West Virginia University
School of Medicine

Occupational Medicine Residency Program

A Handbook for Residents

Revised March 2016
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Introduction/Overview

There is no specialty of medicine as diverse as occupational health. This is at once the greatest strength and weakness of the field. On the plus side, practitioners can choose from a wide variety of areas and settings to accommodate their specific interests. You will never meet two occupational health specialists with the same professional activities.

From a training perspective however, this diversity appears bewildering to the newcomer. Furthermore, it also means that a residency program must incorporate diverse experiences, many outside of the traditional health care system. The traditional apprenticeship model fails us, since you cannot learn all you need to know by following one or even several practitioners.

Our two-year program tries to offer as wide a spectrum as possible given the constraints of time and geography. It is important to note that no two residents have ever had exactly the same set of rotations. We strongly encourage all trainees to be active in identifying experiences specific to their own interests.

The first year of the program, the academic year, is mainly devoted to completion of the requirements for the Master of Public Health (MPH) degree. This is a busy year, since a degree normally taken in two years will be compressed into one. Additional experiences in this year include our clinic, didactics, journal club, board review and grand rounds.

In the second, or practicum year, residents have a variety of rotations to choose from.

This handbook is designed to acquaint residents, faculty and preceptors with the components of the training program. Residents are expected to become familiar with the policies and procedures within, especially those related to the clinical, research and corporate assignments of the practicum.
Facilities

WVU Medicine is West Virginia University’s affiliated health system. Through its eight hospitals, three institutes, and more than 800 physicians, specialists, and sub-specialists, WVU Medicine provides comprehensive healthcare services to all of West Virginia, Southeast Ohio, Western Maryland, and Southwest Pennsylvania.

Occupational Medicine has administrative offices on the third floor of the Health Sciences Center South. Office space, including telephone access and computer facilities are provided for each resident within the Department. Faculty offices and a library are also included in the Department’s quarters.

Occupational Medicine uses the clinical facilities of the Health Education Building (HEB) and the Physician’s Office Center (POC). These areas consist of clinical examination rooms, staff and reception area. Residents are provided appropriate space at these locations.

All of the library facilities of the West Virginia University School of Medicine are available for residents. Residents have ready-access to specialty-specific and other appropriate reference material in print and electronic form. Electronic medical literature databases with search capabilities are available. Extensive collections are available at the department level in the resident library as well as from the director and faculty of the department.

WVU Medicine

WVU Medicine, a tertiary care teaching hospital and referral center, includes Ruby Memorial Hospital, WVU Medicine Children’s, WVU Cancer Institute, WVU Heart Institute, Berkeley Medical Center, Camden Clark Medical Center, Garrett Regional Medical Center, Jefferson Medical Center, Potomac Valley Hospital, St. Joseph’s Hospital, United Hospital Center, Camden Clark Physicians, United Physicians, University Health Associates, University Healthcare Physicians and WVU Physicians of Charleston.

Trainees participate through consultations to other services. A unique aspect of this is the opportunity to participate in the care of adults and children with lead poisoning. Trainees also help create and implement policies that protect hospital employees from workplace hazards.

http://wvumedicine.org/about/

Ruby Memorial Hospital

Ruby Memorial Hospital, the largest facility in the WVU Hospitals family, provides the most advanced level of care available to the citizens of West Virginia and bordering states. Our staff consists of highly-trained, dedicated professionals who are trained in the latest techniques and technologies – and are also skilled in the art of caring.
WVU Medicine Children’s

WVU Medicine Children’s provides the highest standard of specialty care available only at academic medical centers around the country. WVU Medicine Children’s is:

- The only hospital in WV with a pediatric cardiac surgery program
- The only epilepsy monitoring unit in the state equipped to serve children
- (as part of WVU Hospitals) the only hospital in the state to receive MAGNET status for nursing excellence. Only 5% of hospitals in the country have received this designation

WVU Cancer Institute

The WVU Cancer Institute is the state’s premier cancer facility with a national reputation of excellence in cancer treatment, prevention, and research.

Our flagship location, the Mary Babb Randolph Cancer Center, is in Morgantown on the WVU Health Sciences campus, located just steps away from Ruby Memorial Hospital.

The WVU Cancer Institute also includes the Betty Puskar Breast Care Center – an American College of Radiology (ACR) designated Breast Imaging Center of Excellence.

Jon Michael Moore Trauma Center

West Virginia University’s Jon Michael Moore Trauma Center (JMMTC) in Morgantown, West Virginia, is the region’s only American College of Surgeons nationally-verified Level 1 trauma center.

We care for more than 3,000 trauma patients annually, from all parts of West Virginia and from Ohio, Pennsylvania and Maryland. While some patients arrive directly from the scene of the injury, others are treated initially at another health care facility and then transferred to the JMMTC for specialized trauma care.

We offer the full range of trauma care, from pre-hospital teaching and guidance of emergency medical technicians, paramedics and flight teams, to collaboration with surgical subspecialists, to co-management of cases with the surgical intensive care unit.

The hospital's social and rehabilitation services help to coordinate the care of patients when they are ready to leave the acute care hospital, whether they are heading home, to rehabilitation or to skilled nursing.

Our center was created in the 1980s with the assistance and support of U.S. Senator Robert C. Byrd, and is named for his grandson, Jon Michael Moore, who died as the result of an automobile crash.

Chestnut Ridge Hospital

Chestnut Ridge Hospital is a leading regional referral center for treatment of mental health illness and addiction for adults, adolescents, and children. Our programs provide a continuum of care through outpatient, partial hospitalization, inpatient, and residential treatment services.
Patients benefit from Chestnut Ridge Hospital’s intensive approach, which is tailored to each individual’s needs. Quality of care is ensured by the staff’s professional skills and expertise in treatment, teaching, and research. The multidisciplinary team of psychiatrists, psychologists, social workers, nurses, rehabilitation therapists, mental health specialist, dieticians, and educators provide comprehensive care. Additionally the adjunct modalities of art, recreation, and experiential therapy are incorporated into the treatment programs.

**Physician’s Office Center**

The Physician Office Center (POC) adjacent to Ruby Memorial Hospital, houses the largest multi-specialty group practice in West Virginia. WVU Hospitals also provides routine laboratory, electrocardiogram, and radiology procedures in the POC. A Diagnostic Center serves patients who need minor diagnostic procedures.

**WVU Urgent Care**

WVU Urgent Care combines world class care with same day convenience.

WVU Urgent Care is a walk-in clinic that provides a complete range of medical treatment for minor illness and injury. Cases seen are those that need immediate attention but aren’t life-threatening conditions that require an emergency room visit. Appointments are not necessary.

**WVU Sports Medicine Center**

West Virginia University's Sports Medicine Center cares for athletes of all levels, from weekend warriors to competitive college team members. Our physicians manage sports-related injuries and medical conditions that include muscle and joint pain, sprains, and concussions. We also treat and help manage illnesses such as asthma and diabetes that can affect performance.

As part of the WVU Healthcare family, the WVU Sports Medicine Center has access to specialists from multiple disciplines, including orthopaedics and experts from the WVU Spine center.

**WVU Sleep Evaluation Center**

WVU Sleep Evaluation Center provides services that identify and treat sleep-related disorders.

Testing for all types of sleep disorders is conducted by experienced technologists, who are trained in preparing patients for and conducting technically correct sleep studies. The study results are interpreted by doctors experienced in treating sleep disorders.

**Rosenbaum Family House**

The Rosenbaum Family House provides a warm, family-oriented environment for outpatients and guests.

Family House offers programs designed to provide spiritual and emotional support. For many families facing a medical crisis, this is as important as having an affordable place to stay. Over 30 volunteers
and community organizations offer meals, support groups, prayer services, music therapy and other activities that make Rosenbaum Family House a home away from home.

**University Town Centre is home for:**

- Clark K. Sleeth Family Medicine Center
- Dermatology
- Podiatry
- Pediatric and Adolescent Practice
- Obstetrics and Gynecology

**Charleston Division**

The Charleston Division clinical campus provides an educational setting for West Virginia University’s medical, nursing, pharmacy, and dentistry students and is dedicated to seeing that excellence is maintained in many programs and the departments that support them.

We are fortunate to be a clinical campus of the larger Health Sciences Center institution in Morgantown, and to have the partnership of the Charleston Area Medical Center, our sponsoring / teaching hospital. CAMC not only partners with us in the areas of patient care and medical education, they also provide assistance in regard to our research effort to form a network of excellence.

We are also fortunate to be the host location for the [WV Poison Center](http://www.cdc.gov/niosh/contact/im-dsr.html).

**Eastern Division**

The Eastern Division of the WVU Robert C. Byrd Health Sciences Center provides community-based education in the health sciences in the nine-county, Eastern Panhandle of West Virginia -- Jefferson, Berkeley, Morgan, Hampshire, Mineral, Hardy, Grant, Pendleton, and Tucker counties. Our mission is to provide WV residents the opportunity to receive a broad-based professions education. The Eastern Division of the WVU Health Sciences Center provides direct clinical experience to third- and fourth-year medical students.

**National Institute for Occupational Safety and Health**

The NIOSH facility sits on the original 4.6 acres of land just beside the West Virginia University medical campus. The name Appalachian Laboratory for Occupational Safety and Health (ALOSH) is now rarely used, and the sign outside the facility says CDC/NIOSH. From a staff of 20, NIOSH/Morgantown has grown to approximately 600 employees reflecting a steady increase of responsibilities.

Division of Safety Research (DSR) continues to serve as the focal point for the Institute’s traumatic occupational injury research program. [http://www.cdc.gov/niosh/contact/im-dsr.html](http://www.cdc.gov/niosh/contact/im-dsr.html)

Division of Respiratory Health Division (RHD) continues to provide national and international leadership toward the identification, evaluation and prevention of occupational respiratory diseases. [http://www.cdc.gov/niosh/contact/im-drds.html](http://www.cdc.gov/niosh/contact/im-drds.html)
Health Effects Laboratory Division (HELD) continues to focus on establishing the causes of occupational disease and injury and to contribute to the development of valid strategies of intervention and prevention.  

http://www.cdc.gov/niosh/contact/im-held.html

Trainees may interact with this large federal facility at many levels. Lecture attendance at the weekly scientific conference is a rewarding educational experience. NIOSH faculty also participates in the WVU Occupational Medicine conferences and teaching sessions. Innovative resident rotations at NIOSH are available through inter-institutional agreements. Residents, physicians, and students have had the opportunity to perform research projects with NIOSH faculty.

Program Mission & Goals

The Occupational Medicine Residency Program at the West Virginia University School of Medicine is designed to give physicians a firm educational foundation and sound clinical groundwork in occupational and environmental medicine in preparation for board certification.

Mission Statement

It is our mission to prepare physicians for leading roles in occupational medicine to maintain the health of employees throughout the Appalachian region and beyond through a variety of preventive, clinical and workplace safety and environment programs. Our emphasis is on training clinicians who are skilled in the evaluation and mitigation of workplace hazards and the treatment of occupational diseases and injuries.

Goals and Objectives

DIDACTIC

Each resident must either complete or have already completed an appropriate graduate degree. The curriculum is to include courses in environmental/occupational health, biostatistics, epidemiology, health management/policy, social/behavioral science, toxicology, industrial hygiene, and occupational health.

GOAL: completion of an appropriate master’s degree which includes the required courses for board certification

OBJECTIVES:

- Describe the mission and history of public health
- Explain the roles and contributions of public health specialists with other disciplinary training
- Complete a master’s level research project and presentation
- Perform descriptive and inferential statistics including stratified analysis and mathematical modeling
- Assess the health needs of a community
- Describe the nature and role of organizations that provide or pay for health services in the US
- Describe the impact of the environment on the public at large and specific environmental health hazards that may adversely impact the health of patients and the community
- Evaluate and implement appropriate preventive services, both for individuals and for populations
- Recognize and management outbreak situations, including community coordination and communication
- Understand disaster preparedness planning and response

**CLINICAL**

Each resident is to have a longitudinal clinical experience to learn the skill necessary to provide quality clinical care in both a preventive and injury care capacity.

**GOAL**: development of clinical; occupational medicine skills to participate in or manage outpatient preventive and injury services

**OBJECTIVES**:
- Evaluate and recognize work related diseases
- Demonstrate basic clinical procedural skills such as joint injection, laceration repair, foreign body removal
- Demonstrate proficient in the performance and interpretation of occupational medicine testing such as pulmonary function testing, audiograms and urine drug screen
- Navigate the workers’ compensation process and manage patients in that system
- to understand the purpose and limitations of pre-employment examination
- Perform federally mandated exams such as CDL, OSHA respirator clearance and understand the health and safety implications of these exams
- Understand the legal, ethical and regulatory issues in occupational medicine
- Learn the basic skills needed to perform an Independent Medical Evaluation
- Understand medical office management (office flow, billing, compliance and contract services)

**RESEARCH/SCHOLARLY ACTIVITY**

Each resident will spend time at a federal occupational and health research agency (generally NIOSH) and will participate in research projects in their assigned department. Residents will also have the opportunity to participate in research at WVU based on their interests and availability of projects.

**GOAL**: participation in occupational medicine research and presentation of the results of that research

**OBJECTIVES**:
- Learn to identify a research topic
- Develop a study design to address the question to be answered
- Interpretation of results
• Discussion of results with a variety of audiences
• Apply research data to everyday issues
• Evaluate quality of other research papers/studies

INDUSTRIAL
Each resident will spend time at various work sites to be determined by resident interest and work site availability.

**GOAL**: exposure to work sites to understand the industrial health and safety issues and the current state of various industries

**OBJECTIVES**:
• Prepare educational programs for various aspects of the workplace
• Communicate with employees, employers, contractors and union officials
• Participate in an industrial based occupational medicine clinical medicine
• Evaluate needed occupational health services
• Understand the management and issue resolution structure of workplaces
• Conduct walk-throughs of a workplace and identify safety and health issues
• Understand and apply the results of industrial hygiene and safety reports
• Understand the principles of occupational wellness programs
• Understand the application of OSHA standards to the worksite
• Participate in an incident evaluation

GOVERNMENT/PUBLIC HEALTH
Each resident will meet with various health-related agencies at the local through federal level.

**GOAL**: Familiarity with policy making and application of federal rules, regulation, and mandates

**OBJECTIVES**:
• Recognize and manage outbreak situations, including community coordination and communication
• Understand disaster preparedness planning and response
• Participate in policy making processes at the local, county, state or federal level
• Understand the function and resources of the public health department
• Experience the workers’ compensation system from an insurer’s perspective
The Occupational Medicine Residency Program at West Virginia University (WVU) is a two-year program designed to meet the requirements for board certification in Occupational Medicine by the American Board of Preventative Medicine (ABPM) (https://www.theabpm.org/)

The academic and practicum phases of training are provided sequentially. Residents complete coursework over the first year to satisfy the requirements for a Masters of Public Health (MPH) degree and participate in the Occupational Medicine clinic at WVU. During the second year, they carry out research work and engage in clinical, industrial, and administrative experiences. In the event you have already completed an MPH, you will still be required to complete a two-year program.

Residents are expected to develop specific competencies to satisfactorily complete the program, described in Appendix B. We emphasize two broad areas: clinical occupational medicine and workplace hazard evaluation. Accordingly, our residents gain extensive clinical exposure through the Occupational Medicine and other clinical experiences. Residents are also required to take courses in Industrial Hygiene and will participate in workplace evaluations at several levels through NIOSH field investigations and outreach to small businesses in the state.

Patient Care

ACGME defines patient care as providing compassionate, appropriate, and effective care for the treatment of health problems. Residents in the occupational medicine program are expected to:

- Provide evidence based clinical evaluation and treatment for injuries and illnesses that are occupationally or environmentally related
- Properly interpret results in establishing fitness for duty
- Prescribe appropriate work restrictions for an injured worker
- Counsel employees about health risks and lifestyle
- Develop and carry out patient management plans
- Work with health care professionals, including those from other disciplines, to provide patient-focused care

Medical Knowledge

ACGME defines medical knowledge as demonstrating knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents in the occupational medicine program are expected to:

- Demonstrate knowledge and skills to provide guidance to the employee and employer when there is a need for integration of an employee with a disability into the workplace
- Identify and address individual and organizational factors in the workplace in order to optimize the health of the worker and enhance productivity
Demonstrate knowledge and skills to recognize, evaluate and treat exposures of toxins at work or in the general environment

**Practice Based Learning and Improvement**

ACGME defines practice based learning and improvement as the ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents in the occupational medicine program are expected to:

- Advise employees about the reproductive implications of occupational exposure and provide appropriate advice regarding employment
- Analyze practice experience and perform practice based improvement activities using a systematic methodology
- Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Facilitate the learning of students and other health care professionals

**Interpersonal and Communications Skills**

ACGME defines interpersonal and communication skills as the ability to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and professional associates. Residents in the occupational medicine program are expected to:

- Use effective listening skills; elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Communicate detailed health information to patients and families with a wide range of intellectual, cultural and socioeconomic backgrounds
- Collaborate effectively with others as a member or leader of a health care team or other professional group

**Professionalism**

ACGME defines professionalism as demonstrating a commitment to carrying out professional responsibilities, adhering to ethical principles, and exhibiting sensitivity to a diverse patient population. Residents in the occupational medicine program are expected:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
Systems Based Practice

ACGME defines systems based practice as demonstrating an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents in the occupational medicine program are expected to:

- Protect employees’ rights to confidentiality in employer requests for medical records information
- Establish and maintain accurate patient records
- Administer and manage their knowledge and skills to plan, design, implement, manage, and evaluate comprehensive occupational and environmental health programs and projects
- Obtain knowledge and skills necessary to recognize potential environmental causes of concern to the individual as well as to the community health
- Demonstrate skills necessary to assess if there is a risk of an adverse event from exposure to physical, chemical, or biological hazards in the workplace or environment.
- Apply knowledge of the health effects of the broad physical and social environment, which includes housing urban development, land use and transportation, industry and agriculture
Admission to the Residency Program

Application

Interested applicants need to apply online at the ERAS website.
https://www.aamc.org/students/medstudents/eras/

Applicants are expected to meet the uniform requirements for graduate medical education in the United States including satisfactory completion of an ACGME-approved first postgraduate year or internship (PGY-1) involving direct patient care. Applicants who have completed training in a clinical discipline, such as internal medicine or family practice are given priority. International medical graduates are expected to meet standard English fluency tests as well as uniform requirements for IMG's. The requirement of the certifying board for an ACGME-approved clinical year should be borne in mind by applicants from international medical schools.

Candidates already possessing an MPH or equivalent degree are given credit for this and will still be required to complete the two year residency program, plus additional courses needed for eligibility to sit for the board.

Applications and supporting documentation (for July admissions) should be submitted by October. Offers for admittance are made in mid-December.

Funding for the training of residents in occupational medicine is made possible through a training program grant from the National Institute for Occupational Safety and Health (NIOSH).

Admission Policies and Procedures

Purpose

1. To ensure equal and complete consideration of each applicant.
2. To ensure that consideration of non-professional factors does not occur.
3. To select the applicants with the greatest potential for achievement in occupational and environmental health.

Procedures

1. All applicants are asked to complete the ERAS application form online.
2. Faculty may discuss the program with prospective residents prior to application review.
3. Applications will be reviewed as they are submitted to the residency director. Applicants who fail to conform to ACGME training and WV medical license requirements will be rejected. Other applicants will be considered, and interviews will be scheduled. The program will not support applicant travel.
4. Following an interview, the clinical faculty will evaluate each applicant according to these criteria:
   a. Conformity with ACGME requirements.
   b. Passing scores on USMLE Steps 1, 2, 3
      (all three (3) steps required before admission is offered)
c. Eligibility for WV medical licensure.
   http://medicine.hsc.wvu.edu/media/17507/resident-doctor-licensure-requirements-policy-0409-nl.pdf

d. BC or BE in another field.
e. Evidence of clinical competency.
f. Special skills or experience of significance to OM.
g. Additional graduate studies.
h. Communication skills and professional ethics and mannerisms.
i. Reasonable expectations and a professional direction, if not specific objective.
j. Willingness to travel to practicum sites.

5. Final selection of residents will be made in or after December of the preceding year. Residents starting off-cycle, for example in January, may be accepted at other times.

6. Residents are accepted by a collective decision process which considers current resident opinions in addition to those of the faculty.

7. All residents enter at the PGY-2 level.

http://www.hsc.wvu.edu/gme

WV Licensure

Occupational Medicine does not fund licensure costs for residents. Physicians will not be allowed to begin outside practicum rotations until a copy of medical licensure has been presented for departmental files.

It is the policy at the Robert C. Byrd Health Sciences Center that all residents obtain a West Virginia License with 1 year of eligibility to do so under state law. This includes graduates of U.S. and Canadian medical schools, eligible for licensure after one year of postgraduate education.

Information can be obtained regarding licensure from the following:

Doctors of Medicine
West Virginia Board of Medicine
101 Dee Drive, Charleston, WV 25311
(304) 348-2921 or (304) 558-2921

Doctors of Osteopathy (DO's) participating in residency programs at WVUH are required to be licensed by the State of West Virginia. Information on rules and regulations, fees, and applications can be obtained from:

State of West Virginia
Board of Osteopathy
334 Penco Road, Weirton, WV 26062
(304) 723-4638

Please be aware that obtaining licensure in West Virginia may be a long process.

http://medicine.hsc.wvu.edu/gme/gme-policies/
Year 1: The Academic Phase

The academic phase is based in the School of Public Health, West Virginia University. The Master in Public Health (MPH) program was designed with the needs of both preventive medicine trainees and public health professionals in mind. It serves the public health training needs of West Virginia and the surrounding region, and has pioneered distance learning techniques to reach public health professionals throughout the state. It admitted its first class in 1996, and now has 7 year full accreditation status by the Council on Education in Public Health (CEPH).

Residents in occupational medicine receive tuition support to obtain the academic coursework towards a Master of Public Health (MPH) degree. There are now 55 faculty and an increased number of educational programs including a PhD in Public Health Sciences in Epidemiology, Occupational and Environmental Health Sciences, and Social & Behavioral Sciences. All residents in the academic phase enroll in the on-campus MPH degree, Occupational & Environmental Health Sciences track.

Residents are required to complete all MPH coursework, however, to satisfactorily complete the residency and to sit for board certification examination by the American Board of Preventive Medicine (ABPM). Additional or alternative courses may be taken with approval of the Program Director. The MPH degree in occupational and environmental health sciences provides students with the practical skills needed to solve occupational and environmental health problems. Students will focus on understanding occupational and environmental processes and their effects on humankind and developing the skills needed to assess and address their health consequences.

Sample MPH schedule below.

<table>
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<tr>
<th>Course Title</th>
<th>Course #</th>
<th>Cr Hrs</th>
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<tr>
<td>MPH Core Curriculum</td>
<td></td>
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<tr>
<td>Applied Biostatistics &amp; Lab</td>
<td>BIOS 601/602</td>
<td>4</td>
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<td>Public Health Epidemiology</td>
<td>EPID 601</td>
<td>3</td>
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<tr>
<td>Applied Healthcare Leadership</td>
<td>HPML 681</td>
<td>3</td>
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<tr>
<td>Environmental Health</td>
<td>OEHS 601</td>
<td>3</td>
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<tr>
<td>Social and Behavioral Theory</td>
<td>SBHS 601</td>
<td>3</td>
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<tr>
<td>Graduate Seminar</td>
<td>PUBH 696</td>
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<tr>
<td>Concentration Curriculum</td>
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<tr>
<td>Medical Toxicology</td>
<td>OEHS 766</td>
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<tr>
<td>Occ &amp; Environ Hazard Assessment</td>
<td>OEHS 620</td>
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<tr>
<td>Public Health Toxicology</td>
<td>OEHS 622</td>
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<tr>
<td>Occupational Injury Prevention</td>
<td>OEHS 623</td>
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<td>OEHS Graduate Seminar</td>
<td>OEHS 696</td>
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<tr>
<td>MPH Practice Based Experience</td>
<td>OEHS 622</td>
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<td>Capstone</td>
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<td>Electives (6 credits)</td>
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<tr>
<td>Worksite Evaluation</td>
<td>OEHS 665</td>
<td>2</td>
</tr>
<tr>
<td>Intro to Global Public Health</td>
<td>PUBH 605</td>
<td>4</td>
</tr>
</tbody>
</table>

** Please note schedule subject to change.
Residents are expected to plan their academic year to insure that appropriate academic courses are completed within the year. A plan of study must be on file: please consult MPH requirements. Only the practice based experience and capstone may be carried into the next year. Most of the courses are held in the afternoon or evenings; little if any conflict should occur between the clinic times and the MPH course schedule.

Residents are required to provide a copy of their transcripts at the end of each semester to the Program Manager.

The Practice Based Experience have recently been revised and residents are referred to these for scheduling and planning. This information is available at:

http://catalog.wvu.edu/graduate/publichealth/occupationenvironmentalhs/#masterstext

The practicum courses represent the culminating experience for MPH students. The three main outcomes are:

1. To provide the student with an opportunity to apply and synthesize the knowledge what has been learned in the Master's program which entails a formal proposal and leads to a final report and presentation.

2. To provide the student with a professional public health experience, whether it be in the public, private or academic realm.

3. To provide faculty with opportunity to evaluate: a) student success in achieving the program learning objectives; and b) student understanding and application of the public health competencies as related to the five areas of knowledge basic to public health: Biostatistics, Epidemiology, Environmental Health Sciences, Health Services Administration, and Social and Behavioral Sciences.

Year 2: The Practicum Phase

The practicum phase is designed to provide residents with the broad and intensive training in occupational medicine evaluation and treatment. A full spectrum of the practice of occupational medicine is seen in the clinics including workplace injuries, evaluations of toxic exposures, fitness-for-duty and surveillance examinations, disability evaluations, and medicolegal examinations.

The Occupational Medicine clinic serves as a unique resource in its region and in West Virginia. This clinic serves as a referral resource for patients from West Virginia and five or more nearby states. Residents are expected to contact and interact with a wide variety of safety, health, industrial hygiene, regulatory, legal and administrative professionals while managing occupational
illnesses and injuries. In addition, the clinic acts as a major resource for the management of the state-run workers’ compensation system in West Virginia. Residents have an unparalleled opportunity to participate in the clinic’s endeavor to reduce the state’s work-related injury and illness burden through application of the principles of preventive medicine. Residents most often start with the family practice, surveillance, and pre-placement patients and progress to the care of more complex patients and the performance of more difficult evaluations.

All PGY3 residents complete a rotation at NIOSH Morgantown. Residents select a rotation based either at the Division of Safety Research (DSR), Respiratory Health Division (RHD), or Health Effects Laboratory Division (HELD) depending upon interests and scheduling. Approximately three to four half-days per week are spent at NIOSH over a period of 6 months to allow the resident to participate in a national level field investigation.

Additional rotations are spent in a variety of industries, workers’ compensation agencies and clinical settings. Examples include: Charleston, WV (BrickStreet Insurance, Inc., West Virginia Poison Center, Kanawha-Charleston Health Dept.). We also routinely arrange industrial rotations and other experiences out of state and, even internationally, to suit resident career goals and interests. Residents may also spend one or two months in Washington DC at the headquarters of the Occupational Safety and Health Administration (OSHA) and become involved in the regulatory activities of the agency.

Clinical rotations in medical specialties related to the practice of occupational medicine are available. These include dermatology, pulmonary medicine, outpatient orthopaedics, and rehabilitation medicine, sports medicine and may be scheduled depending on resident interest and preceptor availability.

The only rotation taken by residents at both the PGY-2 and PGY-3 levels is the Occupational Medicine clinic. We intentionally do not provide different objectives and competencies for these two levels. Occupational Medicine is a discipline which places relatively greater emphasis on assessment rather than treatment. Therefore, our expectation is that residents progressively assume greater responsibility in achieving the same goals and competencies.

All residents are encouraged to complete one research project or practical public health/preventive medicine intervention of publishable quality to satisfy the requirements of the practicum year, if this was not completed as part of the MPH. Faculty preceptors available for research endeavors are available in WVU Occupational Medicine department, as well as in other departments of the West Virginia University School of Medicine, School of Public Health and NIOSH. Resources include databases of workers’ compensation data for West Virginia and case records of patients referred to the clinic. Approval of proposed research projects should be made by the Program Director. The role of the trainee in these research efforts will depend upon the nature of the project and the background of the trainee. Responsibility will be afforded accordingly. Trainees are supervised by the preceptor who prepares a report following the completion of the assignment and discusses the results with the trainee. Residents are encouraged to submit their papers for presentation at the Academic Section of the American Occupational Health Conference (AOHC) annual meeting, or to other appropriate forums.

Rotations are described in detail in Appendix A.
Residency Promotion Policy

During the academic year, each resident will be responsible for seeing that the Residency Manager is sent a transcript of coursework and grades at the end of each semester. In the practicum year, evaluations will be sent out to preceptors of the practicum rotations, who will complete them and forward them to the Program Director. The residents will also be given the opportunity to evaluate each rotation after its completion.

Each resident will meet with the Program Director, Associate Program Director, as well as other faculty when deemed appropriate by the Program Director, on a quarterly basis to evaluate the resident's performance in the academic and clinical phases of the residency. Practicum evaluations and transcripts will be reviewed with the resident, and any areas of weakness or deficiency noted. In addition, more frequent meetings will be required if there is evidence of substandard performance on the resident's part. Preceptors of the practicum rotations are encouraged to contact the Program Director, who will attempt to address any problems, deficiencies, or concerns with the resident. Residents and faculty will devise a plan to address any serious deficiencies noted in practicum evaluations.

Continued progress in the residency will require that residents meet expectations of the faculty and practicum preceptors, and follow-through on correction of any noted deficiencies. The resident must throughout the year exhibit continued progress toward increased assumption of responsibility in the care of patients and in the management of occupational health and medical services, and must, at the end of the practicum, be ready for the independent assumption of these responsibilities.

Academic or PGY-2 Level
Promotion to PGY-3 depends on successful completion of the PGY-2. The requirements include:

1. Successful completion of the MPH curriculum according to criteria established by the MPH degree program. Only the research project may be carried over into the next year.
2. Satisfactory quarterly reviews.

Note: Promotion from the academic to practicum year is also dependent upon successful completion and ongoing participation in Occupational Medicine activities including the following:

- Clinical Activity: Residents must have a minimum of four months of direct patient care experience in an occupational setting under the direct supervision of the physician staff.
- Occupational Medicine departmental lectures.
- Other activities, including didactics, case presentation seminars, and research seminars.

The following exceptions to the promotional rules may be made at the discretion of the Program Director:

- Residents completing MPH coursework but not completing their MPH project may be permitted to complete their practice based experience project during the practicum year, if the Program Director deems it reasonable based upon performance.
- Residents not completing up to one-MPH course (incomplete grade) may begin practicum training at discretion of the Program Director, provided a concrete and mutually acceptable
plan is presented. No credit will be given for practicum training until all MPH coursework is complete.

**Practicum or PGY-3 Level**

Completion of the PGY-3 year is synonymous with residency completion. The requirements include:

1. Twelve months of clinical (*four months of direct patient care in an occupational setting*) and research rotations of which at least six months must be spent at a site where a comprehensive program of occupational medicine and related health and administrative services exist, as defined by the ACGME. These must take place in settings that provide opportunities for residents to manage the clinical, scientific, social, legal and administrative issues from the perspectives of workers, employers, and regulatory or legal authorities.

2. Satisfactory completion of the MPH practice based experience and all MPH requirements.

3. Satisfactory evaluation from preceptors of the practicum rotations.

4. Satisfactory completion of expected competencies in occupational medicine, outlined in **Appendix B**. These are established by agreement with practicum rotation preceptors and will be outlined with the resident at the commencement of each practicum rotation. It is expected that each resident will fulfill all of the general categories of competency, although specific skills may vary between residents and between practicum sites.

**Conditions for reappointment**

Non-renewal of appointment or non-promotion: In instances where a resident’s agreement will not be renewed, or when a resident will not be promoted to the next level of training, the Sponsoring Institution must ensure that its programs provide the resident(s) with a written notice of intent no later than four months prior to the end of the resident’s current agreement. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the Sponsoring Institution must ensure that its programs provide the resident(s) with as much written
notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the agreement.

Residents must be allowed to implement the institution’s grievance procedures if they receive a written notice either of intent not to renew their agreement(s) or of intent to renew their agreement(s) but not to promote them to the next level of training.

http://medicine.hsc.wvu.edu/gme/gme-policies/

**Dismissal/Termination**

The Program may take corrective or disciplinary action including dismissal for cause.

http://medicine.hsc.wvu.edu/gme/gme-policies/

**Residency Completion**

Residents will be given notification of completion of training through a certificate, which may be used for board application purposes.

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**Occupational Medicine Grand Rounds - Didactics**

Residents in occupational medicine, faculty, interested staff and invited guests attend occupational medicine grand rounds held in the Health Sciences Center (HSC). The purpose of the meeting is to address scientific issues of concern to the practice of occupational medicine and to supplement the didactic component of the residency practicum. Meetings also offer an opportunity for preceptors at participating sites, faculty at the Hospital and residents to become acquainted and to facilitate scientific learning and interchange. Grand rounds are approved for Continuing Medical Education and Continuing Education Unit credits, therefore undergo review and quality assurance for accreditation approval.

All residents are required to attend occupational medicine grand rounds and didactics except when travel on outside rotations is too far away. Residents may now skype, if available. Grand Rounds are held from 12:30 to 1:30 p.m. on Friday’s. In addition, residents will be required to meet for didactics/journal club every Friday from 2:00 – 5:00 pm (time subject to change). These meetings are designed as more informal tutorials covering case presentations, review of recent journal articles, and board review sessions. Residents are required to attend 80%+ sessions quarterly.

Residents have the opportunity to request discussion of any subject at these tutorials. In addition, faculty will review important practical areas that are not amendable to a didactic session.

Additional didactic opportunities are available through NIOSH. In particular, the weekly Respiratory Health Division (RHD) seminars are held on Wednesdays at 10:30 a.m. Residents are forwarded topic announcements each week via email.
Journal Club is presented at the beginning of each didactic session. Each resident is required to find an article of occupational/public health nature, email to all residents, program manager and preceptor 5 days prior to presenting. Journal club schedule is made by the Program Manager.

Resident Supervision Policy

Resident supervision will be in accordance with the policies set forth in Graduate Medical Education Programs at West Virginia University School of Medicine and WVU Hospitals, effective July 1, 2011, revised continuously.

Direct Supervision - physically present during patient encounters

Indirect Supervision:

- Director supervision immediately available - Attending is on site
- Direct supervision available – immediately available by phone and available to provide direct supervision

Oversight – the attending is available to provide review of procedures/encounters with feedback provided after care is delivered

Junior resident: residents that are in their PGY-2 year of training

Senior resident: residents that are in their PGY-3 year of training

Attending faculty/Preceptor – has ultimate responsibility for all medical decisions regarding the patient and therefore must be informed of all necessary patient information

1. The residency program will provide supervision of residents that is consistent with each resident's abilities, with patient care, and with educational needs of the resident.

   a. Academic Year, PGY-2

   Occupational Medicine residents are assigned to specific OM clinics throughout the two-year program. While in these clinics, residents are under the direct supervision of the OM faculty physician specifically designated in the clinic schedule. Each faculty physician supervises no more than one resident in clinic and no more than two residents are scheduled in clinic at any one time. In order to allow sufficient time for review of cases while keeping on schedule, residents and the precepting faculty physician each have the final 30 minutes of clinic time blocked. Using the electronic medical record, all resident notes are directed to the supervising faculty physician for review and co-signature before encounters are closed. Senior residents do not supervise junior residents. The director will provide feedback and formal evaluations concerning resident performances at 3 month intervals.

   While enrolled in the MPH degree, each resident is indirectly supervised by a designated faculty advisor who is an OM physician cross-appointed to the School of Public Health. Direct supervision is not necessary; however, residents are expected to report any departure from class schedule in advance.
b. Practicum Year, PGY-3

While on clinical rotations within WVU Healthcare but outside of OM, the resident is supervised by faculty according to the procedure of the relevant department. When on off-site rotations, the resident is supervised by the designated preceptor as outlined in the Program Letter of Agreement (PLA).

2. The resident should notify the attending of any significant changes in the patient’s status or significant difficulty in developing a plan of care due to conflicts with the patient, their representatives or consultants. This should include but not be limited to: transfer of patient or need to perform an invasive procedure.

3. The program will have methods for providing continuous evaluation of residents. This shall include, but not limited to, oral and written evaluations and chart audits. Written evaluations will be submitted by practicum preceptors at the end of every rotation. Reviews with the Program and Associate Directors will be conducted quarterly, and a summary of the review made in writing. These will be placed in the resident file. The trainee shall have access to this information.

4. Direct personal supervision will be provided by the Program Director and assigned faculty/preceptors. Supervision shall pertain to: discharge of all clinical duties; assessment of ability to gather appropriate information; assessment of ability to integrate and employ state of the art knowledge; application of knowledge to clinical and public health problem solving; ability to communicate this clinical information to patients and their families; ability to communicate public health implications to industry, labor, government, or others who may need it.

5. It is the goal and responsibility of the trainee to continuously demonstrate progress towards acceptance of the responsibility for provision of occupational health care. It is the role of the faculty/preceptor to accept these responsibilities and provide appropriate training to meet these goals. Toward this end, a list of expected competencies in occupational medicine (Appendix B) will be provided to the residents on commencement training. An initial evaluative session between the resident and the Associate Program Director will be held at the start of the residency in order to identify strengths and areas in which the resident could benefit from specifically directed training. The faculty/preceptor will be apprised in advance of the competencies that are expected of the residents at the completion of each rotation, usually through obtaining a copy of the rotation agreement.

6. Residents shall be responsible for compiling and submitting a record of activities. Faculty is responsible for using this information to assure that all required aspects of training occur.
Resident Benefits

Residents in occupational medicine receive all the benefits of house officers of the West Virginia University School of Medicine including malpractice insurance, health and sickness benefits and vacation. [http://medicine.hsc.wvu.edu/gme/salaries-and-benefits/](http://medicine.hsc.wvu.edu/gme/salaries-and-benefits/)

Expenses

Every effort is made to reimburse residents for expenses incurred in the residency. Full stipends and tuition support during the MPH year are provided for all residents. Additional costs may be reimbursed depending on the availability of funds each year. This may include: attendance and registration costs of meetings (including national and regional meetings), courses in Spirometry and Audiology, travel and accommodations for required out of town rotations, and membership dues. In all such cases, residents are required to check with the Program Director or Program Manager in advance to see if the expense can be reimbursed.

Resident Salaries

Academic Year 2016-2017

<table>
<thead>
<tr>
<th>PGY</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>PGY-2</td>
<td>$55,523</td>
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<tr>
<td>PGY-3</td>
<td>$57,023</td>
</tr>
</tbody>
</table>

Payroll

Residents are paid twice a month. Direct deposit is mandatory.

Malpractice Insurance

The West Virginia State Board of Risk and Insurance Management provide professional liability (malpractice) coverage. The Board of Risk is a state agency that self-insures professional liability coverage for all state employees. This occurrence-based coverage provides limits of one million dollars per occurrence. The coverage applies to all acts within the assigned duties and responsibilities of your residency training program; it does not cover you for outside activities such as moonlighting. You are required to provide your professional liability coverage for activities outside your residency training program. You must report any questionable incidents concerning patient care to your residency director and to risk management at the Health Sciences Center. A written report must be completed and sent to Risk Management (P.O. Box 9032) to be reviewed and forwarded to the Board of Risk as needed. Risk Management can be reached at 293-3584 (Health Sciences) and 598-4070 (WVUH).

Lab Coats

Two lab coats will be issued to the resident at the beginning of training. Laundry service for resident training at West Virginia University Hospitals is provided free of charge.
**Health Insurance**

House Officers are eligible to enroll in the state employees’ health insurance or state managed health care options (HMO's, etc.) through our Human Resources/Employee Benefits (293-4103).

**Disability Insurance**

The opportunity to participate in a group, long-term disability coverage is available through TIAA/CREF by contacting the WVU Human Resources/ Benefits Office (293-4103).

**Parking**

Parking is reserved for resident/fellow parking at West Virginia University Hospitals, Inc.

**Meal Allowance**

Each resident is allotted a meal allowance of $200.00/year. A meal card will be given to each resident: $100.00 for the first six months and automatically renewed with $100.00 for the second six months.

**Additional WVU Benefits  (you are considered STAFF not a student)**

- Athletic and Cultural events [http://ccarts.wvu.edu/creative_arts_center](http://ccarts.wvu.edu/creative_arts_center)
- Library Privileges - [https://lib.wvu.edu/](https://lib.wvu.edu/)
- University Club - ([http://universityclub.wvu.edu/](http://universityclub.wvu.edu/))
- Student Recreation Center - ([http://www.studentreccenter.wvu.edu/](http://www.studentreccenter.wvu.edu/))
- Stansbury Hall - [http://cpass.wvu.edu/lap/stansbury_fitness_center](http://cpass.wvu.edu/lap/stansbury_fitness_center)
The resident/fellow leave guidelines of the West Virginia University School of Medicine exist to ensure the safety and general welfare of the residents/fellows and the effectiveness of the training programs. The guidelines are in accordance with the guidelines of West Virginia University, West Virginia University School of Medicine, ACGME, the regulatory and/or accrediting agencies, and the Residency Committee and are approved by the Resident/Fellowship Program Director, the Chair, and the Graduate Medical Education Committee.

The Program Director and Program Manager will review resident/fellow leave time to assure that Residency Review Committee requirements are met. Due to the potential for stress and fatigue during residency training, it is expected that residents/fellows will take advantage of whatever amount of annual leave you are able to take each year in accordance with this policy without consequence to your studies. If not requested, annual leave may be assigned at the discretion of the Program Director.

However, use of leave may impact on a resident's/fellow's ability to complete program requirements. Therefore, a resident/fellow who takes all the allowable annual and sick leave may not be able to complete the program requirements in the allotted training time and/or may not be eligible to take the required and/or applicable board examinations at the conclusion of the training period without additional training time. The Department is not responsible for providing additional training time and, in fact, may not be able to do so without requesting permission from ACGME, which permission may or may not be granted. The grant of permission by ACGME is beyond the control of WVUSOM.

Full time residents will accrue two (2) days of annual leave per month. A day in the leave system is equal to 7.5 hours. While, as a resident, you are entitled to use, and may request the use of, the entirety of your annual leave, the Occupational Medicine program recommends that its residents request no more than 24 days of annual leave per year to ensure that program requirements are met (both PGY2 and PGY3). Annual leave must be accrued prior to using it. Annual leave time caps at 24 accrued days which will appear in the leave system as 180 hours. Once you accrue 24 days, you will stop accruing annual leave.

Annual leave will be granted on a “first come, first served” basis and is determined by the total number of Department providers present during the time period requested. All annual leave must be approved, in advance, by the Program Manager. Program Manager and the Director have the right to deny annual leave at the requested time. The amount of time that can be missed on any one rotation is limited by the educational goals of the rotation. Only 1 week of annual leave may be taken on single month rotations, and only 2 weeks of annual leave may be taken on 2-month rotations. No more than 2 days of annual leave time may be taken during a 2 week rotation. Additional weeks may be taken on multi-month rotations, however no block of time greater than 2 weeks may be granted, and only one week of annual leave time may be used in any one calendar month. Extended annual leave or combining annual leave with meetings is discouraged due to prolonged absence from the program. Such requests require special approval from the Program Director and must fall within the requirements of the ACGME and the applicable Board.
A resident does not have the option of reducing the time required for the residency by forgoing annual leave.

Please note that vacation time is to be used when interviewing.

Sick Leave

Full time residents/fellows will accrue 1.5 sick days per month. Sick leave must be accrued prior to using it. Sick leave may be used by an employee who is ill or injured, when a member of the immediate family is seriously ill, or when a death occurs in the immediate family. Immediate family is defined as: father, mother, son, daughter, brother, sister, husband or wife, mother-in-law, father-in-law, son-in-law, daughter-in-law, grandmother, grandfather, granddaughter, grandson, stepmother, stepfather, stepchildren, or others considered to be members of the household and living under the same roof.

If you have any question regarding whether sick leave can be used, please contact the Program Manager. **Excessive/unexplained absences may affect your competency evaluation and/or your promotion to the next level of training.** Sick leave for more than five (5) consecutive work days cannot be granted to an employee without satisfactory proof of illness or injury as evidenced by a statement of the attending physician or by other proof. An employee who has been absent from work for an extended period because of illness or injury must obtain medical clearance before returning to work. The University may require verification of an illness or other causes for which leave may be granted under this policy regardless of the duration of the leave. A copy of all medical documentation must be sent to the medical management unit.

Holidays

While the University provides scheduled holidays to its employees as state employees, the requirements of medical coverage do not allow for all these holidays to be taken as scheduled. The Program Director and Program Manager will assist in scheduling and coordination of available holiday time.

If you are on a service where physicians observe a state holiday, you will not be required to work on that holiday. As professionals, you are exempt from overtime or compensatory time.

Residents are required to fulfill clinical requirements even if they fall on state holidays. Since residents are granted a generous 24 days of vacation each year, which they are required to take before completion of the program, an extra day will not be granted. No grant of an equivalent number of days is required of or owed by WVUSOM. We will assume that residents will be available for clinic on state holidays and will be scheduled accordingly unless advised otherwise by the resident (i.e. if you wish to take vacation).
Continuing Medical Education Leave

All CME conferences a resident/fellow wishes to attend must be approved, in advance, by the Program Director/Manager. Attendance at CME conferences counts toward duty hours during the actual conference time. As a result, annual leave does not need to be used for CME attendance. One day of travel time, if necessary, will be granted before and after the conference without the use of annual leave.

Leave of Absence

A Leave of Absence (LOA), including Family Medical or Military leave, may be requested by a resident after all applicable leave time has been exhausted. The University policies regarding LOA, WVU BOG 24 regarding leave and the University Human Resources Department provide guidance regarding the procedures and forms that must be completed.

Generally, LOA will be granted based on the need to attend to personal matters such as perinatal care or serious illness. No academic credit may be provided for non-annual leave. Additional months will be added to the training duration if possible, but residents are advised that LOA may impact a resident’s ability to complete program requirements. Therefore, a resident/fellow who takes a LOA may not be able to complete the program requirements in the allotted training time and/or may not be eligible to take the required and/or applicable board examinations at the conclusion of the training period without additional training time. The Department is not responsible for providing additional training time and, in fact, may not be able to do so without requesting permission from ACGME, which permission may or may not be granted. The grant of permission by ACGME is beyond the control of WVUSOM. A maximum of 6 months of LOA may be honored before a resident/fellow may be required to reapply to and be reaccepted into the program.

University policy and applicable laws control compensation and duration of leaves for pregnancy, illness, military, or injury. Educational requirements of the residency must be met irrespective of leave. Such leaves may result in the extension of time necessary to complete the residency. The Program will make every attempt to meet individual needs created by pregnancy or illness, and LOA will be considered and provided in accordance with University policy and applicable law, but the Program cannot control the potential inability of a resident/fellow to complete the required training if a LOA is taken.

Procedure for Requesting Leave

Annual leave requests without the required advance notice may not be approved. Coverage for call schedules, patient care, and other obligations must be adequately arranged for by the resident and communicated.

Grievance, Witness and Jury Leave

Employees who are subpoenaed, commanded to serve as jurors, or required to appear as witnesses or representatives for review proceedings of the Federal Government, the State of West
Virginia, or a political subdivision thereof, or in defense of the University shall be entitled to work release time for such duty and for such period of required absence which overlaps regularly scheduled work time. Employees are entitled to leave with pay for the required period of absence during the regularly scheduled work time including reasonable travel time. For additional information, refer to the WVU Department of Human Resources Policies and Procedures.

When attendance in court is in connection with official duties, time required, including reasonable travel time, shall not be considered as absence from duty.

Inclement Weather

If a resident is absent due to inclement weather, an annual leave day must be taken unless the institution is closed.

WV Licensure

Occupational Medicine does not fund licensure costs for residents. Physicians will not be allowed to begin outside practicum rotations until a copy of medical licensure has been presented for departmental files.

It is the policy at the Robert C. Byrd Health Sciences Center that all residents obtain a West Virginia License with 1 year of eligibility to do so under state law. This includes graduates of U.S. and Canadian medical schools, eligible for licensure after one year of postgraduate education.

Information can be obtained regarding licensure from the following:

Doctors of Medicine
West Virginia Board of Medicine
101 Dee Drive, Charleston, WV 25311
(304) 348-2921 or (304) 558-2921

Doctors of Osteopathy (DO's) participating in residency programs at WVUH are required to be licensed by the State of West Virginia. Information on rules and regulations, fees, and applications can be obtained from:

State of West Virginia
Board of Osteopathy
334 Penco Road, Weirton, WV 26062
(304) 723-4638

Please be aware that obtaining licensure in West Virginia may be a long process.

http://medicine.hsc.wvu.edu/gme/gme-policies/
Statement of need and purpose

The health care professionals of West Virginia University Hospitals are dedicated to providing life-sustaining care where possible and where appropriate. Literature supports the assertion that timely and effective resuscitation improves patient outcome in terms of survival and functional status. ACLS and PALS are effective models of resuscitation that have the potential to affect patient survival. The Medical Executive Committee has approved the requirement that residents maintain training in advanced life support. The purpose of this policy is to describe how residents must comply with the requirement of maintaining their training in advanced life support.

State of General Principles and Rules

Residents will maintain certification in advanced life support through BLS/ACLS. Renewal of certification is required at least every two years.

WVUH will offer courses in BLS, ACLS and PALS to meet the educational needs of the residents. These courses will be provided free at no cost to the resident.

Residents whose certification expires have a maximum of 30 days to renew their certification and may not carry the code pager during this time. If certification has not occurred by the end of the 30-day grace period, patient care activities in the hospital will be suspended until certification is obtained.

Residents will maintain ACLS certification.

Procedure

Provider and Renewal courses in BLS/ACLS and PALS will be provided at no cost to the resident through WVUH’s Education and Training Department. WVUH will pay for an outside course in advanced life support only if WVUH fails to offer advanced life support training in the 6 months prior to the resident’s expiration date or there is documented evidence that all classes were 100% full.

The resident is responsible for submitting proof of certification to the Program Manager.

The School of Medicine House Staff will maintain a database of advanced life support training for residents. Residents will be notified 6 months prior to the expiration of their certification, again 3 months prior to their expiration date, and 30 days prior to their expiration date.

A. If certification expires, the House Staff office will notify the resident and the program manager.

The resident shall have 30 days in order to renew his/her certification. The resident may not carry the code pager until he/she renews the certification.

B. If certification is not obtained within 30 days after the expiration date, patient care activities will be suspended and the resident will be referred to their department for any further action.

Computer Based Learning (CBL’s)

Access WVU Healthcare Connect http://connect.wvuhealthcare.com/Pages/

Left hand column: HR & TRAINING

WVUH Training; my Net Learning; log in with your social security number
Moonlighting

Moonlighting by residents is defined as clinical activities outside the West Virginia University Hospital or approved off-site rotations. Residents on J1 VISA’s are NOT permitted to moonlight, either internally or externally.

Residency training is a full-time commitment. Moonlighting is allowed only if it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Nevertheless, it is recognized that for some residents it is an economic necessity.

Professional liability protection provided to residents through the West Virginia Board of Insurance and Risk Management does not extend to moonlighting activities performed outside the program.

Resident moonlighting is permitted in the PG-2 and PG-3 years if the following conditions are met:

- Residents must have received passing grades for all MPH coursework and satisfactory evaluations for all rotations.
- Any resident on probationary status is prohibited from moonlighting.
- The Program Director, on an individual basis, must approve the amount of moonlighting performed.
- Moonlighting must not conflict with resident responsibilities.
- Residents must complete any moonlighting activities at least 12 hours before they are required to be available for residency clinical activities or practicum rotation.
- The hours spent moonlighting are counted towards the total hours worked for the week.

Any exceptions to this policy must be approved by the Program Director.

Alertness Management/Fatigue Mitigation

Education, via didactic discussions and video, will be provided on signs and symptoms of fatigue.

The Program Director and faculty will monitor each resident carefully for signs of fatigue. The Program Director/Program Manager also monitors fatigue as it relates to duty hours as reported in e-Value submitted by the residents.

If a resident perceives that they are too fatigued or stressed to work, they should immediately notify their supervising attending and the program director/program manager. A suitable arrangement will be made based on the individual situation.
Duty Hours

Residents have no call or weekend responsibilities in the occupational medicine residency. Therefore, duty hours should never be exceeded by any residents. Nevertheless, residents are expected to be in compliance with all of the ACGME Duty Hour Rules at all times. The program complies with the WVU Department of Medical Education policy for duty hours, including the requirement to record and monitor duty hours for all residents. This policy is as follows:

Providing residents with a sound academic and clinical education takes careful planning balanced with concerns for patient safety and resident well-being. Our goal is to enhance the educational experience by allowing the resident adequate time for rest and activities outside the hospital environment.

Duty hours are monitored by the Program Manager and Director through the e-Value online system at www.e-value.net.

Residents are responsible for watching their duty hours using the e-Value system, as each month progresses. If they anticipate that they will be over their maximum number of hours by the end of the month, they should report this to the Program Manager, immediately upon discovery, but always in advance of the violation. Upon notification, the Program Manager will check e-Value to validate the hours and if a violation will occur as a result of the resident working the remainder of the rotation, alternative arrangements will be made to reduce the work hours for the resident to keep them in compliance with the maximum hours that they may work for that month.

Each program letter of agreement indicates the start/end time, Monday – Friday, for that rotation. Residents have no obligations for working after hours or on weekends.

In any situation in which a resident believes he/she is being asked or expected to work in a manner, which is in conflict with the ACGME duty hours, the resident is expected to bring this situation to the attention of the attending of the rotation. The attending will assess the situation and either state that he/she believes the situation is not a work hour violation, or provide coverage for the resident’s patients to avoid a conflict. If the resident does not believe the matter is resolved, they should contact the Residency Director or Program Manager.

* Duty hours are defined as all clinical and academic activities related to the residency program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care such as completing medical records, ordering and reviewing lab tests, and signing verbal orders. For call from home, only the hours spent in the hospital after being called in to provide care count toward the 80-hour weekly limit.

Hours spent on activities that are required by the accreditation standards, such as membership on a hospital committee, or that are accepted practice in residency programs, such as residents’ participation in interviewing residency candidates, must be included in the count of duty hours. It is not acceptable to expect residents to participate in these activities on their own hours; nor should residents be prohibited from taking part in them.

Duty hours do not include reading, studying, and academic preparation time, such as time spent away from the patient care unit preparing for presentations or journal club.
* Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. 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 limit on duty hours.

* Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

* 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 pm and 8:00 am, is strongly suggested.

* 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 hours.

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

* Residents in the final years of education (PM-2 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.

* Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. Such circumstances considered will be: required continuity of care for a severely ill or unstable patient; a complex patient with whom the resident has been involved; events of exceptional educational value, or humanistic attention to the needs of a patient or family.

http://medicine.hsc.wvu.edu/gme/gme-policies/

http://www.acgme.org/What-We-Do/Accreditation/Duty-Hours

WVU Occupational Medicine Residency Transfer of Care Program

To assure continuity of care and patient safety, ACGME requires a minimum number of patient care transitions, a structured and monitored handoff process, training for competency by residents in handoffs, and readily available schedules listing residents and attending physicians responsible for each patient’s care. In addition to resident-to-resident patient transitions, residents must care for patients in an environment that maximizes effective communication among all individuals or teams with responsibility for patient care in the healthcare setting.
The following policy applies to all residents when they are rotating with Occupational Medicine. Any residents rotating with another service will need to follow the transfer of care process of that rotation.

WVU Occupational Medicine provides clinical care primarily in an ambulatory setting and only rarely (once every few years) provides in-patient consultative care for patients admitted to other services. For this reason, the transfer of care policy focuses on transfer of care in the ambulatory setting and between services when a patient requires care from another specialty.

Minimizing Transfers of Care:

Barring emergencies, all patient visits are completed by the same provider(s) who started the visit. All clinic notes are constructed with sufficient detail to allow for follow-up by another provider if necessary. The potential for transfer of care within Occupational Medicine occurs between the initial and subsequent visits. It is the goal in all clinic scheduling to minimize transfers of care. To achieve this all return appointments are scheduled using the following priority scheme:

1. Same resident, same attending
2. Same resident, different attending
3. New resident, same attending
4. Same attending (alone)

Mechanisms for transfer of care:

Transfer of care can occur between office visits or between services. Different approaches are used for these two processes.

For anticipated transitions (such as when a resident graduates or goes on an away rotation) the residents complete an "off-service" type note in Merlin that details open issues for that patient and future plans. The .occoffsvc dot phrase outline will guide the composition of this note. (Sample 1)

Interservice transfers of care occur when a patient requires evaluation or treatment beyond the capabilities of the Occupational Medicine clinic for continued care. Examples would include patients with fracture(s) requiring orthopedic care or cardiovascular instability requiring evaluation in the Emergency Department. Interservice transfers are typically done on an urgent basis and it is expected that the transfer will be done verbally with the receiving service.

The resident is expected to contact a senior resident on the receiving service and provide them with all necessary medical information, specifically including the minimum data set listed below. The .occtransfer dot phrase will guide the completion of the transfer note. (Sample 2)

Interprofessional Transfer of Care within the Occupational Medicine Clinic

The Occupational Medicine clinic nursing staff is composed of healthcare professionals from a variety of backgrounds. Residents interact with these professionals to receive patients needing evaluation and when patients require treatments that are provided by the nursing staff. Transitions of care between the nursing staff and the residents are monitored on a nearly daily basis by the faculty
physicians and this is a topic included in the nursing staff evaluation of the residents. This interaction is evaluated regularly by the faculty physicians as part of the rotation evaluations.

**Resident Self-assessment of interservice Transfer of Care**

Following an actual or simulated interservice transfer of care, the resident will be asked to complete an interservice transfer of care self-assessment. The goal of this is to guide the formation of the resident’s interservice transfer skills. (Sample 3)

**Faculty Monitoring of interservice transfer of care**

It is required that each resident be monitored by faculty for proficiency in verbal transfer of care annually. This can occur when a patient transferred urgently from clinic and the faculty is able to monitor the transfer communication. In this event, the faculty must complete an evaluation of the transfer either directly using eValue or a paper evaluation which is then scanned into eValue. (Sample 4)

Simulated transfer can be used when there are no episodes of faculty monitored verbal transfer of care during a year. The evaluation will use the same eValue or paper forms.

**Minimum data set for interservice transfer of care from Occupational Medicine**

- Patient Name
- Age
- Gender
- Pertinent Diagnoses
- Exam findings
- Lab and Imaging findings (Including how they will be made available to the receiving provider)
- Medications
- Allergies
- Code Status
- Workers Comp Status (is this a WC issue or Private Insurance issue?)
- Are you absolutely clear on when and where the receiving providers will meet the patient and assume care [Office Appt(when, where)? See urgently in ED? Other ???]
- Did you discuss any treatments needed prior to seeing receiving provider and who/how those will be provided (pain meds, immobilization, etc.)
- How will patient reach receiving provider?

**Evaluation of the Occupational Medicine Interservice transfer of care system**

The Annual faculty and resident surveys will complete questions on the efficacy of the transfer of care systems. This evaluation will address both ambulatory and verbal interservice transfer of care systems.
The results of the faculty and resident evaluations will be reviewed at the annual program evaluation committee meeting.

*Effective February 2015*
Sample 1 (Merlin .occoffsvc)

OCCUPATIONAL MEDICINE PATIENT HAND-OFF NOTE

@NAME@ is a @AGE@ @SEX@ who has been cared for in the Occupational Medicine Clinic for ***

Current Medications Include:
@MEDS@

Allergies:
@ALLERGY@

Code Status: {CODE STATUS: 21878}

Pending Studies:
***

Recent Results Awaiting Followup:
***

Pending Consults:
***

Plan:
***

On the basis of the above review of this patient's status, I am transferring care of @NAME@ to Dr. *** effective ***.

@ME@
Sample 2  (Merlin .occtransfer)

OCCUPATIONAL MEDICINE INTERSERVICE TRANSFER NOTE

@NAME@ is a @AGE@ @SEX@ who has been cared for in the Occupational Medicine Clinic for ***

Current Medications Include:
@Meds@

Allergies:
@ALLERGY@

Code Status:{CODE STATUS:21878}

Exam findings:
***

Imaging/test results:
***

These images/test results are available to the receiving service via: ***

Plan:
Due to the need for additional care for *** we are transferring this patient to *** service for continued care. I discussed this patient verbally with *** from the receiving service.

Treatment Provided in clinic: ***

Timing: This patient will come under the care of *** service as follows: ***

Treatment between now and their initial evaluation by *** service will consist of *** and will be provided by ***

@ME@
Sample 3 – Resident Self-Assessment of Interservice Transfer

Transferring Resident _____________ Receiving (Evaluator) ________________

Self-Assessment for inter-service transfer from Occ Med Clinic:

How did you select the service to hand off to? ________________________________

Did you introduce yourself? ___ Yes ___ No

Did you get the name of the receiving resident? ___ Yes ___ No

Receiving Resident’s Name ________________________________

Please rate the clarity of the communications from the receiving resident

Poor  1  2  3  4  5 Excellent

Check off information you effectively conveyed:

___ Patient Name
___ Age
___ Gender
___ Pertinent Diagnoses
___ Exam findings
___ Lab and Imaging findings (Including how they will be made available to the receiving provider)
___ Allergies
___ Code Status
___ Workers Comp Status (is this a WC issue or Private Insurance issue?)
___ Are you absolutely clear on when and where the receiving providers will meet the patient and assume care
   [Office Appt(when, where)? See urgently in ED? Other ???]
___ Did you discuss any treatments needed prior to seeing receiving provider and who/how those will be
   provided (pain meds, immobilization, etc.)
___ How will patient will reach receiving provider?

Comments:
Sample 4 – Evaluator Assessment of Interservice Transfer

Transferring Resident ____________  Receiving (Evaluator) ______________________

Evaluator Assessment Rubric (outbound inter-service transfer from Occ Med):

Did the resident introduce themselves?  ___ Yes  ___ No

   Resident’s Name ____________________________

Did the resident get your name?  ___ Yes  ___ No

Please rate the clarity of the communications from the sending resident

   Poor  1  2  3  4  5  Excellent

Check off information the resident effectively conveyed:

   ___ Patient Name
   ___ Age
   ___ Gender
   ___ Pertinent Diagnoses
   ___ Exam findings
   ___ Lab and Imaging findings (Including how they will be made available to the receiving provider)
   ___ Allergies
   ___ Code Status
   ___ Workers Comp Status (is this a WC issue or Private Insurance issue?)
   ___ Absolute clarity on Receiving providers will meet the patient and assume care [Office Appt (when, where)?
       See urgently in ED? Other ???]
   ___ Discuss any treatments needed prior to seeing receiving provider and who/how those will be provided (pain
       meds, immobilization, etc.)
   ___ How will patient will reach receiving provider?

Comments:
Program Closure/Reductions Policies

West Virginia University School of Medicine
Graduate Medical Education Policy on Program and Institution Closure/Reduction

XXVII. Program and Institution Closure/Reduction Policy:

If the School of Medicine intends to reduce the size of a program or to close a residency program, the department chair shall inform the resident as soon as possible of the reduction or closure. In the event of such reduction or closure, the department will make reasonable efforts to allow the residents already in the Program to complete their education or to assist the resident in enrolling in an ACGME accredited program in which they can continue their education.

Should the WVU School of Medicine decide to discontinue sponsorship for graduate medical education, residents will be notified of the intent in writing by the DIO as soon as possible after the decision is confirmed by the GMEC and the institutional leadership including the Dean of the School of Medicine.

Approved by GMEC 1/12/07 ACGME Institutional Requirements III.B.12

http://medicine.hsc.wvu.edu/gme/gme-policies/

http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements

II.D.5. Closures and Reductions: The Sponsoring Institution must have a written policy that addresses a reduction in size or closure of a residency program or closure of the Institution. The policy must include the following:

II.D.5.a) The Sponsoring Institution must inform the GMEC, the DIO, and the residents as soon as possible when it intends to reduce the size of or close one or more programs, or when the Sponsoring Institution intends to close; and,

II.D.5.b) The Sponsoring Institution must either allow residents already in the program(s) to complete their education or assist the residents in enrolling in an ACGME-accredited program(s) in which they can continue their education.

Institutional Requirements 8 Effective: July 1, 2014
Code of Professionalism

The West Virginia University School of Medicine embraces the following Code of Professionalism amongst all students, residents, faculty and staff. This Code provides the foundation for proper lifelong professional behavior. It is the expectation that this behavior will be consistently maintained at its highest level both inside and outside of the professional training environment. This is one of the core competencies.

The nine primary areas of professionalism are defined as:

**Honesty and Integrity**

- Honesty in action and in words, with self and with others
- Does not lie, cheat, or steal
- Adheres sincerely to school values (love, respect, humility, creativity, faith, courage, integrity, trust)
- Avoids misrepresenting one’s self or knowledge
- Admits mistakes
- Will not provide supervision or evaluation of a first degree relative

**Accountability**

- Reports to duty/class punctually and well prepared
- Keeps appointments
- Is receptive of constructive evaluations (by self and others)
- Completes all tasks on time
- Follows up on communications

**Responsibility**

- Reliable, trustworthy, and caring to all
- Prompt, prepared, and organized
- Takes ownership of assigned implicit and explicit assignments
- Seriously and diligently works toward assigned goals/tasks
- Wears appropriate protective clothing, gear as needed in patient care

**Respectful and Nonjudgmental Behavior**

- Consistently courteous and civil to all
- Tolerates diversity in culture, country of origin, gender, sexual orientation, religious preference, political views, age, ethnicity, and race
- Works positively to correct misunderstandings
- Listens before acting
- Considers others’ feelings, background, and perspective
- Realizes the value and limitations of one’s own beliefs, and perspectives
- Strives not to make assumptions
Compassion and Empathy

- Respects and is aware of others’ feelings
- Attempts to understand others’ feelings
- Demonstrates mindfulness and self-reflection

Maturity

- Exhibits personal growth
- Recognizes and corrects mistakes
- Shows appropriate restraint
- Tries to improve oneself
- Has the capacity to put others ahead of self
- Manages relationships and conflicts well
- Maintains personal and professional balance and boundaries
- Willfully displays professional behavior
- Makes sound decisions
- Manages time well
- Able to see the big picture
- Seeks feedback and modifies behavior accordingly
- Maintains publicly appropriate dress and appearance

Skillful Communication

- Effectively uses verbal, non-verbal, and written communication skills that are appropriate to the culture/setting
- Writes and speaks with clarity at a comprehensible level
- Seeks feedback that the information provided is understood
- Speaks clearly in a manner understood by all
- Provides clear and legible written communications
- Gives and receives constructive feedback
- Wears appropriate dress for the occasion
- Enhances conflict management skills

Confidentiality and Privacy in all patient affairs

- Maintains information in an appropriate manner
- Acts in accordance with known guidelines, policies, and regulations
- Seeks and reveals patient information only when necessary and appropriate

Self-directed learning and appraisal skills

- Demonstrates the commitment and ability to be a lifelong learner
- Accomplishes tasks without unnecessary assistance and continues to work and value the team
- Completes academic and clinical work in a timely manner
- Is honest in self-evaluation of behavior, performance, skills, knowledge, strengths, weaknesses, and limitations, and suggests opportunities for improvement
Is open to change Completes in-depth and balanced self-evaluations on a periodic basis

**LCME Standard 3: Academic and Learning Environments**

A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments, recognizes the benefits of diversity, and promotes students’ attainment of competencies required of future physicians.

**Applicable Element 3.5: Learning Environment/Professionalism**

A medical school ensures that the learning environment of its medical education program is conductive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

Updated: July 2015

http://medicine.hsc.wvu.edu/media/20253/code-of-professionalism.pdf
Appendix A

Practicum Rotations

West Virginia University School of Medicine
Graduate Medicine Education

International Rotation Policy

In order for a resident physician enrolled in any graduate medical education training program sponsored by the West Virginia University School of Medicine to obtain permission to complete an International Health Rotation for academic credit, the following approval process must be followed:

1. Written request for an international rotation must be addressed to the Program Director specifying at a minimum when the rotation will occur, how long the rotation will last, where the rotation will be located, and who the supervising physician will be. If the Program Director approves, go to Step 2. If denied, STOP.

2. The Program Director will send the resident’s request and supporting documentation as described in #1 to the GME office.

3. The GME Office will schedule a review of the request at the regularly scheduled meeting of the GMEC Taskforce. If approved, go to Step 5. If denied, STOP.

4. The GME Office will notify the Program Director, the Resident, and the Dean that the rotation has been approved.

5. The Dean will have the final approval authority to approve or deny the rotation request, once the recommendation of the GMEC is received.

6. Appeals of an unfavorable decision may be pursued through the GME Bylaws academic grievance process as outlined in Section XI.

Once approval has been obtained at the level of the Dean, the resident is responsible for all educational related costs associated with this experience including but not limited to: travel, housing, food, passports, etc.

The resident will need to have their travel coordinated through the School of Medicine Office of International Health to review any State Department travel restrictions and required immunizations.

International rotations for credit will not be permitted beyond one calendar month during the entire training period required for successful completion of the program curriculum.
Occupational Medicine Clinic
West Virginia University School of Medicine
Morgantown, WV

Preceptors On-Site:

Anna Allen, MD, MPH  Board certified in Occupational/Family Medicine
Alan M. Ducatman, MD, MSc  Board certified in Occupational Medicine
Robert Gerbo, MD  Board certified in Family Medicine
ChuanFang Jin, MD  Board certified in Occupational Medicine
Christopher Martin, MD, MSc  Board certified in Occupational Medicine
Carl Werntz, DO, MPH  Board certified in Occupational Medicine

Duration:  3-4 half-days/week

Setting: University medical center based practice serving regional industries and employers as a resource for evaluation and management of occupational illness and injuries, consultation to industry, labor, government, community groups, and academia, worksite evaluation in industrial hygiene and safety, and as a teaching and prevention resources.

Resources on site: Occupational health nursing; Industrial Hygiene and Safety resources and personnel available; Full spectrum of diagnostic testing; Computer resources

Rotation Goals:

- How to evaluate work-related disease by developing clinical occupational medical skills, both in general assessment of patients, and in the areas of dermatology, infectious disease, musculoskeletal injury and orthopedics, ophthalmology, pulmonary medicine, surgery and toxicology as they relate to occupational and environmental illness.
- How to design and establish a medical surveillance program to prevent and detect work-related disease.
- How to establish an occupational health program and how to determine the types of occupational medical services necessary at an organization.
- How to conduct a plant walk-through and to interpret the results of industrial hygiene surveys to assess occupational hazards.
- How to recognize when a clinical study should be initiated in an outbreak of occupational illness. An understanding of epidemiology, biostatistics, and applied toxicology is critical. Trainees should recognize the importance of coordinating the efforts of a variety of professionals to conduct these evaluations.
- How to prepare educational programs and advise employers/employees on preventive measures (work practice controls, engineering controls, and personal protective equipment) in the workplace.
- Familiarity with the legal, ethical, and regulatory issues related to the practice of occupational medicine.
- Understanding the standards, including their basis and application, of the Occupational Safety and Health Administration which address occupational health hazards.
- Awareness of the important medical literature related to occupational and environmental medicine and ability to review and interpret the results of research studies.
- Familiarity with principles of environmental health, including the health effects of water and air pollution, indoor air pollution, hazardous waste in the environment, and ability to recommend measures to reduce health risks from the environment.
- How to develop research protocols in occupational medicine.

**Rotation Objectives:**

- Residents will form an integral part of a major occupational health program that serves as a resource to industries of all sizes and types, labor, and government, throughout West Virginia and neighboring states.
- Residents will interact directly with patients, employers, supervisors, administrative and human resource personnel, industrial hygienists, safety personnel, and labor groups under the direction of the faculty.
- Residents will become familiar, and participate in, the West Virginia Worker's Compensation system, to which the Institute serves as a consultant.
- Residents will learn how to prepare reports of patient evaluations for a variety of sources, including the state workers' compensation system, referring physicians region, and for disability and legal uses.
- Residents are expected to use computer resources to access medical, toxicological, and legal information sources, and to integrate this information into their assessment of patients and worksites.

***The only rotation taken by residents at both the PGY2 and PGY3 levels is the Occupational Medicine clinic. We intentionally do not provide different objectives and competencies for these two levels. Occupational Medicine is a discipline which places relatively greater emphasis on assessment rather than treatment. Therefore, our expectation is that residents progressively assume greater responsibility in achieving the same goals and competencies.***
## Competencies for Occupational Medicine Clinic

<table>
<thead>
<tr>
<th>Competency</th>
<th>Specific Topic/Activity</th>
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</table>
| **Patient Care**                    | • knowledge and skills to provide evidence based clinical evaluation and treatment for injuries and illnesses that are occupationally or environmentally related.  
• properly interprets results in establishing fitness for duty  
• prescribes appropriate work restrictions for an injured worker  
• counsels employees about health risks and lifestyle                                                                                                                                 |
| **Medical Knowledge**               | • knowledge and skills to provide guidance to the employee and employer when there is a need for integration of an employee with a disability into the workplace  
• able to identify and address individual and organizational factors in the workplace in order to optimize the health of the worker and enhance productivity  
• knowledge and skills to recognize, evaluate, and treat exposures of toxins at work or in the general environment                                                                                                                                 |
| **Practice Based Learning and Improvement** | Advises employees about the reproductive implications of occupational exposure and provides appropriate advice regarding employment                                                                                                                                 |
| **Interpersonal and Communication Skills** | Uses effective listening skills; elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills                                                                                                                                 |
| **Professionalism**                | Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development  
Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities  
Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices                                                                                                                                 |
| **Systems Based Practice**          | Knowledge and skills necessary to comply with regulations important to occupational and environmental health. This most often includes those regulations essential to workers’ compensation, accommodation of disabilities, public health, worker safety, and environmental health and safety.                                                                                                                                 |
Protects employees’ rights to confidentiality in employer requests for medical records information

Establishes and maintains accurate patient records

Administrative and management knowledge and skills to plan, design, implement, manage, and evaluate comprehensive occupational and environmental health programs and projects

Knowledge and skills necessary to recognize potential environmental causes of concern to the individual as well as to the community health

Knowledge and skills to plan for mitigation of, response to, and recovery from disasters at specific worksite as well as for the community at large.

Knowledge and skills necessary to assess if there is a risk of an adverse event from exposure to physical, chemical, or biological hazards in the workplace or environment. If there is a risk with exposure, then that risk can be characterized with recommendations for control measures.

Knowledge of the health effects of the broad physical and social environment, which includes housing urban development, land use and transportation, industry and agriculture
BrickStreet Mutual Insurance
Charleston, WV

Preceptor: Randall Short, DO, Medical Director

Duration: One month

Setting: Privatized compensation system

Resources On-site: Full time medical director; several part-time medical advisors; database manager and consultants to this agency

Rotation Goals:

- Residents will understand the workings of an independent run workers’ compensation system
- Residents will learn the techniques of consultation to insurers, employees, governmental agencies, and the legal system
- Residents will understand the means by which management and compensation of workers for occupational injuries and disease is performed
- Residents will become familiar with the workers’ compensation database, and understand the techniques and purposes of using a database in the examination and reduction of compensation costs

Rotation Objectives:

- The preceptor will coordinate interactions with various components of the BrickStreet Insurance to allow the resident to understand how this system operates. The resident should understand the “life of a claim” from the point of a claim is filed to various outcomes such as acceptance, denial and appeal, final closure, etc.
- The resident would participate, as appropriate, in providing medical consultation for BrickStreet Insurance personnel. This will involve formal written file reviews under the supervision of medical staff, as well as less formal verbal interactions
- The preceptor and resident may choose to pursue an independent study project, which may consist of conducting research utilizing the Workers’ Compensation database and/or an educational project for personnel. For research, this will allow the development of personal knowledge in the areas of occupational injury, existing data, and risk factors for injury. The project would include either a written or verbal presentation and will allow the resident to develop in depth knowledge of a topic of current concern.
## Competencies for BrickStreet

<table>
<thead>
<tr>
<th>Competency Area</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Patient Care**                      | Make informed decisions about diagnostic and therapeutic interventions based on patient information, up to date scientific evidence and clinical judgment  
Work with health care professionals, including those from other disciplines, to provide patient focused care  
Ability to perform disability and impairment rating examinations |
| **Medical Knowledge**                 | Knowledge of the independent medical examiner role  
Ability to write appropriate work restrictions  
Ability to provide expert opinions and testimony regarding the work relatedness of disease  
Knowledge of workers’ compensation services rules and reimbursement issues |
| **Practice Based Learning and Improvement** | Ability to recognize and manage delayed recovery  
Understanding of medical information systems and application to surveillance and tracking of worker disability |
| **Interpersonal and Communication Skills** | Ability to advise patients about the basic elements of workers compensation law  
Understanding of the nursing role in an occ. Health services; ability to work effectively with the OHN |
| **Professionalism**                   | Knowledge of the legislation protecting the handicapped in workers selection (Americans with Disabilities Act)  
Ability to determine employees’ rights to confidentiality in employer requests for medical records information |
| **Systems Based Practice**            | Manage worker insurance documentation and paperwork, for work related injuries that may arise in numerous work settings  
Ability to properly report cases of occupational injury and illness according to existing regulations |
National Institute for Occupational Safety and Health
Respiratory Health Division (RHD)
Morgantown, WV

Director: David Weissman, MD
Preceptors: Rachel Bailey, MD and Kristin Cummings, MD
Duration: Six months (part-time)

Setting: The National Institute for Occupational Safety and Health (NIOSH) is an 110,000 square foot, four-story building that houses the Appalachian Laboratory for Occupational Safety and Health. The facility was completed in 1970. A new building, which includes 200,000 square feet of laboratory and office space for occupational medicine research, has been completed adjacent to the present structure. Both buildings are located on the WVU campus within walking distance of the Health Sciences Center. NIOSH is a federal agency and all construction and operational funds are provided by the federal government.

Rotation Goals:
- To introduce the resident to NIOSH and its role in occupational respiratory diseases research, surveillance, and service
- To provide the resident with specialized training experiences in research, surveillance, and service related to occupational respiratory disease
- To allow the resident to actively participate in at least one field investigation, such as a Health Hazard Evaluation
- To allow the resident to explore career opportunities in occupational medicine at NIOSH

Rotation Objectives:
- Work with health care professionals, including those from other disciplines, in outgoing studies, as well as surveillance activities. Emphasis will be placed on principles of surveillance and epidemiology
- Mentored self-study of ILO classification of radiographs of pneumoconiosis using NIOSH syllabus. Develop an understanding of the NIOSH B-reader program. Assist and work effectively with others as a team on the national coal workers’ pneumoconiosis surveillance program
- Become familiar with the various means for communicating occupational respiratory disease abatement information to multiple professional and lay target groups, both in oral and written presentations. Respond, as appropriate, to selected inquiries concerning occupational respiratory disease and related matters.
- Attend team meetings and assist infield investigations and evaluations, as well as in search for and reviewing pertinent existing information. Emphasis will be placed on demonstrating an investigatory and analytical thinking approach to identify disease conditions and potential risk factors and develop recommendations for preventing occupational respiratory diseases.
### Competencies of NIOSH - DRDS

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Ability to advise workers regarding industrial hygiene controls such as work practices, personal protective equipment use, and engineering controls</th>
</tr>
</thead>
</table>
| Medical Knowledge | Knowledge of the key elements of a good respirator program, and ability to perform respirator certification exams  
Knowledge of the proper response to non-occupational public health problems, such as an outbreak of food-borne illness  
Knowledge of primary, secondary, and tertiary methods of prevention |
| Practice Based Learning and Improvement | Ability to perform a workplace walk through and to identify major health and safety hazards  
Ability to recommend control measures to employers to reduce safety and health hazards  
Ability to evaluate and interpret the results of basic industrial hygiene surveys  
Ability to evaluate the health effects of toxic exposures in the workplace, including mixtures |
| Interpersonal and Communication Skills | Communicates professionally with personnel, including supervisors, support staff and outside professionals  
Sensitivity to gender, culture, age and disability issues  
Computer applications relevant to occupational medicine – use of statistical and database software in research work  
Ability to use a computer database to research the health effects of a chemical substance |
| Professionalism | Timeliness  
Demonstrates compassion and integrity  
Adheres top ethical principles |
| Systems Based Practice | Monitor/survey workforces and interpret monitoring/surveillance data for prevention of disease in workplaces and to enhance the health and productivity of workers; Recognize outbreak events of public health significance, as they appear in clinical or consultation settings  
Ability to apply OSHA PEL’s, NIOSH REL’s, ACGIH TLV’s, EPA standards, and other criteria in the assessment of workplace chemical exposures |
Setting: The National Institute for Occupational Safety and Health (NIOSH) is an 110,000 square foot, four-story building that houses the Appalachian Laboratory for Occupational Safety and Health. The facility was completed in 1970. A new building, which includes 200,000 square feet of laboratory and office space for occupational medicine research, has been completed adjacent to the present structure. Both buildings are located on the WVU campus within walking distance of the Health Sciences Center. NIOSH is a federal agency and all construction and operational funds are provided by the federal government.

Rotation Goals:

- To introduce the resident to NIOSH and its role in occupational safety and health research, surveillance, and service
- To provide the resident with specialized research and training experience related to occupational safety and health
- To allow the resident to actively participate in field investigations, such as fatality investigations
- To allow the resident to explore career opportunities in occupational medicine at NIOSH

Rotation Objectives:

- Resident would work effectively with others as a member or leader of a health care team. The resident would attend team meetings and may assist in field investigations and evaluations. Emphasis would be placed on investigation methods and techniques to identify potential risk factors and develop recommendations for preventing future similar deaths
- Observe and participate as appropriate in ongoing morbidity and mortality studies, as well as surveillance activities. Emphasis will be placed on principles of surveillance and epidemiology.
- Use computers for work processing, reference retrieval, statistical analysis and communication. Observe and participate, as appropriate, in ongoing laboratory and computer simulation studies to collect data on human subjects, identify risk factors, and evaluate promising prevention strategies.
- Acquire skills to provide appropriate safety information and education to workers and managers
### Competencies for NIOSH - DSR

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Ability to advise workers regarding safety hazards they are likely to encounter at work and steps that can be taken to reduce the risk for injury</th>
</tr>
</thead>
</table>
| Medical Knowledge | Knowledge of the key elements of a comprehensive safety and health plan  
Knowledge of the role of protective technology and human factors research in studying the etiology and prevention of occupational injuries  
Knowledge of existing occupational injury and illness surveillance systems, their strengths and limitations  
Knowledge of primary, secondary and tertiary methods of prevention |
| Practice Based Learning and Improvement | Ability to perform a workplace walk through and to identify major safety hazards  
Ability to identify probably hazards in specific work places through use of available data systems and published research and resources  
Ability to design an occupational injury surveillance system in a medical or employment setting  
Ability to recommend control measures to employers to reduce safety hazards in the work place  
Ability to identify and apply mandatory and voluntary standards (e.g. OSHA, Wage and Hour, ANSI) to control safety hazards or minimize worker injury  
Ability to describe patterns and risk factors for injury using surveillance data |
| Interpersonal and Communication Skills | Communicates professionally with personnel, including supervisors, support staff and outside professionals  
Sensitivity to gender, culture, age and disability issues |
| Professionalism | Timeliness; Demonstrates compassion and integrity  
Adheres to ethical principles |
| Systems Based Practice | Understanding of the use of source records such as medical records and OSHA 100 logs in occupational injury surveillance systems, and knowledge about critical information to include in these records  
Knowledge about variety of coding systems used to classify industries, occupations and injury circumstances |
Institute for Occupational Safety and Health
Health Effects Laboratory Division (HELD)
Morgantown, WV

**Director:** Don Beezhold  
**Preceptor:** TBD  
**Duration:** Six months (part-time)

**Setting:** The National Institute for Occupational Safety and Health (NIOSH) is an 110,000 square foot, four-story building that houses the Appalachian Laboratory for Occupational Safety and Health. The facility was completed in 1970. A new building, which includes 200,000 square feet of laboratory and office space for occupational medicine research, has been completed adjacent to the present structure. Both buildings are located on the WVU campus within walking distance of the Health Sciences Center. NIOSH is a federal agency and all construction and operational funds are provided by the federal government.

**Rotation Goals:**

- Introduce the resident to NIOSH and its role in occupational safety and health research, in particular the importance of the linkage between causal mechanism and public health relevance
- To provide the resident with specialized research and training experiences related to occupational safety and health
- Too allow the resident to actively participate in literature reviews, seminars, and guided discussions to assess how laboratory and epidemiology methods focused on causal mechanism establish public health relevance

**Rotation Objectives:**

Objectives are tailored to the missions of the six Branches within HELD. For all Branches, the resident will participate in literature reviews, seminars, and guided discussions to assess how laboratory and/or epidemiologic methods focus on establishing the causal mechanism to characterize public health relevance. The resident may engage in the conduct of actual investigations depending on capabilities, expertise, and availability of HELD staff to train and monitor the resident at this level of involvement.

A. **Allergy and Clinical Immunology Branch (ACIB)**
   …transmission of influenza, characterization of allergens derived from molds and fungi relevant to occupational disease, and characterization of epitopes involved in chemical modification of in vivo proteins by exposure to chemical agents.

B. **Biostatistics and Epidemiology Branch (BEB)**
   …1) research methodology, data management, statistical analysis, and quality assurance for laboratory, epidemiologic and public health research; 2) development of new statistical methods to directly support emerging research issues; and 3) conducting collaborative population-based research in occupational health and facilitating use of laboratory-based methodology in epidemiologic research.
Involvement in the Buffalo Cardio-metabolic Occupational Police Stress (BCOPS) Study may be of particular interest to the resident.

C. Engineering and Control Technology Branch (ECTB)
… conducting research that provides workers, employers, researchers, occupational health practitioners, manufacturers, and those responsible for the dissemination of guidelines and standards with the capability to better assess and understand the relationship between physical work activities and worker health. Particular expertise is focused on hand-arm vibration and biomechanical modeling and assessment.

D. Exposure Assessment Branch (EAB)
… exploring and developing novel and improved techniques for assessing the exposure of workers to principally chemical, but also physical and biological hazards. EAB is particularly involved in the interface between research results and standards organizations.

E. Pathology and Physiological Research Branch (PPRB)
… 1) research into innovative techniques to identify disease mechanisms; develop biomarkers and functional tests to identify dysfunction in its early pre-clinical state; identify mechanisms for repair or resolution of disease; and develop and apply new imaging techniques for the evaluation of structure/function;

2) examining in an applied and preventive research mode, the effects of workplace exposures in human and animal models, evaluate changes in system and organ function, cellular response, and receptor activation, and evaluate their role in the development of disease/dysfunction. Researchers will reveal mechanisms of action, identify early functional markers of detection, and make recommendations for prevention and control/intervention;

3) providing advice and collaborative service for NIOSH investigators interested in physiological/pharmacological/pathological effects of workplace exposures on field-based and animal/cellular systems;

4) examining the alteration of function based on pre-existing disease, exposure-induced disease, or cellular/organ structural impairment in the context of responses to occupational exposures, both actual and laboratory-generated;

5) providing animal exposure and pathological support to HELD and other NIOSH divisions in the development, use, and evaluation of exposure systems that mimic the occupational situation, reach the various target organs, and results in sensitive models of structural or functional change; and

6) developing sensitive animal-specific tools, molecular probes, or imaging techniques that can be modified or used for animal models of occupational disease/exposure to provide animal pathology support to researchers.

F. Toxicology and Molecular Biology Branch (TMBB)
… 1) focusing on understanding changes and differences of biological systems at the molecular, cellular, tissue, and organ level. This includes exploration of basic integrative links between various organ systems as they pertain to human health effects of workplace exposures;

2) providing a scientific basis for the development of strategies for early detection, intervention, and therapy of occupational diseases and applying these strategies to practice in the workplace. This
includes facilitating the design of studies for the prevention of occupational diseases through the development of new techniques, new biomarkers, and collaborations with scientific and technical staff from within NIOSH and outside organizations.

Competencies for NIOSH – HELD

Basic Science, Medical, and Public Health Knowledge
- Conceptual grounding and specific understanding of the links between establishing a causal mechanism, clinical manifestation, and particularly public health relevance.
- Capabilities to conduct a literature review and inform as well as be informed by basic and/or observational scientists.

Interpersonal and Communication Skills
- Communicates professionally with personnel, including supervisors, support staff and outside professionals
- Sensitivity to gender, culture, age and disability issues

Professionalism
- Timeliness
- Demonstrates compassion and integrity
- Adheres to ethical principles
Preceptor: Richard Thomas MD, MPH
Duration: Two months
Setting: Governmental Investigative and Enforcement Agency

Rotation Goals:

- To become familiar with the organizational structure and function of the OSHA and the Office of Occupational Medicine (OOM)
- To become familiar with OSHA’s regulatory process; the Occupational Safety and Health Act of 1970; and rulemaking activities
- To become familiar with OSHA’s programs to promote occupational safety and health
- Increase individual proficiency in responding to occupational health related inquiries from health care professionals, academic, industry and the public

Rotation Objectives:

- Resident shall be able to communicate clearly to multiple professional and lay target groups, in both written and oral presentations, by actively participating in the Office of Occupational Medicine’s office activities including staff meetings. A written summary of the work competed during the rotation will be presented at the end of the rotation.
- The resident will work with health care professionals, including those from other disciplines to acquire insight as to their functions and current roles in OSHA activities
- The resident will gather essential and accurate statistics by using information technology to manage data and access on line medical information
- The resident will answer inquiries (verbal and/or written) from other health professionals, government agencies, and/or the public
- The resident will actively participate in a field investigation with OSHA personnel and prepare a written report
## Competencies for OSHA

| Medical Knowledge | Interpret monitoring/surveillance data for prevention of disease in work places and to enhance the health and productivity of workers  
|                   | Recognize outbreak events of public health significance, as they appear in clinical or consultation settings  
|                   | Work with computer applications relevant to occupational medicine – use of statistical and database software in research work |
| Interpersonal and Communication Skills | Communicate effectively while addressing a public audience – presentation of research work at OSHA  
|                   | Demonstrate sensitivity to gender, culture, age, and disability issues |
| Practice Based Learning and Improvement | Gain an understanding of public health policy development and enforcement  
|                   | Help identify OSHA’s various roles in occupational medicine, including enforcement, standards, guidance, compliance assistance and jurisdictional oversight  
|                   | Answer inquiries from health professionals, government agencies and the public  
|                   | Develop an appreciation for the application of epidemiologic and scientific research to public health policy, individuals and populations |
| Professionalism | Ability to meet deadlines and reporting requirements  
|                   | Demonstrate adherence to ethical principles and business practices |
| System Based Practice | Partake in public health risk assessment and risk communication  
|                   | Develop Safety and Health Information Bulletins (SHIBs)  
|                   | Assist OSHA field offices in compliance investigations  
|                   | Design an appropriate health screening questionnaire for workers exposed to toxic materials |
Kanawha Charleston Health Department  
Charleston, WV

Preceptor: Michael Brumage, MD, MPH, FACP  
Executive Director/Health Officer

Duration: One Month

Rotation Goals:
- Be knowledgeable and familiar with the many program and activities of a public health department
- Participate in all of the programs offered by the department
- Become familiar with the West Virginia code establishing the organization and mandated activities of the department
- Understand the budget process and funding of Department programs
- Be familiar with the basis for the authority of the Public Health Officer as well as the interaction with the legal system
- Understand the essential elements of public health administration and the community health assessment planning process

Rotation Objectives:
- Join in the medical supervision of Public Health clinics
- Join in the medical supervision of Environmental programs
- Join in the medical supervision of Home Health Care programs
- Observe medical service to boards of community organizations, study groups and appointed task forces
- Participate in the investigation of illnesses due to infectious agents, environmental agents, and chronic diseases
<table>
<thead>
<tr>
<th>Competencies for Kanawha Charleston Health Department</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
</tr>
<tr>
<td>Knowledge of infectious disease; chronic disease; individual behavior interventions, community based behavior interventions</td>
</tr>
<tr>
<td>Identify resources to improve a communities health</td>
</tr>
<tr>
<td>Appropriately recommends routine adult immunizations</td>
</tr>
<tr>
<td><strong>Practice Based Learning and Improvement</strong></td>
</tr>
<tr>
<td>Employs standard procedures and protocols for the management of hazardous materials incidents</td>
</tr>
<tr>
<td>Assist with development of disaster planning for public health and terrorism response</td>
</tr>
<tr>
<td>Identifies practical challenges to the design of health screening programs</td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
</tr>
<tr>
<td>Ability to recommend methods of reducing environmental health risks</td>
</tr>
<tr>
<td>Ability to recommend methods of control for indoor air pollution problems</td>
</tr>
<tr>
<td>Ability to explain the controversies associated with electromagnetic field exposures</td>
</tr>
<tr>
<td><strong>Systems Based Practice</strong></td>
</tr>
<tr>
<td>Recognizes outbreak events of public health significance, as they appear in clinical or consultation settings</td>
</tr>
<tr>
<td>Recommends primary, secondary, and tertiary methods of prevention, as appropriate</td>
</tr>
<tr>
<td>Responds appropriately to non-occupational public health problems such as an outbreak of food borne illness</td>
</tr>
<tr>
<td><strong>Interpersonal and Communication</strong></td>
</tr>
<tr>
<td>Communicate effectively with the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds</td>
</tr>
<tr>
<td>Communicate effectively with physicians, other health professionals, and health related agencies</td>
</tr>
<tr>
<td>Work effectively as a member or leader of a health care team or other professional group</td>
</tr>
<tr>
<td>Maintain comprehensive, timely and legible medical records, if applicable</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
</tr>
<tr>
<td>Compassion, integrity, and respect for others</td>
</tr>
<tr>
<td>Responsiveness to patient needs that supersedes self-interest</td>
</tr>
<tr>
<td>Respect for patient privacy and autonomy</td>
</tr>
<tr>
<td>Sensitivity and responsiveness to a diverse patient population</td>
</tr>
</tbody>
</table>
## Appendix B
### ACGME Six Core Competencies

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.</td>
</tr>
<tr>
<td>Practice Based Learning and Improvement</td>
<td>Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.</td>
</tr>
<tr>
<td>Systems Based Practice</td>
<td>Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.</td>
</tr>
</tbody>
</table>

### ACOEM TEN CORE COMPETENCIES

<table>
<thead>
<tr>
<th>Clinical Occupational and Environmental Medicine</th>
<th>The physician has the knowledge and skills to provide evidence based clinical evaluation and treatment for injuries and illnesses that are occupationally or environmentally related.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OEM Related Law and Regulations</td>
<td>The physician has the knowledge and skills necessary to comply with regulations important to occupational and environmental health. This most often includes those regulations essential to workers’ compensation, accommodation of disabilities, public health, worker safety, and environmental health and safety.</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>The physician has the knowledge and skills necessary to recognize potential environmental causes of concern to the individual as well as to the community health. Environmental issues most often include air, water, or ground contamination by natural or artificial pollutants. The physician has knowledge of the health effects of the broad physical and social environment, which includes housing urban development, land use and transportation, industry and agriculture.</td>
</tr>
<tr>
<td>Work Fitness and Disability Integration</td>
<td>The physician has the knowledge and skills to determine if a worker can safely be at work and complete required job tasks. The physician has the knowledge and skills necessary to provide guidance to the employee and employer when there is a need for integration of an employee with a disability into the workplace.</td>
</tr>
<tr>
<td>Toxicology</td>
<td>The physician has the knowledge and skills to recognize, evaluate, and treat exposures to toxins at work or in the general environment. This most often includes interpretation of laboratory or environmental monitoring test results as well as applying toxicokinetic data.</td>
</tr>
<tr>
<td>Hazard Recognition, Evaluation, and Control</td>
<td>The physician has the knowledge and skills necessary to assess if there is a risk of an adverse event from exposure to physical, chemical, or biological hazards in the workplace or environment. If there is a risk with exposure, then that risk can be characterized with recommendations for control measures.</td>
</tr>
<tr>
<td>Disaster Preparedness and Emergency Management</td>
<td>The physician has the knowledge and skills to plan for mitigation of, response to, and recovery from disasters at specific worksite as well as for the community at large. Emergency management</td>
</tr>
</tbody>
</table>
most often includes resource mobilization, risk communication, and collaboration with local, state, or federal agencies.

<table>
<thead>
<tr>
<th>Health and Productivity</th>
<th>A physical will be able to identify and address individual and organizational factors in the workplace in order to optimize the health of the worker and enhance productivity. These issues most often include absenteeism, presentism, health enhancement, and population health management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health, Surveillance, and Disease Prevention</td>
<td>The physician has the knowledge and skill to develop, evaluate, and manage medical surveillance programs for the workplace as well as the general public. The physician has the knowledge and skills to apply primary, secondary, and tertiary preventive methods.</td>
</tr>
<tr>
<td>OEM Related Management and Administration</td>
<td>The physician has the administrative and management knowledge and skills to plan, design, implement, manage, and evaluate comprehensive occupational and environmental health programs and projects.</td>
</tr>
</tbody>
</table>

### Occupational Medicine Required Competency Matrix
(taken from ACGME program requirements)

<table>
<thead>
<tr>
<th>Competency</th>
<th>Type (e.g. MPH Class work; Didactic or practicum experience)</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Academic Competencies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Health Services Management and Administration</td>
<td>MPH class work, practicum experience</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>B. Epidemiology/Biostatistics</td>
<td>OM Rounds, MPH class work</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>C. Clinical Preventive Medicine</td>
<td>Occupational medicine clinic, OM Rounds, practicum experiences</td>
<td>West Virginia University Kanawha Charleston Health Dept. NIOSH</td>
</tr>
<tr>
<td>D. Behavior/Mental Health</td>
<td>MPH class work, practicum experience</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>E. Environmental Health</td>
<td>MPH class work, practicum experience</td>
<td>West Virginia University Kanawha Charleston Health Dept.</td>
</tr>
<tr>
<td><strong>Occupational Medicine Knowledge Content Areas</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Toxicology</td>
<td>OM rounds, Occupational Medicine clinic, practicum experiences</td>
<td>West Virginia University OSHA NIOSH</td>
</tr>
<tr>
<td>B. Occupational Epidemiology</td>
<td>OM rounds, MPH class work, Occupational Medicine clinic, practicum experience</td>
<td>West Virginia University NIOSH OSHA</td>
</tr>
<tr>
<td>C. Industrial Hygiene</td>
<td>MPH class work, practicum experiences</td>
<td>West Virginia University NIOSH OSHA</td>
</tr>
<tr>
<td>D. Safety and Ergonomics</td>
<td>OM rounds, MPH class work, Occupational Medicine clinic, practicum experiences, NIOSH-approved Spirometry Course, CAHOC Occupational Hearing Conservation Course</td>
<td>West Virginia University Brickstreet Insurance</td>
</tr>
<tr>
<td>E. Risk/Hazard Control and Communication</td>
<td>MPH class work, practicum experiences</td>
<td>West Virginia University Kanawha Charleston Health Dept.</td>
</tr>
<tr>
<td>Competency</td>
<td>Type (e.g. MPH Class work; Didactic or practicum experience)</td>
<td>Institution</td>
</tr>
<tr>
<td>------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Core Preventive Medicine Competencies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Applied Epidemiology (acute and chronic disease)</td>
<td>MPH class work</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>Advanced Biostatistics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Health Services Management</td>
<td>MPH class work, Occupational Medicine clinic, practicum experience</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>Clinical Preventive Services</td>
<td>Occupational Medicine clinic, OM rounds, practicum experiences</td>
<td>West Virginia University Kanawha Charleston Health</td>
</tr>
<tr>
<td>Risk/Hazard Control and Communication</td>
<td>MPH class work, Occupational Medicine clinic, practicum experiences</td>
<td>West Virginia University Kanawha Charleston Health NIOSH OSHA</td>
</tr>
<tr>
<td><strong>Occupational Medicine Competencies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health</td>
<td>Occupational Medicine clinic, practicum experience</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>Manage the health status of individuals who work in diverse settings</td>
<td>Occupational Medicine clinic, practicum experience</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>Monitor/survey workforces and interpret monitoring/surveillance data for prevention of disease in workplaces and to enhance the health and productivity of workers</td>
<td>Occupational Medicine clinic, practicum experiences, NIOSH-approved Spirometry Course, CAHOC Occupational Hearing Conservation Course</td>
<td>West Virginia University NIOSH OSHA</td>
</tr>
<tr>
<td>Plan at least one surveillance or monitoring program for different types of workforces</td>
<td>Practicum experience</td>
<td>NIOSH</td>
</tr>
<tr>
<td>Manage worker compensation insurance documentation and paperwork, for work-related injuries that may arise in numerous work settings</td>
<td>Occupational Medicine clinic, practicum experiences</td>
<td>West Virginia University Brickstreet Insurance</td>
</tr>
<tr>
<td>Competency</td>
<td>Type (e.g. MPH Class work; Didactic or practicum experience)</td>
<td>Institution</td>
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</tr>
<tr>
<td>Recognize and respond to outbreak events of public health significance, as they appear in workplace settings</td>
<td>MPH class work, Occupational Medicine clinic, practicum experiences</td>
<td>West Virginia University Kanawha Charleston Health NIOSH OSHA</td>
</tr>
<tr>
<td>Approach the practice of occupational medicine from an ethical base that promotes the health and welfare of the individual worker in the context of the workplace environment and public health and public safety</td>
<td>Practicum experiences</td>
<td>Kanawha Charleston Health Dept. NIOSH</td>
</tr>
<tr>
<td>Participate in emergency preparedness programs in at least one workplace setting</td>
<td>Occupational Medicine clinic, practicum experiences</td>
<td>West Virginia University Kanawha Charleston Health NIOSH OSHA</td>
</tr>
<tr>
<td>Demonstrate expertise in their knowledge of all content areas included in the required graduate courses for completion of the program</td>
<td></td>
<td>West Virginia University Kanawha Charleston Health NIOSH OSHA</td>
</tr>
<tr>
<td>Demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self evaluation and life long learning by using computers for reference retrieval, use EPI principles and biostatistics methods, design and conduct an EPI study; conduct an advanced literature search</td>
<td>MPH Classwork</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>Demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, families, and health professionals</td>
<td>Occ Med Clinic; Practicum Experiences</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles</td>
<td>Occ Med clinic; Practicum experiences</td>
<td>West Virginia University</td>
</tr>
<tr>
<td>Competency</td>
<td>Type (e.g. MPH Class work; Didactic or practicum experience)</td>
<td>Institution</td>
</tr>
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<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care</td>
<td>Practicum experiences</td>
<td>Kanawha Charleston Health Dept.</td>
</tr>
</tbody>
</table>

**Appendix C – Evaluations**

1. An initial evaluative session between the resident and the Program Director and Associate Program Director will be held at the start of their residency in order to identify strengths and areas in which the resident could benefit from specially directed training.
2. All residents will meet quarterly with both the Program Director and Associate Program Director. A letter is written detailing the discussion and a copy kept in the resident’s file.
3. At the end of each rotation, the preceptor will evaluate the resident on the basis of acquired knowledge and skills as demonstrated while the resident will provide an evaluation of the rotation regarding strengths and weaknesses and recommendations for modifications or enhancements. All rotation evaluations will be discussed and signed by both resident and Residency Director. Originals are kept in the residents file, with a copy going to the preceptor(s).
4. All residents will evaluate and/or be evaluated, annually, by (random) patients, staff members, peer and self.
5. All residents and faculty members will be asked to complete an annual program evaluation. Evaluations will be discussed during the annual review of the residency program.
6. Confidentiality will be maintained. Residents have access to his/her academic file and evaluations at all times.
7. The Annual faculty and resident surveys will complete questions on the efficacy of the transfer of care systems. This evaluation will address both ambulatory and verbal interservice transfer of care systems. The results of the faculty and resident evaluations will be reviewed at the annual program evaluation committee meeting.
SAMPLE

Rotation Evaluation Form
To be completed by preceptor after rotation

Resident: [Field]
Preceptor: [Field]
Date of Rotation: [Field]

Patient Care:
Advises employees about the implications of occupational exposure and provides appropriate advice regarding employment

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<th>Proficient</th>
<th>Exceeds level of training</th>
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Obtains screening and comprehensive patient histories accurately and with an emphasis on occupation(s) and exposures

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System Based Practice
Works in interdisciplinary teams to enhance patient safety and improve patient care quality

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Practices and advocates for cost-effective responsible care

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<th>Exceeds level of training</th>
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Obtains consultation when needed; makes appropriate referrals

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<th>Proficient</th>
<th>Exceeds level of training</th>
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Practice Based Learning
Locates, appraises, and assimilates evidence from valid sources
Recommends control measures to employers to reduce safety and health hazards in the work place

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ICS

Communicates effectively with physicians, other health professionals, and health related agencies and works effectively as a member or leader of a healthcare team

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Professionalism

Protects employees’ rights to confidentiality

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On time for appointments, appropriately dressed and groomed, and behaves respectfully and professionally towards others

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Medical Knowledge

Knowledge of legal and regulatory issues focusing on OSHA regulations

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Correctly recognizes and diagnoses occupational and environmental illnesses and injuries

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</table>
SAMPLE
Practicum Rotation

*To be completed by resident after rotation*

Constructive criticism and adequate feedback included the resident in all appropriate teaching and learning opportunities

<table>
<thead>
<tr>
<th>NA</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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The preceptor presented information and new perspectives on public health topics

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<thead>
<tr>
<th>NA</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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The preceptor stimulated critical thinking

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<tr>
<th>NA</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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</table>

The preceptor was available when needed

<table>
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<tr>
<th>NA</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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The preceptor provided adequate opportunities for the resident to interact with other public health resources (supervisors, IH, safety, etc)

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<tr>
<th>NA</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
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The preceptor enhanced your understanding of public health issues in OEM

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<tr>
<th>NA</th>
<th>Poor</th>
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<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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At the start of this rotation were you given the goals and objectives? Yes No

Were the goals and objectives of this rotation met? Yes No

What do you like best about this rotation?

What do you like least about this rotation?

What suggestions do you have for improving this rotation?

Were you on duty more than 80 hours per week during your rotation (this includes all in-house call activity) averaged over the four week period? Yes No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Did you work more hours per month than the “continuous duty hours” limit states? (Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Resident may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Did you get at least one 24-hour time period off in seven days averaged over the four week period?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were you ever on call more often than every 3rd night averaged over the four week period?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Appendix D
Selected References in Occupational and Preventive Medicine

Preventive Medicine

Occupational Medicine
LaDou, J. *Occupational Medicine*. Norwalk, CT. Appleton & Lange. 1996
Recommended Journals

Residents are also expected to become familiar with occupational medicine journals including:

- **Journal of Occupational and Environmental Medicine**
  
  [http://journals.lww.com/joem/pages/default.aspx](http://journals.lww.com/joem/pages/default.aspx)

- **The American Journal of Industrial Medicine**
  

- **Occupational and Environmental Medicine (formerly British Journal of Industrial Medicine)**
  
  [http://oem.bmj.com/](http://oem.bmj.com/)

- **Scandinavian Journal of Work, Environment & Health**
  

- **Archives of Environmental Health**
  
  [http://www.tandfonline.com/toc/vaeh20/current#.Vv7R_Xq0fwY](http://www.tandfonline.com/toc/vaeh20/current#.Vv7R_Xq0fwY)

- **American Journal of Public Health**
  

- **American Journal of Preventive Medicine**
  

Many of these journals are maintained in the residency director's office and are also available at the WVU School of Medicine Library.

Residents are also expected to become familiar with articles of occupational medicine importance that are published in major medical journals such as the New England Journal of Medicine and the Journal of the American Medical Association.

Electronic Literature Access

Extensive computer resources are maintained for the residents by the Institute. Facilities for tracking and searching relevant occupational medical data, including HTTP browsers, FTP servers, and other connections are available. A CD-ROM collection, including NIOSHTIC, OEM Silver Platter, and the Code of Federal Regulations, is available in the library.

The library maintains a connection to the National Library of Medicine's MEDLINE literature search service and searchable catalogues of books through MountainLynx. Residents can search the medical literature for preparation of medical reports, research projects, and public health coursework by accessing [http://www.libraries.wvu.edu/](http://www.libraries.wvu.edu/).
MEMORANDUM

TO: WVU Medical Corporation Physicians
FROM: W. Robert Wright, Jr.
President & CEO
DATE: March 15, 1996
SUBJECT: Medicare Documentation Requirements

Periodically, we have written to WVU Medical Corporation Physicians to advise them of the Medicare regulations concerning medical chart documentation as teaching physicians. Due to the addition of several new physician faculties and as a reminder to others, I felt we should again review those requirements.

Attached you will find a page entitled Notice to Teaching Physicians which was the last notice sent to us by Nationwide Insurance, our intermediary for the Medicare program in the State of West Virginia. Please review these requirements closely with your residents and nursing support staff to ensure compliance.

Attachment

NOTICE TO TEACHING PHYSICIANS

As the result of an investigation by the General Accounting Office (G.A.O.) and its report to a congressional committee regarding Medicare documentation of teaching physicians services, Nationwide Mutual Insurance Company, the Part B Medicare carrier for Ohio and West Virginia, is changing its documentation requirements. These changes require more explicit documentation, by teaching physicians, that fully and clearly demonstrates the physicians’ actual, personal and immediate presence and involvement in the treatment and care of the patients for the days the physicians bill the program. These additional requirements will begin with calendar year 1987 dates of services.

The 1980 requirements of Section 1842 (b) (7) (A) (I) of the Social Security Act provide that Part B payments for teaching physicians’ services cannot be made unless:

1. The physician renders sufficient personal and identifiable services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought,
2. The services provided Medicare beneficiaries are of the same character as those furnished to patients not entitled to Medicare benefits, and
3. At least 25% of the hospitals patients who are not entitled to Medicare benefits and who are furnished services as described above paid for all or a substantial part of the charges imposed for such services.

The G.A.O.’s criteria states, that teaching physicians to be reimbursed, must provide personal and identifiable services to program beneficiaries. This requires documentation in-patients medical records that the teaching physicians either personally provided the service or were present when residents provided the services.
The medical record must contain signed notes by physicians showing that he/she personally (1) reviewed the patients’ medical history, (2) performed physical examinations, (3) confirmed or revised the diagnoses, (4) visited the patients during the more critical periods of illness, and (5) discharged the patients. For other individual instances of services billed, notes by residents or nurses indicating that the physicians were physically present when services were rendered constitute sufficient documentation of the physician’s involvement to establish the attending physician relationship.

Reviewing resident’s notes along is generally considered a teaching function reimbursable under Part A and is not sufficient to establish entitlement for a fee-for-service reimbursement under Part B.

Physician’s countersignatures on notes or reports by residents or nurses will not be accepted unless the notes, reports or other evidence in the patients hospital records confirm that the physicians were involved or present when services were provided.
December 6, 2002

MEMORANDUM #02-45

TO: Council of Deans
    Council of Academic Societies
    Council of Teaching Hospitals and Health Systems

FROM: Jordan J. Cohen, M.D.

SUBJECT: Revisions to Medicare Carrier Manual Instructions on Supervising Physicians in Teaching Settings

On November 22, 2002, the Centers for Medicare and Medicaid Services (CMS) published changes to the Carrier Manual Instructions (CMI), Section 15016, Supervising Physicians in Teaching Settings. The revisions are located at http://www.cms.hhs.gov/manuals/transmittals/
the CR # is 2290. The revisions were effective on the date they were issued.

While the teaching physician regulation that was effective on July 1, 1996 remains unchanged, the revised CMI makes important positive changes in the documentation requirements by reducing the amount of personal documentation that the teaching physician must provide when a resident also writes a note. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. Further, the revisions clarify other issues, including the use of documentation by students, and updates regulatory references. The instructions should be carefully reviewed by each institution.

Background

Of special interest to AAMC members have been the federal government’s payment rules when a teaching physician provides care to a Medicare beneficiary while simultaneously teaching a resident. The Health Care Financing Administration (HCFA, now CMS) first established guidelines for billing practices of teaching physicians in 1967. The requirements were again addressed in 1969 when HCFA issued Intermediary Letter 372 (IL-372), which delineated the criteria to be met by teaching physicians before submitting a bill for payment of services. Questions continued to be raised about when and to what extent the physical presence of the teaching physician was required for billing Medicare. Adding to the confusion were the inconsistent interpretation and enforcement of the rules by local Medicare carriers.

In December 1995, HCFA published new regulations, effective July 1996, that detailed when a teaching physician could appropriately bill Medicare for patient care services in which a resident also is involved. The regulations were intended to reduce substantially the ambiguities engendered by the previous HCFA guidelines. They require, with one narrow exception, that the
teaching physician be present to perform or observe the “key portion” of any service or procedure for which payment is sought and provide further guidance on the documentation required in the medical record to substantiate that such services were performed. Soon after the rules were issued, CMS also published a revised CMI to provide additional information needed to implement the new rules. Despite the increased clarity under the new rules and CMI, some of the documentation requirements were considered to be overly burdensome and impeded both the delivery of patient care services and the teaching process.

CMS has been examining the regulatory burden on physicians and attempting to provide relief when feasible. Over the past year, the Agency has worked with AAMC through the Group on Faculty Practice Steering Committee to identify burdensome aspects of the supervising physician requirements that could be addressed through revisions to the Carrier Manual Instructions rather than through changes in the regulation. The revised CMI should significantly reduce the documentation burden on teaching physicians for E/M services when a resident also is involved in the care of a patient. It is important to note that with very limited exceptions, a teaching physician still must write a personal note and, unless the service is provided under the Primary Care Exception, must be present for the “key portion” of the service.

Summary of Revisions

Definitions

Among the definitions that CMS has added to the Carrier Manual Instructions are:

Resident: “The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of “resident”. Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.”

Documentation: “Notes recorded in the patient’s medical record by a resident and/or teaching physician or others as outlined in specific situations regarding the service furnished. Documentation may be dictated and typed, hand-written or computer-generated and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172(b), documentation must identify at a minimum the service furnished, the participation of the teaching physician in providing the service and whether the teaching physician was physically present.”

Physically present: The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.
MEMORANDUM #02-45
December 6, 2002
Page 3 of 4

General Documentation Instructions and Common Scenarios

CMS has clarified that for purposes of payment, Evaluation and Management (E/M) services billed by teaching physicians require that they personally document at least the following:

a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
b. The participation of the teaching physician in the management of the patient.

Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1 –
The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

- In the absence of a note by a resident, the teaching physician must document as he or she would document an E/M service in a non-teaching setting.
- Where a resident has written notes, the teaching physician’s note may reference the resident’s note. The teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. For payment, the composite of the teaching physician’s entry and the resident’s entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 2 –
The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The teaching physician’s note should reference the resident’s note. For payment, the composite of the teaching physician’s entry and the resident’s entry together must support the medical necessity and the level of the service billed by the teaching physician.

Scenario 3 –
The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portions
of the service, and participated in the management of the patient. The teaching physician’s note should reference the resident’s note. For payment, the composite of the teaching physician’s entry and the resident’s entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

**AAMC Teleconferences with CMS Staff on the Revisions**

On December 17, 2002 and January 9, 2003 the AAMC will be hosting two teleconferences with CMS staff to discuss the revisions with members. The teleconferences are open to individuals who work at AAMC member institutions only. Please note that AAMC will be collecting member questions about the changes prior to the call in order to provide CMS staff with the ability to address members’ issues as effectively as possible. There will also be opportunities to ask questions of CMS staff during the calls. For details and registration for the teleconference, please go online to: [www.aamc.org/meetings/specmtgs/cms/start.htm](http://www.aamc.org/meetings/specmtgs/cms/start.htm)

If you have questions on the revised CMI, please contact Denise Dodero, Assistant Vice President, Division of Health Care Affairs at 202-828-0493 or [ddodero@aamc.org](mailto:ddodero@aamc.org) or Ivy Baer, Director and Regulatory Counsel, Division of Health Care Affairs, 202-828-0490 or [ibaer@aamc.org](mailto:ibaer@aamc.org).

**cc:**  
Group on Faculty Practice  
Compliance Officers Forum  
Group on Resident Affairs  
Government Relations Representatives  
COTH Medical Directors  
COTH Faculty Practice Plan Directors
Appendix F
Substance Abuse
WVUH Policy V.231

POLICIES

Substance abuse by employees, staff, residents, or students at West Virginia University Hospitals is unacceptable and will not be tolerated. Our patients have a right to care by providers who are not under the influence of drugs or alcohol. Federal law entitles all employees the right to work in a drug-free environment.

It is everyone’s responsibility to report suspected use of alcohol or drugs to the appropriate supervisor. For residents, medical student, and medical/dental staff, suspected substance abuse should be reported to the Department Service Chief, Chief-of-Staff, or Hospital Administration. For hospital employees, suspected substance abuse should be reported to the department manager or a member of Hospital Administration. The appropriate supervisor is responsible for immediately notifying the Dean or WVUH President, who will consult on the issue.

Uniform policy statements are provided in order to create uniform responses to questions of physician impairment due to alcohol or drug abuse. At the same time, other Health Science entities should implement similar policies.

1. Treatment of physicians and dentists, other health professions, and all other employees with drug or alcohol abuse will not be punitive, so long as the individual voluntarily complies with treatment, aftercare, and monitoring.

2. For physicians and dentists, consultation with the Physician Health Committee is required immediately for all suspected cases of drug or alcohol abuse.

3. Any suspected problem shall be immediately reported to the Service Chief, Chief-of-Staff, or Hospital Administration. The individual will be removed from patient care responsibilities pending further investigation. Reports of suspected problems must be reported to the WVUH President.

4. Immediate on the spot drug and alcohol testing is expected and appropriate after any incident or report suggesting drug or alcohol abuse.

STRUCTURE

The Physician Health Committee will be made a standing committee and will have status in the Medical Staff By-Laws. Its charge includes: (1) Education, (2) Assessment, (3) Intervention, (4) Contracts of Treatment, (5) Monitoring, and (6) Aftercare Supervision.

TESTING

Confidential, independent urine and blood testing will continue to be available 24-hours a day. The Physician Health Committee and Employee Assistance Program (EAP) will ensure that testing and reporting methods continue to support this policy.

PROGRAMS

Educational programs will be broadened and must be repeated on a regular basis in all departments.

APPLICATION
These standards are to be followed by all Hospital and Medical Staff Departments.

1. At the discretion of the Chief-of-Staff, Department Service Chief, or Hospital Administration, an individual department may establish more stringent standards, including, but not limited to, additional testing and educational programs.

2. Similar programs for allied health professionals and other hospital employees are to be available, including education, awareness, and appropriate reporting.

WEST VIRGINIA UNIVERSITY HOSPITALS
and Ambulatory Services

POLICY AND PROCEDURE MANUAL

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<th>Policy V.231</th>
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<tr>
<td>Revised 1-30-95; 4-4-03; 2-20-09; 5-3-12</td>
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<tr>
<td>Reviewed</td>
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</table>

SUBSTANCE ABUSE

POLICIES

Substance abuse by employees, staff, residents, or students at West Virginia University Hospitals, Inc. (WVUH) is unacceptable and will not be tolerated. Our patients have a right to care by providers who are not under the influence of drugs or alcohol. Federal law entitles all employees the right to work in a drug free environment.

It is everyone's responsibility to report suspected use of alcohol or drugs to the appropriate supervisor. For residents, students, UHA allied health providers, and medical/dental staff, suspected substance abuse should be reported to the Department Service Chief, Chief-of-Staff, or Hospital Administration. For WVUH employees, suspected substance abuse should be reported to the Department Manager/Director, Administrator, Human Resources, or Hospital Administration.

Uniform policy statements are provided in order to create uniform responses to questions of practitioner impairment due to alcohol or drug abuse. At the same time, other Health Science entities should implement similar policies.

1. Treatment of physicians and dentists, UHA allied health providers, and all other WVUH employees with drug or alcohol abuse will not be punitive, so long as the individual voluntarily complies with treatment, aftercare, and monitoring.

2. Physicians, dentists, and UHA allied health providers credentialed by the Medical Staff Office will require consultation with the Physician Health Committee immediately for all suspected cases of drug or alcohol abuse.
3. Any suspected problem shall be immediately reported to the Service Chief, Chief-of-Staff, Administrator, Manager/Director, Human Resources, or Hospital Administration. The individual will be removed from patient care responsibilities pending further investigation.

4. Immediate “on the spot” drug and alcohol testing is expected and appropriate after any incident or report suggesting drug or alcohol abuse. Incidents that justify testing may include the discovery of evidence such as improperly disposed of syringes and missing or improperly accounted for medications. In such cases, the testing must be performed in a nondiscriminatory manner, with all individuals in a particular department, on a particular shift or in a particular job classification, as the Service Chief, Chief-of-Staff, Manager/Director, Human Resources, or Hospital Administration determines is appropriate, evaluated on the same basis and in the same manner.

PHYSICIAN HEALTH COMMITTEE

The Physician Health Committee will be made a standing committee and will have status in the Medical Staff Bylaws. Its charge includes: a) Education, b) Assessment, c) Intervention, d) Contracts of Treatment, e) Monitoring, and f) Aftercare Supervision.

TESTING

Confidential, independent urine and blood testing will continue to be available 24 hours a day, seven days a week. The Physician Health Committee and Faculty Staff Assistance Program (FSAP) will ensure that testing and reporting methods continue to support this policy.

APPLICATION

These standards are to be followed by all WVUH and UHA departments.

1. At the discretion of the Chief-of-Staff, Department Service Chief, Hospital Administration, or Human Resources an individual department may establish more stringent standards, including, but not limited to, additional testing and educational programs.

Bruce McClymonds

President & CEO
Appendix G

Academic Discipline and Dismissal Policy:

Preliminary Intervention:

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

Probation:
House Officers may be placed on probation for, among other things, issuance of a warning or reprimand; or imposition of a remedial program. Remediation refers to an attempt to correct deficiencies which, if left uncorrected, may lead to a non reappointment or other disciplinary action. In the event a House Officer’s performance, at any time, is determined by the House Officer Program Director to require remediation, the House Officer Program Director shall notify the House Officer in writing of the need for remediation. A remediation plan will be developed that outlines the terms of remediation and the length of the remediation process. Failure of the House Officer to comply with the remediation plan may result in termination or non-renewal of the House Officer’s appointment.

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

Due Process: Termination, Non-Reappointment, And Other Adverse Action:

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

- unsatisfactory academic or clinical performance;
- failure to comply with the policies, rules, and regulations of the House Officer Program or University or other facilities where the House Officer is trained;
- revocation or suspension of license;
- violation of federal and/or state laws, regulations, or ordinances;
- acts of moral turpitude;
- insubordination;
- conduct that is detrimental to patient care; and
- unprofessional conduct.
The House Officer Program may take any of the following adverse actions:

- issue a warning or reprimand;
- impose terms of remediation or a requirement for additional training, consultation or treatment;
- institute, continue, or modify an existing summary suspension of a House Officer’s appointment;
- terminate, limit or suspend a House Officer’s appointment or privileges;
- non renewal of a House Officer’s appointment;
- dismiss a House Officer from the House Officer Program;
- or any other action that the House Officer Program deems is appropriate under the circumstances.

Resident Dismissal and/or Corrective Action

A resident may be dismissed or corrective action may be taken for cause including but not limited to:

- Has made any misrepresentation on his or her application for admission to Residency Program
- Has engaged in unethical, unlawful or immoral conduct
- Has neglected the tasks, duties or responsibilities assigned by the Program Director or other authorized persons including but not limited to the proper and timely completion of medical records
- Has failed to fulfill his or her obligations as set forth by West Virginia University Hospitals agreement including violating any policy of West Virginia University
- Has committed any act or failure to act which, under applicable state laws, could lead to disciplinary proceeding or the revocation, suspension or termination of a physician license to practice medicine in West Virginia
- Has committed any act or failure to act which, under the Bylaws of the Medical Staff of West Virginia University Hospitals could lead to disciplinary action or the revocation, suspension, or termination of the clinical privileges or appointment of a member of the Medical Staff of West Virginia University Hospitals

If an action is initiated during the term of the resident’s contract, the routine process shall be as follows:

A. The resident will be notified that the Program is considering action
B. Upon notification, the resident will have an opportunity to meet with the Program Director and present verbal and written evidence in support of his/her position in response to the reasons for the action set forth by the Program Director.
C. After the above referenced meeting, if the Program Director believes that action is warranted, action may be taken. Such actions include but are not limited to dismissal, letters of warning or reprimand, suspension with or without pay, and extension of the term of the resident’s program. All are the options that may be instituted by the Program Director.
B. Disciplinary Action

- Residents are expected to meet and adhere to academic, clinical and professional standards set forth by the Institutional Requirements, Common Program Requirements, and Occupational Medicine Program Requirements as well as the West Virginia University Hospitals and the West Virginia University School of Medicine.

- If at any time a house officer exhibits unsatisfactory performance, remediation is necessary. In most circumstances, the resident will continue to perform his/her daily duties during the remediation process.

- Inadequate performance will be clearly communicated, in writing, to the house officer as early as possible, and at minimum, at the four-month formal evaluation.

- If the program director feels that disciplinary action must be taken against a house officer, the institutional process will be initiated. This includes:
  - Departmental remediation
  - Institutional probation

WVU-HR-9

DISCIPLINE POLICY

DISCIPLINARY PROCEDURE

PURPOSE:

The purpose of disciplinary action is to correct, not to punish, work related behavior. Each employee is expected to maintain standards of performance and conduct as outlined by the immediate supervisor and to comply with applicable policies, procedures and laws. When an employee does not meet the expectations set by the supervisor or other appropriate authority, counseling and/or disciplinary action may be taken to address the employee's behavior.

WHO IS COVERED BY THESE PROCEDURES:

All classified employees at WVU are covered by these disciplinary procedures.

COUNSELING:

Counseling is not discipline. Counseling makes the employee aware of the concern and provides the employee with information regarding expectations, basis and measures. The supervisor must listen to the employee's explanation for the behavior in question, consider management options, explain what is unsatisfactory, what is expected and how to avoid
recurrence and/or improve performance. Counseling may or may not be documented, at the discretion of the supervisor. Documented counseling may or may not be submitted to the employee’s personnel file, at the discretion of the supervisor. Documented counseling should confirm the concern, the operational expectation, and the time line for attainment of objectives.

DISCIPLINARY ACTION:

Discipline may be issued to an employee at the discretion of his/her supervisor, dean or director, following an investigation of the matter. Such investigation would include discussions with the employee. Disciplinary actions inform the employee of what is operationally expected and what the consequences are if improvement to a sustained, satisfactory level does not occur.

Discipline may be warranted when the employee fails to meet the performance or conduct standards for his/her position or does not adhere to policy or law requirements.

Disciplinary action may be taken whenever the behavior of an employee violates a statute, rule, policy, regulation or agreement that adversely affects the efficient and effective operations of his/her unit or brings discredit to the University or a subdivision. Dependent upon the actual and potential consequences of the offense, employee misconduct may be considered minor misconduct or gross misconduct.

Minor misconduct is generally of limited actual and potential consequence and deemed by the supervisor as correctable by counseling and/or instruction through progressive discipline for subsequent similar behavior. Progressive discipline requires notice of concern and expectations to the employee through letter(s) of warning. These warning letters are provided progressively for subsequent similar offenses and may provide for suspension, demotion and ultimately termination.

Gross misconduct is of substantial actual and/or potential consequence to operations or persons, typically involving flagrant or willful violation of policy, law, or standards of performance or conduct. Gross misconduct may result in any level of discipline up to and including immediate dismissal at the supervisor’s discretion.

BEFORE DISCIPLINARY ACTION IS TAKEN:

Before disciplinary action may occur, the supervisor must give the employee oral or written notice of the charges against him/her, why the behavior is unsatisfactory, an explanation of the employer’s evidence, and an opportunity to present his/her explanation of the behavior in question.

Written notice of intent must be issued for situations impacting wages and/or terms of employment: i.e. demotion, suspension, or termination, with an opportunity for the employee to present his/her explanation of the behavior in question, prior to any disciplinary action being taken.
All disciplinary action taken will be confirmed in writing to the employee.

See specific sections for details of steps to be taken.

DISCIPLINE DOCUMENTATION:

All disciplinary actions are to be documented. The documentation should include the issue(s) of concern and the impact; the policy, law or standard violated; the operational expectation; the improvement/corrective plan and time line; and the specific level of subsequent discipline for failure to improve and sustain behavior at a satisfactory level.

A copy of the disciplinary documentation is to be forwarded to the Department of Human Resources for inclusion in the employee's personnel file.

Unless otherwise required (through administrative directive) disciplinary documentation will be removed from the employee's file following twelve (12) months of active, continuous employment, and considered inactive.

Provided there has not been a subsequent disciplinary action for a similar or related offense, inactive disciplinary documentation may not be used for the purpose of furthering progressive discipline with an employee.

TYPES OF DISCIPLINE

WRITTEN WARNINGS:
Written warnings may be issued without counseling for minor misconduct, if the employee knows the standard of performance or conduct, policy or law violated.

A non-probationary employee with more than six (6) months of consecutive service with the University may be dismissed under progressive discipline after prior issuance of two (2) written warnings for similar offenses (cross reference Probationary Period policy).

In absence of six (6) months of consecutive service within the University, an employee may be dismissed under progressive discipline after prior issuance of one (1) written warning for a similar offense.

Gross misconduct may result in a one-time warning letter. Written warnings may be issued without counseling for minor misconduct, if the employee knows the standard of performance or conduct, policy or law violated.

A non-probationary employee with more than six (6) months of consecutive service with the University may be dismissed under progressive discipline after prior issuance of two (2) written warnings for similar offenses (cross reference Probationary Period policy).

In absence of six (6) months of consecutive service within the University, an employee may be dismissed under progressive discipline after prior issuance of one (1) written warning for a similar offense.
Gross misconduct may result in a one-time warning letter.

1-15 working days when, in the judgment of the supervisor, improved performance is attainable without resorting to discharge. Exempt employees may be suspended without pay for a period of 1-15 working days, for a major safety violation. In all other circumstances, exempt employee suspensions must be in week long increments to a maximum of three weeks. Suspension shall only occur after consultation with the Department of Human Resources Employee Relations staff at 293-5700. The Department of Human Resources shall consult with the Office of General Counsel regarding the situation prior to any disciplinary action.

Before disciplinary action may occur, the supervisor must give the employee written notice of the intent to suspend, the charges against him/her, why the behavior is unsatisfactory, an explanation of the employer's evidence, and an opportunity to present his/her explanation of the behavior in question within a reasonable timeframe.

Any suspension action taken will be confirmed in writing to the employee.

DISMISSAL:

An employee with less than six (6) months of consecutive service with the University may be dismissed under progressive discipline after prior issuance of one (1) written warning for a similar offense.

A non-probationary employee with more than six (6) months of consecutive service with the University may be dismissed under progressive discipline after prior issuance of two (2) written warnings for similar offenses (cross reference Probationary Period policy).

Gross misconduct may result in immediate dismissal.

Dismissal shall only occur after consultation with the Department of Human Resources Employee Relations staff at 293-5700. The Department of Human Resources shall consult with the Office of General Counsel regarding the situation prior to any disciplinary action.

Before disciplinary action may occur, the supervisor must give the employee written notice of the intent to terminate (dismiss), the charges against him/her, why the behavior is unsatisfactory, an explanation of the employer's evidence, and an opportunity to present his/her explanation of the behavior in question within a reasonable timeframe.

Upon notice of intent to terminate the employee may be assigned work to take place outside of the workplace until the projected date of termination.

Any dismissal action taken will be confirmed in writing to the employee.
VIOLATIONS CONSIDERED GROUNDS FOR DISCIPLINARY ACTION:

Any policy, law or standard of performance or conduct violation may result in disciplinary action.

Behaviors considered gross misconduct and subject to immediate dismissal include, but are not limited to:
• Insubordination and/or disobedience
• Illegal activities
• Neglect of duties, including failure to properly report off work for three (3) consecutive workdays; sleeping on the job; leaving the work site without authorization; disguising or removing defective work; willfully limiting production and/or influencing others to do the same
• Jeopardizing the health, safety or security of persons or University property; verbal or physical assault, bringing weapons to the work site, arson, sabotage
• Supervisory grievance default
• Reporting to work under the influence of alcohol or narcotics, using, possessing or distributing same in the course of employment
• Dishonesty and/or falsification of records
• Convictions with a rational employment nexus

APPEALS:

An employee who believes he/she has been disciplined unjustly may pursue a grievance.

FOR ASSISTANCE AND INFORMATION:

Additional information or questions regarding disciplinary actions should be directed to the Employee Relations Unit in the Department of Human Resources at 293-5700.


WVU POLICY REFERENCE:

http://www.hr.wvu.edu/policies/wvu_hr_9_discipline_policy
POLICIES OF WVUH Practitioner Health Committee

Purpose
The West Virginia University Hospitals, Inc. (WVUH) Practitioner Health Committee serves as the primary resource in the management of impaired Practitioners. Impairment includes any physical, mental, behavioral or emotional illness that may interfere with the Practitioners ability to function appropriately and provide safe patient care. The purpose of impaired Practitioner assistance is to maximize support for Practitioners through appropriate interventions. This process relates specifically to mental, physical or behavioral impairment and does not include performance management or disciplinary actions.

Policy
In order to assure the safety of patients, co-workers and trainees WVUH will address all reports of impaired or possibly impaired performance of Practitioners. WVUH will also strive to maintain the confidentiality of any and all individuals who may report any observed impairment or possible impaired performance of any practitioner(s) affiliated with the hospital. Impairment may be due, but not limited to physical, and/or mental/behavioral problems, including drug and alcohol use, misuse and/or abuse. All assessments, evaluations and treatment recommendations received by the Practitioner Health Committee shall be confidentially maintained under the peer review privilege, except as limited by regulation, ethical obligation, Medical Staff Manuals, and/or threat to patient safety. Practitioners referred to in this policy include, but are not limited to, faculty credentialed by WVUH, fellows, residents, interns and all allied health professionals.

Procedure

A. EDUCATION

WVUH will provide education on Practitioner health and impairment to the Medical, Dental, Allied Health Staff, and WVU Residents.

Hospital administrative leadership will assure that policies and procedures related to impairment and recognition issues specific to impairment are widely disseminated to appropriate hospital staff on an annual basis. WVUH encourages self-referral of any Practitioner in seeking help for health or impairment problem to the Practitioner Health Committee. Practitioners may voluntarily seek assistance from the WVU Faculty and Staff Assistance Program (FSAP) at any time with or without referral from either the Practitioner Health Committee or other administrative personnel.

B. NEW PRACTITIONER

1. Any Practitioner who requests to practice at WVUH whose ability to practice medicine may be affected, is undergoing treatment for substance abuse, any other physical or
mental health problems, or who otherwise is reasonably believed to suffer from a substance abuse problem or any other physical or mental health problem must be referred by the Vice President of Medical Affairs to the Practitioner Health Committee. It is the responsibility of the department chair to notify the Vice President of Medical Affairs and supply in writing the nature of the referral.

2. The Practitioner Health Committee will make their recommendations to the Vice President of Medical Affairs. If determined by the Vice President of Medical Affairs that the Practitioner should seek further evaluation from a specialized counselor for his/her specialized need, at that time an Agreement of Understanding, on behalf of WVUH, as well as a written consent and release, on behalf of WVUH, will be presented to the Practitioner and shall be signed if he/she continues to seek privileges at WVUH. Such information being released is, includes, urine and blood screening times, results, appointment times, and any referrals to other entities/providers.

3. If further evaluation is required, following receipt of the evaluation, the Practitioner Health Committee will provide a recommendation to the Vice President of Medical Affairs on each of the following:

   Advisability of appointment to the Medical, Dental or Allied Health Staff at WVUH, as applicable
   Need for any additional monitoring and treatment
   Need for limitations or conditions on privileges

4. After discussing the Practitioner Health Committees recommendations with the department chair, the Vice President of Medical Affairs will determine the final recommendation regarding the applicant’s ability to practice, which will be presented, to the WVUH Board of Directors, through the Joint Conference Committee. The Vice President may grant temporary privileges or allow a Practitioner to begin to treat patients at WVUH; however, the WVUH Board of Directors through the Joint Conference Committee has the final decision as to whether a Practitioner may practice at WVUH and under what conditions.

5. The Vice President of Medical Affairs will communicate the final recommendations to the Residency Program Director, the Designated Institutional Official (for residents only) and the department chair.

6. When the appointment is contingent upon rehabilitation, counseling or other conditions of appointment or practice, the Practitioner will be referred to WVU FSAP or an agreed upon external provider. The Vice President of Medical Affairs will ensure that the executed "Agreement of Understanding" specifies treatment recommendations and conditions of appointment and/or clinical privileges must be signed in writing, at the minimum, by the Vice President of Medical Affairs and the Practitioner. Such conditions may include, but are not limited to, random drug screens, continued counseling and meeting with the Practitioner Health Committee.
7. All further decisions as to what actions, if any, need to be taken, remain with the Vice President of Medical Affairs.

C. PROCEDURES FOR CURRENT PRACTITIONERS

1. Observed Impaired Behavior

a. It is the responsibility of all medical, dental, allied health staff, and residents to immediately report any observed behavior which establishes a reasonable belief that a Practitioner is impaired or exhibiting inappropriate behavior (physical, emotional or psychological) or evidence of substance abuse problems that could impact on professional/clinical performance in the Hospital (evidence other than or in addition to observation of personal behavior includes, but is not limited to, improperly disposed-of syringes and missing or improperly accounted for drugs) to the Vice President of Medical Affairs and/or the department chair. During off-shift hours, the individual reporting should notify the Administrator-On-Call (AOC).

b. Hospital Staff should notify the Administrator-On-Call (AOC) or the Vice President of Medical Affairs (if during regular business hours) of any inappropriate behavior or suspected substance abuse. In the event that the Administrator-On-Call is notified, he/she will notify the Vice President of Medical Affairs and the Vice President of Medical Affairs will notify the department chair.

c. The department chair, the Vice President of Medical Affairs or the Administrator-On-Call (AOC) during off-shift hours will investigate and verify the credibility of the allegation in C.1.a or C.2.b to ascertain the credibility of the complaint, concern or allegation. The Practitioner will not be told who filed the initial report. If the alleged impairment is deemed credible by the Vice President of Medical Affairs, department chair or the Administrator-On-Call (AOC) during off-shift hours, immediate drug testing may be requested. During business hours, the Practitioner may be referred to Employee Health. After hours, the Practitioner will be referred to the Emergency Department. Refusal to cooperate with testing is grounds for dismissal from WVUH and removal of residents from providing any patient care within the Hospital. Employee Health is the designated department to administer the drug testing as well as provide the results to the Vice President of Medical Affairs and/or the Practitioner Health Committee. Employee Health is not required and will not keep any file for individuals including but not limited to any test results and/or appointment times. If the impairment poses an immediate risk to patient safety, the Practitioner must be immediately removed from patient care and patient contact and an immediate precautionary suspension will occur. (For further information regarding precautionary suspension refer to Article IV, Section 4.3 in the case of credentialed Practitioners, and Appendix O in the case of residents.) If the impairment does not pose an immediate risk to patient safety, the Practitioner may continue with his/her patient care duties. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.
2. Self-Referral

a. All Practitioners are required to self refer to his/her department chair or the Vice President of Medical Affairs in the event that he/she experiences any substance abuse/health problem that could impact on professional/clinical performance in the Hospital. When reported to the department chair, the chair shall report to the Vice President of Medical Affairs. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

b. A Practitioner who seeks assistance with WVU FSAP is required to inform the Vice President of Medical Affairs of this evaluation. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

3. Procedures of the Practitioner Health Committee

a. Upon referral to the Practitioner Health Committee, the Practitioner is required to sign a consent and release, on behalf of WVUH, allowing information regarding their treatment to be released to the Vice President of Medical Affairs and/or the Practitioner Health Committee by both the WVU FSAP and any treatment provider. Such information being released is, but not limited to, urine and blood screening times, results, appointment times, and any referrals to other entities/providers. In the event that he/she refuses to sign the consent and release, on behalf of WVUH, he/she will be precautionarily suspending from duty, until the mental health assessment and the signing of the consent and release, on behalf of WVUH, is resolved. Refer to Article IV, Section 4.3 Precautionary Suspension or Appendix O, as applicable. All such reported information shall be kept confidential except as limited by law, ethical violation, or when patient safety is threatened.

b. Following a referral from the Vice President of Medical Affairs and the receipt of any investigations and evaluations or results of drug testing, the Practitioner Health Committee will recommend to the Vice President of Medical Affairs on each of the following:

   Advisability of continued appointment to WVUH
   Need for any additional monitoring and treatment, continued or privileged, as applicable
   Need for limitations or conditions on privileges

c. After discussing the Practitioner Health Committees recommendations with the department chair, the Vice President of Medical Affairs will determine the final recommendation regarding the practitioner’s ability to practice, which will be presented to the WVUH Board of Directors, through the Joint Conference Committee.

d. The Vice President of Medical Affairs will communicate the final recommendations to the Designated Institutional Official (for residents only) and the department chair (residents and faculty).

e. When the continued appointment is contingent upon rehabilitation, counseling or other conditions of appointment or practice, the Practitioner will be referred to WVU FSAP or an
agreed upon external provider. The Vice President of Medical Affairs will develop an "Agreement of Understanding" with the Practitioner, which specifies treatment recommendations and conditions of appointment and must be signed in writing, at the minimum, by the Vice President of Medical Affairs and the Practitioner. Such conditions may include, but are not limited to, random drug screens, continued counseling and meeting with the Practitioner Health Committee.

f. All further decisions as to what actions, if any, need to be taken remain with the Vice President of Medical Affairs.

g. If at any time the Practitioner fails to comply with the indicated terms and conditions, the Practitioner Health Committee will immediately report this information to the Vice President of Medical Affairs, which will report to the department chair. The Vice President of Medical Affairs has the authority to do one or more of the following:
   Terminate immediately
   Demand compliance or be terminated
   Precautionarily suspend until in compliance

D. CONFIDENTIALITY

a. The Practitioner Health Committee shall handle all communications and discussions in a confidential manner, including the identity of anyone making a report, consistent with applicable legal requirements and patient safety considerations.
Academic Grievance Policy and Procedure

A. The purpose of this policy is to provide a mechanism for resolving disagreements, disputes and complaints which may arise between postgraduate residents and fellows and their Program Director or other faculty member.

B. Policy
   a. Postgraduate residents or fellows may appeal disagreements, disputes, or conflicts with the decisions and recommendations of their program regarding academic related issues using the procedure outlined in this section. This grievance procedure does not cover issues arising out of (1) termination of a resident/fellow during an annual contract period; (2) alleged discrimination; (3) sexual harassment; (4) salary or benefit issues. These grievances are covered under the employment grievance procedures for employees of West Virginia University as outlined in section XXV of these bylaws.

C. Definitions
   a. Grievance: any unresolved disagreement, dispute or complaint a resident or fellow has with the academic policies or procedures of the Residency Training Program or any unresolved dispute or complaint with his or her Program Director or other faculty member. These include but are not limited to issues of suspension, probation, retention at current level of training, and refusal to issue a certificate of completion of training.

D. Procedure
   a. Level I Resolution
      i. A good faith effort will be made by an aggrieved resident/fellow and the Program Director to resolve a grievance, which will begin with the aggrieved resident/fellow notifying the Program Director, in writing, of the grievance within 10 working days of the date of receipt of the dispute or complaint. This notification should include all pertinent information and evidence which supports the grievance. Within ten (10) working days after notice of the grievance is received by the Program Director, the resident/fellow and the Program Director will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step I of the grievance procedure will be deemed complete when the Program Director informs the aggrieved resident/fellow in writing of the final decision. This should occur within 5 working days after the meeting between the resident/fellow and Program Director. A copy of the Program Director’s final decision will be sent to the Department chair and to the Designated Institutional Official for GME (DIO).

   b. Level 2 Resolution
      i. If the Program Director’s final written decision is not acceptable to the aggrieved resident/fellow, the resident/fellow may choose to proceed to a Level 2 resolution, which will begin with the aggrieved resident/fellow notifying the Department Chairman of the grievance in writing. Such notification must occur within 10 working days of receipt of the Program Director’s final decision. If the Department chairman is also functioning as the Program Director, then the Level
2 resolution will be handled by the DIO. If the aggrieved resident is a Transitional Year resident, then the DIO will appoint a Department Chairman to handle the Level 2 grievance. This resident's notification should include all pertinent information, including a copy of the Program Director's final written decision, and evidence which supports the grievance. Within ten (10) working days of receipt of the grievance, the resident/fellow and the Department Chairman or DIO will set a mutually convenient time to discuss the complaint and attempt to reach a solution.

Level II of this grievance procedure will be deemed complete when the Department Chairman (or DIO) informs the aggrieved resident/fellow in writing of the final decision. This should occur within 5 working days of the meeting with the resident/fellow and the Chairman. Copies of this decision will be kept on file with the Program Director, in the Chairman's office and sent to the DIO.

c. Level 3 Resolution

If the resident/fellow disagrees with the Department chairman's final decision, he or she may pursue a Level 3 resolution of the grievance. The aggrieved resident/fellow must initiate this process by presenting their grievance, in writing, along with copies of the final written decision from the Program Director and Department chairman, and any other pertinent information, to the office of the Graduate Medical Education within 5 working days of receipt of the Department Chairman's final written decision. Failure to submit the grievance in the 5 working day time frame will result in the resident/fellow waiving his or her right to proceed further with this procedure. In this situation, the decision at Level II will be final.

Upon timely receipt of the written grievance, the DIO will appoint a Grievance Committee and will contact the aggrieved resident/fellow to set a mutually convenient time to meet with them. The Grievance Committee will review and carefully consider all material presented by the resident/fellow and his or her Program Director or the grievable party at the scheduled meeting, following the protocol outlined in Section F.

The Grievance Committee will provide the aggrieved resident/fellow with a written decision within five working days of the meeting and a copy will be placed on file in the Office of Graduate Medical education, and with the Program Director and Department Chair.

The decision of the Grievance Committee will be final.

E. The Grievance Committee

Upon request for a formal resolution at Level III, the DIO will form a Grievance Committee composed of at least two residents, and three Program Directors. No members of this committee will be from the aggrieved resident's/fellow's own department. The DIO will choose a faculty member appointed to the Grievance Committee to be the chair of the committee. The Grievance Committee hearing should occur within 20 working days from receipt of the Level II grievance.
F. Grievance Committee Procedure
   a. Attendance: All committee members should be present throughout the hearing. The aggrieved resident/fellow must personally appear at the Grievance Committee meeting.
   b. Conduct of Hearing: The chair will preside over the hearing, determine procedure, assure there is a reasonable opportunity to present relevant oral or written information, and maintain decorum. The Chair will determine if information is relevant to the hearing and should be presented or excluded. The aggrieved Resident may present any relevant information or testimony from any colleague or faculty member. The Resident is NOT entitled to legal representation during the grievance committee hearing. The Program Director and Department chair may be requested by the Committee to also be present for oral testimony. The committee chair is authorized to exclude or remove any person who is determined to be disruptive.
   c. Recesses and Adjournment: The committee chair may recess and reconvene the hearing by invoking the right for executive session. Upon conclusion of the presentation of oral and written information, the hearing record is closed. The Grievance Committee will deliberate in executive session outside the presence of the involved parties.
   d. Decisions: Decisions are to be determined by vote of a majority of members of the Committee and are final. After deliberation, the Chair will prepare a written decision to be reviewed and signed by all of the Committee members. The aggrieved resident/fellow should be notified within 5 working days of the hearing.
   e. Meeting Record: A secretary/transcriptionist may be present for the purpose of recording the meeting minutes. Minutes and the final written decision of the committee will be placed on file in the GME Office, and by the Department in the resident or fellow's academic file.

G. Confidentiality
All participants in the grievance are expected to maintain confidentiality of the grievance process by not discussing the matter under review with any third party except as may be required for purposes of the grievance procedures.

Employment Grievance Procedure for Non-Academic Issues
The resident is encouraged to seek resolution of non-academic employment related grievance relating to Resident’s appointment or responsibilities, including any differences between Resident and WVUH, or WVU School of Medicine with respect to the interpretation of, application of, or compliance with the provision of the agreement, in accordance with the grievance procedures set forth on the WVU site:

http://www.hr.wvu.edu/policies

http://medicine.hsc.wvu.edu/gme/gme-policies/

The Grievance Board is currently in the process of developing a new grievance form and administrative procedures. Go to www.hr.wvu.edu for the WVU Interim Grievance Form and more details.
Appendix J – Accreditation Status

CORRECTED LETTER
Christopher J Martin, MD, MSc
Professor and Director, Occupational Medicine, West Virginia University
West Virginia University School of Medicine
PO Box 9145
3858 Health Sciences Center South
Morgantown, WV 26506-9145

Dear Dr. Martin,

Accreditation Council for Graduate Medical Education
515 North State Street
Suite 2000
Chicago, IL 60654
Phone 312.755.5000
Fax 312.755.7498
www.acgme.org

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

Preventive medicine
West Virginia University Program
West Virginia University School of Medicine
Morgantown, WV
Program 3805577094

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Maximum Number of Residents: 8
Effective Date: 01/11/2016

AREAS NOT IN COMPLIANCE (Citations)
The Review Committee cited the following areas as not in substantial compliance with the ACGME's Program Requirements and/or Institutional Requirements:

EXTENDED CITATIONS
Performance on Board Exams | Since: 03/18/2013 | Status: Extended
Program Evaluation, Certifying Examination Pass Rate [Program Requirement, V.C.6.]
75% of a program's graduates from the preceding five years who took the certifying examination for preventive medicine for the first time must have passed. In those programs having fewer than 10 graduates in the past five years, at least 75% of the 10 most recent graduates must have passed.

The information provided did not demonstrate compliance with the requirement for first time pass rate on the certifying examination. Information provided to the Review Committee from the American Board of Preventive Medicine indicates that between 2007 and 2011 the program had 12 first time candidates who took the certifying examination, and of this group, 8 passed the first time. This represents a 67% first time pass rate.

Continued Non-Compliance: 01/12/2015

The Review Committee determined that the program should continue efforts to resolve the citation noted above. The Review Committee will use the program's response to the above
Continued Non-Compliance: 01/11/2016

Information provided to the Review Committee did not demonstrate compliance with the requirement for first time pass rate on the certifying examination. Data provided by the American Board of Preventive Medicine showed a 60% three-year pass rate and a 70% five year pass rate which is below the required 75% level. The Program Director should examine the program’s first time pass rate as part of the Annual Program Evaluation, develop a comprehensive improvement plan and evaluate the effectiveness of that plan during subsequent program reviews.

RESOLVED CITATIONS
The Review Committee determined that the following citations have been resolved:

Institutional Support-Participating Institution | Since: 03/18/2013 | Status: Resolved

PLA for Each Participating Site [Program Requirement, I.B.1.]
There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The information provided did not demonstrate compliance with the requirement that program letters of agreement be renewed at least every five years. The site visitor confirmed that three PLA’s, the National Institute for Occupational Safety and Health (NIOSH) Division of Safety, the NIOSH Division of Respiratory Studies, and BrickStreet, Inc. were signed and dated in Fall 2007, and had expired in 2012 (Program Information Form, p.3).

Evaluation of Residents | Since: 03/18/2013 | Status: Resolved

Verification of Education and Summative Performance Evaluation for Resident Leaving the Program Prior to Completion [Program Requirement, III.C. 2.]
A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

The information provided did not demonstrate compliance with the requirement that the program director provide timely verification of residency education for residents who leave the program prior to completion. The site visitor confirmed that a resident was dismissed in September 2012 during the first year of residency education for not fulfilling a residency prerequisite. Although the resident was aware of the prerequisite, she was not provided a verification letter of this fact.

Curricular Development | Since: 03/18/2013 | Status: Resolved

Curriculum, Graduate Level Courses [Program Requirement, IV.A.3.a.]
Whether through a Master’s in Public Health or other equivalent degree, prior to completion of the residency program, all residents must complete a graduate level course in health services management and administration.

The information provided did not demonstrate compliance with the requirement for graduate level coursework in health services management. Two courses were listed in the Program Information Form (PIF) to fulfill the requirement for graduate level courses in health services management, HPML 601 and PUB A670. Neither of the syllabi for these courses included content in management and it is unclear if there are didactic sessions to support residents’ development of competency in management and administration including management of human and financial resources (Program Information Form, pp. 20, 112-13, 128-129).

ACGME Competencies | Since: 03/18/2013 | Status: Resolved

Curriculum, Graduate Level Courses, Occupational Medicine [Program Requirement, IV.A.3.b).(2)]
Residents should complete a graduate level course in safety and ergonomics prior to completion of the program.
The information provided did not demonstrate compliance with the requirement for graduate level coursework in ergonomics. One course is listed in the PIF to fulfill the requirement for graduate level courses in safety and ergonomics, OEHS691u. The syllabus for this course indicates that there is only part of one lecture devoted to ergonomics and it is unclear if there are didactic sessions to support residents' development of competency in providing direct care for workers and safeguarding employees and others in the workplace (Program Information Form, pp. 22, 156-158).

**Evaluation of Faculty | Since: 03/18/2013 | Status: Resolved**

Program Evaluation, Monitor and Track Program Quality [Program Requirement, V.C.1.d).(1).]

Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually.

The information provided did not demonstrate compliance with the requirement that faculty have the opportunity to evaluate the program confidentially. The site visitor confirmed that although faculty does complete annual evaluations of the residency program, the faculty members' names are on their evaluation so that the process is not confidential.

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

Sincerely,
Lorraine Lewis, EdD, RD
Executive Director, International Accreditation, ACGME International (ACGME-I)
Residency Review Committee for Preventive Medicine
3127555043
llewis@acgme-i.org
CC: Robert Tallaksen, MD
Participating Site(s):
BrickStreet, Inc.
Kanawha-Charleston County Health Department
National Inst for Occupational Safety and Health (Morgantown)
West Virginia University Hospitals
West Virginia University School of Medicine
West Virginia University School of Public Health

Christopher J Martin, MD, MSc
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Appendix K:
Dress Code

All residents are required to abide by the WVU Hospitals Dress and Appearance Policy as outlined below.

All residents are required to come to work Monday – Friday dressed as though they are ready to work in clinic, unless told otherwise. i.e. no jeans, no sandals, no hats, no shorts; only long dress pants, sport (collared) shirts, and ties are not necessary. This includes when attending MPH classes, grand rounds, didactics, and meetings.

While on away rotations, the dress code remains the same, unless the preceptor advises you otherwise.

WEST VIRGINIA UNIVERSITY HOSPITALS
POLICY AND PROCEDURE MANUAL

Policy V.250
1st Effective 1-1-84
Revised 1-3-97; 3-17-95; 5-1-94;
7-14-03; 11-18-05; 1-1-06; 1-12-10
4-16-10; 10-1-12; 7-26-13; 8-15-14
Reviewed

DRESS AND APPEARANCE

POLICY

In no other business are personal dress, cleanliness, conduct and appearance as important as they are in healthcare services. A well-groomed employee with a professional appearance immediately creates a favorable impression of the services provided by West Virginia University Hospitals and Health Sciences Center. Patients, families, accrediting agencies and local health authorities rightfully expect strict standards to be maintained. Employee dress and appearance should not be perceived as a distraction to our guests, visitors, fellow employees, or patients. The Hospital reserves the right to ask employees improperly dressed to go home to change clothing or to improve his/her appearance, with loss of pay for the time off duty. Repeated offenses of the dress code policy will result in progressive disciplinary action.

Off site non clinical locations such as the Ruby Office Complex, Data Center, Scott Avenue, Health Sciences Center Building and the Child Development Center, etc. may establish department polices that differ from this policy. Any such policy should be approved by
the VP or VPs with responsibility at that location as well as the VP of Human Resources. Any employee working at an off site location must comply with the Hospital policy when performing work duties at the Hospital.

PROCEDURE

A. General Standards

1. Clothing must be modest, be reasonably fitted, and allow comfortable ease of movement.
   Clothing must be clean, neat, and stain and wrinkle free. Appropriate underclothing is required and must be undetectable through outer clothing.

2. An approved ID badge must be worn at all times. Employee name and picture must be visible. Service recognition, certification, and school pins may be worn. No more than two pins shall be worn on the I.D. badge.

3. Hair should be kept neat and clean and pulled back if necessary. Extremes in dying, bleaching, coloring and styling are not permitted. Infection control should be considered as well as appearance. Beards and mustaches must be short, clean and well groomed. Nails must be well groomed and manicured (see #15 for specific requirements regarding fingernails for employees rendering direct patient care).

4. Light-scented cologne, perfume, lotion, or aftershave is permitted. Avoid strong perfume and cigarette odor since some patients and staff may be sensitive. Cosmetics may be used in moderation. The employee should use the necessary precautions with regular bathing, deodorants and good dental hygiene to avoid offending patients and staff with body odor or bad breath.

5. Professionalism, quietness and appearance are the main consideration for footwear. Employees must be in compliance with the departmental policy if traveling to that area while on duty. All footwear must be kept clean and intact

Patient Care Areas- For purposes of this policy, patient care areas include nursing units, outpatient clinics or clinical administrative units where clerical duties are performed. Footwear should cover the toes of the foot, and should either cover the heel or have a back lip or strap to prevent accidental slip offs, should be non-canvas, have a non-skid sole and be of reasonable sole and heel height. Tennis shoes (leather or vinyl) and “croc-like” shoes are permitted in the clinical area; however, they must be solid; “jibbitz” or filling of the holes is not permitted.

Non-Patient Care Areas- For the purpose of this policy, administrative or non-clinical areas of the are areas that are not open to patient care. Professional looking shoes with non-skid soles are permitted to be worn in administrative or non-clinical areas of the Hospital if approved by department management. Shoes should also have either a covered heel or have a back lip or strap to prevent accidental slip off while also being of reasonable sole and heel height. Peep toed dress shoes, open toed shoes, and “croc-like” shoes are permitted in
administrative or non-clinical areas of the Organization if approved by Department Management. Flipflop or beach style sandals are not acceptable.

6. Denim clothing or jeans of any color, sleeveless attire, tank/tube tops, tee shirts (with or without logos), sweatshirts, sweatpants walking shorts, capris, running or jogging suits, shorts, exposed midriffs and skirts that are more than 3 inches above the knee are not acceptable. (The exception to denim clothing or jeans will be for laborers only with the approval of senior management.) If the department has an approved hoodie or fleece, it may be worn. If the department does not have an assigned color, any departmental approved zip up hoodie or fleece must be white.

7. Departments may permit employees to wear crop pants as long as they cover the entire calf of the leg.

8. Hospital provided scrubs are to be worn only in hospital approved departments, by employees who are providing clinical care, as outlined in Policy V.251. Please note: In normal situations, hospital provided scrubs cannot be worn in to the hospital from home, nor should they be worn home from the Hospital. However, if the employee’s clothing is damaged while at work, with approval from management the employee may wear scrubs home with the provision that they return them back to the Hospital during their next scheduled shift.

9. Uniforms may be required in hospital departments, especially those in direct patient care. Department uniform colors are approved and the coordination of all requests should go to the Vice President of Human Resources. Only white or uniform matching under shirts may be worn under uniforms or scrubs. Colors and their respective departments include:

   Light Blue – Hospital scrubs only in areas per policy V.251
   RNs and LPNs - White and/or Royal Blue (any combination)

   Clinical Associates & Medical Assistants - Teal Green Top / Khaki Bottoms / Teal Bottoms / White Bottoms

   Support Associates - Grey Top / Black Bottoms

   Unit Clerks - Navy or White Top / Khaki Bottoms / Navy Bottoms / Gray Bottoms / Wine Bottoms

   Housekeeping - Navy Blue

   Cardiac Monitor Tech - Gold Top / Navy Blue Bottom

   Respiratory - Green

   Children’s Hospital Transport Team – White or Navy Top (Polo or Scrub) and Navy Blue Bottoms (Cargo or Scrub)

   Volunteers - Burgundy

   Neuro Labs - Sandstone

   Sleep Lab-Burgundy/Khaki

   Phlebotomist-Gray scrub pants and red scrub tops

   Dietitians - Sea foam (light) green
10. Hats may only be worn when it is part of the uniform specified by the department policy.

11. Body piercings and tattoos – no visible body or tongue piercing is allowed other than ear piercing. A maximum of three (3) modest earrings per ear may be worn. Earrings must be professional in appearance. Solid modest gauges may be approved by department management. Visible tattoos are not part of the WVU Hospitals overall professional appearance. If hired with visible tattoos, employees will be required to cover them as much as is possible unless such covering of the tattoo creates a safety or infection control issue. Such exceptions must be approved by the department management and the Vice President of Human Resources. All materials used to cover tattoos or piercings must be approved in advance by department management. Any covering of tattoos or piercings that does not support the effort of the Hospital to create a favorable impression to our patients will not be permitted.

12. Seasonal holiday clothing (tops, socks, ties) must be consistent with overall appearance standards. Seasonal holiday clothing may only be worn from November 15 to January 1.

13. Appropriate West Virginia University T-Shirts, sweat shirts or Polo shirts may be worn on both away and home football game days by employees. Appropriate shirts may also be worn on Friday’s when games are being played on Saturdays. All shirts that are worn must be appropriate.

14. Where uniforms are not required, clothing must be business appropriate.
15. Employees rendering direct patient care must also comply with the following guidelines concerning fingernails: (Reference the Fingernail Policy V.252)

- Cannot wear artificial nails.
- Should keep their natural nails no longer than a quarter inch past the end of their fingers.
- Should ensure that nail polish, if worn, is free of chips and cracks.

16. Employees are not permitted to use any electronic or battery devices in any public area that may be seen by our patients unless such device is required for them to perform the work assigned to their position. Examples of prohibited devices include, ear buds, blue tooth devices, iPods, headsets etc.

17. The employee is required to be familiar with specific dress code requirements for their individual department.

18. Dress at off site events is also of importance. An employee is to consult with management prior to attending any off site event to ensure their dress and appearance is appropriate.

19. Specific guidelines may be developed by department directors to address job assignment, special circumstances, safety and/or patient care issues. Any department guidelines should be consistent with Hospital policy. When required by Hospital operations, some departmental guidelines may be stricter than Hospital policy. At no time should a departmental policy be more lenient than the Hospital policy. All department policies should be reviewed by the VP of Human Resources if such requirements are more stringent than the Hospital policy. Off site locations policies may be more lenient if approved as noted above.

20. The Vice President of Human Resources will have the authority to grant exceptions to this policy if such request supports the overall mission of the Hospital.

Albert Wright
President & CEO

Author: Director of Human Resources