of the faculty, and the quality of the supervision of the residents.

### Initial Assessment

The written assessment of each incoming resident is accomplished in three ways:

* Completion of a preventive medicine milestones inventory form and interview,
* The faculty assessment of the in-coming resident, and
* The in-service examination (August).

Each resident is asked to complete a self-assessment of their competency in the preventive medicine milestones. The program director conducts a structured interview with each resident to discuss the completed assessment as well as the resident’s educational and career goals. A written educational plan is then developed and placed in the resident’s file. The resident receives a copy of that plan. Updates to the plan are made during the semiannual resident evaluation.

### Evaluations

Written evaluations of each resident will be completed by the preceptor at the end of each rotation or quarterly for longitudinal experiences through the New Innovations online residency management system. The evaluation form assesses the achievement of competency, skill, and knowledge of objectives. The resident and the preceptor should review the evaluation before it is submitted to the program office by the preceptor. The residency program director ensures that the appropriate forms are distributed, completed, and collected, and that exit meetings are held between the residents and the component area coordinators, if applicable. The residency program director also ensures that the evaluations are analyzed, summarized, and forwarded to the Clinical Competency Committee.

**Courses**

Course grades are provided by the faculty of the MPH Program. The resident and the program director will review the resident’s progress in the courses mid semester and at the end of each semester. Problems identified will be addressed to ensure appropriate progression. The program director is a member of the Student Academic Progress Committee of the MPH program.

## Evaluation Activities

Activities such as the seminar series, the community-based rotation, and the clinical duties at the homeless shelter will also be evaluated.

In the seminar series, an evaluation will be completed at the end of each lecture. Residents will evaluate the presenter. For mini courses during the seminar series the presenter will evaluate the residents in terms of participation, completion of assignments, achievement of competency, skill, and knowledge obtained.

Residents will also evaluate the rotation and the preceptor at the end of the rotation and submit the form to the program office.

## Milestones Documentation

Each resident must document which competency milestones have been achieved to submit to the program quarterly. The residents should describe specific activities (courses, practicum, clinical activities, conferences, etc.) and deliverables completed.

## Semiannual Evaluation

The residency program director evaluates each resident’s progress on a semiannual basis. The quarterly reports, submitted by residents and detailing progress in achieving the competencies, are used by the program director in conducting this evaluation. Residents are to bring the following documents: updated evaluations, MPH transcripts, and updated milestones documents.

## Annual Program Evaluation

The Residency Advisory Committee conducts ongoing evaluation of the residency program curriculum and administration. Residents evaluate their learning experiences on each rotation.

## Ongoing Resident Self-Evaluation

Residents must evaluate their own progress throughout the program by completion of the Milestones document and by measuring their own skill and experience against the competencies for public health/preventive medicine in general and for each component area.

# Public Health and Preventive Medicine Clinical Competency Committee Policies

### Policy

Per ACGME Common Program Requirement (V.A.l.), the PH/PM Residency Program has outlined the responsibilities of the Clinical Competency Committee (CCC). The Residency Clinical Competency Committee (CCC) is expected to monitor resident performance in accordance with ACGME Common Program Requirements and the Morehouse School of Medicine (MSM) Graduate Medical Education (GME) policies and procedures regarding promotion and dismissal. The purpose of the CCC is to review resident performance and to make recommendations to the program director for advancement to the next PGY level.

### Committee Composition

The program director has identified and appointed the members of the CCC. This includes four (4) to six (6) faculty members including representation from program affiliates and program graduates. The program director (PD) will be on the committee in a consultative manner to oversee the process. In addition, the associate residency program director will serve as a member. The chair of the PH/PM Residency CCC will be **Dr. Sherry Crump** for the **2018-2019 academic year**. The members will be appointed to the committee for a period of three (3) years.

### Committee Responsibilities

The PH/PM Residency Clinical Competency Committee will:

1. Perform a quarterly review of all resident evaluations as well as the resident’s learning portfolio, individual learning plan, and documented assessment by the resident’s program advisor—done by all evaluators.
2. Prepare and ensure the reporting of milestones evaluations of each resident semi-annually.
3. Make recommendations to the program director and associate program director (APD) for resident progress including promotion, remediation, and dismissal, following all GME policies as outlined in the MSM GME Policy Manual.

### Meeting Frequency

The PH/PM Residency CCC meets twice per year. The exact timing of the meeting may vary depending on the ACGME Milestone Reporting schedule. In addition, the PH/PM Residency CCC will agree to meet as necessary to discuss any urgent issues regarding resident performance.

### Meeting Documentation

The residency program manager will document each CCC meeting held. In addition, the CCC’sreview and recommendation of each resident will be documented in the online residency management system maintained by GME.

### Procedure

The CCC shall evaluate residents on a semiannual basis and provide consensus recommendation to the residency program director and the Residency Advisory Committee (RAC) using the Clinical Competency Committee Report Form as completed by the CCC chair.

The following evaluation measures will be used:

* MPH program transcripts
* Rotation evaluations (to include input from other providers and colleagues, when available (360 evaluations\*)
* Peer review evaluations\*
* Didactic evaluations
* Learning portfolios (to include resident milestone self-assessments and supporting documentation)
* Advisor feedback
* In-Service Exam scores
* Attendance records

The CCC can set thresholds for remediation, probation, and dismissal. The CCC will complete a CCC Recommendation Form for all residents who receive an adverse recommendation. The form for each resident will be sent to the PD and APD. The PD and APD will meet with each resident and communicate the recommendation and design an improvement plan.

### Recommendations

Upon review of each resident’s record, the CCC shall make the following recommendations to the PD and PD in accordance with MSM's Residency Promotion Policy and Adverse Academic Decisions:

* Progression—Resident is performing appropriately at current level of training with no need of remediation.
* Promotion—Resident has demonstrated performance appropriate to warrant move to the next level of training.
* Notice of Deficiency—Resident has demonstrated challenges in a specific competency or area but does not require remediation.
* Notice of Deficiency with Remediation—Resident has demonstrated challenges in a specific competency or area and requires remediation.
* Immediate Suspension—Serious misconduct or threat to colleagues, faculty, staff, or patients’ suspension time shall not exceed 30 days in an academic year. Action remains in permanent record.
* Probation—Resident has demonstrated challenges in a specific competency/area that are disruptive to the program; probation time shall notexceed six (6) months in an academic year. Action remains in permanent record.
* Non-Promotion—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. Resident's current level of training will be extended. Action remains in permanent record.
* Non-Renewal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. Resident’s current level of training will not be extended. Action remains in permanent record.
* Dismissal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. The resident will be dismissed from the program. Action remains in permanent record.

## Resident Evaluation of Faculty Procedures

Residents evaluate faculty at the end of each rotation through the online residency management system within one week of the end of the rotation. Residents also evaluate faculty during didactic lectures. The significant portion of the policy follows:

**V. EVALUATION OF FACULTY**:

**5.1.** Faculty evaluations are performed annually by department chairs in accordance with the faculty bylaws.

**5.2.** The program director must evaluate faculty performance as it relates to the educational program at least annually and include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

**5.3. Resident Evaluation of Faculty**—Residents must be given the opportunity to submit, at a minimum, annual written confidential evaluations of faculty.

**VI. EVALUATION OF PROGRAM**—**Program Evaluation and Improvement:**

**6.1.** Program directors must appoint the Program Evaluation Committee (PEC) to be composed of at least two core faculty members and should include at least one resident. There must be a written description of the PEC responsibilities to include:

**6.1.1.** Planning, developing, implementing, and evaluating educational activities of the program

**6.1.2.** Reviewing and making recommendation for revision of competency-based curriculum goals and objectives

**6.1.3.** Addressing areas of non-compliance with ACGME standards

**6.1.4.** Reviewing the program at least annually using evaluation of faculty, residents, and others as specified below

**6.2.** The program, through the PEC, must annually document formal, systematic evaluation of the curriculum and render a written Annual Program Evaluation (APE) report. The program must monitor and track:

**6.2.1.** Resident performance

**6.2.2.** Faculty development

**6.2.3.** Graduate performance, including board certification examination results

**6.2.4.** Program quality; and the program must:

**6.2.4.1.** Offer faculty and residents annual opportunities to provide confidential written evaluative input.

**6.2.4.2.** Use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.

**6.2.4.3.** Progress on the previous year’s action plan(s)

**6.3.** The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above as well as delineate how they will be measured and monitored.

**6.3.1.** The action plan should be reviewed and approved by the teaching faculty and documented in the meeting minutes.

**6.4.** Program Evaluation Procedure

**6.4.1.** In order to maintain confidentiality of resident and faculty evaluation of program, the GME office provides facilitation and support by generating a standard program evaluation survey delivered to faculty and residents by the GME office.

6.4.2. Results are aggregated and available to the program to review during the annual program evaluation meeting.

## Program Evaluation and Improvement Procedures

The PH/PM Residency Advisory Committee (RAC) also functions as the Program Education Committee (PEC) and must consist of faculty, external members, supervisors, and at least one resident representative, and must include the program director as an ex-officio member.

The RAC, in collaboration with the program director, shall review the Annual Program Evaluation prepared by the Program Evaluation Committee, any written plans of action to improve educational activities and progress reports on the previous year’s action plan(s), and provide recommendations to the Program Director to improve program quality during its yearly fall meeting.

* The RAC, in collaboration with the program director, shall at least annually, review any new or emerging information that might influence the content or conduct of the residency program during its yearly spring meeting.
* The RAC, in collaboration with the program director, shall at least annually, review:
  + The internal review of the residency program,
  + Resident evaluations of faculty and the program,
  + The program director’s evaluations of individual residents, and
  + Faculty evaluations of the program director and the program during its yearly spring meeting.
* The RAC chair shall assist the program director to provide the designated institutional official (DIO) an annual written report of the program’s qualitybetween June and August of each year.
* The RAC shall prepare an annual report summarizing RAC activities. This report will be prepared jointly by the program and the RAC Executive Committee between June and August of each year.

# Program Curriculum

Educational Program Requirements – New Policy effective June 1, 2019

Per ACGME Common Program Requirements Section IV. - accredited programs are expected to define their specific program aims consistent with the overall mission of their Sponsoring Institution, the needs of the community they serve and that their graduates will serve, and the distinctive capabilities of physicians it intends to graduate.

IV.A. All MSM GME programs’ curriculum must contain the following educational components:

1. A set of program aims consistent with the Sponsoring Institution’s mission, the needs of the community it serves, and the desired distinctive capabilities of it’s graduates;

a. The program’s aims must be made available to program applicants, residents/fellows, and faculty members.

2. Competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice.

a. These must be distributed, reviewed, and available to residents/fellows and faculty members.

3. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision.

4. A broad range of structured didactic activities

a. Residents/fellows must be provided with protected time to participate in core didactic activities

5. Advancement of residents’/fellows’ knowledge of ethical principles foundational to medical professionalism.

6. Advancement in the residents’/fellows’ knowledge of the basic principles of scientific inquiry, including how resident is designed, conducted, evaluated, explained to patients, and applied to patient care.

IV.B. ACGME Competencies – referenced and provided in detail previously near the beginning of this policy manual. Should we move the competencies here - tms?

IV.C. Curriculum Organization and Resident Experiences – MSM GME Programs must:

1. Ensure the program curriculum is structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity.

2. Provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of addiction.

IV.D. Scholarship

1. Program Responsibilities include:

a. Demonstrating evidence of scholarly activities consistent with its mission(s) and aims.

b. In partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities

c. Advancing residents’ knowledge and practice of the scholarly approach to evidence-based patient care.

2. Faculty Scholarly Activity (both core and non-core faculty) – programs must demonstrate accomplishments in at least three of the following domains:

a. Research in basic science, education, translational science, patient care, or population health

b. Peer-reviewed grants

c. Quality improvement and/or patient safety initiatives

d. Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports

e. Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials

f. Contribution to professional committees, educational organizations, or editorial boards

g. Innovations in education

h. All MSM GME Programs must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

i. Faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor

ii. Peer-reviewed publication

3. Resident/Fellow Scholarly Activity

a. Residents and Fellows must should participate in scholarship activity.

The GME DIO and GMEC will provide oversight of programs’ compliance with required educational components during the annual institutional and program review process and procedures.

All MSM GME programs are required to:

1. Annually track and document scholarly activity data for residents, fellows, and all faculty involved in teaching/advising/supervising including (both core and non-core faculty) as part of the Annual Program Evaluation (APE) process.

2. Document and implement program level scholarly requirements and guidelines that are distributed and reviewed with the residents, fellows, and faculty members on an annual basis.

## Preventive Medicine Milestones

“The milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The milestones provide a framework for assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.” (**The Preventive Medicine Milestone Project: Public Health and General Preventive Medicine, 2013**)

The acquisition of basic clinical competencies will require an ACGME accredited clinical year (12 months) with six (6) months of direct patient care*.* The following competencies must be obtained. The preventive medicine variation (adapted text in brackets) These competencies may also be acquired during academic and practicum training of the residency program and should be incorporated where applicable:

### Patient Care

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PC1:** Emergency Preparedness and Response:  Apply skills in emergency preparedness and response. | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Demonstrates basic skills in emergency medical care | * Demonstrates knowledge of triage concepts * Demonstrates basic knowledge of emergency preparedness programs | * Demonstrates and applies understanding of emergency preparedness programs | * Demonstrates the ability to develop and evaluate the medical portion of an emergency plan | * Provides leadership in developing, implementing, and evaluating emergency preparedness programs |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Health Systems, Environmental Health, Intro to Clinical PM/OM, Joint Operations/Humanitarian Assistance, Public Health Issues in Disasters, Field Epidemiology, PHEO Training Courses, **FEMA online training (**http://www.training.fema.gov**)**, EPA First Responders Course, EPA Management of Emergency Response Course, Medical Effects of Ionizing Radiation Course, Medical Management. of Chemical and Biological Casualties Course  Relevant Practicum Training: NCDMPH, County, PM Units, HAZMAT Responses and Hospital Disaster Response Exercises, **Table Top Exercises (Simulations)** | | | | |

Relevant Assessment Tools: MPH Transcripts for relevant courses; certificate documenting successful completion of relevant online and in person FEMA and EPA courses; feedback from evaluators of exercise/real world; PE from elective on Disaster Management (at FEMA, National Center for Disaster Management and Public Health, County Disaster Management office); **direct observation, medical reserve core evaluation**

Sample Evaluations to date:

1. GPA 3.7, no grades less than a B; included course on disaster management and two others with relevant sections (B, A, A)
2. FEMA online courses completed
3. Attended disaster management table-top exercise, preceptor recorded: full participation; gave 4/5 on feedback form
4. Attended disaster preparedness drill at the hospital: drill supervisor reported full participation; achieved 4.5 on skill set assessed
5. No disasters requiring real-world response occurred during PH rotation.

(Scored as \_\_\_\_ out of 5 points—range: 1-5)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PC2:** Community Health:  Monitor, diagnose, and investigate community health problems. | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Identifies common health issues in a community | * Identifies basic health status measures to assess/ investigate a community's health | * Selects and describes appropriate health status measures to assess a community’s health | * Monitors and interprets single health status indicator of the community | * Monitors and interprets multiple and/or complex health status indicators of the community |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Biostats, Epi, Health Systems, Environmental Health, Intro to Public Health, Intro to Clinical PM/OM, Field Epi, Program Planning and Development, Joint Operations/Humanitarian Assistance, Public Health Issues in Disasters, Field Epi, JC, Masters Thesis/Project, APTR’s C-POP exercises (<http://www.aptrweb.org/?CaseStudiesCPOP>)  Relevant Practicum Training: County, Surveillance Center, DPC, NCQA/HEDIS Metrics, Community Health Centers | | | | |

Relevant Assessment Tools: MPH Transcripts for relevant course(s), Masters Thesis/Project evaluations; specific feedback from County Health Department preceptor on performance during rotation and competency scoring for area on item from Preceptor Evaluation; DPC preceptor’s assessment of QI project completed in response to problematic process in clinic contributing to community health problem; **public health rotation evaluation, practical project, faculty evaluation**

Sample Evaluations/Assessments to date:

1. GPA 3.9, no grades less than a B; included course on Program Planning and Development (A) and Field Epi (B)
2. Specific feedback received from county preceptor extolling what a pleasure is was to work with the resident on ride-alongs for their rabies abatement and food inspection trips
3. Scored as at “Supervisory” competence for monitoring, diagnosing, and investigating community health problems on county rreceptor evaluation (PE)
4. PE: Scored at “Independent” competence for competency on DPC Preceptor’s evaluation after completion of QI project
5. PE: During evaluation of Health System (MHS, Kaiser, etc.) HEDIS metrics, resident noticed trend on multiple indicators tied to one process and suggested systems fix which could improve all metrics

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC3:** Inform and Educate:  Inform and educate populations about health threats and risks | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Conveys basic health information to individuals or small groups | * Identifies proper communication techniques related to health threats and risks | * Prepares and delivers a basic health hazard/risk presentation | * Conveys complex health information to educate a community or group and responds to queries about risk | * Conveys sensitive/ high-stakes health information to educate a community or group through a variety of media platforms |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Behavioral Health, Intro to PH, Intro to Clinical PM/OM, Intro to Clinical Preventive Services/Occ Health, Epi of Vaccine Preventable Diseases, Travel Medicine, Risk Comm (in person or online) (http://emergency.cdc.gov/cerc/CERConline/index.html), Masters Thesis/Project, JC  Relevant Practicum Training: DPC, Federal/State/County Public Health Departments, Surveillance Center, AHRQ/USPSTF, practicum presentations, national meeting posters/presentations, OSCEs, group visits, Travel Med Clinic, Immunization Clinic, lay public lectures, **Grand Rounds, Risk Comm project** | | | | |

Relevant Assessment Tools: Grades in Risk Comm and other relevant courses; specific preceptor evaluation and/or PD feedback regarding ability to communicate information on basic hazards (PSA, colorectal cancer, breast CA screening) to individuals (DPC) and groups (Journal Club) and more sensitive higher stakes health information to groups at risk (Measles/Influenza outbreak for County; Anthrax, TB, Foodborne Disease Outbreak, or other environmental exposures for other community groups), awards or other evaluation feedback from meetings, OSCE evaluations, clinic patient satisfaction surveys, peer review, **direct observation of Grand Rounds presentation (product in portfolio), evaluation of Risk Comm project**

Sample Evaluations/Assessments to date:

1. Earned an “A” in Risk Comm, B in Behavioral Health, passed Intro to Public Health, A in Intro to CPS/OH, passed Intro to Clinical PM/OM
2. Served as county spokesperson for relaying details to local TV stations and newspapers regarding measles outbreak
3. Worked with local (school, base, ship) to provide group briefings on recent LTBI outbreak to self-perceived “at risk” population
4. Presented high quality surveillance data project on topic of substantial interest to group of subject matter experts
5. Prepared evidence base to support decision making for County/USPSTF recommendation and defended rationales

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC4:** Policies and Plans:  Develop policies and plans to support individual and community health efforts | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Diagnoses disease and develops an individualized treatment plan | * Links individuals to needed personal health services including appropriate referrals and follow-ups | * Applies primary, secondary, and tertiary preventive approaches to disease prevention and health promotion for individuals or communities, with minimal supervision | * Applies primary, secondary, and tertiary preventive approaches to disease prevention and health promotion for the individuals and community | * Contributes to the development and/or implementation of a policy to improve community health efforts |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Epi I and II, Health Systems, Intro to PH, Intro to Clinical PM/OM, Intro to Clinical Preventive Services/Occ Health, Program Planning and Development (PPAD), Chronic Disease Epi, Risk Comm, JC  Relevant Practicum Training: DPC, Surveillance Center, SG Office, Medical Intelligence Center, Federal DHHS, ODPHP, AHRQ/USPSTF, NIOSH, CDC, DOL, OSHA, State/County PH Rotations, ACPM Policy Rotation, QI Projects, State Epi policy making agencies | | | | |

Relevant Assessment Tools: Grades in Epi I and II, Health Systems, Program Planning and Development, Risk Comm and other relevant courses; **PE feedback** from relevant practicum training, especially DPC, **County**, and State or DHHS rotations for all, **relevant work products produced during rotations demonstrating milestone achievement** (Example: Quality Improvement Projects at DPC sites), **direct observation of presentations, chart review, direct observation of patient care (e.g., mini-clinical evaluation exercise (CEX))**

Sample Evaluations/Assessments to date:

1. Grades in Epi I, II, Health Systems, PPAD, Risk Comm (A, B, B, A, A respectively)
2. PE from DPC rotations: functions competently in clinic with appropriate referrals; pleasure to work with
3. PD feedback: has demonstrated understanding of primary, secondary, and tertiary prevention in JC and applied appropriately in DPC activities
4. PE from county: recognizes how to apply prevention approaches on population (vs. just individual) level
5. PE from SG/State/National level rotations: provided evidence base for development and/or implementation of a specific health policy which could improve community health
6. Researched/drafted/edited/revised DoD/Service-specific/other government agency public health policy/instruction/memorandum/initiative

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC5:** Evaluating Health Services:  Evaluate population-based health services | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Recognizes distinctions between population and individual health services | * Describes basic measures of effect (e.g. risk ratio) * Describes basic measures of quality (e.g. benchmarking) * Lists populations known to be underserved (e.g. low income) | * Assesses evidence for effectiveness of a population-based health service * Uses scientific literature to identify a target population for a given population based health service * Uses scientific literature to identify barriers to delivery of population-based health service | * Uses program goals and/or established performance criteria to evaluate a population-based health service * Uses evaluation findings to recommend strategic or operational improvements * Uses data to identify barriers to population-based health services | * Develops program goals and/or performance criteria to evaluate a population-based health service |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Biostats I and II, Epi I and II, Health Systems, Intro to PH, Intro to Clinical PM/OM, Intro to Clinical Preventive Services/Occ Health, Program Planning and Development, Chronic Disease Epi, JC  Relevant Practicum Training: Surveillance Center, AHRQ/USPSTF, Medical Intelligence Center, Travel Clinic, County Rotations, ACPM, ODPHP, Other SG/DHHS/State Epi policy making agencies, VAMC, Systems analysis projects, **MPH project** | | | | |

Relevant Assessment Tools: Grades in Epi I and II, Biostats I and II, Health Systems, Program Planning and Development and other relevant courses, **PE feedback** from relevant practicum training**, especially county**, and state or DHHS rotations for all, relevant work products, **report of QI project, research**

Sample Evaluations/Assessments to date:

1. Grades in Epi I, II, Biostats I and II, Health Systems, PPAD (A, B, B, B, A, A respectively)
2. PD feedback: although passed Health Services, instructor noted didn’t engage much and group project barely passed
3. PD feedback: still primarily functioning as a primary care clinician, not understanding risk/benefits of service for populations
4. PE from county/DHHS/SG rotation: followed directions to do literature search for project
5. Chronic Dz Epi: had trouble describing how to evaluate success of program

(Scored as \_\_\_\_ out of 5range: 1-5

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| **PC6:** Descriptive Epidemiology:  Able to characterize the health of a community | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Identifies and recognizes basic measures of disease frequency (incidence, prevalence, mortality) and risk (risk ratios, odds ratios) | * Knows methods for calculating basic measures of disease frequency and risk | * For a defined population, uses data to calculate measures of disease frequency and one or more risk factors for a specified disease or condition | * Uses data to characterize the health of a local population, compares it with that of other populations, identifies localities or groups with poorer health, and identifies and assesses the importance of different risk factors, for at least one disease or condition | * Uses data to fully characterize the health of a population, compares it with that of other populations, identifies localities or groups with poorer health, and identifies and assesses the importance of different risk factors, for a range of diseases and conditions |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Epi I, II, III Biostats I, II, computer software training (SAS, SPSS, Stata, Epi Info, GIS), classic studies in Epi, Field Epi, Chronic Dz Epi and Control, Infectious Dz Epi and Control, Epi of Vaccine Preventable Dzs, Travel Medicine, Health Systems, Healthy People 2020 training (online or classroom), JC  Relevant Practicum Training: Surveillance Centers, Surgeon General Headquarters, HHS Rotations, County Health Department, AHRQ/USPSTF, MPH Thesis/Project and presentation, Wellness Clinic, Travel Medicine clinic, manuscript publications, College/Recruit health | | | | |

Relevant Assessment Tools: Grades in relevant courses, PEs in relevant practicum training, **in-service score, workshop exercise with assessment, written report/manuscript** **assessment**

Sample Evaluations/Assessments to date:

1. Grades in relevant courses (A, A, B, A, B, B, B)
2. Published spatial determinants of obesity article in International Journal of Obesity
3. PE from county: helped calculate TB prevalence in the county, compared it to state and national rates, and calculated ORs for foreign born and homeless populations—rated middle 50% of residents (“Pass”)
4. Scored at 55th percentile on in-service examination for Epi

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC7:** Analytic Epidemiology:  Able to design and conduct an epidemiologic study | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Distinguishes between experimental and observational studies | * Explains what is meant by validity, bias, confounding, and effect modification; describes commonly used study designs (e.g., RCT, cohort; case-control, cross-sectional); distinguishes between association and causation; lists criteria for causal inference | * Critically reviews and interprets epidemiologic literature for commonly used study designs, identifying purpose, population, design, and biases | * Able to design and conduct a basic epidemiological study (defines aims; selects appropriate study designs; collects, analyzes, and interprets data; identifies limitations; summarizes and discusses findings) | * Independently designs and conducts a complex epidemiological study that addresses confounding and effect modification analytically, suitable for peer-reviewed publication |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Epi I, II, III Biostats I, II, computer software training (SAS, SPSS, Stata, Epi Info, GIS), classic studies in Epi, Field Epi, Chronic Dz Epi and Control, Infectious Dz Epi and Control, JC  Relevant Practicum Training: Surveillance Centers, County Health Department, AHRQ/USPSTF, MPH project and presentation, manuscript publications | | | | |

Relevant Assessment Tools: Grades in relevant courses, PEs in relevant practicum training, in-service score, **direct observation, Journal Club** evaluations of critical appraisals, evaluations of **written report/manuscript**

Sample Evaluations/Assessments to date:

1. Grades in relevant courses (A, A, B, A, B, B, B)
2. MPH project described prevalence of and risk factors for atherosclerosis in defined population (earned a “B”)
3. Scored at 55th percentile on in-service examination for Epi
4. Publication in Annals of Epidemiology on the epidemiology of MS across the U.S.
5. Taught the PGY-2 class on the interpretation of NNT and NNH with exceptionally positive feedback

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC 8:** Disease Outbreak:  Investigate and respond to a cluster or outbreak. | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Understands that clusters or outbreaks occur * Identifies most common methods for preventing individual disease spread (e.g., hand hygiene) | * Understands common environmental, health, and behavioral risk factors associated with clusters or outbreaks occurring (e.g., congregate settings, immuno-compromised populations, and drug abuse) * Understands aspects of disease that predispose to outbreak development (e.g., high infectivity, subclinical phase) * Identifies most common methods for preventing disease spread in populations (e.g., quarantine, isolation) | * Recognizes sentinel event; uses surveillance, hospital, vital statistics, or other data to establish the existence of a cluster or outbreak * Establishes a case definition, including clinical and laboratory findings; participates in collection of demographic, clinical, and/or risk factor information from cases * Understands approaches for mitigating and responding to a cluster or outbreak | * Implements a plan to investigate and collects data to describe a cluster or outbreak * Characterizes and interprets data collected from a cluster or outbreak investigation * Applies a strategy or plan for management of an outbreak (e.g., limiting spread, mitigating effects) | * Designs a strategy to investigate a cluster or outbreak of a novel disease or atypical disease presentation * Leads a team to investigate and manages an outbreak including supervision of staff, assignment of roles, program design, monitoring of effectiveness, etc. |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Epi I, II, III Biostats I, II, computer software training (SAS, SPSS, Stata, Epi Info, GIS), Field Epi, Intro to Public Health; PHEO coursework, Epi of Vaccine Preventable Dzs, **CDC Module**.  Relevant Practicum Training: Surveillance Centers, County Health Department, DPC Rotations (Patient Safety/QI/Infection Control activities), College/Recruit health, other outbreak and contact investigations wherever they occur in real time, PHEO **tabletop exercises** | | | | |

Relevant Assessment Tools: Grades in relevant courses, PEs in relevant practicum training (**Public Health rotation PE**), **table top exercise evaluation, CDC module certificate of completion,** evaluation of QI/Patient Safety/Infection Control activities related to outbreaks

Sample Evaluations/Assessments to date:

1. Grades in relevant courses (A, A, A, B, A (Field Epi), A, P)
2. MPH project described MRSA outbreak and control measures in defined population over last two years (earned an “A”)
3. Hospital preceptor noted substantial work performed during STI contact tracing efforts in support of system-wide efforts to contact all contacts during recent syphilis outbreak
4. County preceptor noted effective engagement during recent Norovirus outbreak (rated “Independent” for competency)
5. Regularly attended patient safety committee meetings in hospital to determine if adverse events qualify as sentinel events initiating or propagating infectious disease outbreaks

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC9:** Surveillance Systems:  Design and operate a surveillance system | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Aware of the need to report selected diseases to public health authorities * Aware of the need for surveillance systems in a variety of settings (e.g., public health agencies, hospitals, clinics, nursing homes) | * Identifies commonly used surveillance data sources (e.g., BRFSS, vital statistics, hospital discharge data) and the conditions typically monitored using such systems * Recognizes difference between active and passive surveillance | * Thoroughly describes the components of an existing surveillance system (e.g., aims, stakeholders, data sources, quality, uses, etc.) * Develops a list of challenges in designing and maintaining a surveillance system | * Analyzes surveillance data to identify appropriate targets for individual, community, and/or systems interventions * Evaluates one or more aspects of the quality and effectiveness of a surveillance system (e.g., data completeness, ease of use, compliance) | * Independently designs and operates a new surveillance system |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Epi I, II, III, Health Systems, computer software training (SAS, SPSS, Stata, Epi Info, GIS), Field Epi, Intro to Public Health; PHEO coursework, PPAD , JC  Relevant Practicum Training: Surveillance Centers, County Health Department, DPC Rotations (Patient Safety/QI/Infection Control activities), College/Recruit Health, **MPH Project**, Establishment, evaluation of or analysis of specific surveillance tools (ESSENCE, Google Analytics for influenza, WNV surveillance systems) during rotation(s) | | | | |

Relevant Assessment Tools: Grades in relevant courses (**Advanced Epi**), PEs in relevant practicum training (**Public Health rotation PE**), evaluation of **project product—surveillance system design or analytics, workshop**

Sample Evaluations/Assessments to date:

1. Grades in relevant courses (A, A, A, B, A (Field Epi), A, P)
2. MPH project describing correlation of Google Analytics for influenza with ICD-9 captures for influenza (“Best in class”)
3. PE for Surveillance Center rotation indicates “high pass” (top 25%) and indicates mostly supervisory competency
4. County preceptor noted good understanding of rabies surveillance/control procedures

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC10:** Clinical Preventive Services:  Analyze evidence regarding the performance of proposed clinical preventive services for individuals and populations | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Locates and appraises evidence from a scientific study related to a patient’s health problem | * Leads a discussion with peers of the strengths and weaknesses of an individual study relevant to CPS | * Participates in the examination of evidence to address a proposed clinical preventive service | * Participates in the development or analysis of a guideline to address a proposed clinical preventive service | * Systematically examines scientific evidence and develops an evidence-based guideline to address a proposed clinical preventive service |
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| **Curriculum Components:**  Relevant Courses: Epi I, II, Health Systems, **CPS**, Intro to Public Health; Travel Medicine, Chronic Dz Epi and Control, Classic studies in Epi, PPAD , **JC**  Relevant Practicum Training: Surgeon General/DHHS HQ, ODPHP, AHRQ/USPSTF, County Health Dept, DPC Rotations (Wellness Clinics), MPH Project, **projects involving clinical guidelines or analysis of guideline** | | | | |

Relevant Assessment Tools: Grades in relevant courses (**CPM Course)**, evaluation of **project product—clinical guideline or analysis of guideline,** **leading JC on USPSTF guideline—direct observation with written assessment, case presentation evaluation**, PEs in relevant practicum training

Sample Evaluations/Assessments to date:

1. Grades in relevant courses (A, A, B, **B (CPS)**, P, P, P, A, B)
2. AHRQ rating on PE = “Independent” for relevant competency; “Pass” (middle 50%) on overall PE
3. DPC PGY-2 evaluatoins indicate satisfactory performance in wellness clinic
4. Presented JC Critical Appraisal of primary source article supporting USPSTF recommendation on screening smokers with LDCT for Lung CA (rating = 4.84 /5); representative comments: “Confident presentation style, great background info. Answered difficult questions quite well and tactfully.” “Comparing NNS of mammography colonoscopy and chest was excellent.”
5. County rotation rating on PE = “Independent” for relevant competency; “Pass” (middle 50%) on overall PE

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC11:** Conditions of Public Health Significance:  Implement appropriate clinical care for individuals with conditions of public health significance | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Obtains history and basic physical * Prescribes indicated medications | * Generates a differential diagnosis for a disease or condition of public health significance and proposes a treatment plan * Identifies diseases and conditions that require a public health response | * Accurately diagnoses and effectively treats common presentations of diseases/conditions of public health significance with direct supervision * Participates in an appropriate public health intervention for a disease or condition that requires a public health response | * Accurately diagnoses and effectively treats common presentations of diseases/conditions of public health significance * Initiates an appropriate public health intervention for a disease or condition that requires a public health response | * Accurately diagnoses and effectively treats complex conditions and unusual presentations of diseases/conditions of public health significance |
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| **Curriculum Components:**  Relevant Courses: Epi I, II, CPS, Intro to Public Health; Travel Medicine, Chronic Dz Epi and Control, Infectious Dz Epi and Control, Field Epi, classic studies in Epi, JC  Relevant Practicum Training: Surgeon General/DHHS HQ, AHRQ/USPSTF, **Public Health Rotation**, DPC Rotations (Wellness, Travel Med, STI, LTBI, Refugee Health, other clinical rotations) | | | | |

Relevant Assessment Tools: Grades in relevant courses, PEs in relevant practicum training (**Public Health Rotation**), **direct observation by clinical preceptor, chart review, OSCE, case log, mini-CEX, case presentation,** 360 Multisource assessments

Sample Evaluations/Assessments to date:

1. Grades in relevant courses (A, A, B, P, P, P, A, B)
2. AHRQ rating on PE = “Independent” for relevant competency; “Pass” (middle 50%) on overall PE
3. DPC PGY-2 evaluations indicate satisfactory performance in wellness clinic, travel med clinic and County Health STI, LTBI, Refugee Health clinics
4. PGY-3 County Rotation rating on PE = “Independent” for relevant competency; “Pass” (middle 50%) on overall PE
5. Average rating on mini-CEX = 7/9

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **PC12:** Preventive Services:  Select and provide appropriate evidence-based clinical preventive services | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Prescribes immunizations and chemoprophylaxis | * Identifies major risk factors of individual patients that would benefit from clinical preventive services (CPS) * Understands the recommenda-tions of the [U.S. Preventive Services Task Force](http://www.uspreventiveservicestaskforce.org/index.html) (USPSTF) | * Assesses relevant risks for disease and injury in individual patients and uses patient information, scientific evidence, USPSTF guidelines, and clinical judgment to select appropriate CPS for individual patients | * Comprehen-sively assesses risks for diseases and injuries, and appropriately applies USPSTF and other evidence-based guidelines regarding screening, counseling, preventive medications, and immunization to individual patients | * Comprehen-sively assesses risks for diseases and injuries and appropriately applies USPSTF and other evidence-based guidelines regarding clinical preventive services in individual patients with complex health or social conditions (e.g., hospitalized, homeless, or nursing home patients) |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Epi I, II, CPS, Intro to Public Health; Travel Medicine, Risk Comm, Chronic Dz Epi and Control, Infectious Dz Epi and Control, Epi of Vaccine Preventable Dzs, JC  Relevant Practicum Training: Surgeon General/DHHS HQ, AHRQ/USPSTF, Public Health Rotation, DPC Rotations (Wellness, Immunization, Smoking Cessation, and other clinical rotations), OSCE | | | | |

Relevant Assessment Tools: Grades and instructor comments from relevant courses, PEs from relevant practicum training, OSCEs, 360 Multisource assessments, **Chart review, mini-CEX, in-service exam, case presentation evaluation**

Sample Evaluations/Assessments to date:

1. OSCE done at commencement of residency: feedback included self-assessment, mock patient and faculty who reviewed the video: they said residency was pleasant, a good listener, and she included prevention in recommendations
2. Clinical rotations: feedback from preceptor on CEX: doesn’t specifically address competency but passes all parameters
3. Chart review: meets HEDIS benchmarks.
4. Case reports: includes USPSTF guidelines in report and recommendation
5. Preceptor evaluation: 4/5 on parameters included in six (6) core competency-based evaluation form
6. Patient survey: all very good; resident well liked by patients
7. 360 (nurses): nurses feel resident is a good communicator, and cares about patients

(Scored as \_\_\_\_ out of 5—range: 1-5)

### Medical Knowledge

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| **MK1:** Behavioral Health | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Lists major effects of individual behavior on health * Recognizes that social and behavioral factors influence population health | * Identifies social and behavioral factors that affect health of individuals * Identifies social and behavioral factors that affect health of populations | * Identifies best practice and tools to assess risk behaviors * Describes effective approaches to modify individual health behaviors * Describes effective approaches to modify population health behaviors * Identifies the causes of social and behavioral factors that affect health of populations | * Integrates best practices and tools to assess risk behaviors * Implements effective approaches to modify individual health behaviors * Integrates best practices and tools to assess population risk behaviors * Implements effective approaches to modify population health behaviors | * Develops and evaluates programs to change health behaviors of individuals |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Human Behavior, CPS, Chronic Dz Epi and Control, Motivation Interviewing course, Risk Comm, PPAD, Global Health, Medical AnthropologyRelevant Practicum Training: MPH Project, SG/DHHS HQ rotations, AHRQ/USPSTF, DPC (Wellness, Travel, STI, LTBI, Refugee, VAMC, Smoking Cessation clinic, other clinical) rotations, Public Health Rotation | | | | |

Relevant Assessment Tools: Grades in relevant courses, PEs in relevant practicum training**, simulation exercise results, in-service exam, course work product (e.g. papers, presentations, policy analysis)**

Sample Evaluations/Assessments to date:

1. Grades (B (Human Behavior), A, P, P, P, A, B, A)
2. Effectively integrated best practices/CPS guidelines into national policy for assessing/screening for suicide risk and helped develop training program to help change peer and supervisor responses to identified risks
3. Scored at the 55th percentile on the Chronic Dz Epi portion of the in-service examination
4. Full participation in two-day motivational interviewing course
5. MPH Project evaluated nationwide program for suicide prevention and evaluated effects, recommended approaches to modify population health behaviors
6. A+ on Behavioral Health group paper developing and evaluating intervention to reduce CVD through moderate alcohol consumption counseling
7. During Public Health Rotation, reviewed literature and drafted original manuscript evaluating health impact of community gardening, school-based garden programs, and public orchards for submission to peer-reviewed journal
8. Evaluations from clinical preceptors (and peer-reviews of clinical notes on smoking cessation/wellness visits/STIs, etc.) indicated that behavioral risk factors were being assessed and behavioral modification was being communicated to the patient.

(Scored as \_\_\_\_ out of 5—range: 1-5)

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| **MK2:**Environmental Health | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Identifies major routes of human exposure to environmental toxicants | * Identifies common illnesses that may be caused or influenced by environmental exposures * Identifies broad environmental factors that may impact the health of a community | * Describes individual factors that impact susceptibility to adverse health effects from environmental exposures * Identifies potential population health effects from exposure to chemical, physical, and biological hazards | * Recommends methods of reducing adverse environmental health effects for individuals * Identifies sources and routes of environmental exposures to chemical, physical, and biological hazards for defined populations | * Recommends, interprets, and explains the results of individual environmental monitoring * Interprets and explains population-level environmental monitoring results |
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| **Curriculum Components:**  Relevant Courses: Environmental Health, Clinical OM, Toxicology, Food Safety classes, Joint Operations/Humanitarian Assistance, Public Health Issues in Disasters, FEMA, **ATSDR**, PHEO, MEIR, MCBC, MRO, JC  Relevant Practicum Training: MPH project, Surveillance Center, Public Health Rotation, SG/DHHS HQ, NIOSH, OSHA, ATSDR, DPC (large industrial worksites, Aerospace Medicine, worker’s comp), Global Health (Int’l) Rotations, food and other facility safety inspections | | | | |

Relevant Assessment Tools: Grades in relevant courses, PEs in relevant practicum training**, simulation exercise results, in-service exam, course work product (e.g. papers, presentations, policy analysis), ATSDR online module certificate of completion**

Sample Evaluations/Assessments to date:

1. Grades (B (Env Health), A, B, A, B)
2. Completed ATSDR, FEMA, PHEO, MEIR, and MCBC courses (online and in-person)
3. MPH project analyzed the association of enclosed space work environments (submarines) with obesity
4. Accompanied industrial hygienist on trips to worksites to identify possible hazards and help formulate recommendations for reducing health effects
5. 65th percentile on OM component of in-service exam

(Scored as \_\_\_\_ out of 5—ange: 1-5)

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| **MK3:** Biostatistics | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Recognizes common statistical concepts (e.g., measures of central tendency,  p-values, and confidence intervals) | * Defines common statistical concepts (e.g., p-values and confidence intervals); describes frequently used statistical tests (e.g., paired and unpaired t-tests, chi-square tests, and others) | * Independently utilizes simple statistical methods (e.g., paired and unpaired t-tests, chi-square tests, and appropriate non-parametric tests) to describe small data sets * Participates in the use of statistical software to perform statistical tests * Understands more advanced statistical methods (e.g., linear and logistic regression) | * Selects appropriate methods for analyzing data * Performs data analyses using more advanced statistical methods (e.g., linear and logistic regression) * Utilizes appropriate software for data management and statistical analyses * Recognizes the need to use complex statistical analyses (e.g., survival analysis, repeated measures) | * Independently analyzes large data sets using complex statistical methods |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Biostats I, II, and III, Epi I, II, and III, **JC**, Research Course,  Relevant Practicum Training: Surveillance Center, Public Health Rotation, Research rotation, thesis / MPH Project, publications, **project report that includes statistical evaluation** | | | | |

Relevant Assessment Tools: Grades and instructor comments from relevant courses, PEs from relevant practicum training, **in-service exam**, evaluation of **project report** (could include MPH Thesis/Project) **that includes statistical evaluation, JC evaluation**

Sample Evaluations/Assessments to date:

1. Grades: A- in intro to biostats, B+ in advanced biostats
2. Thesis/Project: completed epi analysis of existing database of cases of pediatric tuberculosis in the local health region, utilizing primarily bivariate comparisons (compared proportions using chi squared test and Fisher’s exact test)
3. In-service Exam: was at the 60th percentile on in-service, with 50% percentile in Epi portion first year, and 65% second year
4. Manuscript: submitted manuscript of thesis, under review
5. Journal Club: reports are concise, requires some guidance in interpreting the results of some of the more complicated studies
6. Research PE: resident worked hard on thesis, struggled with SAS at first, but completed analysis with guidance

(Scored as \_\_\_\_ out of 5—range: 1-5)

### Professionalism

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PROF1:** Compassion, integrity, and respect for others as well as sensitivity and responsiveness to diverse patient populations including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation  Knowledge about, respect for, and adherence to the ethical principles relevant to the practice of medicine, remembering in particular that responsiveness to patients that supersedes self-interest is an essential aspect of medical practice | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Seeks out, learns from, and models the attitudes and behaviors of physicians who exemplify appropriate professional attitudes, values, and behaviors; includes caring, honesty, genuine interest in patients and families, and tolerance and acceptance of diverse individuals and groups * Aware of basic bioethical principles; identifies ethical issues in clinical situations | * Exhibits appropriate attitudes, values. and behaviors in straightforward situations; includes caring, honesty, genuine interest in patients and families, and tolerance and acceptance of diverse individuals and groups * Consistently recognizes ethical issues in practice * Discusses, analyzes, and manages in common clinical situations | * Exhibits appropriate attitudes, values, and behaviors in difficult situations; includes caring, honesty, genuine interest in patients and families, and tolerance and acceptance of diverse individuals and groups * Effectively analyzes and manages ethical issues in difficult clinical situations | * Balances ethical principles required for individual patient care with those needed for addressing population health * Consistently and effectively analyzes and manages ethical issues in both clinical and population medicine | * Develops organizational policies and education to support the application of these principles in the practice of individual and population based medicine |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Residency Orientation to the ACGME Core Competencies, Intro to Clinical PM/OM, Health Systems, Behavioral Sciences, Intro to Public Health, Global Health, Medical/PH Ethics Course, Online IRB (CITI) Ethics Training, Public Health Law JC  Relevant Practicum Training: DPC, county, potentially every professional situation, representative to Academic subcommittee for DIO’s determination of probation/termination for residents having problems | | | | |

Relevant Assessment Tools: ACGME Global Competency Assessment, grades in relevant courses, **360 degree evaluations**, **PEs,** semi-Annual evaluations, patient satisfaction evaluations, **self-assessment tools (matrix), mini-CEX, OSCE, workshops (e.g., Barry exercise), case study presentation, ethics JC participation,** patient satisfaction surveys, CITI Completion Certificate

Sample Evaluations/Assessments to date:

1. Semi-Annual evaluations continue to comment on occasional lapses in professionalism; ethics strong in individual care arena but fails to recognize and effectively reconcile actions with concomitant responsibilities to system/population health
2. PD observation from JC and other situations: occasional still relates ethnic/gender-based jokes in professional situations despite prior counseling on topic
3. Patient evaluations consistently strong; seems genuinely interested in and cares compassionately for all individual patients in both U.S. and developing country situations
4. PE from Public Health rotation noted “work was prompt, thorough, and of excellent quality”
5. Contributed to development of organizational policies for HIV screening which clearly demonstrated compassion, integrity, and respect for others
6. DIO reports resident’s work as representative to Academic subcommittee for determination of probation/termination for residents having problems demonstrates strong judgment and ethical sensibilities in challenging situations

(Scored as \_\_\_\_ out of 5—range: 1-5)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PROF2:** Accountability to patients, society, and the profession | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Recognizes limits of knowledge in most clinical situations * Understands importance of physician accountability * Aware of the basic causes of impairment in professionals such as fatigue and substance use | * Consistently recognizes limits of knowledge in common clinical situations and asks for assistance * Demonstrates physician accountability to individual patients in clinical situations * Identifies resources to address impairment of professionals | * Appropriately engages other members of the healthcare team * Demonstrates physician accountability to a patient population in clinical situations * Able to recognize impairment in themselves or other members of the healthcare team | * Consistently demonstrates the ability to identify limits of own knowledge and proactively incorporates the expertise of others from the healthcare team into clinical and population based practice * Demonstrates physician accountability to patients, society, and profession in the performance of clinical and population-based duties * Able to respond appropriately to impairment in members of the healthcare team | * Acts as a consultant for clinical and population health topics * Exemplifies ethical leadership in clinical and population based settings |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Residency orientation to the ACGME Core Competencies, Intro to Clinical PM/OM, Health Systems, Behavioral Sciences, Intro to Public Health, Medical/PH Ethics Course, Online IRB (CITI) Ethics Training, Public Health Law, JC  Relevant Practicum Training: DPC, county, potentially every professional situation, representative to Academic subcommittee for DIO’s determination of probation/termination for residents having problems, medical school applicant interviews, medical student teaching | | | | |

Relevant Assessment Tools: ACGME Global Competency Assessment, grades in relevant courses, **360 degree evaluations**, **PEs,** semi-Annual evaluations, patient satisfaction evaluations, s**Self-assessment tools (matrix), mini-CEX, OSCE, workshops (e.g., Barry exercise), case study presentation, ethics JC participation, certificate from online module for *Impaired Physician*, participates in professional/organizational committee,** patient satisfaction surveys, CITI completion certificate

Sample Evaluations/Assessments to date:

1. 360 nurses indicate that the resident is always late, did not respond to pages
2. Semi-annual evaluations and preceptor evaluations reflect consistently late to JC and other meetings during rotations
3. Completed self-assessment exercise and based on results asked for additional training
4. Global review indicates that the resident often goes beyond his or her skill level without asking for help
5. Peers consistently like resident and think (s)he is supportive; subordinates do not (often rude to junior residents and staff)
6. Facebook page shows inappropriate images/behavior
7. Regularly volunteers at free clinic

(Scored as \_\_\_\_ out of 5—range: 1-5)

### Interpersonal and Communication Skills

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ICS1:** Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; communicate effectively with physicians, other healthcare professionals and health-related agencies. Work effectively as a member or leader of a healthcare team or other professional group; act in a consultative role to other physicians and health professionals | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Recognizes the importance of effective communication with patients, families, and public * Recognizes the importance of effective communication with the healthcare team   Recognizes the importance of working with other members of the healthcare team | * Demonstrates effective communication with patients, families, or public in common situations * Demonstrates effective communication with the healthcare team in common situations * Works effectively with the healthcare team in common situations | * Demonstrates effective communication with patients or the public in issues related to confidential and/or highly sensitive medical information * Demonstrates effective communication with the healthcare team in clinical and population settings * Works effectively with the healthcare team in clinical and population settings | * Demonstrates effective communication with patients and the public in issues related to confidential and/or highly sensitive medical information using multiple communication modalities * Able to communicate effectively with the healthcare team in stressful situations/crises * Works effectively with the healthcare team in stressful situations/crisis | * Creates policy for effective communication of complex health information * Demonstrates effective communication outside of the local healthcare environment, such as state and federal agencies, regional healthcare systems * Understands the importance of working with diverse stakeholders outside of the local healthcare environment, such as state and federal agencies, regional healthcare systems |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Residency orientation to the ACGME Core Competencies, Risk Comm, Health Systems, Behavioral Health,JC  Relevant Practicum Training: Thesis/Project presentation, DPC, Public Health Rotation, end of rotation project presentations, potentially every professional situation, teaching fellow residents, teaching medical students, **participate in organizational/professional committee** | | | | |

Relevant Assessment Tools: Grades in relevant courses, **360 degree evaluations**, **PEs in relevant practicum training**, semi-annual evaluations, **patient satisfaction evaluations**, **direct observation of presentations**, **project presentation** **evaluations**, teaching evaluations, evaluations of **participation in organizational/professional committee**

Sample Evaluations/Assessments to date:

1. Gave a presentation to regional medical society; evaluations were 4/5
2. Preceptor/CEX: immediate feedback is that the resident did not understand minor consent and broke confidentiality to the parent
3. End of Rotation evaluation: at the end of stressful community meeting, the resident maintained good communication and remained calm
4. 360 in a research setting: patient ineligible and the resident informed the patient, coordinator reported that the resident handled it well
5. Preceptor evaluation: resident was uncomfortable and clearly embarrassed during patient visit that involved sensitive personal disclosures; resident handled feedback well
6. Patient Survey: patients said resident was knowledgeable but felt resident was “distant”

(Scored as \_\_\_\_ out of 5—eange: 1-5)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ICS2:** Maintain comprehensive, timely, and legible medical records, including electronic health records | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Recognizes the importance of maintaining timely and legible records, including EHR | * Maintains timely and legible records, including EHR | * Maintains complete, timely, and legible records, including EHR | * Consistently maintains complete, timely, and legible records, including EHR | * Develops a protocol for record maintenance |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Residency orientation to the ACGME Core Competencies, Risk Comm, Health Systems, Orientation session to EHR/DPC, JC  Relevant Practicum Training: DPC Rotations | | | | |

Relevant Assessment Tools: **PEs from DPC rotations, chart audit checklist**

Sample Evaluations/Assessments to date:

1. PE reports ~80% of patient encounters completed in EHR within 24 hours; 100% within 72 hours
2. Chart audit notes occasionally fail to document follow-up plans for needed CPS

(Scored as \_\_\_\_ out of 5—range: 1-5)

### Practice-based Learning and Improvement

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PBLI:** Identify strengths, deficiencies, and limits in one’s knowledge and expertise; set learning and improvement goals and identify and perform appropriate learning activities utilizing information technology, evidence from scientific studies and evaluation feedback; systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Acknowledges gaps in personal knowledge and expertise, and frequently asks for feedback. * Understands the importance of setting learning and improvement goals * Identifies problems in healthcare delivery and gaps in care | * Assesses professional performance in a structured manner * Begins to develop learning and improvement goals, based on feedback, with some external assistance * Uses information technology to locate scientific studies related to patient health problems * Understands the essentials of quality improvement | * Incorporates feedback and assessments into practice improvement * Develops learning and improvement goals, based on feedback, with minimal external assistance * Critically appraises scientific studies related to patient health problems * Defines and constructs process and outcomes measures of quality | * Assesses performance by incorporating feedback and assessments from multiple stakeholders (e.g. patients, members of the healthcare team, third-party payers) * Assimilates evidence from scientific studies into practice * Participates in a quality improvement project | * Creates novel ways to assess performance * Creates professional educational opportunities for others * Systematically designs and carries out quality improvement project in clinical and other health settings |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Health Systems I, II, Intro to PH, Intro to CPS/OM, classic studies in Epi, Chronic Dz Epi, JC  Relevant Practicum Training: Thesis/Project presentation, DPC (including clinic/hospital QA/QI projects and patient safety committee participation), Public Health Rotation, portfolio construction , self-evaluations, peer reviews | | | | |

Relevant Assessment Tools: Grades in relevant courses, **PEs from relevant practicum training**, thesis/project evaluations, **QI project** **report** evaluation, **self-assessments**, evaluation of portfolios, **360 evaluations**, **JC** evaluations, semi-annual evaluations

Sample Evaluations/Assessments to date:

1. Grades (B, A, P, A, B, B, P)
2. Most recent semi-annual evaluation reflects improved ability to recognize competency deficits (especially in SBP) and opportunities to address over last 2-3 rotations’ narrative summaries; substantial improvement over last semi-annual evaluation
3. Preceptor evaluation during Public Health Rotation specifically noted ability to recognize personal learning gaps and personal structuring of time to address
4. MPH project identified gaps in treatment of hospital personnel after needlestick injuries reflecting novel and systematically developed QI project (came in second in University-wide research competition)
5. Third critical appraisal of \_\_\_\_\_’s residency career presented recently demonstrated sophisticated growth and development in framing PBLI and PICO-based EBM answerable questions guiding personal practice regarding influenza vaccine administration

(Scored as \_\_\_\_ out of 5—range: 1-5)

### Systems-Based Practice

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SBP-1:** Work and coordinate patient care effectively in various healthcare delivery settings and systems | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| Recognizes various individual and population-based healthcare/ services delivery settings and systems | * Works and coordinates individual patient care in various healthcare delivery settings and systems | * Works and coordinates population-based health services in various health care delivery settings and systems | * Assess organizational performance of healthcare delivery system | * Interacts with other stakeholders to improve the performance of the system |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Health Systems I, II, Intro to PH, Intro to CPS/OM, Global Health, Joint Operations/Humanitarian Assistance, JC  Relevant Practicum Training: Thesis/project presentation, DPC (including clinic/hospital QA/**QI projects** and **patient safety committee** **participation**), **Public Health Rotation**, Systems Analysis projects | | | | |

Relevant Assessment Tools: Grades in relevant courses, PEs from relevant practicum training (**DPC, Public Health Rotation**), thesis/project evaluations, **QI project** **report** evaluation, systems analysis project evaluations, evaluation of **participation in patient safety committee**

Sample Evaluations/Assessments to date:

1. Grades (B, A, P, A, B, B, P)
2. Patient Safety Committee evaluation: participated in root cause analysis through discussion (provided resident perspective) but did no analysis. Appropriate for resident in first six months of training
3. Course certificate: attended a two-lecture series on quality improvement (PDSA cycle)
4. QI project: designing QI project, not yet started
5. Worked and coordinated individual care in wellness and occupational clinics
6. Worked and coordinated individual care in International Health setting, exchanging knowledge and expertise regarding population health management in system very different from U.S. system in order to improve system performance in both

(Scored as \_\_\_\_ out of 5—range: 1-5)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SBP-2:** Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care, as appropriate | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Recognizes the importance of cost awareness and risk-benefit analysis in patient and/or population-based care | * Identifies risks, benefits, and costs for a preventive service in an individual clinical patient | * Demonstrates sound judgment relating to risks, benefits, and costs for a preventive service in an individual clinical patient | * Demonstrates sound judgment relating to risks, benefits, and costs for a preventive service for a population | * Articulates and weighs the costs, benefits, and risks of a proposed population-based service |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Epi I, II, Health Systems I, II, Intro to PH, Intro to CPS/OM, Chronic Disease Epi, JC  Relevant Practicum Training: DHHS/SG HQ, AHRQ, Public Health Department, DPC, thesis/project presentation | | | | |

Relevant Assessment Tools: Grades in relevant courses, **PEs from relevant practicum training**, evaluation of **JC presentation, chart review, practical project**, evaluation of thesis/project presentation

Sample Evaluations/Assessments to date:

1. Grades in relevant courses (B, B, A, B, A, P, P)
2. Preceptor evaluation noted good judgment regarding cost effectiveness on antibiotic choices for patients in Travel Med clinic
3. Critical appraisal in JC on USPSTF recommendation regarding mammogram screening addresses costs/benefits of service (4.9/5.0)
4. Full attendance and participation at County Public Health Advisory committee meetings regarding budgeting priorities noted in preceptor evaluation
5. Worked and coordinated individual care in wellness and occupational clinics

(Scored as \_\_\_\_ out of 5—range: 1-5)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SBP-3:** Work in inter-professional teams to enhance patient safety and improve patient care quality; advocate for quality patient care and optimal patient care systems; participate in identifying system errors and implementing potential systems solutions | | | | |
| Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
| * Recognizes the importance of advocating for quality care and optimal patient care systems   Recognizes that medical errors and healthcare system failures are a significant cause or morbidity | * Advocates for quality care and optimal individual patient care systems * Recognizes and reports errors and near-misses | * Advocates for quality care and optimal population-based care systems * Recognizes potential sources of system failure in healthcare systems such as minor, major, and sentinel events | * Consistently advocates for quality care and optimal individual and population care systems * Participates in a team-based approach to make system changes | * Develops or leads a team to evaluate a system error and improve processes |
|  | | | | |
| **Curriculum Components:**  Relevant Courses: Health Systems I, II, Intro to PH, JC  Relevant Practicum Training: Thesis/project presentation, DPC (including **patient safety committees participation** in hospitals/clinics), Public Health Rotation, SG HQ, HHS HQ, AHRQ, ODPHP, **Quality Improvement projects**, Systems Analysis projects | | | | |

Relevant Assessment Tools: Grades in relevant courses, PEs from DPC and Public Health rotations, thesis/project evaluations, QI project evaluation, systems analysis project evaluations, evaluation of **participation in patient safety committee, 360 evaluations**, evaluation of **QI project report**.

Sample Evaluations/Assessments to date:

1. Grades: (A, A,P, P)
2. Patient Safety Committee evaluation: participated in root cause analysis through discussion (provided resident perspective) but did no analysis; appropriate for resident in first six months of training
3. Course certificate: attended a two-lecture series on quality improvement (PDSA cycle)
4. QI project: designing QI project, not yet started
5. Case report evaluation: presented a case report to other residents identifying a system error

(Scored as \_\_\_\_ out of 5—range: 1-5)

# Rotation Objectives

Each Preventive Medicine resident participates in the following rotations. The rotations are structured around competencies and milestones.

## Epidemiology

*Site: CDC, Georgia Department of Public Health*

Epidemiologic expertise in the Division of Public Health, DHR, is focused in the Office of Epidemiology which coordinates and offers consultation in epidemiology for most of the operating units of the division. The office provides guidance and staff resources not only for state-level programs but also for field investigations and consultation at district and local health unit levels. A skilled staff of epidemiologists, biostatisticians, and related experts conduct epidemiologic investigations and the research that accompanies them.

## Competencies in Epidemiology

1. Design and conduct an epidemiological study including:

* Descriptive or analytical methods
* Approval of state epidemiologist supervisor and/or program director with concurrence of another supervisor

1. Design/operate/evaluate a surveillance system of a disease of public health importance, or of community health needs and health services including:

* Appropriate case definition and identification of appropriate data sources
* Use of appropriate data collection tools
* Analysis and use of data gathered
* Assessment of potential biases and possible effects on conclusions
* Evaluation based on CDC guidelines
* A written report to interested parties that includes rationale, legal basis, data collection instrument, source of data, reporting party, frequency, and mechanism of communicating information, and expected result of reporting

1. Demonstrate knowledge of methods and their limitations in assessing community health needs and evaluating services including:

* Realistic assessment of funding and personnel implications
* Identification of appropriate evaluation techniques

1. Demonstrate knowledge of value and limitations of appropriate epidemiological and statistical methods as applied to describing a health problem and its impact, evaluating literature, and analyzing a data set. Attainment of this competency will be evidenced by a written report that includes:

* Studying a problem:
  + A thorough description of a problem and its public health impact
  + Identification of sources of data relevant to the problem
* Assessment of possible methods of prevention or control and the impact ofeach intervention
* Evaluating literature:
  + Identification of strengths and weaknesses of a selected research article
  + Appropriate distinction between basic epidemiological and biostatistical tools used in data interpretation
  + Appropriate distinction between the significance of a result and its importance in interpretation
* Analyzing a data set:
  + Development of testable hypothesis and analysis plan
  + Identification and documentation of data set characteristics
  + Use of an appropriate statistical test with a description of strengths and limitations of test results of analysis, including relevance and limitations of findings

1. Translate epidemiologic findings into a recommendation for interventions to address public health problems. Recommendation includes:

* Critical review of literature on specific preventive medicine/public health issue
* Identification and interpretation of data on which findings were based
* Application of epidemiologic principles
* Identification of operational limitations and realities
* Development of practical intervention strategies
* Presentation of findings to decision makers

1. Design and/or conduct an outbreak/cluster investigation that includes:

* Use of correct sequence for conducting the investigation
* Verification of cases and identification of possible agent and vehicle responsible
* Development of hypothesis
* Accurate confirmation that outbreak exits
* Interpretation of distribution of cases according to person, time, and place
* Accurate identification of mode of transmission, composition of rate, computation of attack rate, and identification of vehicle of transmission
* Correct identification of other populations who may be at risk
* Knowledge of different study designs, including cross-sectional, case control, and cohort studies
* Use of a study method to test the hypothesis after examining the advantages and disadvantages of the method to be used
* Data summary at least on a 2x2 chart
* Identification of possible confounding factors and effect modifiers
* Interpretation of results found
* Correct distinction between association and causation.

1. Evaluate scientific literature in which epidemiology and biostatistics are crucial to interpretation including:

* Identification of relevant literature
* Identification of strengths and weaknesses of a selected research article
* Ability to distinguish between basic epidemiological and biostatistical tools used in data interpretation
* Ability to distinguish between the significance of a result and its importance in interpretation

1. Teach a beginning course in the principles of field investigations using the fundamental tools of epidemiology and biostatistics that reflects:

* Knowledge of the components of field investigations
* Knowledge of ethical, legal, and epidemiological concerns in using data
* Source of teaching materials is identified
* Needed supported materials are collected and prepared for selected topic
* Skills in leading group discussion
* Skills in delivering lecture
* Use of an appropriate evaluation tool

1. Design and conduct health and clinical outcomes studies

Health Administration and Management

Sites: Atlanta Veteran’s Administration Healthcare; Clayton Board of Health; Morehouse School of Medicine

This rotation provides exposure to an array of health administration services required for comprehensive public health programming. These include programs for personal health services, planning, quality assessment, personnel and fiscal management, and management of healthcare institutions. A coordinator experienced in administration with access to these areas directs resident training in health services administration. Morehouse preventive medicine residents contribute their skills in clinical applications of preventive medicine as part of the health administration practicum.

## Health Administration and Management Objectives

* Participate in formulating government health-related policy. Participation includes:
  + Service on policy committee
  + Attendance at committee meetings
  + Demonstrated understanding of basic public health laws and state regulations as they affect this policy
* Assess unmet needs and capacities by health status of a population.Assessment consists of:

*:*

* + List of available sources of data, data desirable to acquire, and/or proposed new systems of data
  + Written plan that integrates needed information based on these data sources and suggests priorities with supporting explanation
* Design a community intervention program and/or project. Projects include:
  + Needs assessment and strategies for involving funding sources
  + Plan to engage stockholders, advocacy groups
  + Develop policies and plans to support individual and community health efforts
  + Evaluation plan with measurable milestones
  + Basis in accepted guidelines for involving the community
* Demonstrate practical management skills in an office setting. Demonstration consists of:
  + Effective conflict resolution
  + Delegation of responsibility
  + Accountability
  + Customer relations
  + Time management skills
  + Staff development
  + Understanding of grievance process
* Demonstrate knowledge of human relations and management styles. Demonstration includes:
  + Self-assessment of interpersonal and management style, including strengths and weaknesses
  + Presentation of an episode of mismanagement witnessed during residency, and appropriate diagnosis of the problem based on an accepted theory of management
* Demonstrate knowledge of management information systems. Demonstration reflects:
  + Ability to design and use management information systems
  + Ability to plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems

# Clinical Preventive Medicine

*Sites: Community Advanced Practice Nurses, Inc.; Veteran’s Administration; Mercy Healthcare; Healing Center, Inc.; Grady Outpatient Clinics*

Because the MSM program focuses specifically on public health practice and community preventive medicine, the practical application of disease control and prevention strategies is especially important. This rotation addresses community health services, family health services, resources for prevention programs in maternal and child health, nutrition, genetic screening, health risk analysis, non-infectious and infectious disease, dental health, immunization, and rehabilitation. In addition, the Morehouse School of Medicine Department of Community Health and Preventive Medicine collaborates in a variety of family and community-related health care activities. Through these varied county-level and MSM programs, residents have rich opportunities to gain experience in the clinical applications of preventive medicine.

## Clinical Preventive Medicine Objectives

* Develop community-based programs that mobilize community partnerships to identify and solve health problems. Develop and mobilize reflects:
  + Correct utilization of an appropriate model for community development
  + Assessment of community problems
  + Correct identification of community partners and development of coalition/partnership
  + Identification of essential problem in the community for partnership intervention
  + Design and implementation of community intervention
* Develop and refine screening programs for groups and individuals to identify risks for disease or injury and opportunities to promote wellness. Development or refinement reflects:
  + Correct identification of primary, secondary and tertiary preventive approaches to individual and population-based disease prevention and health promotion
  + Correct identification of risk factors for leading causes of death for target groupsAssessment of the clinical basis for the screening tool
  + Program is appropriate for population at risk
* Implement screening programs for groups and individuals. Program reflects:
  + Application of Clinical Preventive Medicine Task Force guidelines and other recognized guidelines
  + Application of lifestyle intervention program that incorporates a health risk appraisal (HRA)
* Evaluate individual, community-based, and population-based interventions to modify or eliminate risks for disease and promote wellness. Evaluation reflects:
  + Assessment of the screening tool
  + Recommendations based on findings and scientific literature
  + Characterization of the population to identify target conditions and effective interventions
  + Ability to monitor personal prevention programs in organized practice settings
  + Development of maintenance procedures that can improve the prevention program in this practice setting
* Diagnose and manage disease/injuries/conditions of significance within public health/general preventive medicine. Diagnosing and managing reflect:
  + Identification of diseases/injuries/conditions of significance within the specific preventive medicine practice area
  + Knowledge of modifiable risk factors
  + Identification of a clinical problem that could be managed better in infectious disease, maternal/child health, nutrition, gerontology, or rehabilitation
  + Implementation of a solution to the problem identified

# Environmental/Occupational Health

*Sites: Caduceus Occupational Medicine Clinics, Agency for Toxic Substances and Disease Registry*

The Environmental Health Section of local health departments is comprised of units dedicated to Environmental Services, Food Services, Occupational Health, Institutional Health, and School Engineering. In addition to inspections, consultations, and investigations, the Environmental Health Section is noted for its training courses, broadly aimed at improving professional and public understanding of important environmental health issues. Moreover, the Environmental Health Section carries out many of the efforts of the Divisions of Public Health for injury control and on behalf of the disabled and the handicapped.

## Environmental/Occupational Health Objectives

* Perform a patient history with particular attention to occupational and environmental factors. History reflects:
  + Environmental issues relating to patient’s age (e.g., childhood or elderly injury), housing, asbestos, lead, sanitation addressed
  + Relevant workplace stresses and hazards addressed
  + Environmental stresses linked with violence addressed as appropriate
  + Appropriate lab tests ordered and appropriate recommendations made
* Conduct a worksite inspection, using appropriate checklist;interpret findings and make recommendations. Interpretation includes:
  + Occupational hazards correctly identified, and ways to minimize these conditions suggested
  + Correct assessment of responsibilities of OSHA and NIOSH and of jurisdiction of state and local agencies related to environmental health
* Order appropriate tests and studies to assess the risk to a community potentially exposed to toxic waste. Interpret results, make recommendations, and communicate these to the community and the media. Interpretation includes major threats to air, water, and food safety in urban and rural Georgia and approaches to alleviating these threats identified.
* Identify relevant environmental factors in review of morbidity and mortality reports. Review includes association with environmental health conditions such as air, water, food, sewage, toxic waste, solid waste, acid rain, metals, chemicals, heat, cold, radiation, noise vibration correctly identified.
* Identify relevant laws and regulations that protect health and ensure safety.

# Longitudinal Social/Cultural/Behavioral Rotation

*Sites: Greenforest Baptist Church, St. Anthony of Padua Catholic Church, and Lutheran of Atonement Church (proposed)*

The Morehouse School of Medicine Department of Community Health and Preventive Medicine offers comprehensive instruction and experience with the vital elements of behavior, personal and community that influence health, health promotion, and disease prevention.

**Goals, Objectives, and Resident Responsibilities**

One of the primary training objectives for the MSM PH/PMR is to train residents to collaborate with community-based organizations to achieve positive health outcomes through the completion of a health needs assessment and an intervention. The PH/PMR is structured to allow residents to complete a longitudinal, community-based, service-learning project with a faith-based organization during the two-year residency training program.

**Goals of the LCHR:**

* Train residents to establish effective community partnerships.
* Impact health outcomes through the related health promotion and education activities.

**Rotation Objectives:**

***By the end of the two year rotation, residents will have the knowledge and skills to:***

* Establish and maintain relationships with community site preceptors, and work collaboratively with the community in conducting health promotion projects.
* Complete a health assessment of a community.
* Design, implement, and evaluate a health promotion intervention in a community.
* Carry out a health assessment and a health promotion intervention in a culturally sensitive, ethical and professional manner.
* Plan and manage the human, time, and financial resources of a project.
* Analyze and interpret the results of a health assessment and of a health promotion intervention evaluation.
* Translate health assessment and intervention evaluation results into education, systems, policy, and research recommendations.
* Present health assessment results, health promotion intervention evaluation results, and recommendations to the community in written and verbal format.

**Resident Responsibilities:**

* Collaborate with the community site preceptor and community members in all aspects of working in the community, including the planning and implementation of the health assessment, health promotion intervention, and the intervention evaluation.
* Complete a learning contract in conjunction with the community site preceptor at the beginning of the rotation.
* Contact the community site preceptor to schedule an initial meeting and tour of the site.
* Conduct a windshield survey of the area surrounding the community site.
* Conduct at least 5 key informant interviews of community members and other individuals familiar with the community.
* By the end of year 1 of the rotation, plan and implement a health assessment by means of focus groups and/or a survey.
* Analyze and interpret health assessment results, and provide an oral presentation of findings and recommendations to the community.
* By the end of year 2, plan and implement a health promotion intervention based on the assessment findings from year 1, and evaluate the intervention.
* Analyze and interpret health promotion intervention results, and provide a written presentation of findings and recommendations to the community.
* Submit written deliverables to the LCHR Coordinator as specified in the LCHR Rotation Timeline (see sample of LCHR Rotation Timeline in Appendix C - pending).
* Maintain regular contact with the community site preceptor, the Residency Program Manager (Mrs. Carla Durham-Walker), and the LCHR Coordinator (Dr. Sherry R. Crump) throughout the two year rotation period.

# Special Project

Sites: Varies

The Special Studies and Major Area of Concentration rotations are elective rotations designed to provide additional time toward the MPH thesis work and to allow the resident the opportunity to pursue further study beyond the regular rotations. Therefore, objectives for these rotations will be set by the resident with his or her preceptor and advisor, and with the approval of the residency director.

A wide variety of resources and facilities at both the sponsoring and collaborating institutions is available for resident research or other special projects.

**Coordination:** Special Project directors are selected by the residency director after the resident, through discussion and counsel, has identified a suitable special project. A preceptor is chosen from the faculty and staff of a sponsoring or collaborating institution who is best able to guide the resident in a project that augments his or her overall practicum.

# Major Area of Concentration

Sites: Varies

The six week rotation devoted to major area of concentration allows the resident to undertake further study in one of the five core areas of public health: epidemiology/biostatistics, health administration and management, clinical preventive medicine, occupational and environmental health, and social/culturally/behavioral aspects of public health.

Residents may select a coordinator from any of the sponsoring or collaborating institutions who is qualified and interested in assisting with the rotation. A work plan for a project in the major area must be developed and submitted to the Program Office within the second week of the rotation. The work plan must have prior approval by the coordinator, and the final report must be submitted to the Program Office.

# Health Policy and Advocacy Rotation

Rationale

Physician leaders have a duty to advocate for their patients, especially for those individuals who are

unable to advocate for themselves.1 However, medical students and residents get limited formal training

in leadership, policy or advocacy.2 Advocacy training provides learners with the knowledge, skills and

relationships necessary to develop as leaders and improve health at the individual and population levels

by addressing social determinants of health and engaging in the policymaking process.3 The Health

Policy and Advocacy elective rotation will be offered to Morehouse School of Medicine fourth year

medical students and residents. The goal of the rotation is to provide learners with knowledge of the

policymaking process and the leadership skills needed to develop meaningful community partnerships

and to inform policies to improve the health of their patients and communities.

Course Logistics & Structure

This rotation will be offered as an elective for 10-12 medical students and residents per rotation. During

this 4-week course students will learn about the policymaking process, community engagement and

leadership from course faculty and experts in the field, including legislators, lobbyists, community

organizations and policy organizations. This course will be offered in the spring (Jan-March) to coincide

with the Georgia legislative session. Course participants will work with their local community

(continuity clinic or community medicine community) to identify issues that can be addressed by policy.

They will track relevant bills, analyze these bills for their impact on the community and reflect on their

role in advocacy to advance health equity. To complete the rotation, students will present their policy

analyses to their communities, peers and faculty.

Course Description for Handbook

While medical students are trained and prepared with the necessary clinical and professional skills,

there are few opportunities for training in health policy. Understanding how health policy is developed

and implemented is important to physician leadership development. Aligned with Morehouse School of

Medicine’s vision to lead in the creation and advancement of health policy, the goal of this elective is to

expose medical students to the intersection of health policy and health equity and prepare them for

leadership roles advocating for policies that advance health equity.

Required Readings

Dobson S, Voyer S, Regehr G. Perspective: agency and activism: rethinking health advocacy in the

medical profession. Acad Med. 2012 Sep;87(9):1161-4. doi: 10.1097/ACM.0b013e3182621c25. PubMed

PMID: 22836842.

Earnest MA, Wong SL, Federico SG. Perspective: Physician Advocacy: What is it and How do we do it?

Acad. Med. 2010 Jan;85(1):63-67.

1  American Medical Association. Declaration of professional responsibility: medicine’s social contract with

humanity. https://www.cms.org/uploads/Declaration-of-Professional-Responsibility.pdf.

2  Freeman J. (2014). Advocacy by Physicians for Patients and for Social Change. Virtual Mentor  16(9):722-25.

Available at http://journalofethics.ama-assn.org/2014/09/jdsc1-1409.html.

3  Dobson S, Voyer S, Regehr G. Perspective: agency and activism: rethinking health advocacy in the medical

profession. Acad Med. 2012 Sep;87(9):1161-4. doi: 10.1097/ACM.0b013e3182621c25. PubMed PMID: 22836842.

Health Policy and Advocacy Elective Rotation – September 2017

Freeman J. Advocacy by physicians for patients and for social change. Virtual Mentor. 2014 Sep

1;16(9):722-5. doi: 10.1001/virtualmentor.2014.16.09.jdsc1-1409. PubMed PMID: 25216311.

Henize AW, Beck AF, Klein MD, Adams M, Kahn RS. A Road Map to Address the Social Determinants of

Health Through Community Collaboration. Pediatrics. 2015 Oct;136(4):e993-1001. doi:

10.1542/peds.2015-0549. PubMed PMID: 26391941.

Pettignano R, Bliss LR, Caley SB, McLaren S. Can access to a medical-legal partnership benefit patients

with asthma who live in an urban community? J Health Care Poor Underserved. 2013 May;24(2):706-17.

doi: 10.1353/hpu.2013.0055. PubMed PMID: 23728038.

Nelson, A. R., Stith, A. Y., & Smedley, B. D. (Eds.). (2002). Unequal treatment: confronting racial and

ethnic disparities in health care (full printed version). National Academies Press.

Berwick D. Moral Choices for Today’s Physician. JAMA. 2017;318(21):2081-2082.

Learning Objectives

By the end of the course, students will be able to:

• Describe the policymaking process from planning to implementation to evaluation, including opportunities for advocacy;

• Identify community and practice-level factors that need to be addressed in order to maximize community health and advance health equity;

• Promote leadership among medical students in health policy and health equity via experiential learning and mentorship;

• Analyze a piece of legislation for its impact on health, especially with regard to underserved and vulnerable populations;

• Inform policy stakeholders, including legislators, patients, communities and other health professionals of the impact of policies on health and/or the need for policies to improve health; and

• Discuss policy priorities and impacts with community members, policymakers and organizations.

Course Faculty

Co-Course Director – Megan Douglas

Co-Course Director – Starla Hairston Blanks

Core Faculty – Glenda Wrenn, MD

Core Faculty – Kisha Holden, PhD

Guest Lecturer – Makia Powers, MD

Guest Lecturer – Jay Berkelhamer, MD

Guest Lecturer – Sylvia Caley, JD, RN

Course Community Partners

The community partners contribute in many different ways, including conducting formal advocacy

trainings, meeting with students, conducting didactic sessions and providing resources. Each year we try

Health Policy and Advocacy Elective Rotation – September 2017

to add community partners based on the students’ interests. The following community partners have

been involved in the rotation in the past, but this list is subject to change for future rotations.

• Mothers & Others for Clean Air

• American Academy of Pediatrics (AAP) – Georgia Chapter

• Leadership Education in Neurodevelopmental Disabilities

• Health Law Partnership (HeLP)

• Prevent Child Abuse Georgia

• Voices for Georgia’s Children

• AID Atlanta

• Georgia Council on Developmental Disabilities

• Georgia Department of Public Health (future partner)

• Georgia Department of Community Health (future partner)

• The Health Initiative (future partner)

• ROSE – Reaching Our Sisters Everywhere (future partner)

• SisterLove (future partner)

Schedule

The following schedule provides the ideal placement for all course activities. However, due to the highly variable legislative and community partner calendars, the schedule is subject (and likely) to change. Students are expected to remain flexible throughout the rotation to accommodate these changes.

Students should contact the course director within 2 weeks of elective start date to schedule orientation and to schedule weekly mentoring sessions. Didactics will take place in the National Center for Primary Care.

Weeks 1 & 2: Didactics & Introduction to the legislative process.

• Didactics:

o Orientation

o Policymaking Process (legislative, regulatory, judicial, organizational)

o Introduction to Health Policy

o Intersection of Health Equity and Policy

o Policy Analysis – legis.ga.gov

o Community Collaboration

o Community Mapping & Policy

o Effective Communication

o Addressing Social Determinants of Health through Policy

o Principles of health leadership

• Capitol Tour

• Lobbyist shadowing (specific to discipline – AAP, AAFP, DPH, MAG, etc.)

• Media Training

• Advocacy Training

Weeks 2 & 3: Community Organizations, Legislative Days & Final Presentation

Health Policy and Advocacy Elective Rotation – September 2017

• Participation in a legislative day at the Capitol

• Meeting with legislator(s) – their own elected officials, representing their communities and/or

sponsors of bills of interest

• 2-3 meetings with community organizations (1 specific to discipline)

o GA-LEND – hypothetical case studies

• 1-2 meetings with government agencies and/or policy organizations

o DPH

o DCH

Week 4: Community Dissemination

• Presentation of policy issues to the community and strategic planning on how to inform the

policy process and implement legislative changes in the community

Course Deliverables

• Community Mapping – policy integration/solutions proposed – 25%

• Policy Analysis – 15%

• Advocacy “Scavenger Hunt” – 5%

• Advocacy writing – LTE, blog post, editorial, reflective journal – 20%

• Legislator discussion – 10%

• Final presentation – 15 minutes, policy analysis and/or community mapping – 25%

Course Policies

This rotation is unique in that most of the activities occur outside the clinic and/or classroom in locations

across the Atlanta metro area. Carpooling is encouraged and any transportation issues should be

discussed with the course directors prior to the first day so that alternative solutions can be sought. The

course calendar, including locations and contact information, is provided on the first day of the rotation.

The calendar is subject (and likely) to change due to the nature of the legislative session and community

partner availability. Students should refrain from scheduling other activities during “open” periods on

the calendar, in case changes are necessary once the rotation has begun. Students are expected to

attend all activities. Two absences are permitted during the 4-week rotation. Absences and late arrivals

should be communicated to the course directors as soon as possible.

Many activities take place at the Georgia Capitol, which has strict security policies that students should

be aware of. Valid identification is required to enter the Capitol and all visitors must go through a metal

detector. No weapons are allowed, including pepper spray/mace. Days at the Capitol are long, so

comfortable shoes are recommended. Bags will get heavy, so feel free to leave your laptop at home.

Parking and entrance to the Capitol can take some time to navigate, so please account for this in

planning.

# Health Equity Elective Rotation

(Description coming soon)

|  |  |  |
| --- | --- | --- |
| Training Sites | Contact | Rotations Completed |
| **Georgia Department of Public Health** | Ms. Yvette Daniels | Epidemiology; Major Area of Concentration; Special Studies; Special Studies; Major Area of Concentration; Health Administration |
| **American Cancer Society** | Ms. Debbie Kirkland | Epidemiology; Health Administration; Social/Cultural/Behavioral Aspects of Medicine; Special Studies; Major Area of Concentration |
| **Centers for Disease Control and Prevention**  **Agency for Toxic Substances and Disease Registry** | Dr. Alex Crosby  Dr. Mona Saraiya  (Others by arrangement)  Dr. Jewel Crawford  Ms. Debra Joseph | Social/Cultural/Behavioral Aspects of Medicine; Special Studies; Major Area of Concentration  Environmental Health |
| **Caduceus Occupational Medicine Centers** | Dr. Stephen Dawkins  Dr. Alton Green | Occupational Medicine Special Studies |
| **Morehouse School of Medicine** | Prevention Research Center  Research Unit  Satcher Health Leadership Institute | Health Administration and Management; Clinical Preventive Medicine; Special Studies; Major Area of Concentration; Health Policy & Advocacy Rotation |
| **Veteran’s Administration Community-Based Outpatient Clinics** | Dr. Anne Tomolo | Health Management/Patient Safety/Quality Improvement |
| **Community Advanced Practice Nurses, Inc.** | Nrs. Connie Buchanan | Clinical Preventive Medicine |
| **Greenforest Baptist Church**  **St. Anthony of Padua Catholic Church** | Ms. Gwendolyn Black  Ms. Theresa Rogers | Longitudinal Social/Cultural/Behavioral Rotation |
| **The Atrium @ College Town** | Ms. Cheryl Knight | Clinical Preventive Medicine  Clinical Preventive Medicine II |
| **Grady East Point Clinic** | Dr. John Hunter | Clinical Preventive Medicine |

# Away Rotations

Residents may spend a maximum of two (2) months away from the program to pursue learning experiences at other agencies/institutions. Some rotations are available through the Association of Teachers of Preventive Medicine (ATPM) or the American College of Preventive Medicine (ACPM).

Residents can design this rotation under the guidance and supervision of the program director (see the checklist below). Many residents choose to travel to another country during this time.

The programes do not provide funding for rotations completed outside the designated program sites.

**Away ROTATION APPROVAL CHECKLIST**

Resident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preceptor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Rotation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Competencies to be Completed (please attach)

Dates of Rotation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRECEPTOR**

Credentials of Preceptor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Affiliation Agreement (please attach)

Proof of off-site living arrangements (please attach)

Proof of travel arrangements (please attach travel approval form)

Source of financial support (please provide letter)

**CONTACT INFORMATION**

Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Journal Club Schedule 2019-2020

**Journal Club Presenter** **Article Submission for Approval**  **Presentation Date**

Jeremy Aguinaldo, MD, MPH August 9, 2019 September 6, 2019

Tramaine Wilkinson, MD October 4, 2019 November 1, 2019

Resident TBN January 10, 2020 February 7, 2020

Resident TBN March 6, 2020 April 17, 2020

**Residents will present Journal Club on the dates listed above, unless otherwise noted. Residents completing the Cancer Prevention and Control track should present articles with a cancer focus.**

The journal articles must be submitted to faculty for approval at least **three weeks prior** to the scheduled presentation. Once the article is approved, residents should disseminate the article to program faculty and residents prior to the presentation dates above. If for any reason Journal Club is cancelled, the scheduled presentation will take place the following month. **Please note the Journal Club assessment rubric on P. 151 of this handbook**.

**Suggested Journals (Other Journals May be Used)**:

American Journal of Public Health

American Journal of Preventive Medicine

Journal of Cancer Epidemiology

Journal of the American Medical Assoc.

# Program Contact Information

Please see the New Innovations Personnel Directory for Faculty and Staff Contact Information

# 

# Forms

**Public Health and Preventive Medicine Residency Program**

## Learning Contract

**Instructions:** The preceptor and resident should complete, sign, and return to the program office **no later than the first week of the rotation**.

|  |  |
| --- | --- |
| Rotation Name: |  |
| Resident: |  |
| Preceptor: |  |
| Dates: |  |

**Competencies to be met:**

*This section should list the specific core and subject area competencies that will be met during the rotation.*

**Core/Milestones Competencies (List each competency and describe how it will be met during rotation)**

|  |  |
| --- | --- |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6. |  |

**Program Goals and Objectives:**

*List the specific goals and objectives of the project*

|  |  |
| --- | --- |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6. |  |

**Specific Strategies:**

*List the ways in which both the competency-based objectives and the program objectives will be met*

|  |
| --- |
|  |

**Resident’s Goals and Objectives:**

*List learning/educational goals and objectives*

|  |
| --- |
|  |

**Oral Communication Requirements (Please describe)**:

*Examples: meetings, speaking engagements, lectures*

|  |
| --- |
|  |

**Written Communication Requirements (Please describe)**:

*Examples: Reports, summaries, educational materials, and other written deliverables*

|  |
| --- |
|  |

**Time Limitations:**

*List proposed schedule here. Include any scheduled clinics, vacation, conferences, and other program obligations.*

Weekly: Ex. **Longitudinal Social/Cultural/Behavioral Rotation (Insert Day)**

**Clinic (Fridays, 8:00 a.m. – 12:00 p.m.)**

**Residency Didactics (Fridays, 1:00 p.m. – 5:00 p.m.)**

\*Other: **Ex. Vacation (include dates)**

**Conferences and other activities (include specific name of activity and dates)**

**Evaluation Process** Preceptors should provide both formative and summative feedback to residents. Preceptors and residents should contact the PH/PM Residency Program Manager via e-mail or phone with any questions or concerns. The final evaluation is to be completed online through the New Innovations Residency Management system.

|  |  |
| --- | --- |
|  | |
| 1. Resident Signature | Date |

|  |  |
| --- | --- |
|  | |
| 1. Preceptor Signature | Date |

|  |  |
| --- | --- |
|  | |
| 1. Program Director/Associate Director’s Signature | Date |

**Journal Article Critique Form**

Please use the below form as a guide for developing your Journal Club presentation.

|  |  |
| --- | --- |
| **Background**  • What is currently known about the topic being examined?  • Why was the study done (what question did it examine)? |  |
| **Hypothesis**  • If an analytic study, what is the hypothesis that is being tested? |  |
| **Objectives**  • What are the objectives of the study? |  |
| **Methods - Design**  • What type of study was done?  • Primary research (experiment, randomized controlled trial, other controlled clinical trial, cohort study, case control study, cross sectional survey, longitudinal survey, case report, or case series)?  • Secondary research (simple overview, systematic review, meta-analysis, decision analysis, guideline development, economic analysis)?  • If a "randomized trial" was randomization truly random? |  |
| **Methods - Setting**  • What is the setting in which the subjects were studied (e.g. inpatient, outpatient, community hospital, teaching hospital, university)?  • If a clinical investigation, was the study conducted in "real life" circumstances? |  |
| **Methods - Subjects**  • Who is the study about?  • How were subjects recruited?  • Who was included in and who was excluded from the study? |  |
| **Methods – Intervention**  • What intervention or other maneuver was being considered? |  |
|  |  |
| **Methods – Outcomes**  • What outcome(s) were measured and how?  • Was assessment of outcome (or, in a case-control study, allocation of cases) "blind"?  · Was follow-up complete? |  |
| **Methods – Statistics**  • What sort of data do the authors have?  • What types of statistical tests were used and were they appropriate to the data type?  • Have the data been analyzed according to the original study protocol? |  |
| **Results**  • Were the groups similar at the start of the trial?  • Aside from the experimental intervention, were the groups treated equally?  • What are the key results? |  |
| **Conclusions**  • Do the results support the original study hypothesis?  • What are the strengths and weaknesses of the study |  |
| **Discussion**  • Will the results help me in caring for my patients/community/population?  • Can the results be applied to my patients/community/population?  • Will the results lead directly to applying the study?  • Are the results useful for reassuring or counseling my patients/community/population?  • Was there any potential bias? What is its impact on the study? |  |

## Residency Travel Checklist

Please follow the above steps for all MSM-sponsored travel (both local and out-of-town meetings, conferences, and other residency-sponsored rotations/activities). Please note that per the MSM Finance Policy, reimbursements are not allowed.

|  |
| --- |
| **Travel Preparation (at least two months prior to travel)** |
| * Complete conference/meeting registration and forward copy to Program Office. * Complete room reservations and forward an electronic copy to Program Office. * Inform preceptors/instructors of conference plans. * Forward travel preferences (i.e. seat assignment, time preference, and airport parking request) to Program Office. * Enter Administrative Leave request in the Kronos System. |

|  |
| --- |
| **2-5 days prior to travel** |
| * Pick up travel advance from Finance Office or Program Office * Remind Preceptors/Instructors of conference travel. * Make arrangements for coverage of any academic/administrative/practicum responsibilities during absence |

|  |
| --- |
| Allowable Expenses |
| * Round-trip baggage fees (I checked bag limit) * Conference Registration * Lodging for duration of conference * Meals * Major Transportation (Air Fare, Train, Mileage for Personal Vehicle; one/trip) * Ground Transportation (Taxi, Bus, Subway, Shuttle, Uber/Lyft) * Miscellaneous Fees (See MSM Travel Policy) |

|  |
| --- |
| ***Program Travel Responsibilities*** |
| * The Program Office will procure major transportation fare for the resident. * The Program Office will submit and track the processing of resident travel requests. * The Program Office will submit and track the processing of resident travel expenses reports. |

|  |
| --- |
| ***Resident Post-Travel Responsibilities (3-7 seven days after trip)*** |
| * Residents are to submit all transportation, parking, lodging, registration, baggage, and miscellaneous receipts to the program office. |



# ACGME Program Requirements for Graduate Medical Education in Preventive Medicine

Please visit the following links to the ACGME Common and Specialty requirements.

[ACGME Common Program Requirements](https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf) (effective July 2019)

[ACGME Preventive Medicine Specialty Requirements](https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/380-Preventive_Medicine_2019.pdf?ver=2018-08-21-130637-697) (effective July 2019)