Boston Medical Center

Preventive Medicine Residency Program

2023-2024

As preventive medicine residents, you are the future of healthcare. Make a difference by preventing disease, disability, and death by promoting health and well-being in patients, communities, and populations.

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Boston Medical Center Preventive Medicine Residency

1. Educational Goals

The Preventive Medicine Residency aims to:

1. Create a pipeline of primary care physicians in population-based research, public health practice and medical education who lead system-level changes to prevent disease and improve health across diverse populations.

2. Recruit and retain underrepresented minority physicians.

3. Provide residents with personalized training and professional development through intensive faculty mentorship and a Master of Science degree in Population Health Research from Boston University School of Public Health, nationally recognized for scholarship on the social determinants of health.

4. Advance skills in patient care and knowledge of clinical preventive medicine through targeted clinical rotations at Boston Medical Center, New England's largest safety-net hospital, and selected community partners.

5. Advance skills in public health practice through practicum rotations at city, state and federal public health agencies.

6. Evaluate our program in an iterative manner through faculty and resident feedback that promotes constant improvement and curricular innovation.

Overall Program Structure: The two-year Boston Medical Center (BMC) Preventive Medicine Residency Program combines the resources of the Chobanian & Avedisian School of Medicine and the BU School of Public Health to offer a comprehensive training program that implements the academic and practicum phases simultaneously and longitudinally. Resident experiences are tailored to the individual's interests and residents are guided by BMC Preventive Medicine faculty mentors. The unique institutional environment at BU and BMC, New England's largest safety net hospital, supports the Preventive Medicine Program focus on training experts in health care needs of urban underserved populations.

The Boston Medical Center Preventive Medicine Program curriculum is organized around four areas, **1) Analytic and Research Skills on Health of Populations, 2) Leadership, Teaching and Administrative Skills for Public Health and Preventive Medicine; 3) Clinical Preventive Medicine, and 4) Identity as a Public Health Physician.** A central focus on health disparities in urban, impoverished and minority populations infuses the entire curriculum described below.

I. GOALS-ANALYTIC AND RESEARCH SKILLS ON HEALTH OF POPULATIONS

The two pillars of research training are the Boston University School of Public Health (SPH) master's degree programs and the Preventive Medicine Residency curricular offerings. The research and analytic competencies are developed and solidified through individual mentored research projects. The specific goals are described in detail below.

A. *Complete a Master's Degree in Population Health Research at the School of Public Health*.

Preventive Medicine (PM) residents enroll at the school as part-time students and may elect to pursue a

Masters of Science in Population Health Research. The MS programs require a core series of coursework, electives, and a 400 hour mentored research experience. In addition PM residents are required to complete the following (some of which are required for the master's degree) to be eligible for board certification:

Required courses (in addition to Masters degree requirements) per ACGME:

- ***Emergency preparedness*** (ACGME requirement).
  Maternal Health Track: Training in Emergency Preparedness occurs typically through an intensive 1 week course at the BUSPH during the January intersession called Public Health Response to Emergencies. In this course, two recent cases, the 2013 Boston marathon bombing and 2009 pandemic flu, are used to teach students how the public health system responds to such crises. During years when this course is not offered, trainees participate in the hospital's disaster planning committee for one of the hospital's three yearly mock disaster exercises. They then participate in the mock exercise itself as a judge of the event and contribute to event debriefing to help improve hospital systems for preparedness.
    - PH 712: Public Health Response to Emergencies (2 credits) (or participation in emergency simulations at BMC)

  Immigrant & Refugee Health Track*: Humanitarian Response Intensive Course*, focuses on effective humanitarian responses to mass population displacement events. Trainees will have the opportunity to apply skills in public health emergency response specific to situations frequently affecting refugee populations. This two-week course focuses on practical training in the frameworks governing humanitarian responses, and culminates in a three-day field simulation exercise where participants work in nongovernmental organization teams to respond to a disaster or conflict scenario.
- ***Environmental Health:*** All trainees should complete EH 730: Methods in Environmental Health Sciences (4 credits), an equivalent or nextgenu.org course
- ***Outbreak investigation curriculum:*** All trainees should complete EP 800 Microbes and Methods: Selected Topics in Outbreak Investigation. If the course is not available then trainees have the options to complete a case-based curriculum in surveillance and outbreak investigation using CDC online cases. Trainees are required to complete one case each year, which takes approximately 4 hours. Trainees who desire additional experience may rotate with the Director of Infectious Disease at the Boston Public Health Commission for hands on experience during a live local outbreak investigation when timing allows.
- ***Health Systems, management, or Policy class (choose one):*** PH 719: Health Systems, Law, and Policy, -SPH PH 718 Leadership and Management for Public Health, SPH PM 835 Lean Management in Healthcare (4), SPH PM 827 Strategic Management of Healthcare Organizations

B. *Participate in Supervised Research Training*. Residents, with the help of program faculty, are expected to choose projects from a selection of ongoing research projects and available research databases of program faculty and affiliated public health agencies. The program directors meet to help steer residents to potential research advisors or the researchers at state and local public health departments. The resident is responsible, under the supervision of their research supervisor, for study design, data acquisition and manipulation, computer and statistical analysis, and the written and oral presentation of the results. These technical skills are obtained through coursework at the SPH. Residents are expected to conduct at least two research projects over the course of their program.

1. *Attend Research-in Progress Meetings.* Residents have two opportunities to participate in research-in-progress seminars. The trainee-focused seminar meets 2 times per month for 90 minutes and is attended by all the PM Residents, post-doctoral fellows in the academic primary care track and addiction medicine track and 3-4 research faculty members. The second Research-In-Progress meeting is by the respective departments (GIM/FM/Ped). The objectives are similar to the trainee-only meeting but are attended by a much larger audience with primary care and public health research faculty and trainees present. *Each resident is expected to present at least two times each year in the trainee-focused and one time in the combined faculty and trainee meeting.*

2. *Present research at national meetings and publish research project results in peer-reviewed journals*. At the conclusion of each research project, the resident is expected to submit written abstracts to regional and national professional meetings and submit and publish projects in peer-reviewed publications (actual publication may occur after completion of residency).

The Health Equity Accelerator is committed to leveraging the power of research to ensure that we truly unlock the contributors to adverse outcomes in people of color. We will utilize the most advanced research methodologies, including detailed clinical, demographic and claims data, qualitative and quantitative statistical analyses, and will actively engage with the community to identify barriers to health justice and solutions and create solutions to eliminate them. We will involve the community to ensure that our research is guided by and relevant to members of our community and that they participate in our scientific pursuit to understand and solve the challenges of health justice. You can find more information, information on seed grants and request a consultation at https://www.bmc.org/health-equity-accelerator/research

II. GOALS-LEADERSHIP, TEACHING, AND ADMINISTRATION SKILLS FOR PUBLIC HEALTH AND PREVENTIVE MEDICINE
Our program's goal is train future leaders in academic and public health preventive medicine. The public health practicum, didactic sessions and teaching seminars of the program prepare the trainees for this role. Residents:

A. Complete a Public Health Agency Practicum. To increase skills for future public health and preventive medicine leadership and administration and to obtain a greater depth of knowledge and experience in a focused are of preventive medicine and public health, each resident is expected to perform an individual project at a public health agency. The Residency Director (Dr. Buitron de la Vega) or Associate Director (Dr. Berz) or faculty (Dr. Gonzalez) help the resident contact key individuals at the Massachusetts Department of Public Health or the Boston Public Health Commission, both who have an affiliation with the program. The resident meets with key individuals in the agency to identify an appropriate project for completion in the time allotted, a minimum of 320 hours, or the equivalent of two months full time.

The resident works with the public health agency official to define the goals and scope of the individual project. Residents typically focus on data-related projects useful to the agency. These projects may also serve as the research project for the SPH program or the residency research requirement.
While most residents do conduct their rotations at these two sites, residents may choose town health departments, national health agencies and international health agencies (e.g., foreign government, UN-based organization). In those instances, the program makes special arrangements for supervision and establishment of program criteria. It is possible to choose more than one public health agency experience to satisfy the total practicum requirement. At least one of the 10 essential public health services should be addressed in the practicum. See the Public Health Practicum Educational Goals for details.

Before starting the practicum, check with Linda to make sure a Memorandum of Understanding between BMC and your governmental agency is up to date and submit the signed practicum agreement to Linda.

Maternal Health Equity Track:
Boston Public Health Commission (BPHC) Public Health Practicum Guide

I. Goals & Objectives of BPHC PH Practicum

The overarching goal of the PH Practicum is for trainees to meet with key individuals at the BPHC to identify a project related to maternal health outcomes to be completed in the time allotted, a minimum of 320 hours, over a twelve-month period. The focus of this practicum is to expose trainees to program planning, public health interventions designed for solving disparities in maternal health, engagement of community organizations, program evaluation, as well as operational management & budgeting.

BPHC & Health Start Systems (HSS) Maternal & Child Health Section Overview

a. *Healthy Baby Healthy Child (HBHC)* -- serves individuals prenatally - 5yo. (Referral at any age within range)

HBHC program provides free home visits and case management for pregnant women and parenting families for children up to 5 years old. The mission and goal of the program is to promote the wellbeing of families in Boston, particularly those living in communities disproportionately impacted by infant mortality rates and other health disparities.

i. Available in more health centers than BSHI
ii. Clients of the program receive services from a team comprised of RN/PHN, CHW, and LISCW who perform home visits., RN visits, LICSW visits.
iii. Prenatal, post-partum health education, monitoring of growth and development of children, connection to medical services (family planning, immunizations, Early Intervention, primary care, etc.)
iv. Connection to resources (e.g TANF, WIC, food stamps, Housing, fuel assistance, ESL, and GED classes, legal and immigration assistance, etc.)

b. HSS Food Pantry

Provides emergency food assistance to HBHC clients, as well as residents of the city of Boston. Member of the Project Bread Food Source Hotline, which coordinates and makes resident referrals.

c. *(Boston) Healthy Start in Housing (HSiH)*

HSiH is a collaboration between the BPHC and the BHA. It works to provide stable housing for families. Families are connected and receive housing through BHA, participants are required to participate in the home visiting program, workshops, and trainings as part of the process.

i. Program prioritizes pregnant patients (HSiH can facilitate placement in ~6 months vs. ~10 years for others)
ii. Must meet BHA housing criteria: e.g. no drug convictions, no history of eviction from BHA apartments, no history of sexual assault convictions
iii. To qualify must be pregnant, permanent address in Boston for the last 3 years, and a chronic medical condition (HTN, DM2, mental health conditions),

multiple pregnancy or poor birth outcome (preterm, low birth weight), or child under 2 with complex condition (CP, SCD, etc.)

iv. Anyone can refer to HSiH program(e.g. residents can self-refer, or be referred social service providers, clinicians, etc.)

d. *Welcome Family Program*

A program of the Mass. Department of Public Health in partnership with HSS, & Maternal Child Health section. Welcome Family is a free program providing one time home visit from a PHN to any and all mothers and newborns in the city of Boston. Visits assess mom and infant's health, offer health and parenting information, advice and a gift bag, as well as refer and connect to any support or resources as appropriate.

i. Universally offered, no income restrictions, must be resident of Boston
ii. MA DPH contracted through BPHC
iii. one time visit for family w/new baby (goals is to visit before age of 8weeks)
iv. will see NICU babies anytime after discharge
v. Offer support groups at local CHCs on health communication, child development, discipline, co-parenting, etc.
vi. Advocacy and support for child support, paternity, visitation, and custody arrangements to enable children to have loving supportive father in their lives

e. *Boston Healthy Start Initiative (BHSI)* -- serves individuals prenatal through delivery, & up to 18mo.

BHSI is a program which aims to reduce disparities in infant mortality, and adverse perinatal outcomes by improving women's health, and strengthening family resilience. BHSI has multiple sites, including CHCs, Hospitals, Clinics, and healthcare agencies serving Black and Latina identified pregnant individuals who are residents of Boston (primarily in the neighborhoods of Dorchester, Mattapan, and Roxbury). BHSI provides case management services to, prenatally and postpartum for up to 18 months after delivery (previously was up to 2 years).

i. BHSI sites: "Teens & Tot Clinic" at BMC, Whittier, Mattapan, Codman, Bodoin Street, and Dimock CHCs, other groups
ii. Services primarily provided and coordinated through Family Partners (Case Managers/CHWs) employed at each BSHI site.
iii. Convenes Centering Pregnancy Groups, and Supports FFI
iv. CHW from community available (as needed PHN/RN, LICSW are assigned to client)

f. *Community Action Network (CAN)*

CAN is comprised of community residents and BPHC professionals working together to reduce racial inequities and disparities in infant mortality and birth outcomes in Boston. It is an opportunity for people to share their voice and impact the health of women, children, and families.

i. Plans activities throughout the year
ii. Coordinates community advocacy and engagement
iii. Weekly meetings on Tuesday afternoons
iv. Invited guests, speakers, community groups, organizations.

g. Father Friendly Initiative (FFI)

FFI was established to support fathers' positive engagement with the lives of their children and families. They focus on offering resources, tools, and support to them, their families, and communities.

They provide case management assistance, for connection to education, job training, placement, health insurance navigation, connection to primary care, counseling, domestic violence, housing issues, or substance use disorders.

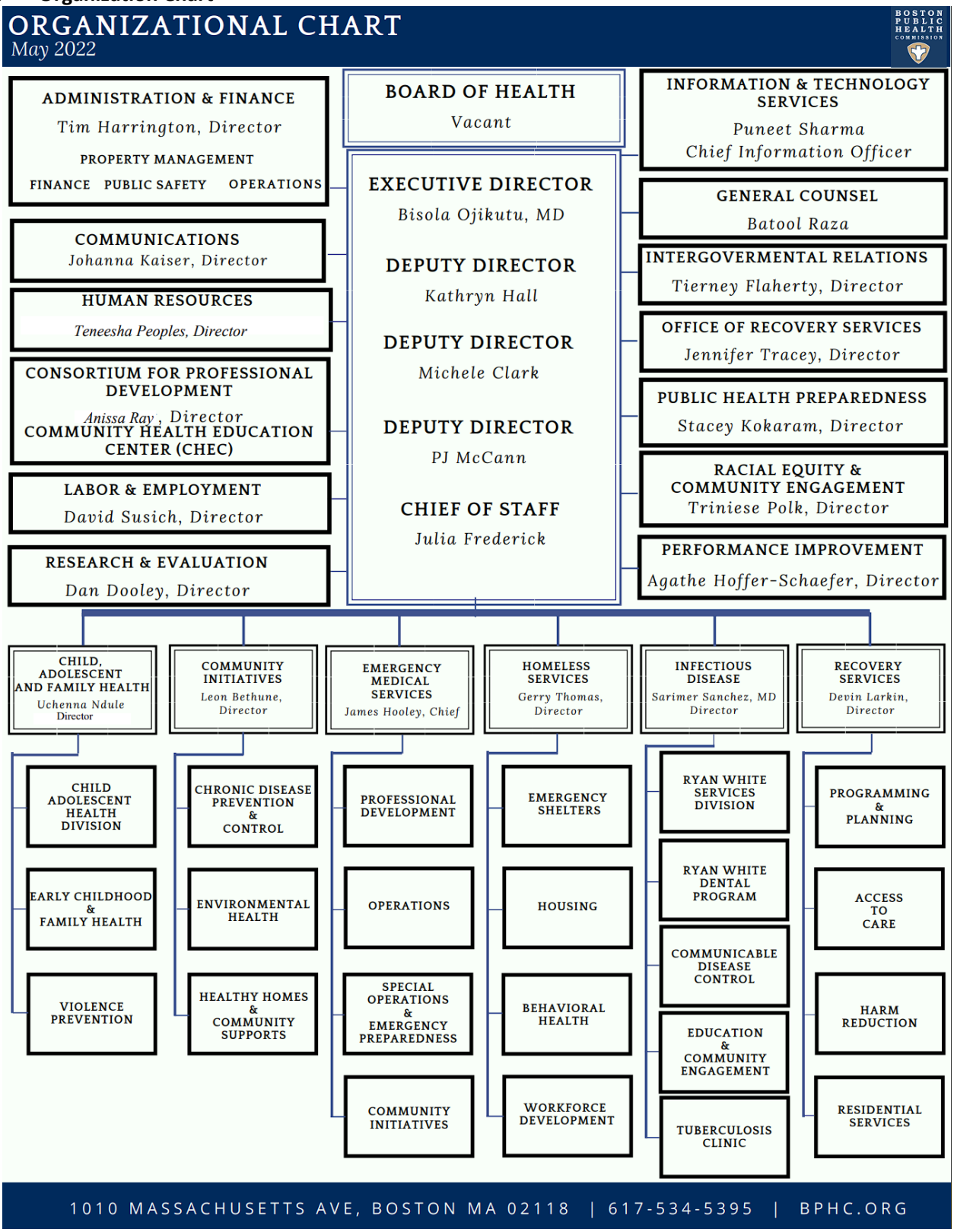
II. Key Contacts

a. Becky Cruz-Crosson, Division Director - Healthy Start Systems (HBHC)

b. Morgan Taylor, Director of BHSI (BHSI, CAN)
c. Adi Rattner, MD (Medical Director – Healthy Start Systems)
d. Nadine Jones Ruffin, (Program Manager of HSS, HSiH)
e. Julie Shaughnessy (ETO, IT/Data Manager)
f. Richard Derosa PhD, (Behavioral Health Director, leads FFI, and supervisor of Carolyn Coleman)
g. Carolyn Coleman (SW, & CHW supervisor)
h. Shieda Gilles, RN (Nurse Supervisor)
i. Elsie Morantus-Petion, RN (Nurse Supervisor)

Mary Morgan, RN (Nursing Coordinator - Education)

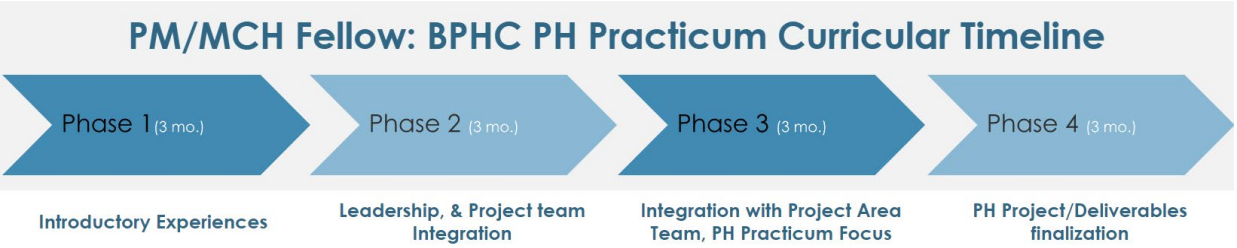
III. Organization Chart



IV. Practicum Structure

A. Length of Practicum

a. 12 months, divided into 4 quarters



B. Goals and Objectives by phase

a. Goals for Phase 1

i. Familiarize Fellows with BPHC Programs (HSS/HSIH/BHSI)

ii. Start home visits with public health RNs/CHWs/Father Friendly Initiative advocates

1. Continue home visits for phases 2-4

iii. Inform fellows re: racism in greater Boston

iv. Network with future project mentors

v. Schedule overview/introductory meeting with section heads (see C (d))

b. Goals for Phase 2

i. Develop/cultivate Systems Leadership understanding of PH programs

ii. Identify interest areas and content-area mentor for fellow Practicum project

iii. Connect clients with needed health services

c. Goals for Phase 3

i. Plan and finalize Practicum deliverable

ii. Determine specific goals for deliverable

iii. Begin work on Practicum deliverable

d. Goals for Phase 4

i. Complete Practicum deliverable

ii. Deliver practicum deliverable to intended recipient(s)

iii. Disseminate as applicable (present internally, conferences, publications, etc.)

C. Core Learning Experiences

These experiences are meetings or events which (as applicable) you should receive BPHC calendar invites. If you are not receiving them by months 3-6 of the practicum, contact your primary nurse contact *(Sheida/Elsie, or whomever you are paired with if this changes in future).*

a. Regularly Scheduled meetings:

i. HSS All Staff Meetings

1. 2nd Thursday of each month from 9:30AM-10:30AM

ii. ii. Nursing Discipline Meeting

1. 1st Tuesday of the month, 10am-12 noon

iii. CAN Meetings
1. Tuesday afternoons weekly at 2:00pm
iv. Monthly Leadership meetings
1. Child and Adolescent Health Bureau Meetings—2nd Mondays of the month
2. HSS Leadership Meetings—1st Mondays of the month

b. Home Visits
i. Nurse Visits
ii. CHW/PHA/SW visits
iii. FFI visits
iv. Welcome Family visits

c. Board of Health Meeting
i. 2nd Wednesday each month
ii. Discuss public health priorities of the city and budget; (mayor attends!)

d. Racial Justice Training(s)
i. Timing variable, coordinate with primary nurse contact

e. Section Head Introductions:

In the first 3 months after the start of the BPHC practicum, be sure to speak with your primary Nurse contact to schedule the following ~30 minute meetings for an intro, & overview with the following section heads:

i. Healthy Start Systems (HSS)/Healthy Start in Housing (HSIH)-- Nadine Jones Ruffin
ii. BHSI—Taylor Morgan
1. CAN--Brandy Watts
iii. Behavioral Health, & FFI -- Richard Derosa, PhD, & Carolyn Coleman
iv. IT/Data Management-- Julie Shaughnessy
v. Admin & Budgeting 101—Becky Cruz-Crosson

III. Day-to-Day Responsibilities

A. Goals and Objectives
a. In coordination with Primary Nurse contact, you are expected to schedule and arrange for the different types of home visits throughout your practicum at the BPHC.
b. You are expected to (as your schedule allows) attend as many of the regularly scheduled meetings, and specifically those which are core learning experiences as you are able to.
c. You are expected to attend each of the different experiences at least once.
d. By the beginning of your last 6 months of the practicum, you should identify a project mentor, and deliverable to work on for the remainder of your practicum.
e. You are expected to complete your deliverable project by the end of the 12 month practicum.

B. Roles and Responsibilities
a. Familiarize self with structure of Healthy Start Systems and each of its programs
b. Support PH nurses/SW/CHWs/advocates in attending home visits
i. This can mean offering specific medical advice with the appropriate qualifying counsel to the patient. Ultimately the degree of support you offer should be both professionally and clinically appropriate for the type of visit you are participating in, and only to the degree and extent you feel comfortable offering in the given circumstances.

c. Identify Practicum deliverable

C. Scheduling home/site visits
   a. Coordinated through primary nurse contact (Shieda or Elsie)
   b. Ideally you will follow 2-3 continuity clients from prenatal to post-partum
   c. As needed to round the scope of visits, you may arrange for additional "one-off" visits to get a sense for types of visits you have been unable to arrange with your continuity clients (e.g. FFI or Welcome Family visit)

IV. Final Deliverable Project Guidelines

A. What is "a deliverable"?

The goal of the deliverable is to work in concert with your content area mentor to develop a concrete project which will have substantive value to the BPHC. You can also continue a project which a prior fellow started or developed, but you are expected to meaningfully further and continue whatever project you work on if this is the case. What this looks like can differ depending on the type of deliverable you are working on.

B. Starting Points for Deliverables:

Below are some folks and the different ideas and areas and the different folks who would be most likely to help with working through realizing the project during your practicum. Below are some of the types of projects (not an exhaustive list if you have another concept you want to pursue see what folks think about it!) which would be considered appropriate deliverables to develop.

Types of projects to consider: Quality Improvement projects, Data analysis and synthesis, needs assessments, process improvement initiatives, data collection improvement/optimization, systems improvement/coordination initiatives, developing organizational policies/processes for performance improvement plans, for struggling employees, organizational improvement initiatives.

   a. Julie Shaughnessy (IT/Data Management)
      i. Data Analysis, & Quality Improvement projects
         1. Review and assessment for right-setting benchmarks for different grant reporting of HSS programs, how and where to pull data for reporting, etc.
         2. Metric development, benchmark development and optimization
            a. FFI, HBHC data reporting/improvement projects
         3. Data dashboard design/Report optimization/improvement
   b. Nadine Jones Ruffin, Taylor Morgan (BHSIH/CAN)
      i. Public facing educational curriculum.
      ii. Community outreach and engagement initiatives
      iii. Community-based participatory processes/projects
      iv. Policy advocacy projects
   c. Richard DeRosa, PhD & Carolyn Coleman LICSW (Behavioral Health, FFI, SW, CHW)
      i. Develop case-based series of talks and professional development curriculum for challenging family encounters/scenarios.
      ii. Streamline/optimize/evaluate challenges with form completion during visit/after visit for SW/CHWs
      iii. Improve outcome data collection for FFI, SW visits, CHW engagement.
      iv. Optimize coordination between MH services from other BPHC departments and Healthy Start/MCH division services.
   d. Mary Morgan, RN (Nursing Coordinator- Education)
      i. Nurse case-based curriculum
      ii. Developing continuing professional education curricula, lecture series, etc.

C. Deadlines/Expectations
    a. Ultimately the final deadline is by the completion of practicum, at the end of the 12 months of your practicum.
    b. It is a good idea to proactively schedule regular check-in meetings with your deliverable content area mentor to remain on track for completing the project (because you can always cancel the meeting if it's not needed!)
    c. If you are struggling to make progress on your deliverable reach out to your Nurse contact to help troubleshoot what might be the issue, or if this is not successful reach out to your faculty mentors at BMC.

Additional Resources:
National Health Start Association—organization that supports the Federal Healthy Start Initiative by providing training and technical assistance through annual conferences and webinars; highlights other programs throughout the country; grant opportunities (https://www.nationalhealthystart.org/)
2021 Impact Report (https://www.nationalhealthystart.org/wp-content/uploads/2021/06/saving-our-nations-babies-impact-report.pdf)

***B. Attend the Preventive Medicine Lecture Series*.** Residents are required to attend a monthly didactic lecture series aimed at ensuring that all residents are exposed to a comprehensive range of topics and issues in preventive medicine and public health, with a focus on areas not covered in a clinical setting, field practice experience, or SPH curriculum. Topics related to leadership and administration include those geared towards increasing the understanding of public health systems, leadership in public health, advocacy and policy. Additional topics in clinical preventive medicine are designed to fulfill any gaps in the curriculum. To expose residents to models of successful public health careers and to the range of career opportunities, we invite leaders in the community to present to the group.

C. *Become familiar with legal processes governing public health*. Residents may achieve familiarity with the legal processes governing public health by identification of legislation and funding mechanisms governing the focus of the practicum topic. Residents are encouraged to attend a state legislative hearing, or take an SPH law course if time permits. Residents participate in an IRB internship https://www.bumc.bu.edu/irb/bumcirb/irb-internship/ which is comprised of three components: orientation, where residents learn the essential components of federal regulations that govern human subject protections; observations where residents participate in two IRB meetings; and presentation where residents complete two protocol reviews. In addition, residents are required to attend at least once during training the Massachusetts Health Policy Forum that occurs in January every year at the Massachusetts State House and Public Health Department.

***D. Attend Teaching Methods Seminars*.** Training in clinical teaching methods is an important component of the Program. It consists of a core seminar series for each residency year on teaching methods and clinical applications. Optional supervised practical teaching experiences and co-attending teaching practicums can be arranged. Dr. Alexandra Bachorik leads the teaching curriculum that is

composed of faculty-led seminars covering a core of topics that relate directly to teaching in academic and clinical preventive medicine environments. Core topics include Promoting a Learning Climate, Large Group Lecturing Skills, and Outpatient Teaching Skills.

E. ***Community Engagement in Research (CEnR) Series***. Topics include principles of community engagement in research grounded in social justice, collaborative planning for research design and goals, equitable distribution of resources and credit, and how to sustain partnerships. Drs. Battaglia and Sprague-Martinez will lead this 4-session series.

F. ***Primary Care Advocacy Training Rotation with People.Power.Health.*** During this rotation, residents will gain community organizing skills and be empowered to redress inequities in the distribution of power and resources while co-creating just systems for communities, caregivers and clinicians. PPH will provide curriculum and mentorship to equip residents with skills needed to become effective community organizers and activists. This six week rotation starts mid-September.

G. Foundations in Health Equity Curriculum. These series of didactics led by Dr. Emily Cleveland Manchanda will happen once a month during the first year of the training and will include interactive lectures, book discussions, grand rounds, journal clubs and workshops. Core concepts of political economy, and structural racism and the relationship between said concepts / systems to our current health inequities will be discussed to help trainees solidified the knowledge needed to address SDOH using a health equity lens.

H. Liberation Health in Clinical Practice. Liberation health, a method developed by Dr. Dawn Martinez, conceptualizes that the problems of individuals and families cannot be understood in isolation from the economic, political, cultural and historical conditions which give rise to them. This method helps clinicians, individuals, families and communities understand cultural (e.g., racism, xenophobia, sexism), institutional (e.g., US health care system, US immigration policy) and personal factors (e.g., living condition, education, health literacy) that determine health and act to change these conditions; to liberate themselves from both internal and external oppressions. We will implement a curriculum with the following learning objectives:

- Describe the root causes of health disparities and inequities.
- Recognize how intersectionality contributes to health disparities.
- Self-reflect on power and positionality, bias and the ways it affects the relationship with patients by reflecting on your own identities.
- Identify key principles from the liberation health framework and practice using cases study.
- Demonstrate knowledge of resources available to patients and patient populations experiencing adverse SDOH.
- Work in Inter-professional teams to develop care plans that address patient's SDOH.
- Practice, observe and participate being community organizers and health activists.

This series of didactics will happen monthly during the second year of training. Trainees will learn how to explore SDOH, including health literacy, by practicing relationship development that considers their own power and positionality while developing an understanding of patients' experiences of discrimination. Trainees learn how to empathize and engage a person who is experiencing adverse

SDOH and align their approach to the patients' priorities. Subsequently, you will discuss and analyze patient cases seen during your FQHC rotations applying the liberation health method. Using this method, trainees will practice integrating strengths and negative SDOH in their treatment plans so that they can be tailored to patients' circumstances and health literacy levels. Additionally, trainees will learn best practices on how to effectively use online repositories of social services to find community organizations that help patients with social needs and they will have field trips to these organizations to understand their strengths as well as the barriers that patients face when trying access them. This will help trainees effectively address SDOH at the individual level as well as to identify structural factors that need to be address at a population health level to better support community organizations that provide social services to communities.

I. Interprofessional Leadership in Healthcare Program. This five-month program developed through a partnership between Sargent College and Boston University School of Social Work will equip residents with the knowledge and skills to effectively lead interprofessional teams. Learners participate in weekly live, online classrooms and engage with self-paced online learning modules featuring interactive exercises, videos, and journals. The online live classroom sessions use Project ECHO® to facilitate technology-enabled, peer-to-peer, collaborative learning, which adopts an 'all teach, all learn' approach. Preventive medicine residents will attend the program to join a global interdisciplinary cohort and complete the following five courses:

- The Interprofessional Team (4 weeks) – Recognize the value of interprofessional collaborative practice, develop team-based approaches to managing ethical issues, and apply practical strategies to foster collaborative teamwork.
- Effective Communication (4 weeks) – Enhance interprofessional communication through reflection on communication theory, techniques, and self-awareness; and develop confidence motivating teams and managing conflict.
- Effective Supervision (4 weeks) – Integrate learning theories and practical strategies to enhance student learning on clinical placement, and develop skills necessary for effective professional supervision and mentorship.
- Leadership of Interprofessional Teams (4 weeks) – Explore the challenges and opportunities of leading interprofessional teams, reflect on leadership styles, and apply contemporary leadership models to effect meaningful change.
- Building Business Acumen (4 weeks) – Understand financial management principles, and develop effective strategies to market and evaluate organizational capacity to offer services.

J. Social Determinants of Health Preventive Medicine Curriculum (IRH track requirement). Because of the deep and pervasive nature in which social determinants affect health, especially in underserved populations such as those served by BMC and associated CHCs, a longitudinal curriculum introducing trainees to this important topic will be developed. Learning sessions will be designed longitudinally through the 2-year curriculum. The curriculum will demonstrate to trainees how to address SDOH at an individual and population health level. This will be achieved through a combination of lectures, seminars, workshops and interdisciplinary experiential learning experiences.

III. Goals- Clinical Preventive Medicine & Quality Improvement

The program's goal is to give trainees a strong foundation in the components of clinical prevention through 1) clinical practice experience and 2) a didactic lecture series.

A. *Maintain a continuity primary care practice.* Each resident maintains a continuity primary care practice of one clinical session per week. The faculty supervisors, trained in internal medicine, family medicine or pediatrics, and often also preventive medicine, emphasize clinical application of skills in health promotion and disease prevention.

B. *Complete rotations in clinical preventive medicine*. All residents are required to complete a series of clinical preventive medicine rotations in addition to the continuity primary care practice (for a total of 80 session per year). These experiences include Boston Public Health Commission Tuberculosis Clinic, Weight Management Center, Integrative Medicine, Smoking Cessation, Addiction Medicine, and STI/Travel Clinics among others. In addition residents may elect to obtain additional clinical preventive training in specific areas such as in breast and cervical cancer screening. Section 3 below lists the electives for the Maternal Health and Immigrant & Refugee Health tracks in detail.

C. Complete a rotation in Occupational Health. Residents are required to rotate through the Occupational Health clinic, OccMed CIC, which provides occupational health services to a variety of public and private organizations including health care delivery programs, industrial sites, and public safety organizations. Residents learn how to conduct evaluations of work related injuries, conduct worksite safety evaluations, and perform disability evaluations.

D. *Attend weekly Departmental and Section Grand Round.* Approximately 50% of departmental grand rounds address public health topics (e.g., substance use disorder, H1N1 flu update, COVID, etc.), and approximately 25% of section grand rounds cover public health topics (e.g., AIDS update). Rounds augment and bolster the existing curriculum; PM resident attendance is required except when rounds conflict with clinical, class or practicum obligations.

E. *Complete the* q*uality improvement and patient safety curriculum.* This curriculum consists of three components

i. GME required modules from the Institute for Healthcare Improvement (IHI)
ii. Attend the QI didactic series
iii. Complete a QI project

IV. IDENTITY AS A PUBLIC HEALTH PHYSICIAN

Identity as a public health physician is nurtured in three ways: 1) the public health practicum, 2) Attending the American College of Preventive Medicine annual meeting and 3) Board certification in general preventive medicine and public health. Residents:

A. *Participate in Public Health Practicum*. As described in detail in the section on Leadership, Teaching and Administrative Skills, each resident performs an individual project at a public health agency, a project designed to give a greater depth of knowledge and experience in a focused area of preventive medicine and public health.

B. *Attend Preventive Medicine Lecture Series*. The lecture series is explained in detail above.

C. *Obtain Board Certification in GPM and Public Health*. It is expected that graduates of the program take the board certification exam upon graduating the program. To support certification, residents take in-service examinations sponsored by the American College of Preventive Medicine each year.

D. ***Attend a national meeting held by the American College of Preventive Medicine, Association for Prevention Teaching and Research, the American Public Health Association, or the North American Refugee Health Conference (IRH)*** each year of the residency program.

2. Map of Curriculum to Preventive Medicine ACGME Competencies

Legend for Learning Activities

CC-Continuity Clinic
CPM- elective Clinical Rotation
EP-Emergency Preparedness Drill
IDP-Individual Development Plan
JC- Journal Club
MS- Master of Science
OH-Occupational Health
PHP-Public Health Practicum
PL- Prevention Lecture
QI- Quality Improvement
RP-Research Project
TS- Teaching Seminar
WIP- Research in Progress

	Curriculum Organization	
	Principal Educational Goal	Learning Activity
IV.A.6.	Advancement in the residents' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care	JC, MS, RP
IV.C.6.c)	Completion of the following graduate level courses: advanced applied epidemiology (to include acute and chronic disease); advanced biostatistics	MS
IV.B.1.a)	**Professionalism**	
	Principal Educational Goal	Learning Activity
IV.B.1.a).(1).(f)	Ability to recognize and develop a plan for one's own personal and professional well-being	IDP
IV.B.1.a).(1).(g)	Appropriately disclosing and addressing conflict or duality of interest	MS:PH842
IV.B.1.b):	**Patient Care and Procedural Skills**	
	Principal Educational Goal	Learning Activity
IV.B.1.b).(1).(a).(i)	Monitoring health status to identify community health problems	PHP
IV.B.1.b).(1).(a).(ii)	Diagnosing and investigating medical problems and medical hazards in the community	PHP
IV.B.1.b).(1).(a).(iii)	Informing and educating populations about health threats and risks	CPM, MS, PHP
IV.B.1.b).(1).(a).(iv)	Mobilizing community partnerships to identify and solve health problems	MS, PHP
IV.B.1.b).(1).(a).(v)	Developing policies and plans to support individual and community health efforts	MS, PHP
IV.B.1.b).(1).(a).(vi)	Applying laws and regulations that protect health and ensure safety of populations	MS, PHP

IV.B.1.b).(1).(a).(vii)	Linking individuals to needed personal health services and ensuring the provision of health care when otherwise unavailable	CC, CPM
IV.B.1.b).(1).(a).(viii)	Evaluating the effectiveness, accessibility, and quality of individual and population- based health services	MS, PHP
IV.B.1.b).(1).(a).(ix)	Conducting research for innovative solutions to health problems	MS, RP, WIP
IV.B.1.b).(1).(a).(x)	Progressive responsibility for patients and the clinical and administrative management of populations or communities	CC, MS, PHP
IV.B.1.b).(1).(a).(xi).(a)	The ability to develop, deliver, and implement appropriate clinical services for both individuals and populations in order to diagnose and treat medical problems and chronic conditions	CC, MS, PHP
IV.B.1.b).(1).(a).(xi).(b)	The ability to apply primary, secondary, and tertiary preventive approaches to individual and population-based disease prevention and health promotion	CC, MS
IV.B.1.b).(1).(a).(xi).(c)	The ability to develop, implement and evaluate the effectiveness of appropriate clinical preventive services for both individuals and populations	CC, MS, RP
IV.B.1.b).(1).(a).(xii)	Skills in occupational and environmental health, including assessing and responding to individual and population risks for common occupational and environmental disorders	OH
IV.B.1.b).(1).(a).(xiii).(a)	Skills in emergency preparedness programs, including determining the nature and extent of injuries sustained and individuals' need for subsequent treatment	EP, MS: PH712
IV.B.1.b).(1).(a).(xiii).(b)	Planning emergency preparedness programs and training exercises;	EP, MS: PH712
IV.B.1.b).(1).(a).(xiii).(c)	Evaluating emergency preparedness training exercises to ensure the health and safety of those involved	EP, MS: PH712
IV.B.1.b).(1).(d).(i).(a)	The ability to investigate a disease outbreak, while assessing the medical needs of both individual patients and populations	CPM, PL
IV.B.1.b).(1).(d).(i).(b)	The ability to implement programs to reduce the exposure to risk factors for an illness or condition in a population	PHP, PL
IV.B.1.b).(1).(d).(i).(b).(i)	The ability to conduct policy analyses to improve the health of a population	MS, PHP
IV.B.1.b).(1).(d).(i).(b).(ii)	The ability to design and operate a surveillance system	PHP, PL
IV.B.1.b).(1).(d).(ii).(a)	The ability to select appropriate, evidence-based, clinical preventive services for individuals and populations	CC, PL
IV.B.1.b).(1).(d).(ii).(b)	The ability to analyze evidence regarding the performance of proposed clinical preventive services for individuals and populations	CC, CPM, PL
IV.B.1.b).(1).(d).(ii).(c)	The ability to manage and administer programs that provide recommended immunizations, chemoprophylaxis and screening tests to individuals and appropriate populations	CC, CPM, PHP, PL
IV.B.1.b).(1).(d).(ii).(d)	The ability to counsel individuals regarding the appropriate use of clinical preventive services and health promoting	CC, CPM

	behavior changes, and provide immunizations, chemoprophylaxis, and screening services, as appropriate	
IV.B.1.c)	**Medical Knowledge**	
	Principal Educational Goal	Learning Activity
IV.B.1.c).(2).(a)	Demonstrate knowledge of principles of advanced health services management	MS, PHP
IV.B.1.c).(2).(b)	Demonstrate knowledge of principles of risk/hazard control and communication	EP, MS: PH712
IV.B.1.c).(2).(c)	Demonstrate knowledge of principles of clinical preventive services	CC, PL
IV.B.1.d)	**Practice-based Learning and Improvement**	
	Principal Educational Goal	Learning Activity
IV.B.1.d).(1).(a)	Identifying strengths, deficiencies, and limits in one's knowledge and expertise	IDP
IV.B.1.d).(1).(b)	Setting learning and improvement goals	IDP
IV.B.1.d).(1).(c)	Identifying and performing appropriate learning activities	IDP
IV.B.1.d).(1).(d)	Systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement	QI
IV.B.1.d).(1).(e)	Incorporating feedback and formative evaluation into daily practice	IDP
IV.B.1.d).(1).(f)	Locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems	JC, RP
IV.B.1.d).(1).(i).(i)	Using epidemiology principles and biostatistics methods, including the ability to characterize the health of a community	MS, RP
IV.B.1.d).(1).(i).(ii)	Using epidemiology principles and biostatistics methods, including the ability to evaluate a surveillance system	MS, RP
IV.B.1.d).(1).(i).(iii)	Select and conduct appropriate statistical analyses	MS, RP
IV.B.1.d).(1).(i).(iv)	Design and conduct a virtual or actual outbreak or cluster investigation	PL
IV.B.1.d).(1).(i).(v)	Translate epidemiologic findings into a recommendation for a specific intervention	MS:PH843, PHP, RP
IV.B.1.d).(1).(i).(vi)	Measure, organize, or improve public health care	PHP, RP
IV.B.1.d).(1).(j)	Designing and conducting an epidemiologic study	JC, MS, PHP, RP
IV.B.1.d).(1).(k)	Conducting an advanced literature search for research on a preventive medicine topic	JC, RP
IV.B.1.e)	**Interpersonal and Communication Skills**	
	Principal Educational Goal	Learning Activity
IV.B.1.e).(1).(a)	Communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds	CC

IV.B.1.e).(1).(c)	Working effectively as a member or leader of a health care team or other professional group	CC, IPC, MS, RP
IV.B.1.e).(1).(d)	Educating patients, families, students, residents, and other health professionals	CC, MS, RP, WIP
IV.B.1.f)	**Systems-based Practice**	
	Principal Educational Goal	Learning Activity
IV.B.1.f).(1).(e)	Participating in identifying system errors and implementing potential systems solutions	QI
IV.B.1.f).(1).(f)	Incorporating considerations of value, cost awareness, delivery and payment, and risk- benefit analysis in patient and/or population- based care as appropriate	CC, PHP
IV.B.1.f).(1).(g)	Understanding health care finances and its impact on individual patients' health decisions	CC, MS, PHP, WIP
IV.B.1.f).(1).(h)	Conducting program and needs assessments, and prioritizing activities using objective, measurable criteria, including epidemiologic impact and cost- effectiveness	MS:HMP814 PHP, RP
IV.B.1.f).(1).(i)	Identifying and review laws and regulations relevant to the resident's specialty area and assignments	MS, PL
IV.B.1.f).(1).(j)	Identifying organizational decision-making structures, stakeholders, styles, and processes	IPC, PHP
IV.B.1.f).(1).(k)	Assessing program and community resources, developing a plan for appropriate resources, and integrating resources for program implementation	MS, PHP, RP
IV.B.1.f).(1).(l).(i)	The ability to assess data and formulate policy for a given health issue	MS:PM740 PHP, RP
IV.B.1.f).(1).(l).(ii)	The ability to develop and implement a plan to address a specific health problem	MS:PH843 PHP
IV.B.1.f).(1).(l).(iii)	The ability to conduct an evaluation or quality assessment based on process and outcome performance measures	QI
IV.B.1.f).(1).(l).(iv)	The ability to manage the human and financial resources for the operation of a program or project	MS:PM790 RP
IV.B.1.f).(1).(l).(v)	The ability to apply and use management information systems	MS:PM790 RP
IV.B.1.f).(1).(l).(vi)	The ability to plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems	MS:PH843 RP
IV.B.1.f).(1).(m)	The ability to assess organizational performances against stated goals	MS:PM862 PHP
IV.B.1.f).(1).(n)	The ability to analyzing policy options for their health impact and economic costs	MS:PM740 PHP
IV.B.1.f).(1).(o)	The ability to evaluate applicants and the performance of staff, and understand the legal and ethical use of this information in decisions for hiring, managing, and discharging staff	MS:PM790

3. Tracks

A. Maternal Health Equity Track

The program's goal is to give trainees a strong foundation in the components of clinical prevention and maternal health equity through didactic and clinical practice experiences. We will achieve this foundation by implementing a continuity clinic experience, clinical preventive medicine rotations, Boston Healthy Start Initiative and an interdisciplinary Virtual Reality Curriculum in Emergency Maternal Health Care. Trainees will maintain a half day per week continuity clinic where faculty supervisors emphasize clinical application of skills in health promotion and disease prevention. In addition, you will be part of our collaborative Maternal Child Health team at Boston Medical Center and will interact with and learn from interdisciplinary team members.

In addition to the community-based clinic experience, trainees participate in a series of clinical preventive medicine rotations in topics critical to the application of preventive medicine and maternal health care. Required rotations include Project Respect, Quality Improvement, Occupational Health, and the Doula Birth Sister Program. Elective rotations include: rural maternal health, SOFAR clinic (Supporting Our Families Through Addiction and Recovery- multidisciplinary medical and psychosocial care for parents in recovery and their children, including care of birthing parent/baby dyads), correctional medicine, refugee health, Positive Hope (HIV clinic), Midwifery clinic, Belkin Breast Center, Family Planning, and the Women's Health Clinic at BMC.

Project RESPECT Rotation: Project RESPECT is a high risk obstetrical and addiction recovery medical home at BMC and BUSM. The Project RESPECT team members include four buprenorphine-waivered obstetric/family medicine providers, a psychiatrist specializing in mood disorders in pregnancy, an Addiction Psychiatry Nurse Practitioner, an RN case manager and a Licensed Independent Clinical Social Worker. Trainees will be supervised while they practice offering monitored, acute substance withdrawal treatment and induction of medication assisted treatment for pregnant patients seeking treatment for opioid use disorder. Additionally, trainees will learn about providing intensive, individualized out-patient treatment plans for each patient based on the severity of their disease and their recovery progress. The out-patient medical home model provides on site, collaborative and multidisciplinary care for pregnant and post-partum patients in recovery. The Project RESPECT clinical team collaborates and coordinates care with the inpatient Obstetric, Family Medicine, Pediatric, Psychiatry, Social Work, Nursing and Lactation teams at BMC to provide supportive and informed care.

Doula Birth Sister Program Rotation: The Birth Sisters Program is an innovative multi-cultural doula service that offers pregnant people "sister-like" support during pregnancy, childbirth, and the postpartum period. Trainees will learn to give social support to at-risk pregnant patients in their community and connect them to needed resources. Birth Sisters offer prenatal home visits, labor support, and help at home after the baby comes. By "mothering the mother", they play an important role in empowering birthing people, their children, and their communities.

Maternal Health Quality Improvement Rotation: Trainees will join the QI team within BMC's Departments of Obstetrics and Gynecology and Family Medicine, including ongoing work within the Committee for Equity and Inclusion. In this rotation, trainees will learn about the process of developing and evaluating QI initiatives implemented to transform maternal health service delivery with the goal of improving safety and health outcomes. Other conferences and meetings that will add to the maternal health experience include:

- Morbidity & Mortality Conferences. Trainees will participate in a monthly conference led by the BMC Obstetrics & Gynecology department. Additionally, trainees will have the opportunity to lead one of the Family Medicine Maternal Child Health Quality, Equity and Safety Rounds (formerly titled Morbidity and Mortality). This provides trainees with an opportunity for group review of challenging maternal or child health cases to identify areas for systems-based and clinical care improvements needed to improve safety and health outcomes for birthing people.
- Perinatal Safety Conference. This is a bi-weekly meeting organized by a Perinatal Safety Specialist (RN) in the Department of Obstetrics & Gynecology, and provides trainees with an opportunity to observe and learn from a collaborative, multidisciplinary team (OB/GYN, MFM, Family Medicine, Midwifery,

Anesthesiology, Nursing, Pharmacy) that reviews safety events reported in RL, the hospital's incident reporting system.

- Perinatal Meetings. These monthly meetings provide an opportunity to review maternal child health (MCH)-related statistics and data with a collaborative, multidisciplinary team (OB/GYN, Family Medicine, Midwifery, Anesthesiology, Pediatrics/Neonatology, and Nursing) and to formulate/update MCH-related hospital policies.

Boston Healthy Start Initiative (BHSI) Rotation: The Boston Healthy Start Initiative, a program of the BPHC, aims to reduce racial inequities in infant mortality and poor birth outcomes. BHSI provides direct support to pregnant and parenting individuals, children and families through care coordination, connection to resources, health education, and advocacy. BHSI also coordinates the Community Action Network (CAN), which is a community coalition that focuses on reducing the inequities in infant mortality and poor birth outcomes through policy strategies. BHSI is a free and voluntary program open to women in Boston who are pregnant or parenting children up to the age of 18 months. Clients are referred to this program from different community health centers in the city. Clients who enroll in BHSI have the opportunity to work one on one with staff called 'Family Partners' who support them to have healthy pregnancies and healthy babies. During this rotation, trainees will be paired with a "Family Partner" that support women and families from Codman Square Health Center. Additionally, women are referred from other centers including: Boston Medical Center - Teen and Tot Program, Bowdoin Street Health Center, Healthy Baby / Healthy Child Program, Mattapan Community Health Center, Whittier Street Health Center. Trainees will learn collaboratively from "family partners" about:

- Discussing information related to healthy pregnancies, infant health, and parenting such as prenatal nutrition, safe sleep, breastfeeding and infant feeding, infant safety, child development, and more;
- Connecting women to resources and programs that help them access food, education, employment, housing, child care, and other support as needed;
- Helping to coordinate medical care and other services such as father engagement and support, home visiting nurses, WIC nutritional support, legal services, immigration support, etc. and;
- Supporting families to advocate for their needs.

Interdisciplinary Virtual Reality Curriculum in Emergency Maternal Health Care in Rural Settings: Training primary care physicians in emergency maternal healthcare is a critical component of improving overall maternal health and reducing maternal mortality in rural areas. In these virtual reality scenarios, trainees will collaborate with a Registered Nurse with experience in providing maternal health care in the rural setting to respond to different cases including: 1) Normal birth, 2) Postpartum bleeding, 3) Hypertensive emergency that progresses to eclampsia, 4) Postpartum pulmonary embolism.. Additionally, learning will focus on communication skills and providing patient-centered, trauma-informed care. The trainees will have the opportunity to debrief with faculty about these scenarios after completing the simulation experience.

Maternal Health Curriculum & Training								
Learning Activities	First Year of Training				Second Year of Training			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mentoring								
Meet with fellowship director (weekly in Y1Q1, then monthly)	■	■	■	■	■	■	■	■
Weekly meeting with research mentor(s), developing ILP	■	■	■	■	■	■	■	■
Scholarship Oversight Committee Meetings		■		■		■		■
Analytic, Research and Quality Improvement Skills								
School of Public Health Coursework (includes statistics & epidemiology training)	■	■	■	■	■	■	■	■

Interdisciplinary Seminars (Academic, QI, Research-In-Progress & Journal Club) weekly starting in September								
Preventive Medicine Lecture Series (monthly starting September)								
BMC Hospital Patient Safety								
Maternal Health QI Project								
Perinatal Safety Meetings								
Public Health Emergency Response Training								
Public Health Response to Emergencies course								
CDC Outbreak modules								
Microbes and Methods: Selected Topics in Outbreak Investigation (SPH EP 800)								
Teaching, Leadership, Advocacy and Administrative Skills								
Interprofessional leadership course (February – June)								
Strategy leadership didactic								
Teaching Seminars								
Clinical Preventive Medicine								
Longitudinal continuity clinic								
Occupational Health (ACGME requirement)								
Electives								
Interventions for SDOH to Promote Health Equity								
Foundations of Health Equity								
Liberation Health								
Community Organizing and Activism								
Population Health								
Healthcare Strategy								
Oasis Clinic at Boston Healthcare for the Homeless Program								
Public Health Agency Practicum (ACGME requirement)								
Professional Meetings								
National Professional Meetings								
Regional Meetings								

B. Immigrant & Refugee Health Track

Our program will allow trainees to develop a transferrable skillset while providing a nuanced understanding of the intersectional ways that immigration status, nativity, and immigrant-identity interact with other SDOH arenas, such as access to safe housing, experiences of discrimination and violence, and economic opportunities. We will focus the didactic and experiential learning opportunities within our program around topics related to immigrant and refugee health within the Massachusetts FQHC and safety-net populations. You will emerge from our program with the skills needed to lead population health programs in FQHCs, study the impact of these programs on health outcomes, and inform policy and best practices for addressing disparities and delivering person-centered equitable care.

THRIVE SDOH Healthcare Strategy Rotation. Preventive medicine physicians need to have leadership and health management skills to effectively collaborate with healthcare strategy members, operation managers and other health professionals when developing and implementing programs to address SDOH, health literacy and health disparities. BMC implemented THRIVE to understand SDOH impacting patients' health, improve patient care by communicating SDOH to care teams, provide patients with information on community resources that can mitigate their social needs and partner with our community to eliminate systemic barriers that prevent patients from thriving. Since its implementation in 2017, THRIVE has expanded to all primary care clinics and the Emergency Department in our institution. The successful implementation of this program is due to the interdisciplinary, nonhierarchical nature of its core team that is composed by a preventive medicine physician (Dr. Buitron de la Vega), a senior strategy staff, a social worker, an operations manager and a data analyst. The core leadership team meets twice a month to develop and implement strategy to effectively address SDOH. During these meetings, team members evaluate current THRIVE operations, identify opportunities for improvement, evaluate metrics of success and collaborate with a patient advisory group to develop new interventions to address SDOH. Preventive medicine residents will join the THRIVE leadership bimonthly meetings starting in Quarter 3 of their first year. This rotation has the following learning objectives:

- Identify the scope of role of operation managers, strategy team members, outreach health care workers and data analyst when developing and implementing programs to address SDOH and health disparities.
- Identify best practices when developing and implementing programs to screen for SDOH and refer patients to social services.
- Implement interdisciplinary skills to effectively communicate and collaborate with THRIVE team members.
- Participate in the design and implementation of enhancements to the THRIVE program
- Participate in the analysis of THRIVE program metrics of success by using a health equity lens.

By the end of the rotation, residents will have the knowledge and ability to develop, implement and evaluate programs to address social determinants of health.

Oasis Clinic at Boston Healthcare for the Homeless Program (BHCHP). This 2-month nonclinical rotation is focused on needs assessment or other projects related to SDOH, and/or analyses of health outcomes data related the unhoused immigrant population served by this FQHC. Oasis is a clinic focused on providing accessible primary care services to immigrants experiencing homelessness in Greater Boston. To understand the Oasis model of care, Preventive Medicine trainees will spend 5-10 sessions in the weekly clinic, providing SDOH screening and clinical care throughout their first year of training. This will lead into a 2-month rotation in their second year of training, which will focus on developing a project on the SDOH needs of the Oasis clinic population, under the mentorship of Dr. Maggie Sullivan.

Civil Surgeon Rotation. The Civil Surgeon rotation will allow trainees to participate in the preparation and evaluation of individuals who are applying for an adjustment of immigration status. These visits are performed by clinicians designated by USCIS and consist of a medical evaluation and physical examination, a review of conditions of public health concern, and a review of vaccinations. Trainees will participate in the clinical review and documentation preparation for individuals in preparation for their Civil Surgeon appointment.

Forensic Medical Evaluation. Throughout the grant, trainees will participate in forensic medical evaluations, which are a potent tool for using medical skills and knowledge to promote human rights and safety for asylum applicants, and can be used in public health emergency settings. A forensic medical evaluation is an evaluation done by a trained clinician for the purposes of documenting physical consequences of harm or torture that an asylum seeker reports. Asylum applicants who submit a forensic medical evaluation are much more likely to be granted asylum than those who don't (81.6% vs 42.4%), demonstrating that this skillset is a critical intervention to help support asylum-seeking patients, and provides an opportunity to participate in interprofessional patient advocacy.

Refugee Health Assessment Program. The Immigrant & Refugee Health Center at BMC is contracted with the Office for Refugees and Immigrants to provide medical assessments and screening for newly arrived refugees in the state of Massachusetts. The Refugee Health Assessment Program sees adult and pediatric new arrivals in Internal Medicine, Family Medicine and Pediatric Infectious Disease and can accommodate trainees in any of these sites. Preventive Medicine residents will be trained in the protocols use to evaluate new arrivals, including screening for infectious and chronic diseases, vaccination guidelines, and screening for mental health conditions (particularly those related to exposure to trauma and violence). Through this program, Preventive Medicine residents will collaborate with the interdisciplinary teams at the IRHC, including case managers, community health workers, and resettlement agency partners.

Refugee Women's Health Clinic (elective). Within the IRHC, the Refugee Women's Health Clinic (RWHC) is a specialty clinic in the Department of Obstetrics and Gynecology at BMC, which provides comprehensive culturally responsive obstetrics and gynecologic health care tailored to recent immigrants, asylum-seekers, and refugees in the Greater Boston area. RWHC currently works closely with mental health providers in the BCRHHR to provide care for pregnant and birthing persons with a history of torture or trauma and other mental health needs. The RWHC is committed to providing trauma informed care to patients and their families. The department prioritizes this care and providers within the RWHC lead trauma-informed care and refugee and immigrant health lectures with residents and other learners. For Preventive Medicine residents who have done Family Medicine training, they will have the option to rotate in the RWHC to participate in specialty obstetrics and gynecologic care.

Immigrant & Refugee Health Curriculum & Training								
Learning Activities	First Year of Training				Second Year of Training			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mentoring								
Meet with fellowship director (weekly in Y1Q1, then monthly)	■	■	■	■	■	■	■	■
Weekly meeting with research mentor(s), developing ILP	■	■	■	■	■	■	■	■
Scholarship Oversight Committee Meetings		■		■		■		■
Analytic, Research and Quality Improvement Skills								
School of Public Health Coursework (includes statistics & epidemiology training)	■	■	■	■	■	■	■	■
Interdisciplinary Seminars (Academic, QI, Research-In-Progress & Journal Club) weekly starting in September	■	■	■	■	■	■	■	■
Preventive Medicine Lecture Series (monthly starting September)	■	■	■	■	■	■	■	■
Public Health Emergency Response Training								

Forensic medical evaluation training								
Public Health Response to Emergencies course								
CDC Outbreak modules								
Humanitarian Response Intensive Course								
Microbes and Methods: Selected Topics in Outbreak Investigation (SPH EP 800)								
Teaching, Leadership, Advocacy and Administrative Skills								
Interprofessional leadership course (February – June)								
Strategy leadership didactic								
Teaching Seminars								
Society for Refugee Health Providers mentorship program								
Clinical Preventive Medicine								
Metta Center longitudinal continuity clinic								
Occupational Health (ACGME requirement)								
Refugee Health Assessment Program								
Civil Surgeon Rotation								
Electives								
Interventions for SDOH to Promote Health Equity								
Foundations of Health Equity								
Liberation Health								
Community Organizing and Activism								
IRHC Patient Advisory Council								
Population Health								
Healthcare Strategy								
Oasis Clinic at Boston Healthcare for the Homeless Program								
Public Health Agency Practicum (ACGME requirement)								
Professional Meetings								
National Professional Meetings								
Regional Meetings								

4. Rotation Goals and Objectives

Lifestyle Medicine curriculum

The lifestyle medicine curriculum will consist of two components:

1) **American College of Preventive Medicine Lifestyle Medicine Core Competencies Program**. This is an entirely web based, online set of learning modules designed to increase knowledge in the core areas of lifestyle medicine, including nutrition, physical activity and sleep. We expect you will find them highly informative. Key things to know are:
    - 10 modules of content take approximately 32 hours to complete
    - Required to be completed during the first 6 months (by Jan 1) of year one of the PMR
    - Go to the following website to register https://www.acpm.org/education-events/continuing-medical-education/2019/lifestyle-medicine-core-competencies-program/
    - The cost will be covered by the PMR. Please contact Linda Neville about the mechanics of covering the cost
2) **Boston Public Health Commission (BPHC) mini practicum in chronic disease prevention.** This component of the curriculum is still in development (as of 6/2023) and is expected to consist of several ½ day to full day experiences learning about programs related to chronic disease prevention.

AMBULATORY CONTINUITY CLINIC (Required)

Each resident will be assigned an Ambulatory Continuity Clinical Practice site. Throughout the two years of the residency program, residents will participate in a weekly outpatient clinical practice at their assigned site in the discipline they are board eligible/board certified in. Under oversight by active faculty members, residents will provide full primary care services to a panel of patients.

Patient Care

Goal

Residents must be able to provide patient care that is compassionate, appropriate, and evidence based for the treatment of health problems and the promotion of health. Residents are expected to:

Objectives

Year 1: Become familiar with searching for and applying guideline consistent preventive care for patients under indirect supervision.

Year 2: Become adept at independently evaluating and applying evidence based guideline care for patients.

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor

Medical Knowledge

Goal

Residents must demonstrate knowledge and implementation of recommended screening and prevention in the following disease areas:

A. Cardiovascular Diseases
B. Respiratory Diseases
C. Neoplastic Diseases
D. Immunizations
E. Metabolic Disorders and Nutrition
F. Oral Health, Vision and Hearing Disorders

Objectives

Year 1: Residents shall hone their understanding of primary, secondary and tertiary preventive approaches to individual and population-based disease prevention and health promotion
Year 2: Residents shall be able to deliver and implement, under supervision, appropriate clinical services for both individuals and populations. Residents shall be able to evaluate the effectiveness of clinical services for both individuals and populations

Evaluation Methods

Supervisor review of chart notes. Perform > satisfactory on mini-clinical evaluation exercise at least once yearly. Comply with HEDIS standards for preventive care in their patient panel.

Practice- Based Learning and Improvement

Goal

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 lifelong learning. Residents are expected to develop skills and habits to be able to:

Objectives

- Identify strengths, deficiencies and limits in one's knowledge and expertise;
- Incorporate formative evaluation feedback into daily practice
- Use information technology to optimize learning

Evaluation Methods

Perform > satisfactory on mini-clinical evaluation exercise at least once a year. Perform > satisfactory on supervisor review of medical records

Systems Based Practice

Goal

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. Residents are expected to:

Objectives

- 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
- Attend weekly clinical practice meetings, where applicable
- Attend weekly Grand Rounds
-

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Professionalism

Goal

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

Objectives

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation and ancillary staff evaluations.

Interpersonal and Communication Skills

Goal

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. Residents are expected to:

Objectives

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds

- Communicate effectively with physicians, other health professionals, and health related agencies

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation. Have satisfactory ratings on Press-Ganey surveys from patients.

-

Assessment Method (residents)

- Supervisor review of medical record documentation
- Mini-clinical Evaluation Exercise
- Notifications of incomplete medical records past 14 days
- Clinical supervisor global ratings
- Report of adherence to HEDIS measures
- 360 Evaluations

Assessment Method (Program Evaluation)

- Biannual resident evaluation of program
- Scores on in-service practice exams- clinical prevention section
- Scores on the ABPM board exam section on clinical prevention

Level of Supervision

- Clinical supervisor
- Clinic administrator

Educational Resources

- United States Preventive Services Task Force website/findings
- UpToDate Online
- Boston University Alumni Library, including electronic journals, databases, Cochrane collection, complete medline

Occupational Medicine Rotation (Required)

This rotation consists of 4 distinct experiences- Clinical Occupational Medicine, Hazardous Exposure Evaluation, Disability evaluation, and Worksite Evaluation.

Patient Care

Goal

Residents must be able to provide patient care that is compassionate, appropriate, and evidence-based to manage disabilities and determine work fitness, and to manage work-related exposures or injuries. Residents are expected to:

Objectives

- Develop an appreciation for the scope of clinical occupational medicine presenting complaints.
- Develop a framework for assessing musculoskeletal problems and their relationship to function in work positions.
- Identify the importance of advocating for the patient's needs after a work related injury has occurred.
- Demonstrate ability to assess patients' musculoskeletal complaints and relationship to work function.

Evaluation Methods

Clinical supervisor rating/feedback

Medical Knowledge

Goal

Residents must demonstrate progressive knowledge and implementation of occupational medicine content knowledge areas:

Objectives

Understand principles of:

- Disability management and work fitness
- Workplace health and surveillance
- Clinical Occupational Medicine
- Hazard recognition evaluation and control
- Regulations and government agencies

Evaluation Methods

Score on ACPM in-service exam in Occupational Medicine

.

Practice- Based Learning and Improvement

Goal

Residents will demonstrate the ability to evaluate their care of patients and to improve patient care based on these assessments and feedback from faculty.

Objectives

- Locate appraise and assimilate evidence related to a potential worksite hazard exposure and to individual occupational medicine evaluations

Evaluation Methods

Copy of worksite exposure report.

Systems Based Practice

Goal

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. Residents are expected to:

Objectives

- Assess work function needs from the viewpoint of employer, and employee who is being assessed

Evaluation Methods

Occupational medicine supervisor assessment of resident performance.

Professionalism

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

Objectives

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest

Evaluation Methods
Occupational medicine supervisor assessment of resident performance.

Interpersonal and Communication Skills

Goal
Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, worksites (including potentially affected employees), and professional associates. Residents are expected to:

Objectives

- Communicate effectively with patients and worksites across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals, and employers

Evaluation Methods
Occupational medicine supervisor assessment of resident performance.

Teaching Methods

- Occupational Medicine Clinical Sessions
- Hazardous Exposure Evaluation
- Disability evaluation
- Worksite Evaluation

Assessment Method (residents)

- Occ. med professional supervisor assessment of resident performance
- Copy of completed worksite evaluation
- Copy of disability evaluation
- In-service exam

Assessment Method (Program Evaluation)

- Biannual resident evaluation of program
- Scores on in-service practice exams- occupational medicine section
- Scores on the ABPM board exam section on occupational medicine

Level of Supervision

- Occupational Medicine Clinical supervisor

Educational Resources

- Boston University Alumni Library, including electronic journals, databases, Cochrane collection, complete medline
  Maxcy-Rosenau-Last *Public health and Preventive Medicine*
  Campos-Outcalt *20 Common Problems Preventive Health Care*

Public Health Practicum (Required)

Each resident will spend the equivalent of at least 2 months full time (320 hours) at a governmental public health agency, and participate in one of the essential public health services. A supervisor in the agency will be identified, and together the resident and supervisor will create specific learning objectives for the resident's rotation. This can occur in a longitudinal fashion or in a dedicated time period.

Goal

To understand and observe first hand each of the 10 essential public health services:

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

To participate and become independent with at least one of the essential public health services.

Objectives

- Gather information for possible PH practicum sites from discussion with program director(s), mentor and other residents/fellows project with site supervisor
- Once practicum site and supervisor identified, negotiate specific tasks and goals for the experience
- Complete a PH practicum agreement form to be signed by site supervisor and program director (obtain from Linda)
- Present practicum experience once at Preventive Medicine lecture series designated time

Teaching Methods

- Apprenticeship model in public health agency

Assessment Method (residents)

- Supervisor evaluation
- Presentation in didactic seminar (program director assessment)
- Any publications, or presentations at national meetings

Assessment Method (Program Evaluation)

- Yearly resident evaluation of program

Level of Supervision

- Field supervisor
- Program Director

Educational Resources

Websites:

Boston Public Health Commission www.bphc.org
Massachusetts Department of Public Health www.mass.gov/dph/dphhome.htm
Center for Disease Control www.cdc.gov
Association for Prevention Teaching and Research https://www.aptrweb.org/mpage/Rotations

Maternal Health Quality Improvement, Patient Safety and Health Equity/DEI (Required Maternal Health Track)

Goal

This rotation is designed to give fellows meaningful exposure to the fields of patient safety and quality improvement. There will be three distinct components of the experience as described below.

Part I- Fellows will contact Ryan Smyth (BMC Risk Management Specialist) to sign up for the one-week patient safety component

Part II – Fellows will contact Jen Pfau, MD (Dep't of Family Medicine) who will serve as guide through the Maternal Health QI component.

Part III- Fellow will complete the 101 level online courses in patient safety and quality improvement on the Institute for HealthCare Improvement (IHI) site

Once fellows have confirmed dates for beginning each rotation component please notify Linda Neville and she will formally add it to your schedule so that you receive credit for participation.

Part I – BMC Hospital Patient Safety

Contact: Ryan Smyth, Patient Safety Specialist

A **one-week** rotation to familiarize residents with the work that is done by BMC Risk Managers in Quality and Patient Safety to mitigate risk, understand potential legal claims processes, learn QI tools such as root cause analysis, and understand regulatory reporting requirements of patient safety events. Through mentoring and doing chart reviews related to events, residents would help develop timelines and case narratives for internal and external review by DPH/BORM.

Part II- Maternal Health QI

Contact: Jen Pfau, MD

There are two components to this part of the rotation:

At the beginning of the first academic year, each fellow should reach out to Jen Pfau to discuss the rotation and obtain guidance on proceeding with the steps below.

1. **QI Project participation**

   The following meetings should occur at the beginning of your fellowship (during the first 3 months ideally)

1) All fellows should meet with Ron Iverson and Clare Cole (see below)
2) In addition, fellows should choose to meet with two additional team members from the list below. Jen Pfau can help direct you in choosing the two who align most closely with your project interests.
3) Based on the discussion with the above 4 people, fellows should select one QI project in which to participate directly and take an active role (can be an existing project). Once selected, fellows should inform Jen Pfau, so she can review and confirm.

- Ron Iverson (Vice Chair of Obstetrics, Director of Quality and Safety)
- Clare Cole (Perinatal Safety Specialist)
- Kari Radoff (Associate Director of Midwifery- QI, EPIC and education focus)
- Teju Adegoke (Director for Equity and Inclusion, Department of OB/Gyn)
- Kara Eisenberg (Quality Improvement Project Specialist)
- Giavanna Gaskin (Project Manager for Equity in Pregnancy, working with Health Equity Accelerator team)

2. **Perinatal Safety Meetings**

   Team leader- Clare Cole, Perinatal Safety Specialist- review flagged cases and RLs, plan action steps with multidisciplinary MCH team- great opportunity to identify potential projects

Flagged cases include: neonatal injuries, babies with low apgars or those who require neonatal cooling, vaginal or c/s births with hemorrhage >2L, ICU admissions, readmissions, etc.

Required: Fellows will attend a minimum of 3 meetings during the first 3 months of the fellowship (meetings occur 2x/month as listed below), and 5 meetings during the second year of the fellowship

1. Fellows to choose meetings times based on their own schedule and the schedule below.
2. Once each meeting is completed, fellows should inform Linda Neville so attendance can be documented in the fellowship portfolio

- 3rd Thurs of the month 1-2 pm- case reviews
  Organized by Clare Cole
- 4th Thurs of the month 1-2 pm- review RLs and action items
  Organized by Clare Cole

Part III- Institute for Healthcare Improvement (IHI) Modules

Modules can be accessed at the IHI website link:
https://education.ihi.org/topclass/
All BMC residents and fellows have free access through GME. If you do not already have access please contact Linda Neville to obtain

All fellows are <u>required</u> to complete the following online learning modules

Quality Improvement (QI): 101-105
Patient Safety (PS): 101-105

All fellows are <u>recommended</u> to complete the additional modules
Leadership (L): 101-103
Peron and Family Centered Care (PFC): 101-104
Triple Aim for Populations (TA): 101-105

Teaching Methods

- In person
- On line modules

Assessment Method (residents)

- Supervisor evaluation
- Presentation of QI project

Assessment Method (Program Evaluation)

- Yearly resident evaluation of program

Level of Supervision

- Field supervisor
- Program Director

Educational Resources

Websites: https://education.ihi.org/topclass/

ELECTIVES:

ADDICTION MEDICINE ELECTIVE

The Addiction Medicine elective can be an inpatient or outpatient experience. Under direct supervision, residents will evaluate and assist with management of patients who present for new or established visits for treatment of

substance use disorders. Residents may spend half days in several other settings, including: 1) Office-Based Addiction Treatment (OBAT) 2) Massachusetts Screening, Brief Intervention, and Referral to Treatment Program (MASBIRT) 3) Boston Public Health Commission AHOPE Syringe Access Program 4) Project Trust - HIV Counseling and Testing Service at BMC 5) FAST PATH (HIV clinic-based substance use treatment program at BMC and 6) Faster Paths bridge clinic. During the inpatient rotation, residents round on the addiction consult service.

Patient Care

Goal

Residents must be able to provide patient care that is compassionate, appropriate, and evidence based for assessment and treatment of patients with opioid and other substance use problems. Residents are expected to:

Objectives

- Gain proficiency obtaining a detailed substance use screening history
- Gain proficiency identifying patients at risk for substance use or addiction
- Develop an appreciation for the scope of drug addiction presenting complaints
- Understand that alcohol and drug use disorders are chronic, relapsing conditions that are:
  1) Preventable with early intervention via screening and brief intervention
  2) Treatable with effective medical and behavioral treatments
  3) Addressable with risk reduction strategies, such as syringe access and overdose prevention

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor.

Medical Knowledge

Goal

To increase resident's knowledge of substance use disorders and prevention and mitigation of complications of such disorders, including the factors that are implicated in etiology and options for management.

Objectives

- Understand strategies used to prevent complications of substance use disorders
- Understand the pharmacologic treatment options available to treat substance use disorders
- Understand co-morbidities associated with substance use disorders
- Understand the risks and benefits of treating substance use disorders using the various modalities

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Practice- Based Learning and Improvement

Goal

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 lifelong learning. Residents are expected to develop skills and habits to be able to:

Objectives

- Identify strengths, deficiencies and limits in one's knowledge and expertise
- Incorporate formative evaluation feedback into daily practice
- Use information technology to optimize learning

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Systems Based Practice

Goal

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, related to the evaluation and treatment of substance abuse and dependence. Residents are expected to:

Objectives

- Understand resources available to patients and clinicians for prevention and management of opioid and other substance use disorders

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Professionalism

Goal

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

Objectives

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Interpersonal and Communication Skills

Goal

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. Residents are expected to:

Objectives

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals, and health related agencies

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Assessment Method (residents)

- Supervisor review of medical record documentation
- Clinical supervisor global ratings

Assessment Method (Program Evaluation)

- Yearly resident evaluation of program

Level of Supervision

- Clinical supervisor
- Clinic administrator

Educational Resources

- UpToDate Online
- Boston University Alumni Library, including electronic journals, databases, Cochrane collection, complete medline
- 4 online modules http://www.bu.edu/act/mdalcoholtraining/slides/index.html.
- https://www.dropbox.com/sh/medxtwr2btpzxkf/AAArKMPslnzdWmvZbzy-Wm2Ea?dl=0

INFECTIOUS DISEASE ELECTIVE (STD Clinic & Travel Clinic)

The overall goals of this elective are to 1) provide an introduction to the clinical skills of travel medicine and sexually transmitted infections.

Travel Clinic: Participants will spend 4 half-day clinical sessions in the Travel Medicine Clinic working alongside the infectious disease faculty attending where they will be expected to take focused patient histories, travel risk assessments and prescribe appropriate preventive therapy and counseling.

STI Clinic: Participants will also spend 4 half-day clinical sessions in the Sexually Transmitted Infection Clinic. The STD clinic is a nurse-led clinic overseen by a Section of ID faculty member. This clinic provides an excellent forum for learning about all aspects of STDs, including diagnosis, treatment, and prevention. The STD clinic is a designated training site for practitioners from the entire New England area. Residents will take appropriate history, perform focused physical exams, and make appropriate diagnostic and therapeutic plans.

Patient Care

Goal

Travel Clinic: Residents must be able to provide patient care that is compassionate, appropriate, and evidence based for assessment of travel related risk and development of customized prevention plans.

STI Clinic: Residents must be able to provide patient care that is compassionate, appropriate, and evidence based for diagnosis, treatment and prevention of sexually transmitted infections (STIs)

Objectives

STI Clinic

- Interview patients to collect relevant data, including sexual histories and epidemiologic data
- Examine patients with focus on relevant organ systems, including pelvic examination and examination of the male genitalia
- Generate an appropriate differential diagnosis and management plans for STIs

Travel Clinic

- Interview patients including travel and vaccination histories and upcoming travel plans
- Generate appropriate preventive management and counseling plans based on geographic epidemiologic data of travel risk

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor.

Medical Knowledge

Goal

Travel Clinic: To increase resident's knowledge of prevention and treatment of travel related illness and injury including the factors that are implicated in etiology and options for management

STI Clinic: To increase resident's knowledge of diagnosis, prevention and treatment of STIs including the applicable knowledge base of the basic and clinical sciences factors and those that are implicated in etiology and options for management

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Practice- Based Learning and Improvement

Goal

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 lifelong learning. Residents are expected to develop skills and habits to be able to :

Objectives

- Identify strengths, deficiencies and limits in one's knowledge and expertise in STI diagnosis and management and in Travel Medicine;
- Incorporate formative evaluation feedback into daily practice
- Use information technology to optimize learning

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Systems Based Practice

Goal

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, related to the evaluation and treatment of STIs and in the prevention of travel related illness. Residents are expected to:

Objectives

- Understand resources available to patients and clinicians for prevention and management of STIs and travel illness and injury
- Collaborate with other members of the health care team to assure comprehensive patient care

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Professionalism

Goal

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

Objectives

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Interpersonal and Communication Skills

Goal

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. Residents are expected to:

Objectives

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals, and health related agencies

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Teaching Methods

- Case presentation and discussion with supervisor

Assessment Method (residents)

- Supervisor review of medical record documentation
- Clinical supervisor global ratings

Assessment Method (Program Evaluation)

- Yearly resident evaluation of program
- Scores on in-service practice exams- clinical prevention section
- Scores on the ABPM board exam section on clinical prevention

Level of Supervision

- Clinical supervisor
- Clinic administrator

Educational Resources

- UpToDate Online
- Boston University Alumni Library, including electronic journals, databases, Cochrane collection

NUTRITION & WEIGHT MANAGEMENT ELECTIVE

Residents observe the nutritionists and endocrinologist evaluate and assist with management of patients who present with nutritional and/or weight management problems.

Patient Care

Goal

Residents must be able to provide patient care that is compassionate, appropriate, and evidence based for assessment and treatment of patients with nutritional and weight management problems. Residents are expected to:

Objectives

- Gain proficiency obtaining a dietary history and using selected tools to assess dietary and lifestyle habits
- Develop an appreciation for the scope of nutrition and weight management presenting complaints
- Identify patients that would be good candidates for medical vs surgical treatment of obesity
- Compare and contrast available evidence based medical treatment options for obesity
-

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor.

Medical Knowledge

Goal

To increase resident's knowledge of nutrition and weight management disorders, including the factors that are implicated in etiology, the associated complications and options for management.

Objectives

- Understand diet and lifestyle habits that contribute to weight and nutritional problems
- Understand the pharmacologic treatment options available to treat obesity
- Understand co-morbidities associated with nutritional and weight disorders
- Understand the risks and benefits of treating obesity using the various modalities
- Understand the nutritional deficiencies associated with bariatric surgery and what monitoring needs to take place in a pre and post-operative patient

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Practice- Based Learning and Improvement

Goal

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 lifelong learning. Residents are expected to develop skills and habits to be able to:

Objectives

- Identify strengths, deficiencies and limits in one's knowledge and expertise in diagnosis and management of nutrition and weight disorder
- Incorporate formative evaluation feedback into daily practice
- Use information technology to optimize learning

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Systems Based Practice

Goal

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, related to the evaluation and treatment of nutritional and weight management problems. Residents are expected to:

Objectives

- Understand resources available to patients and clinicians for management of nutritional and weight disorders
- Identify best practices on how to collaborate with nutritionist for the management of nutritional and weight disorders

-

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Professionalism

Goal

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

Objectives

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Interpersonal and Communication Skills

Goal

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. Residents are expected to:

Objectives

  - Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgroundsUse appropriate concepts and language when educating patients and families about their nutrition and weight disorders, taking in consideration their spiritual and cultural beliefs.
- Communicate effectively with physicians, other health professionals, and health related agencies

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation.

Teaching Methods

- Case presentation and discussion with supervisor
- Weekly clinical practice meetings, where applicable

Assessment Method (residents)

- Supervisor review of medical record documentation
- Clinical supervisor global ratings

Assessment Method (Program Evaluation)

- Yearly resident evaluation of program
- Scores on in-service practice exams- clinical prevention section
- Scores on the ABPM board exam section on clinical prevention

Level of Supervision

- Clinical supervisor
- Clinic administrator

Educational Resources

- United States Preventive Services Task Force website/findings
- UpToDate Online
- Boston University Alumni Library, including electronic journals, databases, Cochrane collection, complete medline

TUBERCULOSIS CLINIC ELECTIVE

The overall goals of this elective are to 1) provide an introduction to the activities and function of a large urban tuberculosis (TB) clinic and 2) provide familiarity with the skills necessary for TB screening, diagnosis, and, to a limited degree, management

While participating in the TB Clinic, trainees will be expected to take patient histories, perform focused physical examinations, read chest X-rays, assess patient risk for latent or active tuberculosis infection and interpret appropriate diagnostic studies. Trainees may also prescribe appropriate therapy for infected patients, and evaluate the public health risks associated with any active cases.

All trainee activities will take place in the setting of a patient care team that includes TB Clinic attendings, BPHC public health nurses, BPHC outreach workers, and translators.

Patient Care

Goal

Residents must be able to provide patient care that is compassionate, appropriate, and evidence based for assessment and treatment of patients with suspected and diagnosed tuberculosis. Residents are expected to:

Objectives

- Learn to evaluate tuberculin skin tests (TSTs) and cultures in the context of other co-morbidities or BCG vaccination
- Learn to evaluate chest x-rays and other radiographic studies in patients with TB
- Understand the important role of treatment of latent TB infection (LTBI) in preventing TB disease and spread of TB

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor

Medical Knowledge

Goal

To increase resident's knowledge of diagnosis, prevention and treatment of tuberculosis including the factors that are implicated in etiology and options for management

Objectives

- Expand clinically applicable knowledge base of the basic and clinical sciences underlying the care of patients with TB
- Understand general principles of therapeutic regimens for different types of *Mycobacterium tuberculosis* infection
- Demonstrate knowledge of the treatment options available for treatment of latent TB

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation

Practice- Based Learning and Improvement

Goal

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 lifelong learning. Residents are expected to develop skills and habits to be able to :

Objectives

- Identify strengths, deficiencies and limits in one's knowledge and expertise in regards to caring for patients with TB;
- Incorporate formative evaluation feedback into daily practice when taking care of patients with TB
- Use information technology to optimize learning
- Critically interpreting the evidence available for treatment of TB and apply it to clinical practice

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation

Systems Based Practice

Goal

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, related to the evaluation and treatment of tuberculosis. Residents are expected to:

Objectives

- Understand resources available to patients and clinicians for prevention and management of tuberculosis including BPHC public health nurses, BPHC outreach workers, and translators
- Collaborate with other members of the health care team to assure comprehensive patient care

aluation Methods

Perform satisfactorily on Clinical Supervisor evaluation

Professionalism

Goal

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

Objectives

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation

Interpersonal and Communication Skills

Goal

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. Residents are expected to:

Objectives

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds by using appropriate concepts and language when educating about TB and treatment options
- Communicate effectively with physicians, other health professionals, and health related agencies

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation

Teaching Methods

- Case presentation and discussion with supervisor
- Weekly clinical practice meetings, where applicable

Assessment Method (residents)

- Supervisor review of medical record documentation, where applicable
- Clinical supervisor global ratings

Assessment Method (Program Evaluation)

- Yearly resident evaluation of program
- Scores on in-service practice exams- clinical prevention section
- Scores on the ABPM board exam section on clinical prevention

Level of Supervision

- Clinical supervisor
- Clinic administrator

Educational Resources

- UpToDate Online
- Boston University Alumni Library, including electronic journals, databases, Cochrane collection

Tobacco Cessation Rotation

Residents participate in the Pulmonary Division Friday morning tobacco cessation groups and smoking cessation consult rounds. The group meetings are 90 minutes long and the resident's role will be to observe the first session, then assist the pulmonary faculty member in running the following group sessions. Specific activities will include 1) assessing readiness to quit, motivation to quit, level of nicotine dependence, and barriers to quit, 2) delivering a 20-30 minute didactic to the group weekly, 3) outlining an individual treatment plan, including pharmacotherapy if participants are ready to quit.

Medical Knowledge & Patient Care

Goals

Understand the addictive nature of tobacco use, its impact on health and other factors, and key clinical activities for assessing the nicotine dependent individual.

- Describe Tobacco's Toll and Benefits to Quitting: Health, Economic, and Other Impacts
- Explain Nicotine dependence to the smoker and why it's so hard to quit
- Develop competency in clinical assessment of the tobacco user including Fagerstrom Test for Nicotine Dependence
- Prepare residents with educational and experiential background to deliver an evidence-based, treatment program for individuals with nicotine dependence.
    - Competency in 5As counseling
    - Pharmacotherapy

Practice- Based Learning and Improvement

Goal

Residents must demonstrate the ability to evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on self-evaluation and learning.

Systems Based Practice

Goals

Residents must demonstrate an awareness of the larger context and system of health care, related to the evaluation and treatment of tobacco dependence.

Objectives:

Demonstrate knowledge about available resources including:

- Public Health Service PHS (2008) Guideline Overview, tobacco cessation websites, and quit lines.
    - American Lung Association:
        - ffsonline.org
    - American Cancer Society:
        - Live chat at 800-227-2345
        - http://www.cancer.org/healthy/stayawayfromtobacco/index
    - National Cancer Institute:
        - 1-800-QUITNOW (1-800-784-8669)
        - Smokefree.gov

Professionalism

Goals

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

Objectives

Residents are expected to demonstrate:

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest

Interpersonal and Communication Skills

Goal

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients and professional associates. Residents are expected to:

Objectives

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals, and health related agencies
- Employ effective strategies to help patients male lifestyle changes that help them quit smoking

Evaluation Methods

Perform satisfactorily on Clinical Supervisor evaluation

Educational Resources

1. US Surgeon General's Report, 1990, pp.193, 194,196, 285, 323
2. US Surgeon General's Report, 1990, pp. 285-287, 304
3. US Surgeon General's Report, 2010, p. 359
4. A Report of the Surgeon General: How Tobacco Smoke Causes Disease The Biology and Behavioral Basis for Smoking-Attributable Disease Fact Sheet, 2010; and Tobacco Control: Reversal of Risk After Quitting Smoking. IARC Handbooks of Cancer Prevention, Vol. 11. 2007, p 341
5. A Report of the Surgeon General: How Tobacco Smoke Causes Disease The Biology and Behavioral Basis for Smoking-Attributable Disease Fact Sheet, 2010; and US Surgeon General's Report, 1990, pp. vi, 155, 165
6. Tobacco Control: Reversal of Risk after Quitting Smoking. IARC Handbooks of Cancer Prevention, Vol. 11. 2007. p 11)

Teaching Methods

- Smoking Cessation Clinical Sessions

Assessment Method (residents)

- Supervisor review of medical record documentation
- Clinical supervisor global ratings

Assessment Method (Program Evaluation)

- Yearly resident evaluation of program

Level of Supervision

- Clinical supervisor

5. Policies

Resident Wellness

The Preventive Medicine Residency recognizes that the psychological, emotional, and physical well-being are critical in the development of competent, caring, and resilient physicians and requires attention spent developing this balance between work and personal life. All physicians are at risk for burnout and depression, and we understand the responsibility of looking after the well-being of both fellows and faculty members in the unit. Self-care and responsibility to support other members of the health care team are skills that must be modeled, learned, and nurtured in the context of other aspects of training in professionalism and patient care. We seek to establish a unit culture that is marked by mutual respect, openness, and support for one another.

Components of Wellness:

Learning and working environment: We strive to provide a healthy learning and working environment for fellows and faculty with a culture of respect and accountability. This includes offering protected time for didactics and minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships. We pay special attention to scheduling, work intensity, and work compression that impact fellow and faculty well-being. We regularly evaluate workplace safety data and address the safety of both fellows and faculty. See below for reporting mechanisms.

Physical wellness: We recognize that a sense of well-being includes physical wellness. We encourage the fellows to have a personal primary care physician and we provide them time to go to these appointments. They are given the opportunity to attend medical, dental, optical and any mental health appointments as needed. We encourage them about the importance of a healthy diet, exercise, and adequate rest.

Social wellness: Spending time away from work with family and friends and finding support and purpose outside of medicine is also important. We also encourage regular fellow group activities outside of work.

Mental health: Special attention is paid to the possibility of fellow and faculty burnout, depression, and substance use. Using resources available to us through BMC, we educate faculty and fellows in the identification of the symptoms of burnout, depression, and substance use, including the means to assist those who experience these conditions. Fellows and faculty are educated to recognize these symptoms in themselves and how to seek appropriate care. We encourage them to alert the Program Coordinator, Program Director, or DIO when they are concerned that another fellow or faculty may be displaying signs of burnout, depression, substance use, suicidal ideation, or potential for violence, whether to themselves or others. We provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24/7, to ensure that fellows and faculty have access at all times to a mental health professional. Financial cost is not a barrier to obtaining care.

Time-off/ Leave: There are circumstances in which fellows or faculty may not be able to attend work, such as fatigue, illness, family emergencies, and parental leave. We allow leave of absence for each fellow and faculty unable to perform their patient care responsibilities, as assessed on an individual basis. We have policies and procedures in place to ensure coverage of patient care that are implemented without fear of negative consequences for the fellow or faculty who is unable to perform their patient care responsibilities.

Faculty mentor: At the beginning of training, residents are assigned a faculty mentor. The goal of assigning the mentor at the beginning of the training is that the resident can connect and grow with the faculty member over their course of training. Mentors and mentees formally meet at least monthly to check in and offer any needed support, both personally and professionally. The program director is also expected to meet with all of the fellows as a group throughout the year for both social events and team building. Additional wellness resources available are a list of books, web-based modules, and articles. The list is reviewed and updated every few years for relevancy.

Wellness Resources

BMC Employee Assistance Program
BMC's Employee Assistance Program (EAP) provides employees and their families with confidential short-term counseling and referral services for a wide range of concerns including mental health, alcohol/substance use disorder, smoking cessation, depression, anxiety, career concerns, elder care support, and more. They are available 24/7. Call 833-306-0107. More information, as well as addiction and mental health assessments, are available online at guidanceresources.com (register with Web ID: BMC).

Your call will be answered by a clinician, who may help you by:

- Responding to a mental health or substance use emergency
- Evaluating your problem or concern
- Providing telephone counseling
- Referring you directly to an EAP clinician for a face-to-face visit
- Locating, qualifying, and referring you to a local clinician

The EAP provides you and each of your eligible dependents with up to five in-person counseling sessions per each different presenting problem with an EAP clinician at no cost to you and your eligible dependents per calendar year. If additional counseling services are needed, the EAP will work with your medical provider to ensure you receive the care you need. The EAP is not part of your health insurance and is a separate service that does not require health insurance to participate. However, an EAP counselor may recommend extended services beyond the scope of the EAP, at which time your EAP counselor would assist you in accessing your health insurance plan for further coverage.

Employee Assistance Clinicians
If you are looking for mental health or substance use disorder treatment programs for yourself or a family member and you don't know where to start, or are having difficulty getting a timely appointment, you can contact our **Employee Assistance Clinician**, Beth Milaszewski, LICSW. Beth provides the following services:

- Care Navigation: Beth can assist with navigating and triaging services to help you find the most appropriate site/providers for your specific needs, both at BMC and elsewhere. This includes referrals for long-term counseling and substance use disorder treatment programs.
- Social Support Resources: If you have social support needs such as housing, food, and family issues, Beth can help find available resources to address these needs.

Beth can be reached by email: **Beth.Milaszewski@bmc.org**, phone: 617-414-4357, or pager: 8010.

Roopa Mathur, DO: Dr. Mathur is available to treat or to help employees find pschiatric and therapy services. Contract Dr. Mathur at roopa.mathur@bmc.org.

Izzy Berenbaum, MD: Dr. Berenbaum is available to see residents and attendings for therapy and/or psychiatric medication needs, using medical insurance. Please note that medical and behavioral health notes are not kept in Epic. You may contact him by paging 0196 or emailing bbq@bu.edu.

Physician Health Services (PHS)
Consultation and support services for physicians, residents, and medical students. Call 781-434-7404 or 800-322-2323 x7404.

Sleepio
Research shows that people who suffer from chronic sleep problems have more difficulty managing emotions, are at double the risk of developing depression and respond less to treatment for mental health disorders. The sleep experts at Sleepio can help you get the best sleep possible. This six-week personalized sleep program uses Cognitive Behavioral Therapy (CBT) to teach you techniques to get your sleep schedule, thoughts, lifestyle and sleep environment into shape. Discover your Sleep Score and how to improve it at www.sleepio.com/bmc.

Daylight
Daylight is a digital therapy program designed to help you build your resiliency so you can feel better when facing life's tough challenges. It was created with evidence-based research and uses Cognitive Behavioral Therapy to teach you ways to manage your daily stress, worries, and anxiety, based on your specific needs. Register at www.trydaylight.com/bmc.

Doctor on Demand: Telemedicine Services
If you are enrolled in a BMC employee medical plan with Health Plans, Inc. you can receive convenient and confidential behavioral health visits through online video chat with licensed practitioners. Conditions treated include depression, anxiety, addiction, trauma, and loss.
You can select a mental health appointment with a psychologist for talk therapy for 25 or 50 minute sessions. You may also schedule an appointment with a psychiatrist for an initial assessment and medication management, including prescribing/renewing prescriptions (45 minutes). Subsequent 15-minute follow-up sessions are available for ongoing medication management. Medications that the psychiatrist prescribes can be called into a local pharmacy, including BMC. The cost for each visit is typically $5, but all copays are being waived during the COVID-19 pandemic. To find out more and register, visit www.doctorondemand.com/health-plans-inc.

Domestic Violence Program
Provides support and resources for employees and patients with suspected or known domestic violence situations. Contact Joanne Timmons at 617-414-5457 or view the BMC Domestic Violence Program site for more information.

Spiritual Care
Provides immediate support and pastoral counseling for employees and patients. Contact:
Chaplain Samuel Lowe, PhD, Mdiv, at pager #3658
Rev. Jennie R. Gould, Ph.D., BCC, at pager #4578
Spiritual Care main pager #4578 or #3658

What to do when a patient dies

- Notify program director/mentor
- Call family and send a condolence card from the program
- Notify staff as soon as possible
- Cancel future appointments in the scheduling system
- Clinician to document death in the medical record

- Notify medical records
- File an incident report, QA/QI meeting
- Contact chief's of service
- Notify department of public health

www.Acgme.org/what-we-do/initiatives/physician-well-being

1b. Jeopardy (Fatigue, Illness and backup coverage)

In the event that a resident is ill or too tired to come to work, the program office will be notified and the backup system initiated. If a resident is sent home during their shift, the program office will do its best to find coverage, and will let the attending know that there may not be a resident on that day. It is the expectation that faculty monitor fellows for fatigue and burnout, and send resident home when necessary.

1c. Confidential Reporting & Workplace Safety

Anonymous Reporting of Resident Issues
This form allows an anonymous report by anyone with concerns regarding the work or treatment of Boston Medical Center trainees. In addition to residents and fellows, any BMC employee or a resident's family member can make the report

Examples for using this report:
•instances of coercion to exceed duty hours involving the person reporting the violation or observed coercion of others.
•observation of evidence for excess fatigue and sleep deprivation in residents who continue to engage in active patient care.

When this form is used, we guarantee that no demographic information such as IP address, workstation ID, or any other identifying information is captured, and you will remain anonymous. The secure information you provide in this form will be immediately routed to the Designated Institutional Official (DIO) Jeffrey Schneider, MD, for investigation and implementation of corrective action as warranted. When submitting the below form, please indicate the department, the date of the violation/incident (if applicable), and the nature of the violation/incident.

RL Incident Reporting System
BMC commits to fostering a work environment that is professional, respectful, and supportive of all personnel to provide optimum patient care and a safe, supportive work environment. BMC expects all employees, regardless of position, to support this aim, and BMC has a zero-tolerance policy for behaviors that undermine our culture of safety. Behaviors that are not tolerated include but are not limited to: aggression/bullying, inappropriate communication, destructive behavior, discrimination, harassment, physical abuse, and retaliation.

Gaps in communication (lack of, ineffective, disruptive) are cited as a root cause in the vast majority of all preventable patient harm events. The effect of destructive behaviors on others can result in anxiety, depression, health issues and ineffective teamwork; ultimately, they can have a negative impact for both staff well-being and patient safety. BMC leadership has prioritized a strong culture of safety in which all employees, licensed independent practitioners (LIP) and patients feel safe.

It is understood that BMC employees and staff are human beings and that we all may need the occasional thoughtful reminder for behavioral mindfulness. Ideally, missteps in communication and professional conduct can be addressed and resolved in the moment through de-escalation and respectful discussion or escalated through employee/provider chain of command. However, there may be times when this is not a viable solution, or when a

negative pattern continues. In these cases, the event should be reported in RL. In order to facilitate reporting of more serious or problematic behavior, the employee/LIP professional conduct icon has been added to the RL incident reporting system. As with entering patient safety events, respectful, factual descriptions with sufficient detail for the reviewer will expedite event review and intervention. A standardized, non-punitive process has been developed to optimize confidentiality, timely review, and intervention. Limited, specific designated leaders will be assigned to event review for each discipline.

Professional Resource Services

The Professionalism Resource Service (PRS) promotes the development of professional attitudes, behaviors, and practices at Boston University School of Medicine (BUSM) and Boston Medical Center (BMC) in order to support a learning environment where all are treated with respect, humility, and compassion.

A confidential, independent, non-adjudicating service available at no cost, PRS can assist individuals, groups, and departments at BUSM and BMC in developing remediation strategies that preserve relationships and careers. PRS also monitors and reports on professionalism within the learning environment, supporting education activities and assessments.

BMC Human Resources

Fellows can reach out to BMC Human resources at 617-638-8585 to speak to the Human Resource Business Partner for residents for issues regarding BMC employees.

BMC Compliance

BMC Compliance covers the following areas: prevention of fraud, waste, and abuse; protection of patient privacy and HIPAA; research compliance; billing compliance audit; disclosure and management of conflicts of interest; pharmacy compliance; and monitoring of workforce relationships with industry vendors.
Compliance receives reports of concerns, questions and other inquiries via the Compliance Hotline (800-586-2627) and through other means such as telephone calls and in-person visits. Every report received by Compliance is investigated and resolved. We actively work to prevent retaliation against any workforce member who makes a report to Compliance or who participates in the investigation of a report.
DG-ComplianceHelp@BMC.org: for anyone who'd like to report concerns, leave tips, and have questions regarding compliance

BU Human Resources

Fellows can reach out to the BU HR Service Center at 617-353-2380 or email hr@bu.edu for issues regarding BU employees (faculty).

BU Ombuds

The Office of the Ombuds is an independent, impartial, informal problem-solving resource serving faculty, staff, and students on the Charles River and Medical Campus. The Office maintains strict confidentiality, and provides a safe place for you to have off-the-record conversations on issues related to life, work, or study at Boston University. Talking to the Ombuds can be a good first step if you have a concern and you don't know where to turn for help.

Solomon Carter Fuller Building
85 East Newton Street, Suite 818
(617) 358-7645
ombuds@bu.edu

Supervision of Residents, Resident Duty Hours, Work Environment and Moonlighting *Approved November 25, 2019*

As per ACGME requirements, the Preventive Medicine Residency maintains strict requirements governing the supervision of resident trainees. As part of this policy:

1) The attending, resident, and nurse caring for each patient are identified on the Boston Medical Center Electronic Medical Record (EMR). This system is available to all practitioners at Boston Medical Center. The attending physician identified is ultimately responsible for the patient's care.
2) Residents and faculty members are responsible for informing patients and their family members of their respective roles in each patient's care. With all preventive medicine resident patients, there is either *Direct Supervision*, *Indirect Supervision Immediately Available, or Oversight.* Depending on patient acuity, resident PGY level, and the rotation the resident is on, the attending evaluation may occur prior to the resident evaluation, concurrent with the resident evaluation, or subsequent to the resident evaluation. Because trainees have completed a clinical residency in a primary care specialty (internal medicine, pediatrics or family medicine), and are board certified, they will be overseen by the clinic preceptor while in their continuity clinic. The preceptor will be on site and available by phone at all times when the trainee is providing patient care. Supervision while on elective rotations will vary between direct and indirect supervision based on the rotation and the faculty's evaluation of the resident's skill.
3) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members.
4) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
5) Senior residents should serve in a supervisory role of junior residents in recognition of their progress towards independence, based on the needs of each patient and the skills of the resident.
6) As patients are seen by an attending in immediate proximity to the resident evaluation, all critical decisions (e.g., end-of-life decision, admission to a critical care unit, etc.) are made with real-time input from attending physicians.
7) Each resident must know the limits of their scope of authority and the circumstances under which they are permitted to act with conditional independence.
8) The clinical responsibilities for each resident must be based on PGY level, patient safety, resident education, severity and complexity of patient illness/condition, and available support services.
9) Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in emergency medicine.

Faculty evaluation of the resident's abilities is a cornerstone of the BMC Preventive Medicine Residency and the data generated through a variety of different evaluation processes are critical to their training. Each rotation has specific goals and objectives and the residency leadership and faculty utilize these goals and objectives to assess residents' readiness to assume progressive responsibility, conditional independence, and a supervisory role in patient care (if applicable to the rotation).

The program assesses the ability of residents via several complementary and overlapping methods. Direct observation of patient care, including management plans, is the most important of these mechanisms and time at monthly Executive Committee meetings is set aside to discuss the performance of each resident as they relate to the Core Competencies. Additional information is gathered via resident evaluations, as well as nursing and patient feedback.

The criteria on which residents are judged allowing for their progressive authority and responsibility, conditional independence, and a supervisory role in patient care are presented below (one component of "milestones").

Preventive Medicine Milestones include, but are not limited to:

Program Year 1 (PGY 4):

Clinical Preventive Medicine: With clinical oversight, residents will manage the primary preventive care and chronic disease for a panel of patients in an ambulatory primary care clinic.

Occupational Medicine: Residents will assess, evaluate and manage occupational health exposures and injuries, including fit for duty evaluations. This will be accomplished under direct supervision, where they will evolve from observation toward independence by the completion of the rotation.

Behavioral Change Counseling Skills: Weight management, addiction medicine, behavioral change: Under direct supervision, residents will assess and practice behavioral change clinical skills, including directly counseling patients on behavior change, prescribing appropriate adjunctive medication use.

Population Knowledge: Residents will take and pass with a grade of B introductory graduate level courses in biostatistics, epidemiology and health policy and management.

Research Skills: Under Direct supervision, residents will identify a research or policy question, identify sources of data to answer the question, define an analytic plan, conduct the analyses, present them orally to peers and supervisors, and develop an abstract for submission to regional meeting, present at regional meetings.

Program Year 2 (PGY 5):

Clinical Preventive Medicine: With clinical oversight, residents will manage the primary preventive care and chronic disease for a panel of patients in an ambulatory primary care clinic.

Public Health Infectious Disease: With direct supervision, residents will evaluate and treat infectious diseases such as sexually transmitted diseases and tuberculosis.

Behavioral Health Change Counseling Skills: Under indirect supervision, residents will assess and practice behavioral change clinical skills, including directly counseling patients and groups on behavior change, as well as prescribing appropriate adjunctive medication use.

Population Knowledge: Residents will take and pass with a grade of B advanced graduate level courses in biostatistics, epidemiology and health policy and management.

Research Skills: Under indirect supervision, residents will independently identify a research or policy question, identify sources of data to answer the question, define an analytic plan, conduct the analyses, present them orally to peers and supervisors, develop an abstract for submission to national scientific meetings, present at national meetings, draft and publish a manuscript in peer-reviewed journal.

Public Health Administrative Skills: Under indirect supervision, residents carry out the previously developed plans for the public health agency project including appropriate use of data sources, key personnel and community partners. With supervision, they will develop a written report/summary of the project and present to agency personnel and also at regional and national meetings. Part of their skills will include independently performing one or more public health agency capacities, including: conducting program assessment and population needs assessment, identification of community resources, and quality assurance.

Duty Hours

Duty hours are defined as all clinical and academic activities related to the residency program. This includes clinical care, in-house call, transfer of patient care and administrative activities related to patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. For Call from Home (at-home

call), only the hours spent in the hospital after being called in to provide care count toward the 80-hour weekly limit.

Hours spent on activities that are required by the accreditation standards, such as membership on a hospital committee, or that are accepted practice in fellowship programs, such as fellows' participation in interviewing fellowship candidates, must be included in the count of duty hours. Any tasks related to performance of duties, even if performed at home, count toward the 80 hour, such as completion of medical records, submitting orders, reviewing lab tests and verbal orders that can be signed at home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours.

Maximum Hours of Clinical & Educational Work Per Week

- Work hours must be limited to **no more than 80 hours per week**, **averaged over a four-week period (or the length of the rotation, if shorter than four weeks)**, including in-house clinical and educational activities, clinical work done from home, and moonlighting.

Mandatory Time Free of Clinical Work & Education

- Trainees should have **eight hours off between** scheduled clinical work and education periods.
- Trainees must be scheduled for a minimum of **1 day (a full 24 hours!) in 7 free** of clinical work and required education, **averaged over four weeks (same as above)**. At-home call cannot be assigned on these free days.
- Clinical & educational work periods must not exceed 24 hrs of continuous scheduled clinical assignments.
- Up to 4 hours of additional time may be used for activities related to patient safety (transitions of care, trainee education, etc.)

Call from Home (at-home call)

Time spent in the hospital by fellows on Call from Home (at-home call) must count towards the 80 hour maximum weekly hour limit. The frequency of Call from Home (at-home call) is not subject to the every third night limitation, but must satisfy the requirement of one-day-in-seven free of duty (when averaged over a four-week period).

Fellows are permitted to return to the hospital while on Call from Home (at-home call) to care for new or established patients. Each episode of this type of care, while it must be included in the 80 hour weekly maximum, will not initiate a new "off-duty period."

Moonlighting

Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program. The fellow and Program Director must comply with BMC's Moonlighting Policy and all relevant provisions in the BMC/CIR Collective Bargaining Agreement.

Time spent by fellows in Internal and External Moonlighting must be counted towards the 80 hour maximum weekly hour limit.

Logging Duty Hours

Reporting of Duty Hours is written into the CIR Union Agreement. Trainees must accurately record all work hours worked weekly. No Trainee will be disciplined or retaliated against for accurately recording work hours regardless of whether such hours comply with ACGME regulations. Failure to record work hours will result in a mandatory meeting with the PD to discuss professionalism and determine a plan to ensure future compliance. If a Trainee repeatedly fails to accurately record all hours worked, the CMO will immediately convene a meeting with the Trainee and PD to address the problem and determine a course of action to ensure the Trainee and Program complies with the ACGME.

Fellows shall enter duty hours weekly to the extent practicable. The Work Hour Types used by our program are:

Call from Home (at-home call) - Called In: A call taken from outside the assigned site that requires going into the assigned site. Time in the hospital/medical center counts against the 80 hour per week limit but does not restart the clock for time off between scheduled in-house duty periods.
Call from Home (at-home call) - Not Called In: A call taken from outside the assigned site that does not require going into the assigned site.
Daily Assignment: This covers all patient care, education and research activities assigned
Moonlighting: Voluntary, compensated, medically-related work (not related to training requirements) performed internally or externally to the institution in which the resident/fellow is in training. Privileges can be revoked if you're not logging in this time.
Vacation: You must log vacation time, and should be logged M-F for a 5-day period *only.*

Oversight
The Preventive Medicine Residency follows the Institutional Policy on Duty Hours and the specific program requirements for resident duty hours and the working environment. The program coordinator reviews the duty hour dashboard weekly to ascertain if the violation is due to a scheduling error. If it is not, the coordinator reaches out to the resident to verify the error and to have the resident submit a justification to the program director.

Back-up support systems are provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create fellow fatigue sufficient to jeopardize patient care.

Duty Hour Exception
A Review Committee does not grant exceptions to the 80-hour limit to the residents work week.

Protocol for episode remaining on duty beyond scheduled hours
In unusual circumstances, preventive medicine residents on their own initiative, may remain beyond their scheduled period of duty to continue to provide care for a single patient. However, this period of time must be no longer than an additional 4 hours, according to their program's policy on duty hours. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under these circumstances, the ***resident*** must:

- appropriately hand over the care of all other patients to the team responsible for their continuing care.
- document the reasons for remaining to care for the patient in questions and submit that documentation in every circumstance to the Program Director via email.

The ***Program Director*** must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty. In all instances in which duty hour violations occur, daily emails are automatically generated and sent to the Program Director identifying such violations. The Program Director tracks these via New Innovations, examines them for trends, and discusses the violations with the resident, as well as with the service on which they are rotating. The Program Director adjusts schedules based on duty hour reports to ensure compliance with all of the requirements enumerated in the Duty Hours Policy. A back-up support systems is available when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

POLICY ON ADEQUATE REST
It is the responsibility of the program to:

1) Educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation.

2) Educate all faculty members and residents in alertness management and fatigue mitigation processes.
3) Adopt fatigue mitigation processes to manage the potential negative effects of fatigue such as on-call rooms, naps, and back-up call schedules.
4) Provide adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home (e.g. the taxi voucher program).

PGY-4 and PGY-5 residents must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have 8 hours free of duty between scheduled duty periods, there may be circumstances (required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved, events of exceptional educational value, or humanistic attention to the needs of a patient of family) when these residents must stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of duty. Circumstances of return-to-hospital activities with fewer than 8 hours away from the hospital by residents in their final years of education will be monitored by the Program Director.

6. Quality Improvement and Safety Projects (examples)

AY 2017	
Lemkin	Communication between schools and medical homes for maltreated children
Murphy	A curriculum that combines social determinants of health and QI work
Seibert	VA Work Safe with WIN (wellness is now)
Cordella	Hospital Readmissions and risk scores
Lerner	MD burnout and ordering back pain images
AY 2018	
Cordella	Hospital Readmissions and risk scores
Lerner	MD burnout and ordering back pain images
Buchheit	Public bathroom safety: preventing overdoses on BMC property
Jia	How ACOs can address sdoh
Patel	Resident Clinic workflow-Communication
AY 2019	
Buchheit	Public bathroom safety: preventing overdoses on BMC property
Rodriguez	Impact of displacement on health seeking behaviors in low-income families
Jia	How ACOs can address sdoh
Patel	Resident Clinic workflow-Communication
Rawlins-Pilgrim	PrEP in Student Health Services
Yan	chronic disease care cascades
Bovell-Ammon	Improving Patient-Provider Communication
Tori	Improving Patient-Provider Communication
AY 2020	
AY 2022	
Gonzalez	Family Medicine Resident Burnout Qualitative Study
AY 2023	
Sabharwal	Preeclampsia education video series: Improve the quality of educational material for patients with preeclampsia.

7. **Clinical Competency Committee** *Approved November 25, 2019*

Policy

Per ACGME Common Program Requirement V.A.1.c)-V.A.1.d).(3), the Preventive Medicine Residency Program has outlined the responsibilities of the Clinical Competency Committee (CCC). The purpose of the CCC is to review resident performance and make a recommendation to the Program Director for advancement to the next PGY level. The Preventive Medicine Residency CCC monitors resident performance in accordance with ACGME Common Program Requirements and the Boston Medical Center GME policies and procedures regarding promotion and dismissal.

Committee Composition

The Program Director has identified and appointed the members of the CCC which includes at least 3 members and is composed of core faculty members, representation from rotation sites, and a non-physician member. The Program Director will be on the Committee in a consultative manner to oversee the process. The Chair of the Residency CCC will be the departmental Vice Chair of Research or a similar appointee. CCC membership is for two year term and will be evaluated each academic year. The members will consist of the Executive Committee which meets on a monthly basis.

Chair: Marc LaRochelle
Non-physician member: Linda Neville
Other official members: Pablo Buitron de la Vega, Jonathan Berz, Tracy Battaglia, Sarah Kimball, Amy Linsky, Jennifer Pfau, Stephen Wilson

Committee Responsibilities

The Clinical Competency Committee will participate actively in:

1. Reviewing all resident evaluations by all evaluators semi-annually as well as the resident's learning portfolio, individual learning plan and documented assessment by the Program Director or Associate Program Director.

   Tasks:

   Program Coordinator to compile

   [] Individual Development Plan
   [] Resident clinical and other evaluations
   [] Clinical PM rotations completed (including # of sessions)
   [] Review fellow meeting attendance (fellows work in progress, academic seminar, etc.)

2. Preparing and assuring the reporting of Milestones evaluations of each resident semi-annually to ACGME.

   [] Milestone evaluations to be reviewed by the committee

3. Making recommendations to the Program Director for resident progress including promotion, remediation, and dismissal, following all BMC GME and program-specific policies.

Meeting Frequency

In order to meet the ACGME Milestone reporting deadline of May and December, the CCC will meet twice per year in November/early December and April/early May. The exact timing of the meeting may fluctuate depending on the ACGME Milestone Reporting schedule and the number of residents to be reviewed. In addition, during the monthly Executive Committee Meeting resident performance is discussed.

Meeting Documentation

The Program Coordinator will document each CCC meeting held. In addition, the CCC review and recommendation of each resident will be documented in the New Innovations residency management system.

8. Program Evaluation Committee *Approved November 25, 2019*

Policy

Per ACGME Common Program Requirement V.C., the Preventive Medicine Residency Program has outlined the responsibilities of the Program Evaluation Committee (PEC) as well as defined the process for the Annual Program Evaluation (APE). Each year the PEC reviews the mission, aims, strengths, areas for improvement & threats to the program. The PEC is expected to monitor and improve the quality and effectiveness of the training program.

Committee Composition

The committee consists of the existing executive committee of the Academic Primary Care Fellowship. This includes the Program Director, Associate Program Director(s), appropriate Section Heads and leadership and core faculty from any rotation sites, core teaching faculty and peer-selected residents from each level are also members of the PEC. Members may be rotated to and from the PEC as deemed necessary. This will be evaluated each academic year.

Meeting Frequency

The PEC will meet annually in May/June to conduct the Annual Program Evaluation (APE). The Executive Committee will track progress of the action items during their monthly meeting.

Committee Responsibilities

The Program Director will lead the PEC to actively participate in:

1. Planning, developing, implementing, and evaluating all significant activities of the residency program.
2. Developing and reviewing competency-based curriculum goals and objectives
3. Assuring that areas of non-compliance with ACGME standards are corrected
4. Reviewing the results of residents' assessments of the program together with other program evaluation results (internal and external) to improve the program
5. Reviewing, monitoring and tracking progress in each of the following areas:

    - resident performance
    - faculty development
    - graduate performance, including performance of program graduates on the certification examination
    - program quality

Data Collection for Review

In order to accomplish the Committee's responsibilities and thoroughly review all aspects of the training program, the following is data that may be used during the APE. This list is not all inclusive and should be viewed as the minimum.

Resident Performance

1. Evaluations – aggregate, program, rotation
2. Results of In-Service Exams including trends and analysis
3. Resident Scholarly Activities
5. Participation in Hospital and Departmental Patient Safety and QI projects
6. Patient evaluations by using survey provided during clinic

Faculty Development

1. CME activities
2. Didactic conferences, Participation in Journal Clubs and other Residency Activities

3. Experiential workshops
4. Participation in Hospital and Departmental QI/Patient Safety Projects
5. Practice improvement self-study

Graduate Performance

1. Board Pass rates/results
2. Alumni Surveys

Program Quality

1. Resident & Faculty Evaluations of Programs
2. ACGME Faculty & Resident Survey Results
3. Most current Program Improvement Plan
4. Last RRC Notification Letter and status of citation corrections
5. Written action plan from last APE and status of action plan
6. Programmatic concerns

Documentation of the APE

The Program Manager will document the formal, systematic evaluation of the curriculum as well as a full, written APE and action plan to document program improvement initiatives. The APE and action plan will be uploaded into the GME residency management system by July 15th of each year. The APE will be reviewed and monitored by the DIO and GME.

The Program Director will present the results of the APE for approval to the teaching faculty and will be documented in meeting minutes. The APE will also be reviewed with all residents in the program. During the monthly Executive Committee Meeting items on the action plan are reviewed and further addressed.

9. Current Action Plan

ACTION ITEM 1 AY 2023	
Date Created	6/21/2023
Action Item Name (from Citation, Concern, Survey, SWOT, APE, Other)	Faculty Evaluation
When/How did you first learn about this issue	Ongoing issue due to program size (see below). Making it a priority to re-address this year.
Actions Needed / Person Responsible	Refine current processes for trainees to evaluate faculty: 1) bi-annual anonymous evaluations by each trainee that can be released or held until there are 5 2) meet as a cohort and submit evaluations on all faculty (still a small group) Buitron de la Vega, Gonzalez, Neville
How will you measure the success of your efforts	Better feedback from trainees that we can give to faculty
How will you monitor this in the future	Percent of completed evaluations
Status / Date (Resolved, In Process, Extended)	Ongoing
ACTION ITEM 2 AY 2023	
Date Created	6/21/23
Action Item Name (from Citation, Concern, Survey, SWOT, APE, Other)	Concern: Appropriate amount of teaching in all clinical and didactic activities=50%.
When/How did you first learn about this issue	Resident Multi-Year Survey May 2023
Actions Needed / Person Responsible	The lower percentage can be attributed to the clinical rotations that are primarily designed to provide trainees with opportunities to observe how their colleagues provide healthcare to diverse communities. Consequently, the focus on teaching and didactic activities may not be as pronounced in these rotations. To address this concern, we will: • Initiate a comprehensive review of our rotations to identify areas for improvement and ensure a well-balanced approach that encompasses teaching, observation, and practical skill development. • Prior to starting the rotation, review the expectations with the trainees, including the amount of didactic teaching they can anticipate during each rotation.
How will you measure the success of your efforts	Increased score on ACGME Resident Survey
How will you monitor this in the future	ACGME Resident Survey Rotation Evaluations
Status / Date (Resolved, In Process, Extended)	New

Ongoing Action Items			
Area for Improvement	**Intervention/Initiative**	**Responsible Individual(s) and Resources**	**Follow-up/ Reassessment Method**
PMR Rotation Evaluations	- Evaluations for all rotations are assigned to be completed at the end of the rotation -Provide weekly reminders to faculty to complete their assigned evaluations. -Completion rates will be reported to and examined by the PC weekly, and if an evaluation remains incomplete after two weeks, the program director will contact the faculty member directly. -After 30 days if still incomplete, the PD will escalate the concern to the section chief for additional action.	Pablo & Linda	Track timeliness of completion of the feedback/evaluation forms during monthly Executive Committee meetings
PMR Multi-Source Evaluations	- Assign the following in NI: self-evaluation; evaluation from the research team; evaluation from clinic staff; feedback from peers at research in progress; ad-hoc evaluations. -PD will review with the resident re appropriate evaluators. -Work with the resident clinic directors to develop a process to gather this patient feedback and include it in New innovations	Pablo & Linda	Clinic staff- create QR code to do this as well for fellows to request feedback Create QR code to disseminate to pts via Qualtrics
PMR Learning Portfolio	Biannual review form with a checkbox to indicate that the resident learning portfolio was reviewed during the biannual meeting with the PD. Residents will be required to send a copy of their portfolio to the PD & PC at least one week prior to the meeting. Additionally, a copy of the portfolio will be saved in the residents electronic personnel file.	Pablo & Linda	IDP's? Update biannual review forms How do we want to capture the portfolio-modified IDP
PMR Faculty evaluations	The program continues to look for ways to improve confidential feedback to faculty from a small cohort. We want to ensure residents feel safe in reporting any concerns and are certain that their feedback is confidential. The program has instituted a new processes to the current faculty feedback process. Under the GIM fellowship umbrella (bringing the cohort to 14), one trainee will lead the group in gathering biannual feedback on all the faculty involved in the training program. That trainee will be responsible for entering the feedback anonymously into New Innovations. The program coordinator will compile the responses into one report that will remove names and any other identifying data (i.e. project names, departments etc.) to present to the Executive Committee in January and		Combine student, resident and fellows evaluations, report out by section/department Make sure the forms are the same and ask the same questions for resident med student and fellow

	July. This data will also be reviewed during the PEC meetings and is tracked on the Action Plan.		
Didactic offerings	Ensure topics fellows requested are included in either Tuesday mornings or in the new CTSI program	Linda & Leadership Team	Review at mid-year and end of year survey
Scholarship oversight committee (SOC) meetings	- Clarify instructions, including who should be at the meetings, and carefully reviewed at orientation and again in September. Include someone from a different department at the meetings or review the form after the meetings for a more global assessment - Form should be completed by all trainees no matter what track	Linda with individual mentors	Slow to be implemented with GIM & PMR
COMPLETED			
PMR Program director responsibilities:	The program has scheduled resident group meeting every other month with the program director. The purpose of these meetings will be to review schedules, get feedback on any additional learning experiences (clinical & didactic) the residents want, and for the PD to ask if there are any problems the residents are having. These meetings are in addition to the regularly scheduled every other week mentorship meeting that is scheduled with either the PD or APD.		
PMR Review evaluations	thorough review of the continuity clinic and research evaluations to ensure that they capture the specific learning objectives and expectations for the rotation, are applicable to the longitudinal experience, include an open ended comment box for the evaluator to comment on the residents progress, and include a section asking who else on the team should evaluate the resident.		
PMR Summative Evaluation	The program has updated the biannual review form to create an end of year “Summative Annual Review” form. The competencies will be updated on this form and a statement added to indicate that the resident is able to progress to the next level of training.		
PMR Semiannual evaluation process	The program acknowledges the occasional inconsistencies that occurred between the semiannual evaluation process for the preventive medicine residency and the combined internal medicine-preventive medicine residency program. The program is in the process of creating one semiannual evaluation form that will be used for all residents. The program has updated the forms to include mandatory signatures from both the resident and the program director.		

PMR Longitudinal Experience Evaluations	- Evaluations for all longitudinal experiences are assigned every 3 months -Provide weekly reminders to faculty to complete their assigned evaluations. -Completion rates will be reported to and examined by the PC weekly, and if an evaluation remains incomplete after two weeks, the program director will contact the faculty member directly. -After 30 days if still incomplete, the PD will escalate the concern to the section chief for additional action.	Pablo & Linda	Track timeliness of completion of the feedback/evaluation forms during monthly Executive Committee meetings