Welcome and Introduction
Welcome to the Johns Hopkins Bloomberg School of Public Health General Preventive Medicine Residency Program. This information is designed to give you an overview of the program and to guide you through the academic and practicum years.

Please use this as a frequent reference for the questions that will come up as you complete your training. The first sections provide an overview of the program, policies, benefits, administrative structure, and governance, and the competency and knowledge areas of preventive medicine. Sections that follow guide the academic and practicum years. The roles and responsibilities of the resident and the program are delineated.

This is not intended as a stand-alone resource. You will find valuable and pertinent information regarding the MPH (https://e-catalogue.jhu.edu/public-health/departments/master-public-health/) and the Johns Hopkins Bloomberg School of Public Health (https://e-catalogue.jhu.edu/public-health/) in this online catalogue. Many preventive medicine resources are now online and useful websites are also included.

The General Preventive Medicine Residency (GPMR) Clinical Director, Academic Director, Chief Resident, administrative staff, and I are here to provide direction throughout your program. In addition, be sure to talk to faculty and rotation preceptors whose interests, research, and practice activities can help to guide you. These contacts can prove invaluable to your career. Plan to meet frequently with me, and be specific about your interests as well as your uncertainties.

Finally, make the most of your associations with fellow residents and students in the school. You may well find that these relationships are your richest continuing source of support, encouragement, and professional stimulation.

Again, welcome, and my very best wishes for a wonderful training experience and a successful career in the exciting field of preventive medicine!

Clarence Lam, MD, MPH
Director, General Preventive Medicine Residency

Mission Statement
The mission of the Johns Hopkins Bloomberg School of Public Health General Preventive Medicine Residency Program is to prepare physicians in the theoretical, practical, and clinical knowledge and skills essential to leadership roles in the design, management, and evaluation of population-based approaches to health. Fundamental to this mission is the program’s commitment to instilling in residents the ability to synthesize clinical and population-based approaches to disease prevention and health promotion, to impact health issues on a broad continuum from local to international in perspective, and to discover and apply knowledge toward the protection of the public’s health.

Residency Accreditation
The Johns Hopkins Bloomberg School of Public Health General Preventive Medicine Residency Program is fully accredited by the Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (https://acgme.org/) (ACGME) for Preventive Medicine for both the academic and practicum years of training. The GPMR Program recently underwent an ACGME site visit in 2017 and remains fully accredited.

Program Overview
The mission of the Johns Hopkins Bloomberg School of Public Health General Preventive Medicine Residency Program is to prepare physicians in the theoretical, practical, and clinical knowledge and skills essential to leadership roles in the design, management, and evaluation of population-based approaches to health.

Five key strategies are basic to this mission:
1. to instill in residents the ability to synthesize clinical and population-based approaches to disease prevention and health promotion,
2. to view health issues on a broad continuum from local to international in perspective,
3. to discover and apply knowledge toward the protection of the public’s health,
4. to provide residents with the management and epidemiologic skills needed to address the overall health needs of underserved populations, and
5. to provide residents with the clinical skills needed to treat specific diseases that disproportionately affect underserved populations.

The goal of the residency program is to train physicians in the knowledge and skills that will allow them to advance the health of populations and individuals by promoting health-enhancing behaviors and preventing disease and disability. The residency program accepts physicians who have completed their requisite appropriate clinical training, into the academic phase of general preventive medicine training. Residents may join the program having previously earned a Master of Public Health (MPH) or seeking an MPH.

Although the residency does not have an internship year, it does have an arrangement with The Mary Imogene Bassett Hospital (https://www.bassett.org/medical-education/residency-programs/transitional-year/) in Cooperstown, New York, where one resident a year may complete a transitional PGY-1 year before entering the Hopkins GPMR Program. The residency program also trains one combined family medicine-preventive medicine resident per year in conjunction with MedStar Franklin Square Medical Center (https://www.medstarhealth.org/education/affiliated-hospitals-2/medstar-franklin-square-medical-center/combined-family-medicine-preventive-medicine-residency/) in Baltimore, Maryland, for which fourth-year medical students or other appropriately qualified applicants may apply through the National Resident Matching Program.

The GPMR Program is committed to maximizing the educational process for each resident so that each may become a competent preventive medicine physician and meet his or her professional goals. In addition to the residency director, who supervises and guides all aspects of the residency program and is readily accessible to each resident, the residency program also has a Chief Resident, Academic Director, and
Clinical Director who all assist residents with various aspects of the training program.

The PM-1\(^1\) (Preventive Medicine Year 1) year is an opportunity to gain the theoretical knowledge and skills necessary to become a preventive medicine physician, and the PM-2\(^2\) year allows residents to apply the knowledge and skills that they have acquired. The PM-2 year continues to provide didactic education with an emphasis on “real-world” issues. These educational experiences encourage residents to become lifelong learners. Furthermore, they encourage residents to be constantly intellectually inquisitive and to use practical situations to uncover new knowledge. The residency program makes available a variety major textbooks in the field of preventive medicine that are available for reference in the residency on-campus office. In addition, the skills that residents gain in the academic year are used on a regular basis during the practicum rotations.

All residents are expected to attend the annual meeting of the American College of Preventive Medicine (https://www.acpm.org/) (ACPMM). Any exceptions must be approved by the Program Director. Residents are encouraged to be involved in national preventive medicine resident activities and Hopkins residents often hold national leadership positions. The residency program provides all residents funds to offset the costs of these prevention-related conferences. The residency program also reimburses the annual membership dues for the ACPM (https://www.acpm.org/) for all residents.

Upon completion of the residency, all residents are expected to sit for the American Board of Preventive Medicine Certifying Examination.

PM-1 may also be referred to as PGY-2 in GPMR documentation

PM-2 may also be referred to as PGY-3 in GPMR documentation

Clinical Overview (PM-1 and PM-2 years)

In accordance with ACGME Preventive Medicine Guidelines, all residents will complete two months (320 hours) of clinical activities during each year of the program. Residents will be training in clinical environments focused on preventive medicine and where patient responsibilities are paramount.

PM-1 (First Year)

The first year (PM-1 year) of the General Preventive Medicine Residency Program is an intensive academic experience. Residents who have not already obtained a Master of Public Health (MPH) prior to coming to GPMR will complete the required coursework during the PM-1 year. Coursework for the MPH is completed in an 11-month program that is divided into 5 terms. The MPH-seeking PM-1 residents spend the majority of their year engaged in the MPH courses, pursuing didactic and independent study that leads to the MPH degree.

Although nearly all of the requirements of the MPH degree are to be completed during the PM-1 year, residents will not receive the degree until May of their last year of training. The MPH degree requires the completion of a practicum experience, and this requirement will be fulfilled through the completion of a PM-2 practicum rotation. While the MPH Capstone can be completed either at the end of either academic year, but it is encouraged that the Capstone be completed during the PM-1 year.

Residents select from among 400 courses offered in the School of Public Health. The MPH requirements account for approximately 60% of preventive medicine residents’ responsibilities. Residents will spend approximately 20% of their time completing clinical preventive medicine activities and 20% of their time participating in residency-sponsored seminars and supplemental educational activities (e.g., modules). Residents may also receive special studies credit for research conducted with a faculty mentor during their academic year. With the depth and breadth provided by the large faculty and the large number of course offerings, residents are able to customize their academic training to be closely aligned with their professional interests. Each resident receives advice on choice of courses from the residency program director, the GPMR Chief Resident, his/her assigned MPH adviser, and other faculty and students, as needed.

Residents who have previously obtained an MPH degree prior to entering GPMR are required to complete two years of preventive medicine residency training. In the first year, the program will review each MPH-holding GPMR resident’s MPH transcript to devise an individualized academic plan. This will ensure that the combination of their prior and Hopkins coursework meets the standards of those residents who are undergoing their MPH academic requirements at the Johns Hopkins Bloomberg School of Public Health. The MPH-holding GPMR residents will also be required to complete the clinical program, and to attend all residency-sponsored seminars and supplemental educational activities. The remainder of the MPH-holding resident’s time will be spent working with pre-established practicum rotation sites on a specific project that is mutually agreed upon by the rotation site, the resident, and the GPMR Program.

Residency training and all educational endeavors at the school are based on competencies. Students define their career and educational objectives with the guidance of their advisers and other resources. This process enables students to appropriately select options for fulfilling core requirements, electives that develop the desired competencies, and a focus for a self-directed integrating experience project. Such a resident-centered programmatic orientation and philosophy necessitates a multi-dimensional view of curriculum organization. This multi-dimensional organization facilitates thinking of the program in ways that assure requisite knowledge and skills are addressed across the breadth of the core curriculum within a context that promotes the rapid integration of these skills into professional practice behaviors.

On entry into the program, each resident meets with the program director and then prepares an educational plan that outlines their educational goals for the year, with an emphasis on coursework and residency activities that will maximize their background and allow them to gain competence in the field of preventive medicine. In addition to the in-service exam, this plan serves as the incoming assessment. Each resident will receive a grade report at the end of each term and at the end of the year. They will meet semi-annually with the program director during each year of study to review performance and progress.

The MPH curriculum is organized around the core functions of public health practice as defined by the Institute of Medicine and enhanced by Johns Hopkins: assessment, policy and program development, assurance, and communication. These functions are embodied within the school’s problem-solving paradigm. This integrative paradigm serves as an organizing principle for the structure and sequencing of the core (discipline-based) curriculum in the form of a professional practice paradigm that progresses through each of these core functions.

Within each broad discipline area as defined by the Council on Education for Public Health (CEPH), a set of competencies defines the level of mastery expected of all MPH graduates, irrespective of the student’s intended focus of study. The MPH Executive Committee also uses these competencies to determine the suitability of courses and combinations
of courses to fulfill core area requirements, and the entire matrix is used to identify gaps in the overall program.

The MPH Program also has competencies that transcend disciplinary boundaries and demonstrate synthesis, analysis, and integration of multiple cognitive, attitudinal, and behavioral domains. These competencies include activities that are inherently integrative in nature, requiring students simultaneously to draw upon and selectively and critically utilize the array of knowledge and skills in their possession. These competencies are most closely associated with the behavioral outcomes MPH graduates are expected to manifest in their professional practice activities. In addition, all residents, regardless of whether they are pursuing the MPH degree during their PM-1 year, will be required to take courses that uniquely meet the needs of preventive medicine residents (see (p. 8) Course Requirements). The MPH final project, the Capstone Project, is tailored to the residents’ needs and is a project that is the culmination of a practicum or research experience and may be written using the Problem Solving Paradigm.

Other residency activities (e.g. modules) complement the educational experience during the academic year. An extensive summer seminar series introduces residents to role models for careers in public health. Each week throughout the summer, public health and preventive medicine professionals, including School faculty and our own residency graduates, present information on how their own careers have developed and share ongoing activities at the health agencies and organizations where they are employed. In this way, residents learn about potential career paths early in their academic year.

Throughout the first year, residents participate in modules to acquaint them with the breadth and depth of the field of preventive medicine. They gain experiences with modules such as those focused on Problem Solving in Public Health, Public Health Preparedness, Quality Improvement, and Conflict Management and Negotiation. Environmental Health site visits to a water filtration plant, a wastewater treatment plant, and a waste management facility are also part of the PM-1 curriculum. Residents also receive professional development training in skills such as leadership, management, advocacy (including media advocacy), project management, and oral and written presentation skills. The advocacy series culminates with a trip to Capitol Hill where the residents can practice presenting to legislative aides and receive feedback on their presentations.

Another important component of the PM-1 curricula is the opportunity to teach graduate students in the “Problem Solving in Public Health” course. All first year (PM-1) residents serve as teaching assistants for this course. Residents work with professors in the School of Public Health to prepare for this course and receive student feedback on their teaching abilities.

All residents in the PM-1 year are required to complete a direct patient care clinical component that is equivalent to 2 months (320 hours) of clinical interaction. The program has developed these clinical experiences to advance the mission of the preventive medicine residency program and meet ACGME requirements. All clinical experiences are approved by the program director and clinical director. Residents must have a minimum of two months of direct patient care experience (clinical rotations) during each year of the program, and all patient care experiences must be supervised (see Supervision section for additional details). Given the structure of the program, this requirement is spread across the year by completing 80 half-days in a clinic (of note, a half-day should equal approximately 4 hours). Residents will track their clinical hours in New Innovations with the goal of obtaining 320 hours each year.

Please note that the program does not permit residents to obtain all 320 hours over a one-month period.

The residents spend a large portion of their time together in the first year as they take required courses and participate in didactic resident activities. These activities help to build group cohesiveness and provide a distinct identity for the residents within the MPH class. Residents are encouraged to participate in research projects and often work with faculty on such endeavors. Residents have the chance to be involved in school-wide and residency committees and can participate in many different community-based projects.

PM-1 residents are expected to attend monthly didactic Administrative Rounds if there is no pre-existing conflict with a regularly scheduled course (or with overnight call, for the Franklin Square combined residents). This also applies to PM-1 residents who already have their MPH and are on practicum rotations. Finally, all first year residents are expected to attend the annual Preventive Medicine/Public Health Grand Rounds.

**PM-2 (Second Year)**

The PM-2 year, the practicum year, is individualized to meet the educational and experiential needs of each resident. Residents plan their rotations to be consistent with their professional goals and to maximize their prior education and experiences. It is expected that residents’ practicum experiences will build on the theoretical models that they studied in their academic year. Residents must complete the practicum year to meet the eligibility requirements for certification by the American Board of Preventive Medicine.

During the practicum year, residents are required to complete at least four practical preventive medicine rotations, including one from each of the following categories:

1. Biostatistics and Epidemiology
2. Management and Administration
3. Occupational/Environmental Health or Clinical Preventive Medicine

The content of each rotation is designed to focus on the competencies established for that category of rotation. These competencies were adopted and adapted from competencies developed by national preventive medicine forums to focus on the knowledge and skills needed to function effectively as a preventive medicine specialist in local, state, federal, international, clinical, corporate, and academic settings. Similar to the PM-1 year, all residents in the PM-2 year are required to complete a direct patient care clinical component that is equivalent to 2 months (320 hours) of work.

Practicum year residents also register for 16 credits per term for Special Studies course PH.550.890 SS/R: General Preventive Medicine Residency-Residency Year, which is fulfilled through monthly administrative rounds. (Note: Residents in their third and fourth year of the combined program should follow the instructions provided by the Residency Program Manager regarding their credit requirement in those years.) These monthly rounds (one day a month) provide an ongoing opportunity for residents to receive the didactic portion of their education during their practicum year. The monthly rounds may include journal club, guest lecturers who speak on current topics in public health, professional skill building didactics, and opportunities for residents to present their practicum projects to the group. Other pertinent information, such as information on board preparation and job search techniques may be presented at appropriate times of the academic year. Residents are
expected to attend the annual Preventive Medicine/Public Health Grand Rounds if their rotations are within the Baltimore-Washington area.

**Resident Benefits**

Residents receive a stipend in each year of the program as well as a tuition (https://www.jhsph.edu/admissions/tuition-and-fees/) scholarship for the Master of Public Health program. Residents also receive a comprehensive benefits package which includes health insurance, dental insurance, life insurance, long-term disability, and professional liability insurance. Residents are also provided allowances for conference travel and professional membership, as well as an annual vacation and sick time allotment. These benefits are reviewed annually.

**Advisory Committees**

Formally established advisory committees play a role in the governance of the General Preventive Medicine Residency. Residency representatives from both years of training, as well as the GPMR Program Director, Clinical Director, Academic Director, and Chief Resident, serve as members of each committee.

**Program Evaluation Committee (PEC)**

**Committee Charge**

The goal of the Program Evaluation Committee is to serve as a formal, systematic assessment of the educational components of the residency program, including the examination and monitoring of areas, measures, and progress undertaken to improve the program curriculum.

**Committee Membership**

- Committee must be composed of at least two members of the program faculty and at least one resident as designated by the program director. (The program director may serve as one of the two faculty members of the Committee.)
- The Program Coordinator will assist in the administrative functions of the committee, which include managing the logistics and scheduling for the Program Evaluation Committee meetings, and recording and retaining of meeting minutes.

**Committee Meetings**

The Committee will meet at least once per year. Additional meetings may be scheduled at the discretion of the chair.

**Committee Accountability**

Responsibilities of the Program Evaluation Committee must include:

- Acting as an advisory to the program director, through program oversight.
- Annual review of the program’s self-determined goals and progress toward meeting them.
- Guiding ongoing program improvement, including development of new goals, based upon outcomes.
- Review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program’s missions and aims.
- The Committee is responsible for assessing the following areas for the purpose of program improvement (not to identify individual residents for personal improvement or remediation):
  - Resident performance, including examining cohort-wide data aggregated from transcripts, milestones, resident feedback/evaluation (including at least one opportunity to evaluate the program confidentially and in writing at least annually), and other materials as deemed necessary.
  - Resident well-being, recruitment and retention, workforce diversity
  - Faculty development, including annual data aggregated from preceptor evaluations, faculty evaluations, and other materials as deemed necessary.
  - Graduate performance, including performance of program graduates on the board certification examination.
  - Program quality, through materials and assessments as deemed necessary.

**Documentation of the Annual Program Evaluation:**

- The Committee must prepare a written plan of action known as the Annual Program Evaluation (APE) that will identify areas of improvement and ensure that recommendations are measured and monitored annually.
- A consensus for initiatives and recommendations to be documented in the APE should be determined by the end of each Committee meeting. The Program Director and Program Coordinator will be responsible for developing a written plan based on the proceedings of the meeting.
- The APE should be reviewed and approved by the teaching faculty to ensure widespread agreement and support.
- The Program Director will carry out the recommendations as outlined in the APE.
- APE does not need to be submitted to the ACGME but documentation should be distributed to and discussed with members of the teaching faculty and residents, submitted to the DIO, and retained by the program.

**Clinical Competency Committee (CCC) Committee Charge**

The goal of the CCC is to review and document residents’ progression through the ACGME milestones.

**Committee Accountability**

The Committee will prepare and assure the reporting of milestones evaluations of each resident semi-annually to the ACGME.

The responsibilities of the CCC include, but are not necessarily limited to, the following:

1. The Committee will meet, review, and advise the Program Director on each resident’s progress through the program, including promotion, remediation, and dismissal.
2. The Committee will make a determination of each resident’s progress through all preventive medicine milestones.
3. The Committee will prepare and assure the reporting of milestones evaluations of each resident semi-annually to the ACGME.
4. Milestones evaluations for each resident will be entered directly into the ACGME Accreditation Data System (ADS) during both of the following reporting windows: November 1-December 31, and May 1-June 30 (exact dates determined by ACGME).

**Committee Channels of Communication**

The Clinical Competency Committee will make its recommendation to the GPMR Program Director. The Program Director will ensure milestones evaluations for each resident are entered in to the ACGME Accreditation Data System.
Committee Membership
The Clinical Competency Committee will be composed of at least three members of the program faculty as designated by the Program Director.

Committee Chair
The Program Director will serve as Chair of the Committee.

Committee Meetings
The Clinical Competency Committee will meet at least twice annually each academic year to discharge its responsibilities. Fall meeting to be scheduled in November/December and the Spring meeting to be scheduled in May/June, to coincide with ACGME data reporting requirements. Additional meetings may be scheduled at the discretion of the chair.

Committee Staff
The Program Coordinator will handle the administrative functions of the committee, which include collecting data on each resident, managing the logistics and scheduling for the Clinical Competency Committee (CCC) meeting, and recording the decisions of milestone levels for each resident as determined by the Committee.

Graduate Medical Education Committee (GMEC)
Committee Charge
The Graduate Medical Education Committee shall be responsible for meeting the sponsoring institution responsibilities for preventive medicine education activities in the School, including establishment and implementation of Graduate Medical Education Policies (https://e-catalogue.jhu.edu/public-health/departments/residency-programs/#facultytext) and procedures set forth by the Accreditation Council for Graduate Medical Education (ACGME).

The committee shall advise the School on and monitor the following:

1. Establishment and maintenance of appropriate liaison with residency directors and with the administrators of other institutions participating in programs sponsored by the School of Public Health.
2. Regular review of all ACGME program accreditation letters and action plans for the correction of concerns and areas of noncompliance.
3. Regular review of the Sponsoring Institution's Letter of Report from the ACGME Institutional Review Committee (IRC) and development and monitoring of action plans for the correction of concerns and areas of noncompliance.
4. Review and approval prior to submission to the ACGME of:
   a. all application for ACGME accreditation of new programs and subspecialties;
   b. changes in resident complement;
   c. major changes in program structure or length of training;
   d. additions and deletions of participating institutions used in a program;
   e. appointments of new program directors;
   f. progress reports requested by any Review Committee;
   g. responses to all proposed adverse actions;
   h. requests for increases or any change in resident duty hours;
   i. requests for “inactive status” or to reactivate a program;
   j. voluntary withdrawals of ACGME-accredited programs;
   k. requests for an appeal of an adverse action;
   l. appeal presentations to a Board of Appeal or the ACGME.
5. Establishment and the implementation of policies and procedures for the selection, evaluation, promotion, and dismissal of residents.
6. Establishment and implementation of institutional policies and procedures for discipline and the adjudication of complaints and grievances relevant to the graduate medical programs.
7. Assurance of appropriate and equitable funding for resident positions, including stipends, benefits, and support services.
8. Regular review of ethical, socioeconomic, medical/legal, and cost-containment issues that affect graduate medical education.
9. Assurance of the incorporation of School-wide policies and procedures into the residency programs.
10. Review all resident applicants after acceptance to the programs.
11. Review and monitor the progress of all residents through the academic and practicum years.
12. Establish and implement formal written policies and procedures governing resident duty hours in compliance with the Institutional and Program Requirements.
13. Assure that each program provides a curriculum and evaluation system so that residents demonstrate achievement of general and program-specific competencies.
14. Serve as an appeal or arbitration group if problems arise in the programs.
15. Regular review of all residency training programs in relation to their compliance with institutional policies and the program requirements of the Accreditation Council for Graduate Medical Education Residency Review Committee for Preventive Medicine.
16. Conduct internal reviews of all ACGME-accredited programs to assess their compliance with the Institutional Requirements and the Program Requirements of the ACGME Residency Review Committees.

Professional Organizations Related to Preventive Medicine
American Board of Preventive Medicine (https://www.theabpm.org/)
The purpose of the American Board of Preventive Medicine (ABPM) is to grant and issue to qualified physicians who are licensed to practice medicine, certificates of special knowledge in preventive medicine and in one of the specialty areas of aerospace medicine, occupational medicine, or public health and general preventive medicine. It is also its purpose to encourage the study, enhance the standards of practice, and advance the cause of preventive medicine.

All Johns Hopkins preventive medicine residents are expected to sit for the American Board of Preventive Medicine (ABPM) Certifying Examination upon completion of the residency. Information about the board exam, the board study guide materials, and board applications are available at the ABPM website.

American College of Preventive Medicine (https://www.acpm.org/)
The American College of Preventive Medicine (ACPM) is the national professional society for physicians committed to disease prevention and health promotion. ACPM’s 2,700 members are engaged in preventive medicine practice, teaching, and research. Many serve on ACPM committees and task forces and represent preventive medicine in national forums, contributing to the organization's role as a major national resource of expertise in disease prevention and health promotion. ACPM was founded in 1954.

Specialists in preventive medicine are uniquely trained in both clinical medicine and public health. They have the skills needed to understand
and reduce the risks of disease, disability, and death in individuals and in population groups. You can find preventive medicine trained physicians working in primary care settings and managed care organizations, in public health and government agencies, in workplaces and in academia.

The ACPM has developed core competencies and performance indicators for preventive medicine residents. The organization also offers a review course for the preventive medicine board exam. In addition, ACPM offers a Lifestyle Medicine Core Competency Online Program.

**Resident Physician Section (RPS) of the ACPM:** Residents are eligible for Resident Membership of the ACPM throughout their residency training, and for one transitional year after. Resident members may vote and hold office in the Resident Physician Section (RPS). RPS is the national voice of preventive medicine residents on issues that affect training, policy, and education. The College provides RPS members with educational resources and puts them in touch with many of the best clinicians and educators in preventive medicine.

RPS members receive the RPS Newsletter and membership includes an active subscription to the *American Journal of Preventive Medicine*. Members are eligible for discounted rates on annual meeting fees and scholarships to attend the meetings of both parent associations, the American College of Preventive Medicine and the Association for Prevention Teaching and Research. Members are also included in the discussions that occur on the RPS email listserv, which includes over 300 preventive medicine residents.

The residency program pays for membership in RPS for both years of the residency training. After completing registration, residents should submit reimbursement requests for RPS registration with receipts to program staff within 30 days of incurring the expense. Residents in the second year are asked to renew their membership and again submit a receipt for reimbursement.

Many GPWR residents are interested in holding a national position with RPS. Elections are in or around February/March of each year; 1-year terms start in April.

**American Public Health Association (https://www.apha.org/)**

The American Public Health Association (APHA) is the oldest and largest organization of public health professionals in the world, representing more than 50,000 members from over 50 occupations of public health. APHA has been influencing policies and setting priorities in public health for over 125 years. It brings together researchers, health service providers, administrators, teachers, and other health workers in a unique, multidisciplinary environment of professional exchange, study, and action.

APHA is concerned with a broad set of issues affecting personal and environmental health, including federal and state funding for health programs, pollution control, programs, and policies related to chronic and infectious diseases, a smoke-free society, and professional education in public health. APHA actively serves the public, its members, and the public health profession through its scientific and practice programs, publications, annual meeting, awards program, educational services, and advocacy efforts.

The achievements of APHA are the achievements of the thousands of federal, state, community, and academic health professionals who seek to assure the conditions in which people can be healthy. Whether APHA is proposing solutions based on research, helping to set public health practice standards, or working closely with national and international health agencies to improve health worldwide, its mission is to continue to strive to improve public health for everyone.

**Association of American Medical Colleges (https://www.aamc.org/)**

The Association of American Medical Colleges is a nonprofit association of medical schools, teaching hospitals, and academic societies. The AAMC seeks to improve the nation’s health by enhancing the effectiveness of academic medicine. It assists academic medicine’s institutions, organizations, and individuals in three main mission areas: medical education, medical research, and patient care.

The AAMC represents and supports its constituents through a broad array of programs and studies, and the administrative leadership of medical schools and teaching hospitals are served by a variety of professional development groups housed within the AAMC. The AAMC provides services to those entering the medical field, including the American Medical College Application Service (AMCAS), the Electronic Residency Application Service (ERAS), MEDLOANS, and the National Resident Matching Program (NRMP). Its full-time staff of 350 is based in Washington, D.C., and is divided into several offices and divisions, from member services to governmental relations to biomedical and health sciences research.

The AAMC has recently launched an online resource bank for educational materials called the MedEdPORTAL (https://www.mededportal.org/).

**Association for Prevention Teaching and Research (https://www.aptrweb.org/)**

The Association for Prevention Teaching and Research (APTR) is the national association supporting health promotion and disease prevention educators and researchers. Since 1942, APTR has been in the forefront of advancing, promoting, and supporting health promotion and disease prevention in the education of physicians and other health professionals. APTR members include members of the Association of Preventive Medicine Residents. Individual members include physicians, nurses, public health professionals, and health services researchers. Institutional members include academic departments and programs, health agencies, and schools of public health.

APTR provides essential linkages to bring together individuals and institutions devoted to health promotion and disease prevention education and research. APTR develops vital curriculum, professional development, and communication tools for educators, researchers, residents, and students.

**Program Requirements**

Course location and modality is found on the JHSPH website (https://www.jhsph.edu/courses/).

**Requirements and Expectations for All Residents**

The General Preventive Medicine Residency (GPMR) Program is a broad, two-year training program of academic and applied learning in a school of public health, accredited by the Accreditation Council for Graduate Medical Education. The primary purpose of the residency is to prepare physicians in the theoretical, practical, and clinical knowledge and skills essential to leadership roles in the design, management, and evaluation of population-based approaches to health — i.e., to prepare physicians to recognize that their primary patient is a population and that their goal is to improve the health of that population in the aggregate. In accordance
with the Accreditation Council for Graduate Medical Education Preventive Medicine Program Requirements (https://www.acgme.org/Specialties/Overview/pfcastid/20/), the program consists of Master of Public Health coursework, practicum and clinical rotations, and preventive residency-specific modules.

In pursuit of that purpose, it is fundamental that the residency and the residents work together to help each other meet their respective needs. Residents must speak directly with the Program Director, Clinical Director, Academic Director, and/or Chief Resident regarding their individual needs and must clearly verbalize their expectations. Similarly, residents should bring problems or issues to the attention of the Program Director, Clinical Director, Academic Director, Chief Resident, or Program Manager for assistance. Additionally, residents may submit feedback anonymously to the program through an online comment box: www.tiny.cc/GPMRcommentbox (http://www.tiny.cc/GPMRcommentbox). This link brings you to a Qualtrics form that allows anyone to submit information to the program. All submissions are completely anonymous — no location information, IP addresses, etc. are collected except for a timestamp and the content you submit.

REQUIREMENTS AND EXPECTATIONS FOR PM-1 RESIDENTS
To meet the objectives of the residency, residents will fulfill the following roles and responsibilities in securing training in the teaching, research, and practice of preventive medicine. The common knowledge base that all residents should master is most effectively acquired through shared experiences. Among such experiences are summer orientation, the MPH coursework, the clinical program, and participation in first year training modules, residency administrative rounds, Grand Rounds, and other program activities — all of which are designed to enable residents to gain the skills, knowledge, and experience in competencies required for preventive medicine training.

Roles and Responsibilities of Residents
Although it is important that all guidelines be met, the program attempts to accommodate and remains flexible to allow for residents’ interests.

1. All residents must know and follow the policies and procedures, including but not limited to the Professional Conduct Code — Residency Expectations and Requirements and GPMR Attendance Policy.

2. All residents must meet with the principal faculty on a regular basis. These meetings include a formal, written semi-annual evaluation with Program Director, Chief Resident, and Clinical Director as well as periodic meetings with the Academic Director. Evaluation will consist of a discussion of the didactic work, applied work, clinical work, courses, research projects, papers, and related activities in which the resident has been involved. Residents’ academic transcripts also will be reviewed as a part of the process. Evaluation of resident’s activities includes identification of areas of strength, areas needing additional emphasis, and professional goals. At the conclusion of each meeting there will be a summary of the resident’s performance in New Innovation. This information is required for performance evaluation and credentialing of residents. A sample schedule of when these meetings occur is shown below:

PM-1 Residents:
August and October: Meet with Academic Director
December: Semi-annual review with Program Director and Clinical Director
February and April: Meet with Academic Director
June: Semi-annual review with Program Director and Clinical Director

3. For those residents who are pursuing an MPH:

4. For those residents who have completed an MPH prior to coming to GPMR:

5. All residents must complete the clinical component, equivalent to 2 months (320 hours) of work, each year. All clinical experiences must be approved by the Program Director. Residents are required to complete similar rotation evaluation forms for each clinical rotation including:

a. Complete MPH coursework. Discuss plan for completing Capstone project during PM-1 year or prior to April of PM-2 year.
b. Remain in satisfactory academic standing in the MPH program in accordance with the standards set by that program or be subject to dismissal from the General Preventive Medicine Residency Program. Any resident dismissed from the MPH program will be dismissed from the residency.
c. Maintain full-time registration (minimum of 16 credits for GPMR) in all five terms of the academic year.
d. Maintain a 2.75 GPA for the MPH program.
e. Complete all core MPH and all GPMR requirements prior to beginning the Practicum Year.
f. Residents will receive their MPH during the PM-2 year after completing their practicum rotation that fulfills the MPH practicum requirement.

4. For those residents who have completed an MPH prior to coming to GPMR:

a. Participate fully in scheduled PM-1 didactic and educational modules, as well as other educational activities.
b. Complete all MPH courses identified by the GPMR program as necessary for preventive medicine training.
c. Maintain a 3.0 GPA in all residency-required courses that are taken for a letter grade.
d. Maintain full-time student status. Register for up to 16 credits of Special Studies (PH.550.890 SS/R: General Preventive Medicine Residency-Residency Year) per term.
e. Plan to schedule primarily part-time rotations (3-4 days a week) in consultation with the GPMR Chief Resident and Program Director during the PM-1 year, in order to allow sufficient time to participate in PM-1 activities and to take any required classes. All rotation schedules are subject to final approval of the Program Director.
f. With prior approval of the Program Director, may schedule one unfunded or partially-funded rotation during the PM-1 year, for a period of up to three months. Other rotations shall be fully funded at the PM-2 rotation fee rates.
g. Complete a project at each practicum site.
h. Complete and submit all assigned rotation reports. A resident is required to submit:
   i. A Rotation Plan form, which is due one week after beginning the rotation.
   ii. A form evaluating the rotation overall (Resident Evaluation of Rotation/Preceptor), which is due one week after completing the rotation.
   iii. During the last week of a rotation, the resident must meet with the preceptor as part of an “exit interview” and to help facilitate and ensure the timely completion of the Preceptor’s Evaluation of the Resident. Residents must receive at least a satisfactory evaluation from each rotation preceptor.

5. All residents must complete the clinical component, equivalent to 2 months (320 hours) of work, each year. All clinical experiences must be approved by the Program Director. Residents are required to complete similar rotation evaluation forms for each clinical rotation including:

a. A Rotation Plan form, which is due one week after beginning the rotation.
Residents pursuing an MPH at JHSPH must:

b. A form evaluating the rotation overall (Resident Evaluation of Rotation/Preceptor), which is due one week after completing the rotation.

c. During the last week of a clinical rotation, the resident must meet with the preceptor as part of an "exit interview" and to help facilitate and ensure the timely completion of the Preceptor's Evaluation of the Resident.

**Course Requirements**
The following is a list of the curriculum requirements for residents during the PM-1 year. *Note that MPH-required courses must be taken for a letter grade; courses taken to fulfill residency requirements may be taken Pass/Fail unless they are also fulfilling MPH requirements.*

All residents must take the following courses (or courses deemed to be equivalent in prior studies) as required by the GPMR Program:

<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
<th>Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH.188.686</td>
<td>Clinical Environmental and Occupational Toxicology</td>
<td>3</td>
</tr>
<tr>
<td>PH.188.840</td>
<td>Special Studies and Research Environmental Health &amp; Engineering (INTRO TO PROBLEM SOLVING)</td>
<td>2</td>
</tr>
<tr>
<td>PH.300.651</td>
<td>Introduction to the U.S. Healthcare System</td>
<td>4</td>
</tr>
<tr>
<td>PH.305.623</td>
<td>Fundamentals of Clinical Preventive Medicine</td>
<td>3</td>
</tr>
<tr>
<td>PH.550.860</td>
<td>Academic &amp; Research Ethics at JHSPH</td>
<td></td>
</tr>
<tr>
<td>PH.552.622</td>
<td>Creating, Implementing and Monitoring Budgets for Projects and Programs</td>
<td>1</td>
</tr>
<tr>
<td>PH.552.623</td>
<td>Principles of Negotiation and Mediation for Public Health Professionals</td>
<td>0.5</td>
</tr>
<tr>
<td>PH.552.624</td>
<td>Applications of Negotiation and Mediation for Public Health Professionals</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Advanced Epidemiology Course** ³

³ An advanced epidemiology course that builds on the knowledge and skills of Epi 1 (may be methods course, applied course, content area course, etc.) Please check with the Program Director as you choose this course.

**COURSE suggestions**
The following is a list of courses suggested (but not required) for residents during the PM-1 year.

<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
<th>Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH.140.621</td>
<td>Statistical Methods in Public Health I</td>
<td>4</td>
</tr>
<tr>
<td>PH.140.622</td>
<td>Statistical Methods in Public Health II</td>
<td>4</td>
</tr>
<tr>
<td>PH.140.623</td>
<td>Statistical Methods in Public Health III</td>
<td>4</td>
</tr>
<tr>
<td>PH.187.610</td>
<td>Public Health Toxicology</td>
<td>4</td>
</tr>
</tbody>
</table>

**Residents pursuing an MPH at JHSPH must:**

1. Register for one credit of Special Studies (PH.550.880 SS/R: General Preventive Medicine Residency-MPH) during each of the five terms of the MPH year. Regular attendance at all seminars, completion of knowledge assessment quizzes of training modules, and other required residency activities is a condition for receiving a Pass in this course.

2. Complete the MPH Capstone project, which must be in a residency-determined area and format, unless a waiver is given by the Program Director.

**All residents who have previously completed an MPH must:**

1. Complete any additional coursework required by the GPMR program as necessary for educational enrichment based on an individual academic plan developed upon review of each resident's MPH transcript, per the required course list above.

2. Enroll as full-time student. Register for up to 16 credits of Special Studies (PH.550.890 SS/R: General Preventive Medicine Residency-Residency Year) during each of the five terms of the MPH year. Regular attendance at all seminars, completion of knowledge assessment quizzes of training modules, and other required residency activities is a condition for receiving a Pass in this course.

3. Discuss any additional coursework you wish to complete with the GPMR Chief Resident and Program Director.

**Educational Plan**
Early in the year, first year residents must prepare and submit to the Program Director a written educational plan for the first year of the General Preventive Medicine Residency. Residents who are pursuing an MPH will likely incorporate the MPH Goals Analysis into their educational plan. The deadline for this plan will be announced, but will be well before the MPH deadline. This plan will follow the MPH Goals Analysis guidelines, with the addition of residency-specific information regarding your goals, additional skills, knowledge, competencies you hope to gain from the residency training, and your plans for obtaining these. The plan will include activities outside of the residency itself, such as attendance at professional conferences, research projects, etc. For residents who have already completed an MPH prior to coming to GPMR, your plan should also include the rotations and other activities you are thinking of completing, and how these will help you in your educational goals. A template for this Plan will be provided.

**Advising and Customized Program**
As the GPMR Program Director, Dr. Clarence Lam will have responsibility for overseeing overall advising and mentoring of all residents.

Dr. Lam will serve as the summer adviser for all PM-1 residents. At the end of the summer term, the MPH office will assign residents in the MPH program to academic advisers based on background and area of interest. In addition, residents in the MPH program must select a Capstone adviser; this adviser may be their MPH academic adviser, the GPMR Program Director, or another faculty member. PM-1 residents who already have an MPH will select an academic adviser in consultation with Dr. Lam based on the resident's area(s) of interest. All PM-1 residents will be expected to meet with Dr. Lam on a semi-annual basis to review their academic performance and professional development within the program.

For PM-2 residents, Dr. Lam will serve as the formal primary faculty adviser for all residents.

In both PM-1 and PM-2 years, all residents will create an individualized academic plan that will meet their professional training needs. PM-1 residents submit both a Goals Analysis to the MPH office and an individualized program-oriented educational plan to the Residency Program Office. PM-2 residents submit this plan to Residency Program Office. This individualized academic plan will be reviewed annually by the Chief Resident and Program Director.

PM-1 residents should elect a customized program of study for their MPH degree, although residents may informally follow the sequence of classes for any of the MPH (https://e-catalogue.jhu.edu/public-health/departments/master-public-health/) concentrations offered. Residents
that wish to apply for and complete an MPH concentration should first receive approval from the Program Director and Chief Resident.

**Extracurricular Activities**

Crucial to resident learning and success is resident involvement in the opportunities that become available through the MPH and residency programs. Although it is extremely difficult to measure its impact, involvement in classes, in projects, in residency activities, and in the community is the main mechanism for personal growth. We will bring to residents’ attention numerous public health-related activities during the year, and residents will hear about many opportunities from other sources.

We expect and strongly encourage residents to:

1. Be involved in as many of these opportunities as their time and energy permit. We encourage residents to engage in at least one preventive medicine research project or preventive medicine practice activity (i.e. community project) either as a part of the residency program or independent of it. Residents also are strongly encouraged to publish any research results and to present them at a residency seminar and national scientific meetings.
2. Serve as visiting instructors in courses when requested.
3. Participate in Special Studies projects that can be organized with faculty and preceptors at the local, state, national, or international health levels in order to gain experience in the solution of practical problems in preventive medicine.
4. Participate actively in departmental and school-wide activities including seminars, required courses, and teaching opportunities.
5. Seek advice and assistance from a faculty member designated as faculty adviser in the planning of both academic and field research experience.
6. Attend preventive medicine/public health national meetings, such as the annual meetings of the American College of Preventive Medicine and the American Public Health Association.

**SAMPLE Calendar of Major PM-1 Year Residency Events**

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>July-August</td>
<td>Orientation</td>
</tr>
<tr>
<td></td>
<td>Meet the Professor series</td>
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<tr>
<td></td>
<td>Public Health Preparedness module</td>
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<tr>
<td></td>
<td>Journal Club</td>
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<tr>
<td></td>
<td>Clinical component orientation</td>
</tr>
<tr>
<td>September-December</td>
<td>Professional development and skill-building seminars</td>
</tr>
<tr>
<td></td>
<td>Introduction to Problem Solving in Public Health course</td>
</tr>
<tr>
<td></td>
<td>Fundamentals of Clinical Preventive Medicine course (Term 1)</td>
</tr>
<tr>
<td></td>
<td>Creating, Implementing and Monitoring Budgets for Projects and Programs</td>
</tr>
<tr>
<td></td>
<td>Intro to U.S. Healthcare course (also offered in Term 4)</td>
</tr>
<tr>
<td></td>
<td>Public Health Toxicology course (optional course offered in Terms 1 and 2)</td>
</tr>
<tr>
<td></td>
<td>Health Equity sessions</td>
</tr>
<tr>
<td></td>
<td>Clinical program</td>
</tr>
<tr>
<td>January-Intersession</td>
<td>Advocacy module</td>
</tr>
<tr>
<td></td>
<td>Clinical program</td>
</tr>
<tr>
<td>January-May</td>
<td>Clinical Environmental and Occupational Toxicology</td>
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<tr>
<td></td>
<td>Foundations of Leadership seminar</td>
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<tr>
<td></td>
<td>Practicum Leadership seminar</td>
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<tr>
<td></td>
<td>Project Management (biennial)</td>
</tr>
<tr>
<td></td>
<td>Leadership and Management module</td>
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<tr>
<td></td>
<td>Health Equity sessions</td>
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<tr>
<td></td>
<td>Colman Grand Rounds</td>
</tr>
<tr>
<td></td>
<td>Clinical program</td>
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<tr>
<td></td>
<td>TA the Term 3 Online Problem Solving Course</td>
</tr>
<tr>
<td>May-June</td>
<td>MPH Capstone Project due</td>
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<tr>
<td></td>
<td>ACPM Preventive Medicine Conference</td>
</tr>
<tr>
<td></td>
<td>Preparations for second year</td>
</tr>
<tr>
<td></td>
<td>TA the MPH Summer Intersession Problem Solving in Public Health course</td>
</tr>
<tr>
<td></td>
<td>Environmental Health Seminar series with site visits</td>
</tr>
<tr>
<td></td>
<td>Clinical program</td>
</tr>
</tbody>
</table>

PM-1 residents are required to be present and participate in all residency activities through June 30 of that year, except when vacation for the PM-1 class is scheduled.

**MPH Capstone Overview**

The MPH capstone project is a graduation requirement for students in the MPH program. The goal is for students to synthesize, integrate, and apply the skills and competencies they have acquired. Completion of the MPH capstone project requires both written and oral components. Additional detailed information is available in the MPH Program guides; some key excerpts are shown below:

- There are no formal guidelines on the length of the paper; range is generally between 15 and 25 double spaced pages.
- The paper must include an executive summary (limited to 300 words) and references.
- The final written project, along with a letter from your faculty capstone supervisor approving your project, will be due in the MPH Program Office by a specified date.
- Indicate on your MPH Capstone Information form that you will be presenting the oral component with the overall MPH program, scheduled for a Saturday early in May by the MPH program, but should be assigned to the General Preventive Medicine Residency group, which will be moderated by GPMR leadership and faculty.
- During 3rd and 4th terms, you must sign up for at least 1 credit of special studies each term with your capstone supervisor. The capstone supervisor may be your residency adviser, but it can be another faculty member in your area of interest. If you are working with Dr. Lam as your capstone adviser, you should register for
PH.300.800 MPH Capstone Health Policy and Management (MPH Capstone – HPM).

- Although it is encouraged that all residents complete their Capstone during PM-1, residents may seek to complete their Capstone during PM-2.

GPMR Capstone Focus
Preventive medicine residents have a unique opportunity within the School of Public Health to complete multiple “capstones” during residency practicum rotations, with more intensive exposure to chosen areas of interest. The MPH capstone project should contribute to each resident’s foundation for engaging in a productive PM-2 year.

The MPH capstone experience in the residency program is designed each year with the goals of meeting all MPH Program educational experiences but also allowing the residents to demonstrate competence in areas that have been a focus of residency seminars during the year. Each year these competencies will vary based on the internal and external environments of public health. The Problem Solving Paradigm may be utilized. All residents will fulfill their MPH oral presentation requirement by presenting at a Capstone Symposium in May. The program faculty and staff will provide specific guidelines as the year progresses.

Rotation Selection Process
Mid-way through their PM-1 year of training, residents begin to plan for the practicum year by reviewing the rotation guidelines, the available established rotations, and other materials such as reports and evaluations submitted by current and former practicum year residents. Rotation Descriptions and Planning Documents can be found in New Innovations.

Calendar for Rotation Selection Process
The selection of rotations follows approximately the schedule below.

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-Feb</td>
<td>Rotation information distributed, selection process reviewed, and residents attend Meet the Preceptors sessions to familiarize themselves with established rotation site preceptors and learn more about those rotations</td>
</tr>
<tr>
<td>March</td>
<td>Rotation preferences are submitted to program manager</td>
</tr>
<tr>
<td>April</td>
<td>Rotation schedule is drafted and refined</td>
</tr>
<tr>
<td>April-June</td>
<td>Residents contact preceptors to confirm rotations, program manager finalizes rotation agreements</td>
</tr>
</tbody>
</table>

PM-1 Vacation Guidelines
Residents have 15 vacation days per year. Vacation during the PM-1 year will be determined by the academic calendar and the GPMR-required didactic modules. The GPMR program schedules modules and learning opportunities for the PM-1 residents during many of the MPH breaks, including spring break, winter intercession, and summer intercession.

Residents will be provided an annual calendar, which includes holidays, vacation time, and other important residency activities. Please consult the annual calendar carefully and discuss with the Chief Resident before making travel plans. Residents who have completed an MPH prior to coming to GPMR should consult with the GPMR Chief Resident before scheduling vacation; rotation dates will surround the PM-1 vacation schedule as to minimize time away from rotations you will complete during the first year.

All residents will have days off according to Johns Hopkins University holidays:

- Fourth of July,
- Labor Day,
- Thanksgiving,
- Winter holidays,
- Martin Luther King, Jr Day, and
- Memorial Day.

PM-1 SICK TIME GUIDELINES
All residents at JHSPH are entitled to 15 days (three weeks) paid sick leave per year. Days may be used for a resident’s own sickness or to care for a family member. Unused days may not be carried over into the following 12-month period and are not payable upon departure.

When a resident takes sick leave, they should notify their Program Director and keep them as up to date as feasible. The Program Director may require the resident to submit verification of the need for sick leave from their healthcare provider to the University Health Service Center for review. Any documents containing a resident’s medical information must be kept separate from their academic file. Extended absences (more than two weeks) must be reported by the resident and the Program Director to the Program Manager as quickly as possible. If the illness requires an extended absence, the resident may apply for a leave of absence.

PM-2 (Second Year) Information

Requirements and Expectations for PM-2 Residents (Practicum Year)
To meet the objectives of the residency, residents will fulfill the following roles and responsibilities in securing training in the teaching, research, and practice of preventive medicine. The residency believes there is a common knowledge base that all residents should acquire and that this knowledge base will be most effectively acquired through shared experiences. Among such experiences are the earning of the MPH degree, attending Grand Rounds, completing clinical preventive medicine training, and meeting the requirements for rotations and administrative rounds during the second year.

Roles and Responsibilities of Residents
Although it is important that all guidelines be met, the residency will do all it can to accommodate residents’ interests. However, PM-2 residents must:


2. Attend all residency activities unless formally excused by the Chief Resident. These activities include monthly Administrative Rounds and Grand Rounds.

Note: Monthly Administrative Rounds are a requirement of the program. If you are on an away rotation, you may be excused up to 3 Administrative Rounds.

Note: You may submit request to the Program Director to be excused for up to 6 Administrative Rounds; prior approval of the Program Director is required. You are expected to plan for completing any missed clinical sessions prior to participating in away rotation(s).
are not allowed to take a vacation day to miss Administrative Rounds if that is not your scheduled vacation time.
3. Complete the practicum experience required for the MPH degree.
4. Register for 16 credits of Special Studies (PH.550.890 SS/R: General Preventive Medicine Residency-Residency Year) per term during their Practicum Year.
   (Note: residents in their third and fourth year of the combined program should follow the instructions provided by the Residency Program Manager regarding their credit requirement.)
5. Complete and submit all assigned rotation reports per the Practicum Rotations (p. 11)/Resident Requirements (p. 11) guidelines.
6. Engage in at least one preventive medicine research project or preventive medicine project (e.g. a community project) either as part of the residency program or independent of it.
7. All residents must meet with the principal faculty on a regular basis. These meetings include a formal, written semi-annual evaluation with program director and clinical director as well as periodic meetings with the academic co-directors. Evaluation will consist of a discussion of the didactic work, applied work, clinical work, courses, research projects, papers, and related activities in which the resident has been involved. Residents’ academic transcripts also will be reviewed as a part of the process. Evaluation of resident’s activities includes identification of areas of strength, areas needing additional emphasis, and professional goals. At the conclusion of each meeting there will be a summary of the resident’s performance in New Innovation. This information is required for performance evaluation and credentialing of residents. For residents on rotations outside of the Baltimore/Washington area, evaluations will be conducted by telephone, as appropriate.
8. Participate in the preventive medicine clinical component – equivalent to 2 months (320 hours) annually. All clinical experiences are subject to approval by the Program Director.

PM-2 Residents' meeting expectations:
September: Meet with Academic Director
December: Semi-annual review with Program Director and Clinical Director
March: Meet with Academic Director
May: Semi-annual review with Program Director and Clinical Director

PM-2 Educational Plan
Residents are required to prepare an educational plan for their practicum year, using the following instructions to develop the plan. A template for this plan will also be shared with the residents at the start of the academic year.

1. Referring to the competency descriptions in this packet, write a narrative (several pages) that details your educational objectives for the practicum year. Include the knowledge, skills, and competencies you hope to acquire in each of your planned rotations and how you believe each rotation will help you meet your professional goals.
2. Include in your narrative the knowledge, skills, and competencies you expect to gain in the residency-sponsored modules, monthly rounds, including didactic sessions, Grand Rounds, and your own readings.
3. Include a paragraph on what you expect to be doing in one year, five years, and ten years from now.

Practicum Rotations
The major activity of residents in the practicum year of training is participation in practicum rotations. The following section outlines the guidelines for Practicum Preventive Medicine Rotations. More detailed information can be found in New Innovations.

Resident Requirements
1. Each resident must complete twelve months of rotations consisting of a minimum of four different rotations. Rotations must be two to three months in duration. One month rotations are not permitted; four month rotations must be approved in advance by the program director.
2. Each resident must complete at least one rotation of 2-3 months in
   a. Biostatistics/Epidemiology
   b. Management and Administration/Medical Management, and
   c. Either Occupational/Environmental Health or Clinical Preventive Medicine.
3. If you are on an away rotation (outside of the Baltimore-Washington area), you may be excused for up to 3 Administrative Rounds. Note: You may submit request to the Program Director to be excused for up to 6 Administrative Rounds for participation in an away rotation, though prior approval is required. You are expected to submit a plan for completing any missed clinical sessions prior to participating in away rotation(s).
4. Each resident must select at least two rotations from the list of established rotations.
5. All residents must attend the monthly Administrative Rounds and Grand Rounds during all months that they are doing rotations in the Baltimore-Washington area. They must be present for the entire day of activities. Residents may not take a vacation day on the day of Administrative Rounds unless that is their regularly scheduled vacation.
6. Based on accreditation requirements, each resident must do at least one rotation in a public health agency. Public health agencies are defined as any local health department, any state health department, any federal health agency (such as NIH, NIAID, ODPHP, AHRQ, FDA), and international health agencies such as PAHO.
7. In order to receive credit for each rotation, a resident is required to submit:
   a. A Rotation Plan form, which is due one week after beginning the rotation.
   b. A form evaluating the rotation overall (Resident Evaluation of Rotation/ Preceptor), which is due one week after completing the rotation. These forms are available in electronic format and should be completed and submitted through the New Innovations system. Failure to submit these documents as required in a timely fashion may lead to a grade of Incomplete in the Special Studies course PH.550.890 SS/R: General Preventive Medicine Residency-Residency Year and/or denial of the residency certificate of completion. Disciplinary action will be taken if rotation reports are >2 months late. The purpose of these reports is to enable the residency to support residents more effectively in the field and to identify and resolve problems in a timely manner. These forms are mandatory as a part of accreditation of the residency.
8. During the last week of a practicum rotation, the resident must meet with the preceptor as part of an “exit interview” and to help facilitate and ensure the timely completion of the Preceptor’s Evaluation of the Resident.
9. Residents must receive at least a satisfactory evaluation from each rotation preceptor. All rotation schedules are subject to final approval by the director of the residency program.
10. Residents must complete the clinical component, equivalent to 2 months (320 hours) of work. All clinical experiences must be
approved by the program director. Residents are required to complete similar rotation evaluation forms for each clinical rotation including:

a. A Rotation Plan form, which is due one week after beginning the rotation.

b. A form evaluating the rotation overall (Resident Evaluation of Rotation/Preceptor), which is due one week after completing the rotation.

c. During the last week of a clinical rotation, the resident must meet with the preceptor as part of an “exit interview” and to help facilitate and ensure the timely completion of the Preceptor’s Evaluation of the Resident.

New Innovation Evaluation Forms and Due Dates

<table>
<thead>
<tr>
<th>Evaluation Form</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotation Plan</td>
<td>One week after beginning rotation (each rotation)</td>
</tr>
<tr>
<td>Resident Evaluation of Rotation/Preceptor</td>
<td>One week after completing rotation (each rotation); This form is confidential between the resident and program.</td>
</tr>
<tr>
<td>Preceptor Evaluation of Resident</td>
<td>One week before completing rotation (each rotation); Residents encouraged to review with preceptor.</td>
</tr>
<tr>
<td>Principal Faculty Assessment of Resident Performance</td>
<td>During Semi-annual and Quarterly meetings; Residents encouraged to review with principal faculty.</td>
</tr>
</tbody>
</table>

Residency Rotation Support
It is the residency program’s responsibility to ensure that all practicum year residents receive an equitable stipend. The residency is able to do this because rotation sites support the program through rotation fees. The fee is used to support the cost of the residency program.

PM-2 Vacation Guidelines
JHSPH GPM residents are entitled to 15 business days of vacation during the practicum year plus any standard holidays or office closures that fall during a rotation period. (Residents in the combined family medicine/preventive medicine program receive vacation according to MedStar Franklin Square guidelines per the agreement.) Be sensitive to the impact of your vacation absence on your rotation project(s). **You may not take all 15 days during one rotation.** We suggest that you take no more than 2-3 vacation days in a two-month rotation and no more than 5 days in a three-month rotation, while vacation time taken during a longer rotation may be adjusted accordingly. **Vacation time must be approved in advance by:**

1. the program director (vacation requests must be submitted via New Innovations) and
2. by the preceptor.

Vacation days during a rotation must be reported on your end of rotation evaluation report (within New Innovations).

Time taken off to attend required residency activities (including Administrative Rounds and Grand Rounds) should not be counted as vacation days, but you should be sure to inform your preceptor at the start of each rotation that you are required to attend these activities. Days taken off for job interviews or other personal reasons are counted as vacation days. Days taken off to attend conferences are not considered vacation days; however, your total conference plus vacation days in one rotation should not exceed the total suggested number of vacation days for rotation’s length.

As with any professional work situation, you likely will be responsible for completion of specific projects or other deliverables as part of your rotations and you should plan your time toward that end, regardless of vacation time off. Evening and weekend work, while not routinely required on most rotations, is nevertheless a possibility.

**PM-2 sick time GUIDELINES**

All residents at JHSPH are entitled to 15 days (three weeks) paid sick leave per year. Days may be used for a resident’s own sickness or to care for a family member. Unused days may not be carried over into the following 12-month period and are not payable upon departure.

When a resident takes sick leave, they should notify their Program Director and Preceptor and keep them as up to date as feasible. The Program Director may require the resident to submit verification of the need for sick leave from their healthcare provider to the University Health Service Center for review. Any documents containing a resident’s medical information must be kept separate from their academic file. Extended absences (more than two weeks) must be reported by the resident and the Program Director to the Program Manager as quickly as possible. If the illness requires an extended absence, the resident may apply for a leave of absence.

Practicum Year Reading List

<table>
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<tr>
<th>Rotation</th>
<th>Texts to be Utilized</th>
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Practicum Year Didactics
Description and Responsibilities
Didactics for practicum year residents are designed to enhance training and provide academic and practical knowledge for critical content areas and/or where gaps are identified in the existing curriculum. Didactic material will be covered at monthly administrative rounds. Each didactic topic will be introduced and discussed with a guest speaker. The residents are responsible for engaging with the speaker and participating in discussions or Q&A.

Practicum year residents must sign up for 16 credits per term for the following special studies course for this didactic component: PH.550.890 SS/R: General Preventive Medicine Residency-Residency Year.

This Preventive Medicine Core Course is designed to expose residents to essential areas in General Preventive Medicine and Public Health. Residents will have been exposed to the content areas of this course during previous training or work experiences. As such, we assume a basic level of familiarity with the course content. The course will be structured around 12 topics. Each topic will consist of introductory comments, didactic materials, and discussion. All residents are required to complete the indicated readings and be active participants in discussion.

Course structure for PH.550.890 SS/R: General Preventive Medicine Residency-Residency Year

Didactic Topics
1. Healthcare Delivery/Health Systems
2. Public Health Nutrition
3. Injury Epidemiology and Prevention
4. Socio-economic Aspects of Public Health
5. Health Promotion
6. Infectious Diseases
7. International Health
8. Occupational Medicine
9. Outbreak and Surveillance System
10. Public Health Practice
11. Global Health
12. Career/Professional Development

Course Objectives by Topics
1. **Health Care Delivery/Health Systems**: To become familiar with basic concepts and organizational design and function of the US healthcare system including Medicaid, Medicare, managed care, and quality assurance.
2. **Public Health Nutrition**: To understand mechanics of micro and macro-nutrition, diagnosis and treatment of over and under-nutrition, anthropometrics, and population-based nutritional interventions.
3. **Injury Control**: To develop a public health approach to injury assessment, management and intervention, and prevention. To learn basic biomechanics of childhood injuries. To learn how to obtain injury information from various sources.
4. **Socio-economic Aspects of Public Health**: To learn major theories of health behavior, the relationship among SES, race, and population-level health determinants, and the implications of these factors for population-based health promotion and primary prevention.
5. **Health Promotion**: To become familiar with principles of providing cost-effective services within clinical encounters. Preventive recommendations for specific disease states will not be addressed but will instead focus on a conceptual framework for the provision of services in private and public practice settings.

6. **Infectious Diseases**: To understand the importance, characteristics, epidemiology, prevention, and treatment of vaccine preventable, sexually transmitted, and other important infectious diseases. To become familiar with the current U.S. Recommended Childhood Immunization Schedule. To gain understanding of vaccine policy.

7. **International Health**: To understand health-related problems and approaches to evaluating, intervening, and promoting health, and preventing diseases in developing countries.

8. **Occupational Medicine**: To understand the historical, legislative framework involving occupational medicine, develop competence in the administration and leadership of an occupational health and safety program, and evaluate and develop therapeutic and preventive interventions for occupational problems.

9. **Outbreak and Surveillance System**: To learn how to investigate an outbreak. To learn how to evaluate and develop good surveillance systems.

10. **Public Health Practice**: To explore the concepts, definitions, and settings of public health practice. To consider the legal and ethical contexts within which public health practice operates. To survey tools available to the public health practice doctor and the challenges they face.

11. **Global Health**: To learn the scope of work for the most important organizations involved in international health. To state the top causes of adult and child morbidity and mortality and the determinants affecting child and adult morbidity and mortality in developing countries. To review the fundamentals involved in disaster relief. To understand the global burden of HIV/AIDS.

12. **Career/Professional Development**: To develop and evaluate residents’ curriculum vitae. To provide a venue for residents to self-evaluate their knowledge, skills, and competencies in order to allow them to hone their deficiencies over the remainder of their residency training. To review strategies on networking, interviewing, finding the right first job, negotiating terms, and developing a plan of continuous professional development.

**PREVENTIVE MEDICINE IN-SERVICE EXAMINATION**
The Preventive Medicine In-Service Examination, provided by the American College of Preventive Medicine (ACPM), is designed for residents in all specialty areas of Preventive Medicine. The material covered in the exam relates to the core (morning) portion of the American Board of Preventive Medicine (ABPM) examination. The exam enables residents and their directors to determine if there are specific areas where more study and experience are needed. It also enables residents to compare themselves with others at the same level nationally. Though it is not intended to be an examination preparation tool, it can be a gauge of how well residents are being trained and prepared for the content of the board examination.

All residents are required to take the annual Preventive Medicine In-Service Examination in each year of training. The exam is given during the summer of each year. The exam is two hours long and all of the questions are “one best response,” which is the type of question the American Board of Preventive Medicine now is using in the certifying examination. The Chief Resident and program staff will schedule the exams for both resident cohorts.

Reflecting the content on the core part of the certifying examination, the categories covered are: Epidemiology, Biostatistics, Infectious Disease, Chronic Disease, Occupational Medicine, and Health Services.
Administration. The number of questions per category is evenly distributed. There are a very few questions on the topic of Health Promotion.

**General Textbooks and Resources**

- Maxcy, Rosenau, Last - *Public Health and Preventive Medicine*
- Levy and Wegman - *Occupational Health: Recognizing and Preventing Work-Related Diseases*
- McCally - *Life Support: The Environment and Human Health*
- Heymann - *Control of Communicable Diseases Manual*
- Scutchfield, Keck - *Principles of Public Health Practice*
- Novick, Mays - *Public Health Administration: Principles for Population-based Management*
- USPSTF - *Guide to Clinical Preventive Services 2014*
- WWW, scientific and lay literature, and other resources as indicated in specific modules

**Program Policies**


Additional program-specific policies are outlined in this section.

**Professional Conduct Code**

The purpose of these guidelines is to foster an atmosphere of professionalism and respect between the GPMR residents, program and guests (e.g. speakers, lecturers, visitors). Residents’ first duty is to the Residency Program (accredited by the Accreditation Council for Graduate Medical Education).

**Residency Expectations and Requirements**

1. Meet all expectations of the GPMR program, as described in this handbook and elsewhere.
2. Attend all residency activities unless formally excused by the Chief Resident or Program Director. These include, but are not limited to:
   - All residency module activities, journal clubs, seminars, and site visits
   - Monthly administrative rounds
   - In-Service Examination in August
   - Service as teaching assistant for the School of Public Health “Problem Solving in Public Health” courses, including attending the lectures of those intersession courses
   - Additional activities as required by the Program Director or Chief Resident.
3. Attend and participate in all assigned clinical activities and must meet minimum ACGME requirements of 80 shifts per year (4 hours per shift). The Clinical Director must be notified in advance of schedule conflicts or absences. Failure to do so will result in disciplinary action.
4. Notify the Chief Resident well in advance if you unable to attend any GPMR activity. Failure to do so in a timely fashion may result in disciplinary action. Absences may only occur within the framework described in the GPMR Activity Attendance section (p. 14), as below.
5. Arrive on time and remain in attendance until the activity is formally closed. Late arrivals and early departures will be treated as unexcused absences.
6. Attend sessions actively - physically, cognitively, psychologically. Unless otherwise specified, we expect residents to refrain from the use of laptop computers, cell phones, tablets, and other digital or distracting devices during residency activities, as distraction detracts from the educational experience and is disrespectful to our invited speakers.
7. If a resident’s performance or conduct is determined to require action, the Residency Program Director will follow the procedures as listed in the Graduate Medical Education Policies (https://e-catalogue.jhu.edu/public-health/departments/residency-programs/#facultytext).
8. Maintain regular communication. Residents are explicitly expected to:
   - Check their JHU email account every day Monday through Friday (except when on vacation). **Read all emails from the Program Director, Chief Resident, and GPMR staff and respond within an appropriate time period (within 48 hours during the work week)**
   - Regularly check the Residency Program calendar for schedules and updates
   - Return all phone calls and text messages from the Program Director, Chief Resident, and staff within 48 hours.
9. Complete readings and submit assignments by specified deadlines.
10. Promptly update GPMR staff with any changes in contact information.
11. Meet individually with the Chief Resident each MPH term or more frequently and meet individually with the Program Director semi-annually to review progress on career development objectives and academic performance.

**GPMR Attendance Policy**

GPMR training is an educational experience that serves to develop the skills and experiences necessary for a graduating physician to begin a career in preventive medicine and population health and to excel in his or her own chosen area of the specialty.

As a specialty training program, there are certain core competencies that must be met as part of ACGME accreditation standards. The program expects residents to have a strong motivation to learn about preventive medicine and hopes to create an environment that encourages residents to look forward to activities and events that enhance the breadth and understanding of a resident's educational experience.

Since repeated absences serve to diminish a resident’s learning opportunities and might even be detrimental to the educational experiences of other residents, this attendance policy has been adopted by the program in order to ensure a positive experience for all residents:

1. GPMR activities include, but are not limited to, those described above.
2. For all residency-required activities and events, attendance will be recorded by the Chief Resident.
3. It is the resident’s responsibility to be up to date on all scheduled GPMR activities and activity updates.
4. Arrive on time or early. Late arrivals demonstrate disorganization and disrespect for one’s peers, and will be treated as unexcused absences and recorded.
5. Remain in attendance until the activity is formally adjourned by the Chief Resident. Early unexcused departures will be treated as unexcused absences.

6. Notify the GPMR Chief Resident well in advance if you are unable to attend any GPMR activity. Failure to do so in a timely fashion may result in disciplinary action.

7. Given the wide range of activities and conferences held in the School of Public Health, GPMR understands that residents may desire to attend other activities of professional interest. Residents may be allotted one (1) absence per academic term, in consultation with the Chief Resident and/or Program Director. Permission from the Chief Resident and/or Program Director must be sought well in advance of the desired absence and will only be granted at their discretion. Such professional interest absences can only be used for GPMR lectures. In general, absences will not be allowed for seminar series (such as Problem Solving in Public Health, Public Health Preparedness, etc.), site visits, Administrative Rounds, Grand Rounds, Winter Intersession, or Summer Institute (May-June) activities. Moonlighting is not considered an acceptable reason to miss scheduled residency activities. All moonlighting must be scheduled around residency activities. The moonlighting privilege may be revoked in the event of repeated absences.

8. Excused residents have the same responsibility as their present peers for all activities missed, announcements made, and materials distributed. It is the resident’s responsibility to inquire about and complete any missed assignments. Failure to do so may result in disciplinary action.

9. In the event of unforeseen circumstances that fall outside the control of the resident (e.g., illness), the resident must notify the Chief Resident as soon as possible. Permission for such absences may only be granted at the discretion of the Chief Resident and Program Director after consultation with the resident. In the event that such circumstances occur with frequency, the resident will work with the Chief Resident to develop a remediation plan to account for material that was missed.

10. For repeated absences, sanctions may be imposed according to the following attendance policy:

<table>
<thead>
<tr>
<th>Number of Absences Per Term</th>
<th>Sanction</th>
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<tbody>
<tr>
<td>First absence</td>
<td>None if prior approval given by Chief Resident</td>
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<tr>
<td>Second absence</td>
<td>Warning and discussion with the Chief Resident</td>
</tr>
<tr>
<td>Third absence</td>
<td>Letter in permanent record and meeting with the Program Director</td>
</tr>
<tr>
<td>Fourth absence</td>
<td>Develop a remediation plan with the consent of the Chief Resident and the approval of the Program Director</td>
</tr>
<tr>
<td>Fifth absence</td>
<td>&quot;F&quot; grade for GPMR course and/or other sanctions to be determined by the Program Director</td>
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</table>

1 Where multiple sanctions are listed, determination is made by the Program Director in consultation with the GPMR Chief Resident.

GPMPR Clinical Requirement and Attendance Policy

As part of the ACGME requirements, residents will be training in environments where patient responsibilities are paramount. Similar to other clinical settings, it is not permissible to be absent from your clinical responsibilities without proper notice. (e.g. you would not find it acceptable if a colleague were absent from patient care duties without notice or coverage while you were in clinic or on the wards.) It is important that you take these responsibilities seriously, and failure to do so is not appropriate behavior.

The procedure and consequences of missed clinical shift are articulated below.

Absences that require at least 2 weeks of notice: this should be reserved for a significant activity that will result in your absence. This does not include routine activities, meetings with faculty/preceptors, but does include exceptional activities such as presenting at a conference, etc. You should notify both the Chief Resident and Clinical Director of your potential absence with as much advance notice as possible or as soon as you are aware of the conflict. This request must be approved by the Clinical Director. You are also responsible for notifying the preceptor for the clinic site and arranging a make-up session.

Less than 2 weeks of notice: This is reserved for illness, family emergencies, and similar circumstances. You should notify both the Chief Resident and Clinical Director, and this must be approved by the Clinical Director. You are also responsible for notifying the preceptor for the clinic site and arranging a make-up session.

1st unexcused absence: a formal letter documenting the unexcused absence will be filed in the resident’s electronic file. This documentation will be taken into account when drafting letters of recommendation/reference, etc. The resident will be required to meet with the Clinical Director to discuss the absence.

2nd unexcused absence: another formal letter documenting the absence will be included in the resident’s file. The resident will be required to meet with both the Clinical Director and Program Director to discuss the absence.

3rd unexcused absence: another formal letter documenting the absence; a meeting with both the Clinical Director and Program Director. The chair of the Graduate Medical Education Committee (Vice Dean for Public Health Practice and Community Engagement) will be formally notified in writing, and the resident may be requested to meet with the Vice Dean.

Additional unexcused absences: disciplinary actions will be determined by the Program Director in consultation with the Clinical Director and chair of the Graduate Medical Education Committee.

Grading Evaluation Policy

Grading is based on presence of residents at administrative rounds, both physically and cognitively, and active participation in discussions and Q&A

SUPervision Policy

Preventive Medicine Competencies

Generic

1. Communicate to target groups including health professionals, the public, and the media, in a clear and effective manner, both orally and in writing, the levels of risk from real or potential hazards, and the rationale for selected interventions

2. Demonstrate the ability to prioritize new or ongoing projects or programs according to their potential impact, as defined by objective, measurable criteria

3. Use information technology for specific applications relevant to Preventive Medicine and Public Health
4. Interpret relevant laws and regulations relating to protection and promotion of the public's health
5. Identify ethical, social, and cultural issues relating to policies, risks, research, and interventions in Public Health and Preventive Medicine contexts
6. Identify the processes by which decisions are made within an organization or agency and their points of influence
7. Identify and coordinate the integrated use of available resources to improve the community's health

**Epidemiology and Biostatistics**
1. Characterize the health of a community
2. Design and conduct an epidemiologic study
3. Design and operate a surveillance system
4. Select and describe limitations of appropriate statistical analyses as applied to a particular data set
5. Translate epidemiologic findings into a recommendation for a specific intervention to control a public health problem
6. Design and/or conduct an outbreak and/or cluster investigation

**Management and Administration**
1. Assess data and formulate policy for a given health issue
2. Develop and implement a plan to address a specific health issue or problem
3. Conduct an evaluation or quality assessment based on process and outcome performance measures
4. Manage the operation of a program or project, including human and fiscal resources

**Clinical Preventive Medicine**
1. Develop, implement, and refine screening programs for groups to identify risks for disease or injury, and opportunities to promote wellness
2. Design and implement clinical preventive services for individuals
3. Implement community-based interventions to modify or eliminate identified risks for disease or injury and to promote wellness
4. Diagnose and manage diseases/injuries/conditions in which prevention plays a key role

**Occupational and Environmental Health**
1. Assess individual risk for occupational/environmental disorders using an occupational and environmental history
2. Identify occupational and environmental hazards, illnesses, and injuries in defined populations, and assess and respond to identified risks

**MONITORING AND EVALUATING RESIDENTS**

**Definitions:**
- **PM-1** = resident in the 13th through the 24th month of preventive medicine training
- **PM-2** = resident in the 25th through 36th month of preventive medicine training

**Clinical Skills:**
Each resident entering the program as a PM-1 will have completed at least one year of ACGME-accredited clinical residency training. The program director will ascertain from the resident's previous clinical program (or other source as appropriate) that the resident has achieved the six core clinical competencies.

**Outpatient Care:**
All patients seen by a resident on an outpatient basis must be seen by, discussed with, or reviewed by the responsible site preceptor.

**Communication:**
Communication with the site preceptor is mandatory in the case of emergent and/or critical incidents or other significant changes in clinical status.

**Monitoring/Evaluation:**
The goals and objectives as well as the process of evaluation for the training program are discussed at orientation. The goals and objectives are available to all residents and faculty on the residency website. Rotation specific evaluations mirror the goals and objectives for a given rotation. At the end of each rotation, a formal written evaluation is completed for each resident by the site preceptor. A copy of this evaluation is provided to the resident.

Assessment of resident performance will be based on multiple evaluation strategies and may include:
- Direct observation of clinical and interpersonal skills
- Case-based discussion
- Completion of teaching modules
- Review of medical records
- Preparation and delivery of teaching sessions
- Participation in conferences
- Review of patient and/or procedure logs
- Feedback from patients and families
- Feedback from allied health professionals
- Assigned projects such as a clinical research project

Non-compliance with responsibilities or performance problems are generally discovered and addressed in one of the following ways:

1. The site preceptor may address isolated problems with specific individuals. The problem and corrective actions are documented by the site preceptor, who notes the problem, and are transmitted to the program director.
2. Each resident has a faculty mentor who meets with his/her advisee a minimum of twice a year to review evaluations and provide career counseling. The mentor may be invoked to provide counseling to his/her mentee.
3. The program director reviews all resident evaluations. The Clinical Competency Committee consisting of leadership and key faculty members and as required by ACGME guidelines, meet semi-annually to discuss the progress of each resident. Any identified problems will be discussed and remediation plans will be implemented.
4. Semi-annual, annual, and summary evaluations are completed on each resident in accordance with ACGME-RRC and JHSPH requirements.

In order to be promoted to the PM-2 year, the resident must have demonstrated satisfactory performance in academic coursework and all practicum evaluations must reflect satisfactory performance.