

West Virginia University
School of Public Health

Department of Occupational and
Environmental Health Sciences

Division of Occupational Medicine

A Handbook for Residents

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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.

Occupational Medicine is housed within the WVU School of Public Health's Occupational & Environmental Health Sciences (OEHS) department. The SPH is made up of a diverse faculty including basic scientists, engineers, physicians, bioinformaticians, epidemiologists, and other public health scientists, dedicated to the excellence in teaching and mentoring of students.

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 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

Occupational Medicine's office space is located on the third (3rd) floor at the Health Sciences Center (HSC). Telephone access and computer facilities are provided for each resident within the Department. Faculty offices and a library are also included in the Department quarters.

Occupational Medicine uses the clinical facilities of the Health and Education Building (HEB) located at 390 Birch Street on the Evansdale campus. This area consists 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 library as well as from the program director and faculty.

WVU Medicine

WVU Medicine's mission is to **improve the health of West Virginians and all we serve** through excellence in patient care, research, and education. WVUH is West Virginia's foremost health care institution, offering a full range of medical and dental services.

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.

National Institute for Occupational Safety and Health

The National Institute for Occupational Safety and Health (NIOSH), a federal agency, sits behind the WVU Health Sciences Center and is home to the Division of Safety Research (DSR), Health Effects Laboratory Division (HELD) and the Respiratory Health Division (RHD).

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 Occupational Medicine conferences and teaching sessions. Innovative resident rotations at NIOSH are available through inter-institutional agreements. Residents, physicians, and students also 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 Public Health 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 and 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

Miscellaneous

Inclement Weather Protocol

- Clinic is open Monday – Friday, 8:00 – 5:00 pm.
 - If clinic has been cancelled, you will be notified by phone/text message.
 - If you cannot make it to clinic, or if you are going to late, it is *your* responsibility to contact clinic – please email Robin, Julie O’Neil and Dr. Rob Gerbo no later than 7:00 am
- WVU Classes: Classes are rarely cancelled. It is your responsibility to inform your instructor if you will not be attending class due to inclement weather

Parking

Security office is located in the hospital, each resident will receive a parking pass

Dress Code

- **Clinic:**
 - Business casual; khakis or pants, full button-down shirt with tie, loafers or loafer-style shoes
 - NO t-shirts, shorts, jeans or flip-flops/open-toed sandals
 - Approved ID badge must be worn at all times at a location above the waist
- **Office/Didactics/MPH Classes:** Business casual; khakis or pants, casual button-down shirt, open-collar or polo shirt; loafers or loafer-style shoes
 - NO t-shirts, shorts, jeans or flip-flops/open-toed sandals

<http://wvumedicine.org/wp-content/uploads/2017/12/Dress-Code-Policy-122617.pdf>

Cell Phones

Cell phones are not to be used for personal matters during clinic, grand rounds and didactics. During these times, all phones should be turned to silent/vibrate only. This includes text messages!

Who Do I Contact for?

Benefits Questions	Human Resources	(304) 293-4103
CBL's	CBLC	(304) 293-6128
Employee Health		(304) 598-4160
Employee Health online		Wvuhealthcare.readysetsecure.com
Faculty & Staff Assistance Program (FSAP)	Employee Assistance program	Janie Howsare (304-293-5323 1085 Van Voorhis Road, St 218
IT HelpDesk		HSC – (304) 293-3631 WVUH – (304) 598-help
SOLE Support		(304) 293-2491

Admission to the Residency Program

Resident Eligibility and Selection (III.A)

Interested applicants need to apply on line 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.

Applications and supporting documentation (for July admissions) should be submitted by August. Offers for admittance are made 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 on line.
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 does not support applicant travel.*
4. Following an interview, the OM faculty will evaluate each applicant according to these criteria:
 - a. Conformity with ACGME requirements.
 - b. Passing scores on USMLE Steps 1, 2, 3.
 - c. Eligibility for WV medical licensure.
 - 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.**

WV Licensure

The department 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.

<https://wvbom.wv.gov/>

Educational Program (IV)

Year 1 (PGY2): The Academic Phase

The academic phase is based in the School of Public Health, West Virginia University, chaired by Dean Jeff Coben, MD. 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 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 Masters Degree in Public Health (MPH). There are now 50+ faculty and an increased number of educational programs including a Doctor of Philosophy in Epidemiology, PhD in Occupational & Environmental Health Sciences and a PhD in 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 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. By the end of the academic phase the resident will:

- Judge the precision and accuracy of methods for quantifying environmental agents
- Understand the routes of entry of environmental agents into the body and how those routes affect toxicity
- Provide management expertise for planning and carrying out disaster preparation
- Determine the relevance of toxicological and epidemiologic data for regulatory use. Integrate scientific, regulatory and social information for risk communication
- Design approaches for achieving environmental sustainability in communities and industry
- Integrate multiple data sources to determine the underlying causes of injury
- Understand the role of genetics in mediating host susceptibility to disease

Sample MPH schedule below. 44 total Credit Hours

Course Title	Course #	Cr Hrs
MPH Foundational Courses		
Contemporary Foundations of Public Health Practice	PUBH 610	2
Epidemiology for Public Health Practice	PUBH 611	2
Research Translation and Evaluation in Public Health Practice	PUBH 612	4
Building and Sustaining Public Health Capacity	PUBH 620	2
Public Health Prevention and Intervention	PUBH 621	3
MPH Field Practicum	PUBH 630	3
Leadership and Collaboration in Public Health	PUBH 640	3
Systems Thinking in Public Health Practice	PUBH 641	2
Graduate Seminar	PUBH 696	1
OEHS Major Courses		
Environmental Practice	OEHS 610	3
Occupational and Environmental Hazard Assessment	OEHS 620	4
Public Health Toxicology	OEHS 622	3
Occupational Injury Prevention	OEHS 623	3
Capstone	OEHS 629	
Electives		
Worksite Evaluation	PUBH 665	3
Intro to International Health	PUBH 605	4

**** Please note schedule subject to change.**

Admissions & Records Schedule of Courses

https://star.wvu.edu/pls/starprod/bwckschd.p_disp_dyn_sched

Residents, with the help of the program director and manager, will plan their academic year to insure that appropriate academic courses are completed within the 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.

<http://publichealth.hsc.wvu.edu/students/graduate-programs/master-of-public-health/>

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

Culminating Experience/Capstone

OEHS 629 Capstone is generally to be taken in the last semester of study. In the Capstone, students are required to demonstrate the ability to synthesize and integrate knowledge and competencies across the full breadth of the MPH-OEHS curriculum.

MPH Field Practicum

The MPH field practicum provides students with the opportunity to develop their practical skills and enhance professional competencies by applying the knowledge and techniques gained from their MPH coursework to public health practice.

Year 2 (PGY3): 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 of the occupational medicine 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 two to three 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.) and US Steel in Pittsburgh, PA.. 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 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 orthopedics, rehabilitation 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 occupational medicine as well as in other departments of the West Virginia University School of Public Health and NIOSH. Resources in the occupational medicine department include databases of workers' compensation data for West Virginia and case records of patients referred to the clinic. Approval of proposed research projects will 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](#).

Occupational Medicine Grand Rounds

Each month, residents in occupational medicine, faculty, interested staff and invited guests attend occupational medicine grand rounds. The purpose of the lecture is to address scientific issues of concern to the practice of occupational medicine and to supplement the didactic component of the residency practicum. Lectures also offer an opportunity for preceptors at participating sites, hospital faculty 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 except when travel on outside rotations prohibits their travel. Grand rounds are held from 12:30 to 1:30 p.m. on Friday. In addition, residents will be required to meet for didactics and journal club. These meetings are designed as more informal tutorials covering case presentations, review of recent journal articles, and board review sessions.

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.

An updated schedule is maintained at our website:

<http://publichealth.hsc.wvu.edu/occmed/residency-program/occupational-medicine-rounds/>

Promotional Policy

During the academic year, each resident will be responsible for seeing that the Program Director 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 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, 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.
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, journal club, 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 practicum project may be permitted to complete their thesis 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 practicum 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/qme/qme-policies/>

Dismissal/Termination

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

<http://www.hr.wvu.edu/policies/wvu-hr-9-discipline-policy>

Residency Completion

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

Occupational Medicine Competencies (IV.A.5)

The Occupational Medicine Residency Program at West Virginia University School of Public Health 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 below and again 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 patients 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

Evaluations (V.)

1. An initial evaluative session between the resident and the 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. 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.
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 program review of the residency program.
6. Confidentiality will be maintained. Residents have access to his/her academic file and evaluations at all times.

Learning and Working Environment (VI.)

Transitions of Care

To minimize the number of transitions in patient care the OM clinic eliminated a separate residents' schedule and patients are now only scheduled with attending faculty physicians. Return appointments are scheduled using the following priority scheme:

1. Same resident, same attending
2. Different resident, same attending
3. Same attending (alone)

For OM, this includes primarily out-patients, but is also applicable to any in-patients we may be following as consultants.

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 the clinic occurs between the initial and subsequent visits. It is the goal in all clinic scheduling to minimize transfers of care.

Interservice transitions of care are extremely infrequent, but may occur when a patient requires evaluation or treatment beyond the capabilities of the OM clinic for continued care. Examples would include patients with fracture(s) requiring orthopedic care or cardiovascular instability requiring evaluation in the Emergency Department. 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.

It is required that each resident be monitored by faculty for proficiency in verbal transitions of care annually. Following an actual or simulated inter-service transition of care, faculty will complete an evaluation of the transition, and the resident will be asked to complete a self-assessment. The goal of this is to guide the formation of the resident's inter-service transition skills.

Consistent processes of transfer of care as well as efficient communication are essential to ensure safe and effective patient care.

Supervision and Accountability (VI.A.2.)

Resident supervision will be in accordance with the policies set forth in ACGME Common Program Requirements, effective July 1, 2017.

Levels of Supervision (V1.A.2.c)

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 guided by the Milestones.

a. Academic Year, PGY-2

Occupational Medicine residents are assigned to specific clinics throughout the two-year program. While in these clinics, residents are under the direct supervision of the 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. Using the electronic medical record (EMR), 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 program 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 occupational medicine 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 occupational medicine, 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.

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 care 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 Director 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. (V.A.2b)

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 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 are responsible for using this information to assure that all required aspects of training occur.

Fatigue Mitigation (VI.D)

The Occupational Medicine clinic is open 8:00 – 5:00 pm Monday-Friday. Occupational Medicine residents do not work nights or weekends, although most MPH courses are scheduled for the late afternoon/early evening.

Residents are encouraged to evaluate their schedule, create healthy sleep habits and get regular exercise.

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. If a resident feels they are unable to drive they should ask for a ride from a co-worker, or taxi vouchers are available at the Emergency Room check-in desk for a taxi ride home.

Moonlighting (IR IV.J.1, IV.J.1.a-d)

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.

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

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.

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 2018-2019

PGY-2	\$56,180
PGY-3	\$57,993

Payroll

Residents are paid every two weeks. 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).

<https://talentandculture.wvu.edu/benefits-and-compensation/insurance-plans/disability-insurance>

Parking

Residents will receive a parking pass and a designated parking lot is reserved for all residents.

Additional WVU Benefits

- Athletic and Cultural events
- Library Privileges
- University Club - (<http://www.wvu.edu/~uniclub/>)
- Student Recreation Center - (<http://www.studentreccenter.wvu.edu/>)
- Shell Building (weight room, gym, indoor/outdoor track)
- Coliseum (racquetball, squash, and tennis courts)
- Stansbury Hall (gym)
- Natatorium (pool)
- Wellness Center – one time fee of \$10.00

Annual Leave

Occupational Medicine residents follow the resident leave guidelines of the West Virginia University School of Medicine 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 (WVU), WVU School of Public Health, WVU School of Medicine, ACGME, the regulatory and/or accrediting agencies, and the Residency Committee and are approved by the 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 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.

During the PGY2 – Academic Year – residents are asked to use their vacation time in accordance with the WVU Academic calendar: i.e. Thanksgiving week, Christmas holiday, Spring break.

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 required to use the entirety of your annual leave. 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. The Program Manager and/or Director has 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. 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

Residents are given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

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

The 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, therefore, if a service requires you to work on a state holiday, you will not be compensated additional amounts for that worked holiday.

However, residents/fellows who work on State-defined Holidays (for example, Thanksgiving Day or a service where physicians do not observe a state holiday) may be granted an equivalent number of alternate days to be taken at a time mutually agreed upon by the resident and the Program Manager. No grant of an equivalent number of days is required of or owed by WVUSOM.

Continuing Medical Education Leave

All CME conferences a resident/fellow wishes to attend must be approved, in advance, by the Program 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 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.

Practitioners Health

<http://www.wvmphp.org/>

West Virginia Medical Professionals Health Program is committed to the safety of the public by promoting the physical and mental well-being of West Virginia healthcare providers. WVMPHP offers the following:

- Assistance, Guidance and Support
- Confidentiality for “voluntary” participants
- Initial Assessments
- Interventions
- Assist with referrals for Evaluation and/or Treatment
- Multi-year Recovery Contract
- Case Management
- ADVOCACY with Regulatory agencies and hospitals
- Consultations for clinics, hospitals and other healthcare facilities

Finding Balance in a Medical Life (book review)

http://www.wvmphp.org/Finding_Balance..._Book_review-P_Bradley_Hall_MD.pdf

Workplace Stress and the Healthcare Provider (article)

http://www.wvmphp.org/WVAPA_Bulletin_-_Workplace_Stress_and_the_Healthcare_Provider.pdf

Physician Suicide (article)

http://www.wvmphp.org/Selby-PhysSuicide_WVSMA_article.pdf

RESIDENT ADVANCED LIFE SUPPORT TRAINING POLICY

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 must maintain ACLS certification during their program.

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.

- A. If certification expires, the House Staff office will notify the resident and the program coordinator. 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/>

Left hand column: HR & TRAINING

WVUH Training

NetLearning Learner Interface

Log in with your social security number

Work Hours

Residents have no call or weekend responsibilities in the occupational medicine residency. Therefore, work hours should never be exceeded by any residents. Nevertheless, residents are expected to be in compliance with all of the ACGME Work Hour Rules at all times. The program complies with the ACGME policy for Work hours, including the requirement to record and monitor work 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.

Work hours are monitored by the Program Manager through the e-Value online system at www.e-value.net with a copy kept in their files.

Residents are responsible for watching their work 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 regulations, 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 Program Director or Program Manager.

* *Work hours are defined as all clinical and academic activities related to the program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Work hours do not include reading and preparation time spent away from the duty site.*

Work hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in house call activities and all moonlighting.

** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety*

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.*

** Work 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.*

** Intermediate-level residents (PM-1 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.*

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/380_preventive_medicine_2016_TCC.pdf

Appendix A

Participating Sites

West Virginia University School of Public Health 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 Public Health 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 and a copy of the supervising physician's CV. 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 Program Manager.
3. The Program Manager will schedule a review of the request at the regularly scheduled GMEC meeting. If approved, go to Step 5. If denied, STOP.
4. The Program Manager 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 Public Health
Morgantown, WV

Preceptors On-Site:

Anna Allen, MD, MPH	Board certified in Occupational/Family Medicine
Robert Gerbo, MD	Board certified in Family Medicine
ChuanFang Jin, MD, MPH	Board certified in Occupational Medicine
Jennifer Lultschik, MD, MPH	Board certified in Occupational Medicine
Christopher Martin, MD, MSc	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.*

Milestones for Occupational Medicine Clinic

Patient Care	<ul style="list-style-type: none"> • Recognize, evaluate, and treat exposures to toxins at work or in the general environment • Assess if there is risk of an adverse event from exposure to physical, chemical, or biological hazards in the workplace or environment, and characterize, make recommendations for control of, and communicate the risk • Apply skills in emergency preparedness and response • Monitor, diagnose, and investigate community health problems • Inform and educate populations about health threats and risks • Develop policies and plans to support individual and community health efforts • Evaluate population-based health services • Provide evidence-based clinical evaluation and treatment for injuries and illnesses that are occupationally or environmentally related • Comply with regulations important to occupational and environmental health; workplace hazard related, and consumer/community hazard related • Determine if a worker can safely be at work/complete required job tasks, and provide guidance for integrating 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 • Develop, evaluate, and manage medical surveillance programs for the workplace • Apply an ethical approach to promote the health and welfare of the individual worker and protect worker rights and privacy in the context of overriding workplace public health and safety
Medical Knowledge	

	<ul style="list-style-type: none"> • Behavioral health: identifies best practice and tools to assess risk behaviors • Environmental health: describes individual factors that impact susceptibility to adverse health effects from environmental exposures • Biostatistics: describes frequently used statistical tests • Epidemiology: knows methods for calculating basic measures of disease frequency and risk
Practice Based Learning and Improvement	<ul style="list-style-type: none"> • Identify strengths, deficiencies, and limits in one's knowledge and expertise; set learning and improvement goals and identify and perform appropriate learning activities utilizing information technology, evidence from scientific studies, and evaluation feedback; systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
Interpersonal and Communication Skills	<ul style="list-style-type: none"> • Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; communicate effectively with physicians, other health care professionals and health-related agencies; work effectively as a member or leader of a health care team or other professional group; act in a consultative role to other physicians and health professionals • Maintain comprehensive, timely and legible medical records, including electronic health records (EHR)
Professionalism	<ul style="list-style-type: none"> • Compassion, integrity, and respect for others, as well as sensitivity and responsiveness to diverse patient populations, including diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; knowledge about, respect for, and adherence to the ethical principles relevant to the practice of medicine, remembering in particular that responsiveness to patients that supersedes self-interest is an essential aspect of medical practice • Accountability to patients, society and the profession

Systems Based Practice	<ul style="list-style-type: none">• Work and coordinate patient care effectively in various health care delivery settings and system• Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care, as appropriate• Work in inter-professional teams to enhance patient safety and improve patient care quality; advocate for quality patient care and optimal patient care systems; participate in identifying system errors and implementing potential systems solutions

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:

- Apprehend the workings of an independent run workers' compensation system
- Learn the techniques of consultation to insurers, employees, governmental agencies, and the legal system
- Understand the means by which management and compensation of workers for occupational injuries and disease is performed
- 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 a less formal verbal interactions

Milestones for BrickStreet	
Patient Care	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Understanding 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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, DO and Randall Nett, MD

Duration: Six months (2 days/week)

Setting: The Division provides national and international leadership for preventing work-related respiratory disease and optimizing workers' respiratory health by generating new knowledge and transferring that knowledge into practice for the betterment of workers. RHD has a multidisciplinary approach and specializes in identifying, evaluating, and preventing a spectrum of work-related respiratory diseases, such as work-related asthma, chronic obstructive pulmonary diseases, and pneumoconiosis.

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 in field investigations and evaluations, as well as in search for and reviewing pertinent existing information. Emphasis will be placed

don demonstrating an investigatory and analytical thinking approach to identify disease conditions and potential risk factors and develop recommendations for preventing occupational respiratory diseases.

Milestones of NIOSH - RHD	
Patient Care	<ul style="list-style-type: none"> • Ability to advise workers regarding industrial hygiene controls such as work practices, personal protective equipment use, and engineering controls
Medical Knowledge	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Timeliness

	<ul style="list-style-type: none"> • Demonstrates compassion and integrity • Adheres top ethical principles
Systems Based Practice	<ul style="list-style-type: none"> • 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

National Institute for Occupational Safety and Health
Division of Safety Research (DSR)
Morgantown, WV

Director: Dawn Castillo, MD
Preceptor: Paul Moore -- Chief, Special Studies Section
Duration: Six months (2 days/week)

Setting: The Division works to address the safety issues of the 21st century workplace, and is the focal point for traumatic injury research at NIOSH. Through research they identify, reduce, and prevent work-related injuries and deaths across all industries. Programs are rooted in a public health approach which includes: injury data collection and analysis; field investigations; analytic epidemiology; protective technology and safety engineering.

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

Milestones for NIOSH - DSR

Patient Care	<ul style="list-style-type: none"> • 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
Medical Knowledge	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • Ability to describe patterns and risk factors for injury using surveillance data
Interpersonal and Communication Skills	<ul style="list-style-type: none"> • Communicates professionally with personnel, including supervisors, support staff and outside professionals • Sensitivity to gender, culture, age and disability issues
Professionalism	<ul style="list-style-type: none"> • Timeliness; • Demonstrates compassion and integrity • Adheres to ethical principles
Systems Based Practice	<ul style="list-style-type: none"> • 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

National Institute for Occupational Safety and Health
Health Effects Laboratory Division (HELD)
Morgantown, WV

Director: Don Beezhold, Ph.D.

Duration: Six months (part-time)

Setting: The Division conducts basic and applied laboratory research. Primarily staffed by engineers and biologists, its focus is to establish the causes of occupational disease and injury, and to contribute to the development of valid strategies of intervention and prevention.

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.

Milestones 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

Occupational Safety and Health Administration (OSHA)
Office of Occupational Medicine – Resident Elective
Washington, DC

Preceptor: Richard Thomas, MD

Duration: Two months

Setting: Governmental Investigative and Enforcement Agency

Rotation Goals:

- Become familiar with the organizational structure and function of the OSHA and the Office of Occupational Medicine (OOM)
- Become familiar with OSHA's regulatory process; the Occupational Safety and Health Act of 1970; and rulemaking activities
- 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:

- 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 completed during the rotation will be presented at the end of the rotation.
- Work with health care professionals, including those from other disciplines to acquire insight as to their functions and current roles in OSHA activities
- Gather essential and accurate statistics by using information technology to manage data and access on line medical information
- Answer inquiries (verbal and/or written) from other health professionals, government agencies, and/or the public
- Actively participate in a field investigation with OSHA personnel and prepare a written report

Milestones for OSHA

<p>Medical Knowledge</p>	<ul style="list-style-type: none"> • 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
<p>Interpersonal and Communication Skills</p>	<ul style="list-style-type: none"> • Communicate effectively while addressing a public audience – presentation of research work at OSHA • Demonstrate sensitivity to gender, culture, age, and disability issues
<p>Practice Based Learning and Improvement</p>	<ul style="list-style-type: none"> • 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
<p>Professionalism</p>	<ul style="list-style-type: none"> • Ability to meet deadlines and reporting requirements • Demonstrate adherence to ethical principles and business practices
<p>System Based Practice</p>	<ul style="list-style-type: none"> • 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: Lolita Kirk, Acting Executive Director and
Michael Brumage, MD, MPH

Duration: One Month

Rotation Goals:

- Be knowledgeable and familiar with the many program and activities of a public health department
- Be 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:

- Participate in the clinical public health clinics/programs: Sexually Transmitted Disease, Well Child, Tuberculosis and other chest disease, Breast and Cervical Cancer Screening, Early Periodic Screening Testing and Diagnosis, Hypertension and diabetes screening, Family Planning Services, Immunization Services, Right from the State High Risk Infants and Mothers Case Management
- Participate in the environmental programs: Well water, Septic system inspection and permitting, municipal water and sewage treatment monitoring, Restaurant and food service inspection, Emergency response to industrial chemical releases and natural disasters, Animal bite management, Indoor air quality, Environmental contamination: air, water and ground
- Observe medical service to boards of community organizations, study groups and appointed task forces

Milestones for Kanawha Charleston Health Department

Patient Care	<ul style="list-style-type: none"> • Knowledge of infectious disease; chronic disease; individual behavior interventions, community based behavior interventions • Identify resources to improve a communities health • Appropriately recommends routine adult immunizations
Practice Based Learning and Improvement	<ul style="list-style-type: none"> • Employs standard procedures and protocols for the management of hazardous materials incidents • Assist with development of disaster planning for public health and terrorism response • Identifies practical challenges to the design of health screening programs
Medical Knowledge	<ul style="list-style-type: none"> • Ability to recommend methods of reducing environmental health risks • Ability to recommend methods of control for indoor air pollution problems • Ability to explain the controversies associated with electromagnetic field exposures
Systems Based Practice	<ul style="list-style-type: none"> • Recognizes outbreak events of public health significance, as they appear in clinical or consultation settings • Recommends primary, secondary, and tertiary methods of prevention, as appropriate • Responds appropriate to non-occupational public health problems such as an outbreak of food borne illness
Interpersonal and Communication	<ul style="list-style-type: none"> • Communicate effectively with the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds • Communicate effectively with physicians, other health professionals, and health related agencies • Work effectively as a member or leader of a health care team or other professional group • Maintain comprehensive, timely and legible medical records, if applicable
Professionalism	<ul style="list-style-type: none"> • Compassion, integrity, and respect for others • Responsiveness to patient needs that supersedes self-interest

	<ul style="list-style-type: none">• Respect for patient privacy and autonomy• Sensitivity and responsiveness to a diverse patient population
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Appendix B

ACGME Competencies *ACGME Common Program Requirements*

<p>Patient Care and Procedural Skills <i>IV.A.5.a).(1)</i></p>	<p>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</p> <p>Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice</p>
<p>Medical Knowledge <i>IV.A.5.b)</i></p>	<p>Residents must demonstrate knowledge of established an evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.</p>
<p>Practice Based Learning and Improvement <i>IV.A.5.c)</i></p>	<p>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</p> <p>Residents are expected to develop skills and habits to be able to meet the following goals:</p> <ul style="list-style-type: none"> • Identify strengths, deficiencies, and limits in one’s knowledge and expertise • Set learning and improvement goals • Identify and perform appropriate learning activities • Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement • Incorporate formative evaluation feedback into daily practice • Located, appraise, and assimilate evidence from scientific studies related to their patients’ health problems • Use information technology to optimize learning, and • Participate in the education of patients, families, students, residents and other health professionals
<p>Interpersonal and Communication Skills <i>IV.A.5.d)</i></p>	<p>Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals</p> <p>Residents are expected to:</p>

	<ul style="list-style-type: none"> • Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds • Communicate effectively with physicians, other health professionals, and health related agencies • Work effectively as a member or leader of a health care team or other professional group • Act in a consultative role to other physicians and health professionals, and • Maintain comprehensive, timely, and legible medical records
<p>Professionalism <i>IV.A.5.e)</i></p>	<p>Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles</p> <p>Residents are expected to demonstrate:</p> <ul style="list-style-type: none"> • Compassion, integrity, and respect for others • Responsiveness to patient needs that supersedes self-interest • Respect for patient privacy and autonomy • Accountability to patients, society and the profession, and • Sensitivity and responsiveness to ad diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
<p>Systems Based Practice <i>IV.A.5.f)</i></p>	<p>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</p> <p>Residents are expected to:</p> <ul style="list-style-type: none"> • Work effectively in various health care delivery settings and systems relevant to their clinical specialty • Coordinate patient care within the health care system relevant to their clinical specialty • Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate • Advocate for quality patient care and optimal patient care systems • Work in inter-professional teams to enhance patient safety and improve patient care quality, and • Participate in identifying system errors and implementing potential systems solutions

Appendix B (cont.)

ACOEM TEN CORE COMPETENCIES

Clinical Occupational and Environmental Medicine	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.
OEM Related Law and Regulations	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.
Environmental Health	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.
Work Fitness and Disability Integration	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.
Toxicology	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.
Hazard Recognition, Evaluation, and Control	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.
Disaster Preparedness and Emergency Management	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 most often includes resource mobilization, risk communication, and collaboration with local, state, or federal agencies.
Health and Productivity	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, presenteeism, health enhancement, and population health management
Public Health, Surveillance, and Disease Prevention	The physician has the knowledge and skill to develop, evaluate, and manage medical surveillance programs for the work place as well as the general public. The physician has the knowledge and skills to apply primary, secondary, and tertiary preventive methods.
OEM Related Management and Administration	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.

<https://www.acoem.org/OEMCompetencies.aspx>

Click to access the full [OEM Competencies Statement](#)
which defines and expands each competency.

Appendix B (cont.)

Milestones

Occupational Medicine Milestones

<http://www.acgme.org/Portals/0/PDFs/Milestones/PreventiveMedicineMilestones-OccupationalMedicine.pdf?ver=2015-11-06-120521-090>

Milestones Guidebook for Residents and Fellows

<http://www.acgme.org/Portals/0/PDFs/Milestones/MilestonesGuidebookforResidentsFellows.pdf?ver=2017-06-29-090859-107>

Appendix C

SAMPLE

Rotation Evaluation Form *To be completed by preceptor after rotation*

Resident:
Preceptor:
Date of Rotation:

Date:
Rotation:

This evaluation summarizes the resident's performance at the end of this rotation.

 Criteria: **Unsatisfactory** **Satisfactory** **Superior**
 1 2 3 4 5 6 7 8 9
 Evaluation levels below "4" require comment

	Unsatisfactory	Satisfactory	Superior	NA
Patient Care				
Obtains screening and comprehensive patient histories accurately and with an emphasis on occupation(s) and exposures				
Encourages rapid return to work when medically appropriate				
Performs a complete, accurate, and organized physical exam				
Manages the health status of individuals who work in diverse settings				
Performs pre placement and fitness for duty evaluations in compliance with the American Disabilities Act and DOT regulations				
MEDICAL KNOWLEDGE				
Correctly recognizes and diagnoses occupational and environmental illnesses/injuries				
Knowledge of legal and regulatory issues focusing on OSHA regulations				
PRACTICE BASED LEARNING AND IMPOVEMENT				

Utilizes workers' compensation services and reimbursement rules				
Advises patients about the basic elements of workers compensation law, with emphasis That this is a physician understanding not a legal one				
Manages worker insurance documentation and paperwork for work related injuries that may arise in numerous work settings				
INTERPERSONAL AND COMMUNICATION SKILLS				
Communication skills – verbal & written				
Interacts well with staff, faculty & colleagues				
PROFESSIONALISM				
Protects employees' rights to confidentiality				
Sensitive to culture, age, gender and disability issues				
SYSTEMS BASED PRACTICE				
Understand DOT regulations in application to commercial drivers.				
Ability to provide impartial, expert opinions regarding the work-relatedness of disease.				
Understanding of medical information systems and application to surveillance and tracking of worker disability.				

Resident signature

Residency Director Signature

SAMPLE

Practicum Rotation

To be completed by resident after rotation

<u>Evaluation Item</u>	<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>N/A</u>
The preceptor(s) were available when needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The preceptor stimulated critical thinking:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constructive criticism and adequate feedback included the resident in all appropriate teaching and learning opportunities:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The preceptor demonstrated the ability to interact with multidisciplinary resources (supervisors, IH, safety, work comp. etc.) was:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The preceptor presented information and new perspectives on OEM topics:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The preceptor enhanced your understanding of public health issues in OEM:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The preceptor provided adequate opportunities for the resident to interact with other occupational health resources (supervisors, IH, safety, etc.):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
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.)	Yes	No
Did you get at least one 24-hour time period off in seven days averaged over the four week period?	Yes	No
Were you ever on call more often than every 3 rd night averaged over the four week period?	Yes	No

Resident signature

Residency Director Signature

Appendix D

Selected References in Occupational and Preventive Medicine

Preventive Medicine

Control of Communicable Disease Manual. 20th ed. (David L. Heymann)

Maxcy-Rosenau-Last Public Health and Preventive Medicine. 15th ed. (Robert B. Wallace)

A Study Guide to Epidemiology and Biostatistics. 7th ed. (J. Richard Hebel, Robert J. McCarter)

Guide to Clinical Preventive Services, (Recommendations of the US Preventive Services Task Force) <https://www.uspreventiveservicestaskforce.org/browserec/index>

Mayo Clinic Preventive Medicine and Public Health Board Review (Mayo Clinic Scientific Press) 1st Edition (Prathibha Varkey MD, MPH MHPE)

Occupational Medicine

Brooks S. Environmental Medicine. St. Louis. Mosby-Year Book Inc. 1995

Felton JS. Occupational Medical Management. Boston. Little, Brown & Co. 1989

Guidotti, Tee. The Praeger Handbook of Occupational and Environmental Medicine (3 volumes).

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

Levy BS, Wegman DH. Occupational Health: Recognizing and Preventing Work-Related Disease. 3rd ed. Boston. Little, Brown & Co. 1995

McCunney RJ. A Practical Approach to Occupational and Environmental Medicine. 2nd ed. Boston. Little, Brown & Co. 1994

Moser R. Effective Management of Occupational and Environmental Health and Safety Programs. Beverly, MA. OEM Press. 1992

Occupational Medicine State-of-the-Art Reviews. Volumes 1-11. 1985-present. Philadelphia. Hanley & Belfus

Rom W. Environmental and Occupational Medicine. 3rd ed. Boston. Little, Brown & Co. 1998

Rosenstock L, Cullen MR. Textbook of Clinical Occupational and Environmental Medicine. Philadelphia. WB Saunders Co. 1994

Sullivan and Krieger. Hazardous Materials Toxicology. Baltimore. Williams and Wilkins. 1992

Zenz C, Dickerson OB, Horvath EP. Occupational Medicine. 3rd ed. St. Louis. Mosby-Year Book Inc. 1994

Recommended Journals

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

Journal of Occupational and Environmental Medicine

The American Journal of Industrial Medicine

Occupational and Environmental Medicine (formerly British Journal of Industrial Medicine)

Scandinavian Journal of Work, Environment & Health

Archives of Environmental Health

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 Department. 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/>

Appendix E Medicare Documentation Requirements

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

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December 6, 2002

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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.

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

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December 6, 2002

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of the service, and participated in the a 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

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 or Ivy Baer, Director and Regulatory Counsel, Division of Health Care Affairs, 202-828-0490 or 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 (Effective 04/18/90; Revised 6-9-17)

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 Affairs 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 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 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.

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

February 1998

POLICIES OF PHYSICIAN HEALTH COMMITTEE

The Physician Health Committee serves as a resource in the management of impaired physicians, especially drug and alcohol related problems. In an effort to ensure some consistency in our approach to these difficult problems, the Physician Health Committee has formulated the following guidelines.

New Residents/Faculty

Any resident or faculty who requests an appointment to practice at WVUH where there exists a reasonable suspicion of substance abuse or who has a history of substance abuse and/or treatment of substance abuse must be initially referred to the Physician's Health Committee. The Physician's Health Committee will determine whether the resident or faculty needs additional evaluation from a psychiatrist or other person specializing in substance abuse.

After receiving an evaluation, and consulting with the Department Chairperson, the Physician's Health Committee will make a recommendation concerning:

Advisability of an appointment to WVUH Need for restriction of privileges; Need for monitoring; Need for consent agreement in regard to recovery program, counseling or other conditions of appointment

These recommendations will be communicated to the House Staff Coordinator (for residents), the Medical Director (for faculty) and the Department Chairperson.

Decision to grant Hospital staff privileges or residency privileges, and terms of appointment at WVUH are at the discretion of the WVUH Board of Directors based upon the recommendation of the Departmental Chairperson, the Medical Director and the Physician's Health Committee.

If agreed that the resident or faculty is to have an appointed position at WVUH, the resident/faculty must sign an agreement that upon granting privileges, he/she will submit to a blood and urine drug screening before assuming any patient care responsibilities.

Where the circumstances dictate a need for monitoring, the resident/faculty must sign an agreement that he/she will meet with a member of the Physician's Health Committee and agree to random blood and urine drug screens and other conditions that the Committee determines are appropriate in their sole discretion as requested by the Physician's Health Committee, Medical Director, and other supervisors.

All conditions of privileges and all test results will be communicated in writing to the House Staff Coordinator (for residents) and the Medical Director (for faculty) within the Department of Medical Staff Affairs.

Practicing Residents/Faculty

It is the responsibility of all faculties, residents, or any other person observing, to immediately report any inappropriate behavior or other evidence of substance abuse/health problems that could impact on professional/clinical performance in the Hospital.

If a Chairperson receives a report suggesting impairment of a physician (faculty or resident) or observes- behavior suggesting impairment, then the following actions are required:

The Chairperson must notify the Dean, Medical Director or WWH, and the Physician Health Committee (within twenty-four (24) hours) in writing of any reported incidents or observed behavior suggesting impairment

The Chairperson or Supervisor must immediately send the physician to Employee Health or the Emergency Department for blood and urine drug screening, as set forth in WVUH policy. Refusal to cooperate with testing is grounds for dismissal from the medical staff.

The Chairperson or Supervisor must immediately remove the physician from patient care or patient contact.

The Chairperson or Supervisor must immediately make a mandatory referral to Employee Assistance Program (EAP), based on the possibility of impaired performance.

The EAP office will require that the physician sign a release, authorizing exchange of medical information between EAP, the Chairperson, WWH, and the Physician Health Committee. EAP will provide a report of their evaluation and treatment recommendations in a timely manner to the Dean, Physician's Health Committee, Chairperson, and Medical Director of WWH.

The Physician Health Committee will review the report from EAP and provide a recommendation to the Medical Director of WWH who will be responsible for the final decision concerning return to work and monitoring.

The Physician Health Committee will participate in the monitoring of physicians under treatment.

<http://wvuhealthcare.com/wvuh/MediaLibraries/GlobalFiles/fhpfiles/OrganizationManual.pdf>

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.

EFFECTIVE DATE: July 7, 2000.

WVU POLICY REFERENCE:

http://www.wvu.edu/~adminfin/policies/hr_policies/WVU-HR-09.html

<https://sole.hsc.wvu.edu/courses/741/Forms/Policies/GMEByLawsJuly2011.pdf>

Appendix G

Grievance Procedures

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/fellows 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.

<https://sole.hsc.wvu.edu/courses/741/Forms/Policies/GMEByLawsJuly2011.pdf>

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 Public Health 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://grievanceprocedure.wvu.edu/>

<https://talentandculture.wvu.edu/employee-relations/filing-a-grievance>

Appendix H – Accreditation Status

11/30/2017

Accreditation Council for Graduate Medical Education
401 North Michigan Avenue
Suite 2000
Chicago, IL 60611
Phone 312.755.5000
Fax 312.755.7498
www.acgme.org

Christopher J Martin, MD, MSc
Professor and Residency Director, Occupational Medicine, School of Public
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West Virginia University School of Public Health
PO Box 9145
3852Health Sciences Center South
Morgantown, WV 26506-9145

Dear Dr. Martin

The 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 School of Public Health Occupational Medicine Program.

West Virginia University School of Public Health
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: 11/16/2017

The Review Committee commended the program for its demonstrated substantial compliance

with the ACGME's Program Requirements and/or Institutional Requirements without any new citations.

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 (ADS).

Sincerely,

Lorraine Lewis, EdD, RD
Executive Director, International Accreditation, ACGME International (ACGME-I)
Review Committee for Preventive Medicine
312.755.5043
llewis@acgme-i.org

CC:
Christopher J. Martin, MD, MS

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 Public Health

