West Virginia University
School of Public Health

Department of Occupational and
Environmental Health Sciences

Division of Occupational Medicine

Public Health - General Preventive Medicine

Resident Physician Manual

Updated June 2020

Table of Contents

Introduction/Overview

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

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

Our two-year program tries to offer as wide a spectrum as possible given the constraints of time and geography. We strongly encourage all trainees to be active in identifying experiences specific to their own interests.

Both program years are devoted to completion of the requirements for the Master of Public Health (MPH) degree in Epidemiology. Additional experiences include clinic, didactics, exposure to research, and grand rounds.

This manual is designed to acquaint residents, faculty and preceptors with the components of the training program. Residents are expected to become familiar with the policies and procedures within.

Faculty

Program Director: Jennifer Lultschik, MD, MPH Board Certified in Occupational Medicine
Program Manager: Ms. Robin Altobello

Anna Allen, MD, MPH, Board Certified in Family Medicine and Occupational Medicine
Robert Gerbo, MD, Board Certified in Family Medicine
ChuanFang Jin, MD, MPH, Board Certified in Occupational Medicine
Chris Martin, MD, MSc, Board Certified in Occupational Medicine

Facilities

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

Occupational Medicine uses the clinical facilities of the Health and Education Building (HEB) located at 390 Birch Street on the Evansdale campus. This area consists of clinical examination rooms, staff and reception area. Residents are provided appropriate space at these locations.

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

WVU Medicine

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

National Institute for Occupational Safety and Health

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

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

Program AIMS, Mission & Goals

AIMS:

- Provide a 2 year environment for the trainee to complete an MPH in Epidemiology
- Train individuals to work with a broad range of patients to understand the overlapping spectrum of care between clinical, population health, and broader public health
- Train individuals with expertise in population health and general preventive medicine, and a commitment to serving the medically underserved populations of Appalachia and other rural areas.
- Produce excellent, independent practitioners capable of passing the ABPM certification exam, who will be local, national, and international leaders in advocating for public health programs and measures that address the health challenges facing rural and underserved populations, and who will be well prepared for further Fellowships, academic practice, and other leadership roles.

The Public Health - General Preventive Medicine Residency Program at the West Virginia University School of Public Health is designed to give physicians a firm educational foundation and sound clinical groundwork in public health and general preventive medicine in preparation for board certification and the independent practice of general preventive medicine.

Mission Statement

The West Virginia University PH-GPM Residency trains residents to become fully competent, board-certified community health strategists who adeptly apply population-based methods to promote, protect, preserve and rehabilitate the public health of our Appalachian communities with particular sensitivity to the needs and concerns of rural and underserved populations across the overlapping domains of clinical preventive medicine, population health and public health. Residents will become, to quote ACPM Board President Stephanie Zaza, experts in 'prevention, preparedness, and resiliency'. These broad areas of expertise will be addressed with particular focus on the needs of the medically underserved populations of Appalachia and other rural areas

Goals and Objectives

Medical Knowledge and Didactics

Each resident must either complete or have already completed an appropriate graduate degree. The curriculum is to include courses in epidemiology, including acute and chronic disease, biostatistics, clinical preventive services, health services management and risk/hazard control and communication.

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

OBJECTIVES:

- Describe the mission and history of public health
- Explain the roles and contributions of public health specialists with other disciplinary training
- Complete a master's level research project and presentation
- Perform descriptive and inferential statistics including stratified analysis and mathematical modeling

- Assess the health needs of a community and devise an implementation plan to address the needs identified
- Describe the nature and role of organizations that provide or pay for health services in the US
- Describe the impact of the environment on the public at large and specific environmental health hazards that may adversely impact the health of patients and the community
- Evaluate and implement appropriate preventive services, both for individuals and for populations
- Recognize and management outbreak situations, including community coordination and communication
- Understand disaster preparedness planning and response
- Communicate clearly to multiple professional and lay target groups, in both written and oral presentations, the level of risk from hazards and the rationale for and results of interventions

Patient Care and Clinical Skills

Each resident is to have a longitudinal clinical experience to learn the skills necessary to provide quality preventive clinical care, occupational health care, and connect that care to population health and public health guidelines as well as local, State, and Federal rules and regulations.

GOAL: development of clinical preventive medicine skills to provide evidence-based population health and public health screening and interventions aimed at primary, secondary, and tertiary prevention

OBJECTIVES:

- Evaluate and recognize work related diseases and injuries
- Demonstrate basic clinical procedural skills in family planning, sexually-transmitted illnesses, age-appropriate immunizations, international travel planning, and implementation of USPSTF guidelines as appropriate
- Demonstrate the overlap between clinical care, population health, and public health by following examples of reportable medical illnesses and conditions from the point of care through the local or state health departments
- Demonstrate cultural competency, professionalism, and interpersonal and communication skills with patients and clinical staff
- Participate in clinical quality improvement activities
- Participate in prevention and wellness activities at a clinical level, individually or in groups
- Understand the legal, ethical and regulatory issues in preventive medicine
- Understand medical office management (office flor, billing, compliance and contract services)
- Participate in an industrial based occupational medicine clinical medicine
- Evaluate needed occupational health services
- Understand the management an disuse resolution structure of workplaces
- Conduct walk-throughs of a workplace and identify safety and health issues
- Understand the principles of occupational wellness programs
- Understand the application of OSHA standards to the worksite

RESEARCH/SCHOLARLY ACTIVITY

Each resident will rotate through the West Virginia University School of Public Health Prevention Research Center and the Injury Control Research Center to understand possibilities for participating in or conducting research in various topics in public health.

GOAL: participation in public health or population health research and presentation of the results of that research.

OBJECTIVES:

- Learn to identify a research topic
- Develop a study design to address the question to be answered
- Interpretation of results
- Discussion of results with a variety of audiences, in both oral and written presentations
- Apply research data to everyday issues
- Evaluate quality of other research papers/studies

Government and Public Health/Systems of Care

Each resident will meet with various health-related agencies at the local through federal level and interact with other systems of care. The resident will gain an understanding of each system and how they interact as part of a greater system of disease management and health care.

GOAL: Familiarity with differing systems of care, how they interact, policy making and application of federal rules, regulation, and mandates.

OBJECTIVES:

- Recognize and manage outbreak situations, including community coordination and communication, from the clinical to the public health level.
- Understand the role of private and public partners in disaster preparedness planning and response.
- Participate in policy-making processes at the local, county, state or federal level through disaster preparedness and response or through health policy implementation and analysis.
- Understand the function and resources of the public health department.
- Experience the workers' compensation system from an insurer's perspective.

Code of Professionalism

The West Virginia University School of Public Health embraces the following Code of Professionalism amongst all students, residents, faculty and staff. This code provides the foundation for proper lifelong professional behavior. It is the expectation that this behavior will be consistently maintained at its highest level both inside and outside of the professional training environment. The nine primary areas of professionalism are defined as:

https://publichealth.wvu.edu/media/5485/gmec-professionalism.pdf

Admission to the Residency Program

Resident Eligibility and Selection *(III.A)*

Each applicant must have graduated from:

- a medical school in the US or Canada, accredited by the Liaison Committee on Medical Education (LCME)
- a college of osteopathic medicine in the US, accredited by the American Osteopathic Association (AOA), or
- a medical school outside of the US or Canada, and meeting one of the following additional qualifications:
    - hold a currently valid certificate from the Educational Commission for Foreign Medical Graduate (ECFMG)
    - hold a full and unrestricted license to practice medicine in a US licensing jurisdiction in his or her current ACGME specialty/subspecialty program

Applicants are expected to meet the uniform requirements for graduate medical education in the United States including *satisfactory completion of an **ACGME**-approved first postgraduate year or internship (PGY-1) involving direct patient care*. Applicants who have completed training in a clinical discipline, such as internal medicine or family practice are given priority. International medical graduates are expected to meet standard English fluency tests as well as uniform requirements for IMG's. The requirement of the certifying board for an ACGME-approved clinical year should be borne in mind by applicants from international medical schools. **All residents enter at the PGY-2 level.**

Candidates already possessing an MPH or equivalent degree are given credit for this and will still be required to complete the two-year residency program.

Applications and supporting documentation (for July admissions) should be submitted by August prior year. Offers for admittance are made mid-January.

Funding for the training of residents in occupational medicine is made possible through a grant from the Health Resources and Services Administration (HRSA).

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

Admission Policies and Procedures

Purpose

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

Procedures

1. All applicants are asked to complete the ERAS application form on line.
2. Faculty may discuss the program with prospective residents prior to application review.

3. Applications will be reviewed as they are submitted to the residency director. Applicants who fail to conform to ACGME training and WV medical license requirements will be rejected. Other applicants will be considered, and interviews will be scheduled. *The program does not support applicant travel.*
4. Following an interview, the faculty will evaluate each applicant according to these criteria:
    a. Conformity with ACGME requirements.
    b. Passing scores on USMLE Steps 1, 2, 3.
    c. Eligibility for WV medical licensure.
    d. Evidence of clinical competency.
    e. Special skills or experience of significance to public health
    f. Additional graduate studies.
    g. Communication skills and professional ethics and mannerisms.
    h. Reasonable expectations and a professional direction, if not specific objective.
    i. Willingness to travel to practicum sites.
5. Final selection of residents will be made in or after January of the preceding year.
6. Residents are accepted by a collective decision process which considers current resident opinions in addition to those of the faculty.
7. **All residents enter at the PGY-2 level**

Recruitment Policy

https://publichealth.wvu.edu/media/5488/gmec-resident-recruitment-and-selection.pdf

West Virginia Medical Licensure

As of July 2019, ALL residents in training programs sponsored by the West Virginia University School of Public Health must hold at all times during their training *either* a valid educational training permit or a valid unrestricted license by either the West Virginia Board of Medicine or the West Virginia Osteopathic Board of Medicine. You are eligible for an educational permit if you meet the educational eligibility requirements by:

a. Having graduated from an allopathic medical school approved by the LCME;
b. Having graduated from a medical college that meets the requirements for ECFMG certification; or
c. Having completed an alternative pathway for initial entry or transfer requirements by the ACGME;

It is the trainee's responsibility to request the initial permit or license from the appropriate board of medicine and to annually renew this authorization during their training. Should the resident fail to obtain or renew the appropriate authorization from the appropriate board of medicine the resident will be immediately suspended from all duties and failure to renew the appropriate authorization to practice medicine in a timely manner may result in termination from the training program.

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

For more information:

https://wvbom.wv.gov/

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

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

For More information:

https://www.wvbdosteo.org/

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

Salary and Benefits

Resident Salaries

Academic Year 2020-21

PGY-2 $56,292
PGY-3 $58,109

Residents are paid every two weeks (in arrears). Direct deposit is mandatory.

Health Insurance

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

Disability Insurance

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

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

Procedure for Requesting Leave

Annual leave requests without the required advance notice may not be approved. Coverage for patient care and other obligations must be adequately arranged for by the resident ***and*** communicated to the Program Manager and/or Program Director.

Annual Leave

Preventive Medicine residents follow the leave guidelines of West Virginia University to ensure their safety and general welfare. Residents will accrue two (2) days of annual leave per month. A day in the leave system is equal to 7.5 hours. **Annual leave must be accrued prior to using it.** Annual leave time caps at 24 accrued days which will appear in the leave system as 180 hours. Once you accrue 24 days, you will stop accruing annual leave.

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

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

Annual leave will be granted on a "first come, first served" basis and is determined by the total number of Department providers present during the time period requested. All annual leave must be approved, in advance, by the Program Manager. The Program Manager and/or Director has the right to deny annual leave at the requested time. The amount of time that can be missed on any one rotation is limited by the educational goals of the rotation. Only 1 week of annual leave may be taken on single month rotations, and only 2 weeks of annual leave may be taken on 2-month rotations. Additional weeks may be taken on multi-month rotations, however no block of time greater than 2 weeks may be granted, and only one week of annual leave time may be used in any one calendar month. Extended annual leave or combining annual leave with meetings is discouraged due to prolonged absence from the program. Such requests require special approval from the Program Director and must fall within the requirements of the ACGME and the applicable Board.

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

A resident does not have the option of reducing the time required for the residency by forgoing annual leave.

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

Sick Leave

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

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

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

Continuing Medical Education Leave

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

Leave of Absence

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

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

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

Grievance, Witness and Jury Leave

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

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

Holidays

The Program Manager will assist in scheduling and coordination of available holiday time.

If you are on a service where physicians observe a state holiday, you will not be required to work on that holiday. As professionals, you are exempt from overtime or compensatory time, therefore, if a service requires you to work on a state holiday, you will not be compensated additional amounts for that worked holiday.

Inclement Weather

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

The Occupational Medicine clinic is open Monday - Thursday: 8:00 – 5:00 pm and Friday's: 8:00 – 12:00 pm

- If clinic has been cancelled, you will be notified by phone/text message
- If you cannot make it to clinic, or if you are going to be late, it is your responsibility to contact clinic ASAP: please text Dr. Gerbo, Ms. Julie O'Neil and Robin Altobello

WVU Classes: Classes are *rarely* cancelled. It is your responsibility to inform your instructor if you will not be attending class.

Lab Coats

Two lab coats will be issued to the resident at the beginning of training. Laundry service for resident training is provided free of charge.

Parking

Residents will receive a parking pass and a designated parking lot is reserved for all residents. The Security office is located in the hospital on the 4th floor.

Expenses

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

Additional WVU Benefits

- Athletic and Cultural events
- Library Privileges

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

Malpractice Insurance

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

BASIC LIFE SUPPORT (BLS)

Statement of need and purpose

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

State of General Principles and Rules

Residents will maintain certification in advanced life support through BLS. Renewal of certification is required at least every two years. *ACLS is not required for this program, but can be maintained if desired.

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

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

Residents must maintain BLS certification during their program.

Procedure

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

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

A. If certification expires, the Program Manager will notify the resident and the program manager. The resident shall have 30 days in order to renew his/her certification.
B. If certification is not obtained within 30 days after the expiration date, patient care activities will be suspended and the resident will be referred to the Program Director for any further action.

Educational Program

PGY2, PGY3 (GPM-1, GPM-2): Academics and Didactics

The academic phase is based in the School of Public Health, West Virginia University, chaired by Dean Jeff Coben, MD. The Master in Public Health (MPH) program was designed with the needs of both preventive medicine trainees and public health professionals in mind.

It serves the public health training needs of West Virginia and the surrounding region, and has pioneered distance learning techniques to reach public health professionals throughout the state. It admitted its first class in 1996, and now has full accreditation status by the Council on Education in Public Health (CEPH).

Residents in general preventive medicine receive tuition support to obtain the academic coursework towards a Master of Public Health (MPH) degree. All residents in the academic phase enroll in the on-campus MPH degree, Epidemiology track.

Residents are required to complete all MPH coursework to satisfactorily complete the residency and to sit for board certification examination by the American Board of Preventive Medicine (ABPM). Additional or alternative courses may be taken with approval of the Program Director. By the conclusion of training, the resident will, through academics (and didactics):

- Apply principles and methods of biostatistics and epidemiology effectively
- Plan, administer, and evaluate health systems and medical programs
- Recognize, assess, and control environmental and occupational health hazards
- Address social, cultural and behavioral factors influencing individual and public health
- Implement primary, secondary, and tertiary prevention for assessed needs
- Identify and counter disease and injury threats related to military service

- Communicate clearly to multiple professional and lay target groups, in both written and oral presentations, the level of risk from hazards and the rationale for and results of interventions

Suggested Plan of Study		
FALL Semester	**Course**	**Hours**
Leadership and Advocacy in PH Practice	PUBH 640 (F)	3
Contemporary Foundations of Public Health Practice	PUBH 610 (F)	2
Research Translation and Evaluation in PH Practice	PUBH 612 (F)	4
Systems Thinking in Public Health Practice	PUBH 641 (F)	3
Epidemiology for PH Practice	PUBH 611 (F)	2
Data Management and Reporting	BIOS 611 (M)	3
SPRING Semester		
Graduate Seminar	PUBH 696 (F)	1
PH Prevention and Intervention	PUBH 621 (F)	3
Community Engagement & Advocacy in Public Health	SBHS 617 (M)	2
Applied Epidemiology of Public Health	EPID 611 (M)	3
Building and Sustaining PH Capacity	PUBH 620 (F)	2
SUMMER		
MPH Field Practicum	PUBH 630 (F)	1
Intro to Global Medicine (Module 1)	PUBH 605 (E)	4
Public Mental Health	PUBH 693B (E)	3
FALL Semester		
Applied EPI for Public Health	EPID 612 (M)	3
Geospatial Modeling	RESM 540 (E)	3
MPH Field Practice	PUBH 630 (F)	3
SPRING Semester		
Epidemiology Capstone	EPID 629 (M)	2

**** Schedule subject to change**.

For more information:

http://catalog.wvu.edu/graduate/publichealth/

PGY2, PGY3 (GPM-1, GPM-2): Practicum

The PH-GPM program is designed for residents to assume progressive authority and responsibility both within rotations and throughout the two years of training. Residents are overseen by faculty on site and their performance is reviewed quarterly by the Program Director. The resident will be closely supervised throughout the program with end-of-rotation faculty evaluations, resident feedback at each rotation, patient feedback (when appropriate) for clinical rotations, and review and recommendations of the Clinical Competency Committee (CCC). Academic progress will be measured by the MPH

course evaluations and grades. The ACPM in-service examinations at the beginning of the GPM-1 and GPM-2 years will serve as another means to assess knowledge base and progression. During quarterly evaluations, the Program Director will review the milestones and progress made through all evaluations described above. Based on these evaluations, the resident will receive a letter outlining progress made to date, areas of improvement required, and direction for the next 3 month period with expectations for advancing in milestones, knowledge, responsibility, and authority. The resident will gain foundational knowledge in public health and general preventive medicine that will progress from the GPM-1 year to apply in the GPM-2 year.

For example, experience in the OM clinic (GPM-1) is progressive. Initially, residents are expected to discuss each patient with the attending before the patient is permitted to leave. As the resident gains skill, they are allowed to dismiss patients for fit-for-duty evaluations which are entirely normal and discuss them with the attending later during the clinic. For treatment and exposure assessment patients, while the attending physician must see and examine each patient before they leave, initially the attending will repeat much of the history and examination and will provide most of the communications to the patient. As the resident gains skill, the attending physician will still meet the patient, but the resident will be relied upon for the history, examination, assessment plan, and ultimately all communications with the patient and the insurance carrier.

In another example, experience in the Harrison-Clarksburg Health Department rotation (GPM-2), which includes clinical and non-clinical experiences, is a progressive rotation that takes the various outpatient clinical experiences gained in the OM clinic, the Student Health Services Clinic, and the Cabin Creek Health Systems (CCHS) clinics and culminates in a supervised, acting health officer role which will closely simulate the leadership, authority, responsibility, and conditional independence that serves as a key experience in determining the resident's ability to perform the work of an independent practitioner once they have completed the program. The idea is to simulate the role of a community health strategist as outlined in the Health and Human Services (HHS) Public Health 3.0 model. A health officer is expected to have a broad foundational knowledge of public health and preventive medicine, experience as a competent clinician within the scope of a preventive medicine physician, an understanding of the systems of care and the overlapping roles of primary care/clinical medicine, population health, and public health. A health officer is also expected to display professionalism, interpersonal and communication skills, understand and utilize practice-based learning and improvement.

Rotations are listed in Appendix A

Curriculum Organization and Resident Experiences *(IV.A.6)*

Resident education must take place in settings where decisions about the health of defined populations are routinely made and where analyses and policies affecting the health of these individuals are under active study and development.
IV.A.6.d).

Residents must have a minimum of two months of direct patient care experience during each year of the program. *IV.A.6.d).(2)*

Residents must have a minimum of two months (or equivalent) experience at a governmental public health agency. *V.A.6.d).(4)*

The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.*IV.B.1.*

Residents should participate in scholarly activity *IV.B.2.* The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. *IV.B.3.*

Promotion

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

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

Academic or PGY-2 Level

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

1. Successful completion of the MPH curriculum according to criteria established by the MPH degree program. *Each resident will be responsible for seeing that the Program Manager is sent a transcript of coursework and grades at the end of each semester.
2. Satisfactory quarterly reviews.

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

- Clinical Activity**:** Residents must have a minimum of *two months of direct patient care experience during each year of the program* under the direct supervision of the physician staff.
- Preventive Medicine departmental lectures, including participating in learning activities related to the current recommendations of the US Preventive Services Task Force

- Other activities, including didactics, journal club, case presentation seminars, and research seminars.

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

- Residents not completing up to one-MPH course (incomplete grade) may begin practicum training at discretion of the Program Director, provided a concrete and mutually acceptable plan is presented. No credit will be given for practicum training until all MPH coursework is complete.

Practicum or PGY-3 Level

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

1. Minimum of two months of direct patient care experience during each year of the program
2. Minimum of two months (ore equivalent) experience at a governmental public health agency
2. Satisfactory completion of the MPH practicum and all MPH requirements.
3. Satisfactory evaluation from preceptors of the practicum rotations.
4. Satisfactory completion of expected competencies in preventive medicine. These are established by agreement with practicum rotation preceptors and will be outlined with the resident at the commencement of each practicum rotation. It is expected that each resident will fulfill all of the general categories of competency, although specific skills may vary between residents and between practicum sites.

Conditions for reappointment/Non-renewal of appointment or non-promotion

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

programs provide the resident(s) with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the agreement.

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

https://publichealth.wvu.edu/media/5486/gmec-promotion-and-or-appt-renewal.pdf

Dismissal/Termination

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

https://publichealth.wvu.edu/residents/resident-resources-manuals/

Residency Completion

Residents will be given notification of completion of training through a certificate, which may be used for board application purposes. (see ABPM Board Certification Requirements)

https://publichealth.wvu.edu/residents/resident-resources-manuals/

Board Certification Requirements
American Board of Preventive Medicine (ABPM)

Overview

Preventive medicine focuses on the health of workers, including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures. Practitioners in this field address the promotion of health in the workplace, and the prevention and management of occupational and environmental injury, illness, and disability.

General Requirements

- **Medical License** – An unrestricted and currently valid license(s) to practice medicine in a State, the District of Columbia, a Territory, Commonwealth, or possession of the United States

or in a Province of Canada is required. If the applicant has licenses in multiple states, no license may be restricted, revoked, or suspended or currently under such notice.

- **Medical Degree** – Graduation from a medical school in the United States which at the time of the applicant's graduation was accredited by the Liaison Committee on Medical Education, a school of osteopathic medicine approved by the American Osteopathic Association, an accredited medical school in Canada, or from a medical school located outside the United States and Canada that is deemed satisfactory to the Board is required.
- **Graduate Coursework** – At least 15 total equivalent hours of graduate level courses are required in the core coursework areas of biostatistics, epidemiology, social and behavioral sciences, health services administration and environmental health sciences. The minimum 15 credit hours of coursework should appropriately reflect the 5 content areas listed above to ensure applicants are well grounded in foundational public health knowledge and should be graduate level courses. Courses that may include multiple content areas must meet the equivalent academic requirements and content of the traditional individual courses. Undergraduate courses and course work in medical school will not be considered to meet these requirements.

For More Information:
https://www.theabpm.org/

Schedules

The Program Manager will work with the residents to coordinate a monthly schedule. Residents must have a minimum of two months of direct patient care experience during each year of the program. Clinics, rotations and conferences are planned around the MPH course schedule.

Preventive Medicine Grand Rounds – Didactics

Residents, faculty, interested staff and invited guests attend preventive medicine grand rounds and didactics. The purpose of the grand round lecture is to address scientific issues of concern to the practice of preventive/occupational medicine and to supplement the didactic component of the residency practicum.

Lectures also offer an opportunity for preceptors at participating sites, hospital faculty and residents to become acquainted and to facilitate scientific learning and interchange. The WVU Office of CME designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit(s)* ™.

All residents are required to attend grand rounds and didactics except when outside rotations prohibits their travel or when on vacation and/or sick.

As scheduling permits, residents are encouraged to attend the NIOSH Respiratory Health Division (RHD) seminars held on Wednesdays at 10:30 a.m. Residents are forwarded topic announcements each week via email.

Journal Club

Journal Club is conducted monthly by the residents on a rotating basis.

Learning and Working Environment

Patient Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. Both residents and faculty participate in patient safety systems and contribute to a culture of safety (i.e. hospital committees)

Quality Improvement

Residents will have the opportunity to participate in inter-professional quality improvement activities.

Supervision and Accountability

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

Direct Supervision - physically present during patient encounters

Indirect Supervision:

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

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

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

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

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

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

a. Academic Year, PGY-2

General Preventive Medicine residents are assigned to specific clinics throughout the two-year program. While in these clinics, residents are under the direct supervision of the faculty physician specifically designated in the clinic schedule. Each faculty physician supervises no more than two residents in clinic and no more than three residents are scheduled in clinic at any one time. Using the electronic medical record (EMR), all resident notes are directed to the supervising faculty physician for review and co-signature before encounters are closed. Senior residents do not supervise junior residents. The Program Director will provide feedback and formative evaluations concerning resident performances at 3-month intervals.

While enrolled in the MPH degree, each resident is indirectly supervised by the Program Director. Direct supervision is not necessary; however, residents are expected to report any departure from class schedule in advance.

b. Practicum Year, PGY-3

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

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

3. The program will have methods for providing continuous evaluation of residents. This shall include, but not limited to, oral and written evaluations and chart audits. Written evaluations will be submitted by practicum preceptors at the end of every rotation. Reviews with the Program Director will be conducted quarterly, and a formative evaluation made in writing. These will be placed in the resident file. The trainee shall have access to this information. *(V.A.2b)*

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

5. It is the goal and responsibility of the trainee to continuously demonstrate progress towards acceptance of the responsibility for provision of health care. It is the role of the faculty/preceptor to accept these responsibilities and provide appropriate training to meet these goals. Toward this end, a list of expected competencies in public health – general preventive medicine (Appendix B) will be provided to the residents on commencement training.

An initial evaluative session between the resident and the Program Director will be held at the start of the residency in order to identify strengths and areas in which the resident could benefit from specifically directed training. The faculty/preceptor will be apprised in advance of the competencies that are expected of the residents at the completion of each rotation, usually through obtaining a copy of the rotation agreement.

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

Resident Forum

A resident forum will be conducted on a quarterly basis. Any resident from the program(s) will have the opportunity to directly raise a concern to the forum. Residents also have the option, at least in part, to conduct their forum without the DIO, faculty members or other administrators present. Residents will have the option to present concerns that arise from discussions to the DIO and GMEC.

Dress Code

ID Badges must be worn at all times. Employee name and picture must be visible. Hair should be kept neat and clean and pulled back if necessary.

Light-scented cologne, perfume, lotion, or aftershave is permitted.

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

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

- **Office/Didactics/MPH Classes**: Business casual; khakis or pants, casual button-down shirt, open-collar or polo shirt; loafers or loafer-style shoes
  - NO t-shirts, shorts, jeans or flip-flops/open-toed sandals

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

Cell Phones

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

Lactation Network

The WVU Lactation Network is a list of locations that faculty, staff, and students may access to express breast milk.

https://advance.wvu.edu/services/lactation-network

Well Being

Fatigue Mitigation

Residents do not work nights or weekends in clinics, although most MPH courses are scheduled for the late afternoon/early evening.

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

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

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

If a resident perceives that they are too fatigued or stressed to work, they should immediately notify their supervising attending and the program director/program manager.

A suitable arrangement will be made based on the individual situation. If a resident feels they are unable to drive they should ask for a ride from a co-worker, or taxi vouchers are available at the Emergency Room check-in desk for a taxi ride home.

Transitions of Care

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider (ACGME, CPR, VI.B.5.)

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

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

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

All patient visits are completed by the same provider(s) who started the visit. All clinic notes are constructed with sufficient detail to allow for follow-up by another provider if necessary. The potential

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

Interservice transitions of care are extremely infrequent, but may occur when a patient requires evaluation or treatment beyond the capabilities of the OM clinic for continued care. Examples would include patients with fracture(s) requiring orthopedic care or cardiovascular instability requiring evaluation in the Emergency Department. It is expected that the transfer will be done verbally with the receiving service. The resident is expected to contact a senior resident on the receiving service and provide them with all necessary medical information.

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

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

Clinical and Educational Work Hours

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

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

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

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

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

In any situation in which a resident believes he/she is being asked or expected to work in a manner, which is in conflict with the ACGME regulations, the resident is expected to bring this situation to the attention of the attending of the rotation. The attending will assess the situation and either state that he/she believes the situation is not a work hour violation, or provide coverage for the resident's

patients to avoid a conflict. If the resident does not believe the matter is resolved, they should contact the Program Director or Program Manager.

- Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)
- The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
- Residents should have eight hours off between scheduled clinical work and education periods. (Detail)
- Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)
- Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.
- Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
- Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core
- In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; (Detail) VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, (Detail) VI.F.4.a).(3) to attend unique educational events. (Detail)
- These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)
- A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

Moonlighting

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

Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

Residency training is a full-time commitment. Moonlighting is allowed only if it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety. Nevertheless, it is recognized that for some residents it is an economic necessity.

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

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

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

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

Practitioners Health

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

- Assistance, Guidance and Support
- Confidentiality for "voluntary" participants
- Initial Assessments
- Interventions
- Assist with referrals for Evaluation and/or Treatment
- Multi-year Recovery Contract
- Case Management
- ADVOCACY with Regulatory agencies and hospitals
- Consultations for clinics, hospitals and other healthcare facilities
- **http://www.wvmphp.org/**

Finding Balance in a Medical Life (book review)
http://www.wvmphp.org/Finding_Balance..._-Book_review-P_Bradley_Hall_MD.pdf

Workplace Stress and the Healthcare Provider (article)
http://www.wvmphp.org/WVAPA_Bulletin_-Workplace_Stress_and_the_Healthcare_Provider.pdf

Physician Suicide (article) http://www.wvmphp.org/Selby-PhysSuicide_WVSMA_article.pdf

International Travel

https://wvuabroad.wvu.edu/index.cfm?FuseAction=Security.LoginWizardStepOne

Appendix A

Participating Sites

Below is a list of current rotation sites. You will receive a binder outlining all goals/objectives for each site. *Sites are subject to change.

Required:

1. Medical Weight Management, WVU, Morgantown, WV
2. Harrison County Health Department, Clarksburg, WV
3. Adolescent Ambulatory Medicine, WVU, Morgantown, WV
4. Student Health, WVU, Morgantown, WV
5. Cabin Creek Health Systems, Cabin Creek, WV
6. Bureau for Public Health, Charleston, WV

Electives:

1. General Ambulatory – Pediatrics, WVU, Morgantown, WV
2. Diabetes Education Clinic, WVU, Morgantown, WV
3. Urgent Care, WVU, Morgantown or Fairmont, WV
4. WV Poison Center, Charleston, WV
5. Environmental Health & Safety, WVUH, Morgantown, WV
6. Population Health, WVU, Morgantown, WV
7. WVU Infectious Disease, WVU, Morgantown, WV
8. Louis A Johnson VA Medical Center, Clarksburg, WV

Appendix B

Competencies

The Public Health - General Preventive Medicine Residency Program at West Virginia University School of Public Health is a two-year program designed to meet the requirements for board certification in General Preventive Medicine by the American Board of Preventive Medicine (ABPM) (**https://www.theabpm.org/**)

The academic and practicum phases of training are provided concurrently. Residents complete coursework over the two-year program to satisfy the requirements for a Master of Public Health (MPH) degree and participate in the clinical rotations at WVU in Morgantown, WV. During the second year, they continue the academic, didactive and practicum experiences in Charleston, WV. *In the event you have already completed an MPH, you will still be required to complete a two-year program.*

Residents are expected to develop specific competencies to satisfactorily complete the program.

Patient Care and Procedural Skills

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

- Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core) IV.B.1.b).(1).(a) If the
- prerequisite clinical education is integrated into a 36-month preventive medicine residency program, residents must demonstrate competence in: IV.B.1.b).(1).(a).(i) obtaining a comprehensive medical history; (Core) IV.B.1.b).(1).(a).(ii) performing a comprehensive physical examination
- assessing a patient's medical conditions; (Core) IV.B.1.b).(1).(a).(iv) making appropriate use of diagnostic studies and tests; (Core) IV.B.1.b).(1).(a).(v) integrating information to develop a differential diagnosis; and, (Core) IV.B.1.b).(1).(a).(vi) developing, implementing, and evaluating a treatment plan. (Core)
- Residents must demonstrate competence in the following, regardless of their specialty area:
- assessing and responding to individual and population risks for common occupational and environmental disorders; (Core) IV.B.1.b).(1).(b).(ii) conducting research for innovative solutions to health problems; (Core) IV.B.1.b).(1).(b).(iii) diagnosing and investigating medical problems and medical hazards in the community; (Core) IV.B.1.b).(1).(b).(iv) directing individuals to needed personal health services; (Core) IV.B.1.b).(1).(b).(v) informing and educating populations about health threats and risks; (Core) IV.B.1.b).(1).(b).(vi) planning and evaluating the medical portion of emergency preparedness programs and training exercises; (Core) IV.B.1.b).(1).(b).(vii) providing clinical preventive medicine services, including the ability to: (Core)
- diagnose and treat medical problems and chronic conditions for both individuals and populations; (Core) IV.B.1.b).(1).(b).(vii).(b) apply primary, secondary, and tertiary preventive approaches to individual and population-based disease prevention and health promotion; and, (Core)
- evaluate the effectiveness of clinical preventive services for both individuals and populations. (Core) IV.B.1.b).(1).(b).(viii) developing policies and plans to support individual and community health efforts.

public health practice, including the ability to: (Core) IV.B.1.b).(1).(e).(i).(a) develop plans to reduce the exposure to risk factors for an illness or condition in a population; and, (Core) IV.B.1.b).(1).(e).(i).(b) recognize and respond to a disease outbreak, involving individual patients and populations. (Core)

- clinical preventive medicine, including the ability to: (Core) IV.B.1.b).(1).(e).(ii).(a) analyze evidence regarding the performance of proposed clinical preventive services for individuals and populations; (Core) IV.B.1.b).(1).(e).(ii).(b) recommend immunizations, chemoprophylaxis, and screening tests to individuals and appropriate populations; and, (Core) IV.B.1.b).(1).(e).(ii).(c) select appropriate, evidence-based, clinical preventive services for individuals and populations. (Core)
- Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

Medical Knowledge

ACGME defines medical knowledge as demonstrating knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

- Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and socialbehavioral sciences, as well as the application of this knowledge to patient care. (Core) IV.B.1.c).(1) Residents must demonstrate competence in their knowledge of all content areas included in the required graduate courses for completion of the program. (Core) IV.B.1.c).(2) Residents must demonstrate competence in their knowledge of factors that impact the health of individuals and populations, including: IV.B.1.c).(2).(a) lifestyle management; and, (Core) IV.B.1.c).(2).(b) social determinants of health. (Core)
- Residents must demonstrate competence in their knowledge of the use of available technology, such as telemedicine, to reduce health disparities. (Core)
- For programs with a concentration in public health and general preventive medicine, residents must demonstrate competence in their knowledge of principles of: IV.B.1.c).(6).(a) application of biostatistics; (Core) IV.B.1.c).(6).(b) applied epidemiology, including acute and chronic disease; (Core) IV.B.1.c).(6).(c) clinical preventive services; (Core) IV.B.1.c).(6).(d) health services management; and, (Core) IV.B.1.c).(6).(e) risk/hazard control and communication. (Core)

Practice Based Learning and Improvement

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

- 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. (Core)
- Residents must demonstrate competence in: IV.B.1.d).(1).(a) identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core) IV.B.1.d).(1).(b) setting learning and improvement goals; (Core) IV.B.1.d).(1).(c) identifying and performing appropriate learning activities; (Core) IV.B.1.d).(1).(d) systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement; (Core) IV.B.1.d).(1).(e) incorporating feedback and formative evaluation into daily practice; (Core) IV.B.1.d).(1).(f) locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; (Core) IV.B.1.d).(1).(g) using information technology to optimize learning; (Core) IV.B.1.d).(1).(h) using information technology for reference retrieval, statistical analysis, graphic display, database management, and communication; (Core) IV.B.1.d).(1).(i) using epidemiologic principles and biostatistics methods, including the ability to: (Core) IV.B.1.d).(1).(i).(i) characterize the health

- of a community; (Core) IV.B.1.d).(1).(i).(ii) conduct a virtual or actual outbreak or cluster investigation; (Core) Preventive Medicine ©2020 Accreditation Council for Graduate Medical Education (ACGME) Page 28 of 64 IV.B.1.d).(1).(i).(iii) evaluate a surveillance system and interpret, monitor, and act on surveillance data for prevention of disease and injury in workplaces and populations; (Core) IV.B.1.d).(1).(i).(iv) measure, organize, or improve a public health service; (Core) IV.B.1.d).(1).(i).(v) select and conduct appropriate statistical analyses; and, (Core) IV.B.1.d).(1).(i).(vi) translate epidemiologic findings into a recommendation for a specific intervention. (Core) IV.B.1.d).(1).(j) designing and conducting an epidemiologic study; and, (Core) IV.B.1.d).(1).(k) conducting an advanced literature search for research on a preventive medicine topic. (Core)

Interpersonal and Communications Skills

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

- Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core) IV.B.1.e).(1) Residents must demonstrate competence in: 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; (Core) IV.B.1.e).(1).(b) communicating effectively with physicians, other health professionals, and health-related agencies; (Core) IV.B.1.e).(1).(c) working effectively as a member or leader of a health care team or other professional group; (Core) IV.B.1.e).(1).(d) educating patients, families, students, residents, and other health professionals; (Core) IV.B.1.e).(1).(e) acting in a consultative role to other physicians and health professionals; and, (Core) Preventive Medicine ©2020 Accreditation Council for Graduate Medical Education (ACGME) Page 29 of 64 IV.B.1.e).(1).(f) maintaining comprehensive, timely, and legible medical records, if applicable. (C
- Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.

Professionalism

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

- Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.
- Residents must demonstrate competence in: IV.B.1.a).(1).(a) compassion, integrity, and respect for others; (Core) IV.B.1.a).(1).(b) responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy; (Core) IV.B.1.a).(1).(d) accountability to patients, society, and the profession; (Core) IV.B.1.a).(1).(e) respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core) IV.B.1.a).(1).(f) ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core) IV.B.1.a).(1).(g) appropriately disclosing and addressing conflict or duality of interest. (Core)
- For programs with a concentration in public health and general preventive medicine, residents must demonstrate competence in counseling individuals regarding the appropriate use of clinical preventive services and health promoting behavior changes, and providing immunizations, chemoprophylaxis, and screening services, as appropriate.

Systems Based Practice

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

- Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core) Preventive Medicine ©2020 Accreditation Council for Graduate Medical Education (ACGME) Page 30 of 64 IV.B.1.f).(1) Residents must demonstrate competence in: IV.B.1.f).(1).(a) working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)
- coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Co
- advocating for quality patient care and optimal patient care systems; (Core) IV.B.1.f).(1).(d) working in interprofessional teams to enhance patient safety and improve patient care quality; (Core) IV.B.1.f).(1).(e) participating in identifying system errors and implementing potential systems solutions; (Core) IV.B.1.f).(1).(f) incorporating considerations of value, cost awareness, delivery and payment, and riskbenefit analysis in patient and/or populationbased care as appropriate; and, (Core) IV.B.1.f).(1).(g) understanding health care finances and its impact on individual patients' health decisions. (Core) IV.B.1.f).(1).(h) engaging with community partnerships to identify and solve health problems; (Core) IV.B.1.f).(1).(i) conducting program and needs assessments, and prioritizing activities using objective, measurable criteria, including epidemiologic impact and costeffectiveness; (Core) IV.B.1.f).(1).(j) identifying and review laws and regulations relevant to the resident's specialty area and assignments;
- identifying organizational decision-making structures, stakeholders, styles, and processes; (Core) IV.B.1.f).(1).(l) demonstrating skills in management and administration, including the ability to: (Core) IV.B.1.f).(1).(l).(i) assess data and formulate policy for a given health issue; (Core) IV.B.1.f).(1).(l).(ii) assess the human and financial resources for the operation of a program or project; (Core) IV.B.1.f).(1).(l).(iii) apply and use management information systems; and, (Core) IV.B.1.f).(1).(l).(iv) plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems. (Core) IV.B.1.f).(1).(m) analyzing policy options for their health impact and economic costs; and, (Core) IV.B.1.f).(1).(n) participating in the evaluation of applicants and the performance of staff, and understand the legal and ethical use of this information in decisions for hiring, managing, and discharging staff. (Core) IV.B.1.f).(2) Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, endof-life goals. (Core)

Appendix C

Milestones

General Preventive Medicine Milestones

https://www.acgme.org/Portals/0/PDFs/Milestones/PreventiveMedicineMilestones-PublicHealthandGeneralPreventiveMedicine.pdf?ver=2016-03-13-093616-740

Milestones Guidebook for Residents and Fellows

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

Appendix D

Evaluations

1. An initial evaluative session between the resident and the Program Director will be held at the start of their residency in order to identify strengths and areas in which the resident could benefit from specially directed training.

2. All residents will meet quarterly with the Program Director. A formative evaluation is written detailing the discussion and a copy kept in the resident's file.

3. At the end of each rotation, the preceptor will evaluate the resident on the basis of acquired knowledge and skills as demonstrated while the resident will provide an evaluation of the rotation regarding strengths and weaknesses and recommendations for modifications or enhancements. All rotation evaluations will be discussed and signed by both resident and Residency Director. Originals are kept in the residents file and uploaded into e-Value resident portfolio.

4. All residents will evaluate and/or be evaluated, annually, (random) patients, staff members, peer and self.

5.. Annually, there will be a summative evaluation of each resident that includes their readiness to progress to the next year of the program.

6. All assigned evaluations are expected to be completed in a timely manner. The ACGME defines "timely" as within two weeks of assignments.

7. All residents and faculty members will be asked to complete an annual program evaluation. Evaluations will be discussed during the annual program review of the residency program.

8. Confidentiality will be maintained. Residents have access to his/her academic file and evaluations at all times.

Faculty Evaluations

1. Annually, the residents will evaluate faculty performance, as it relates to the educational program.

2. These evaluations will include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

Clinical Competency Committee (CCC)

The Clinical Competency Committee (CCC) is appointed by the program director and will meet semi-annually to review all resident evaluations to determine each resident's growth on achievement of the Milestones and advise the program director regarding each resident's progress.

Program Evaluation Committee (PEC)

The Program Evaluation Committee (PEC) is appointed by the program director to conduct and document the Annual Program Evaluation (APE) as part of the program's continuous improvement process. The committee acts as an advisor to the program director, through program oversight, reviews the program's goals and objectives and progress toward meeting them and helps to identify program strengths, challenges, opportunities and threats as related to the mission and goals.

Appendix E

Selected References in Occupational and Preventive Medicine

Preventive Medicine

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

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

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

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

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

Occupational Medicine

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

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

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

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

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

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

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

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

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

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

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

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

Recommended Journals

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

Journal of Occupational and Environmental Medicine

The American Journal of Industrial Medicine

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

Scandinavian Journal of Work, Environment & Health

Archives of Environmental Health

American Journal of Public Health

American Journal of Preventive Medicine

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

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

Electronic Literature Access

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

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

Appendix F

Policies

All other policies can be viewed at our website

https://publichealth.wvu.edu/residents/resident-resources-manuals/

Substance Abuse

WVUH Policy V.231 (Effective 04/18/90; Revised 6-9-17)

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

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

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

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

2. Physicians, dentists, and UHA allied health providers credentialed by the Medical Staff Affairs Office will require consultation with the Physician Health Committee immediately for all suspected cases of drug or alcohol abuse.

3. Any suspected problem shall be immediately reported to the Service Chief, Chief-of-Staff, Administrator, Manager/Director, Human Resources, or Hospital Administration. The individual will be removed from patient care responsibilities pending further investigation.

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

PHYSICIAN HEALTH COMMITTEE

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

TESTING

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

APPLICATION

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

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

DISCIPLINE POLICY

DISCIPLINARY PROCEDURE

PURPOSE:

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

WHO IS COVERED BY THESE PROCEDURES:

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

COUNSELING:

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

DISCIPLINARY ACTION:

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

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

Disciplinary action may be taken whenever the behavior of an employee violates a statute, rule, policy, regulation or agreement that adversely affects the efficient

and effective operations of his/her unit or brings discredit to the University or a subdivision. Dependent upon the actual and potential consequences of the offense, employee misconduct may be considered minor misconduct or gross misconduct.

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

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

BEFORE DISCIPLINARY ACTION IS TAKEN:

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

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

All disciplinary action taken will be confirmed in writing to the employee.

See specific sections for details of steps to be taken.

DISCIPLINE DOCUMENTATION:

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

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

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

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

TYPES OF DISCIPLINE

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

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

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

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

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

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

Gross misconduct may result in a one-time warning letter.

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

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

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

DISMISSAL:

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

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

Gross misconduct may result in immediate dismissal.

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

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

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

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

VIOLATIONS CONSIDERED GROUNDS FOR DISCIPLINARY ACTION:

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

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

APPEALS:

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

FOR ASSISTANCE AND INFORMATION:

Additional information or questions regarding disciplinary actions should be directed to the

Employee Relations Unit in the Department of Human Resources at 293-5700.

EFFECTIVE DATE: July 7, 2000.

WVU POLICY REFERENCE:

https://talentandculture.wvu.edu/policies-forms-and-resources/hr-policies/discipline