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The Residency Program Director's Handbook

THIRD EDITION

Linda S. Nield, MD
Jennifer L. Reemtsma, M.Ed

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Contents

About the Authors	vii
Chapter 1: Graduate Medical Education	1
The Accreditation Council for Graduate Medical Education	1
Residency Review Committees of the ACGME	2
ACGME Policies for Programs	4
Chapter 2: The Program Accreditation Process Overview	7
Program Evaluation Committee and Annual Program Evaluation	8
Accreditation for New Programs	10
Chapter 3: Institutional Requirements: The Program Director’s Role	13
Annual Institutional Reviews	14
Residents and the Institution	14
Chapter 4: Residency Program Personnel and Resources	23
Program Director	23
Program Coordinator	24
Faculty	26
Chief Resident	26
Liaison	27
Departmental Chair and Vice Chair	27
Other Program Personnel	28
Program Resources	28
Chapter 5: Sponsoring Institution Requirements of ACGME-Accredited Programs	29
Organization of the Graduate Medical Education Committee	29
Responsibilities for Oversight: GME Policies	31
Resident Contracts/Agreement of Appointment	33
Annual Institutional Review	34
Special Review Process	34

Chapter 6: Education Program Requirements: Structuring Your Curriculum	37
Didactic Curriculum	37
Residents as Teachers	42
Developing Goals and Objectives	42
Evaluating Effectiveness/Assessing Strengths and Weaknesses	43
Linking Goals and Objectives to Outcomes	48
Chapter 7: Measuring Outcomes in Medical Education	51
Entrustable Professional Activities	52
Core Competencies and Subcompetencies	53
Milestones	57
Chapter 8: Clinical Learning Environment Review	61
The Six Focus Areas	61
Before the CLER Site Visit	63
The CLER Site Visit	64
After the CLER Site Visit	64
Chapter 9: Resident Wellness	67
Monitoring Wellness	68
Strategies to Promote Wellness	69
Chapter 10: Program Director Duties	73
Resident Recruitment	73
SOAP	74
Visas	75
Resident Orientation	76
Policies	76
Didactic and Clinical Education	77
Faculty	78
Interface With ACGME	78
Resident Transfers	79
Changes in Resident Complement	79
Resident Rotation Schedule	80
Off-Site Rotations	80
Supervision	81
Scholarly Activity	82

Evaluations	82
Goals and Objectives	82
Program Budget	83
Committees.	83
Transition of Care	83
Alertness Management/Fatigue Mitigation	84
Semiannual Resident Performance Reviews	84
Resident Retreat	85
Resident Graduation	85
Chapter 11: Single Accreditation System	87
Becoming ACGME-Accredited.	87
USMLE vs. COMLEX	88
The Match	90
Chapter 12: Committees	93
The Clinical Competency Committee.	93
The Program Evaluation Committee.	94
The Resident Selection Committee	95
The Graduate Medical Education Committee	95
Chapter 13: Evaluations.	97
Residents.	97
Faculty.	105
Program.	107
Chapter 14: Developing a Resident Disciplinary Policy.	117
Setting Expectations	118
Setting Minimum Performance Standards	118
Developing the Disciplinary Policy	118
Basics of a Grievance Policy	122
Chapter 15: Surveys	127
Annual ACGME Resident Survey	127
Annual ACGME Faculty Survey.	128
Institutional Resident and Faculty Surveys	128
Graduate Surveys	130
Graduate Employer Surveys	131

Chapter 16: Electronic Resources	133
ACGME’s Accreditation Data System	133
Electronic Residency Application Service	134
National Residency Matching Program.	135
Fellowship and Residency Electronic Interactive Database	135
Electronic Residency Program Management Systems	135
Chapter 17: Graduate Medical Education Funding and Budgeting.	137
Budgeting for Your Program	138

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1

Graduate Medical Education

As a program director, you may be asking yourself what you've gotten yourself into by taking on this new role. Although there are certainly many rewards to this position, it brings many challenges as well. Some of these challenges come from trying to successfully navigate the different regulatory and accreditation requirements and managing the ups and downs of working with young physicians, all while trying to maintain your own clinical activities (and still have a life outside of the clinical setting). This manual is designed to help program directors navigate this landscape without having to reinvent the wheel, so you can focus more of your time on educating our next generation of physicians.

The Accreditation Council for Graduate Medical Education

Part of being a successful program director is understanding the context in which the current system of graduate medical education (GME) accreditation came to be through the Accreditation Council for Graduate Medical Education (ACGME). This nonprofit organization is responsible for evaluating, accrediting, and reaccrediting residency programs within the United States. The mission of the ACGME (2014) is "to improve health care and population health by assessing and advancing the quality of resident physicians' education through accreditation." The ACGME (2019) states that it is committed "to improving the patient care delivered by resident and fellow physicians today, and in their future independent practice, and to doing so in clinical learning environments characterized by excellence in care, safety, and professionalism."

Prior to the establishment of the ACGME in 1981, five organizations under the direction of the American Medical Association (AMA)—the AMA, the American Board of Medical Specialties (ABMS), the American Hospital Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies—collaborated to create the Coordinating Council on Medical Education (CCME). This group was created to oversee all aspects of medical education, and it also brought together the existing residency review committees (RRC) to create the Liaison Committee for Graduate Medical Education (LCGME). Due to its many layers of red

Figure 1.1: Accreditation review committees

- Allergy and Immunology
- Anesthesiology
- Colon and Rectal Surgery
- Dermatology
- Emergency Medicine
- Family Medicine
- Institutional Review
- Internal Medicine
- Medical Genetics and Genomics
- Neurological Surgery
- Neurology
- Nuclear Medicine
- Obstetrics and Gynecology
- Ophthalmology
- Orthopedic Surgery
- Osteopathic Neuromusculoskeletal Medicine
- Otolaryngology Head and Neck Surgery
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Preventive Medicine
- Psychiatry
- Radiation Oncology
- Radiology
- Surgery
- Thoracic Surgery
- Transitional Year
- Urology

Understanding the program requirements produced by the RRCs

The program requirements for each specialty are classified into three categories: core requirements, detail requirements, and outcome requirements.

According to the ACGME, the definition for each requirement is as follows:

- *Core requirements: Statements that define structure, resource, or process elements essential to every GME program.* In other words, you must adhere to this standard regardless of the type of accreditation your program currently holds. An example of a core requirement might be, “Program leadership and core faculty members must participate in faculty or leadership development programs relevant to their roles in the program.” As of July 2019, the majority of the Common Program Requirements are core requirements.
- *Detail requirements: Statements that describe a specific structure, resource, or process for achieving compliance with a core requirement.* The 2019 Common Program Requirements have very few detail requirements. Examples can be found in Section VI: Learning and Working Environment.
- *Outcome requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of GME.* In other words, these statements reflect what residents should be expected to know and what they should be able to demonstrate by the end of their residency programs and prior to entering unsupervised practice.

2

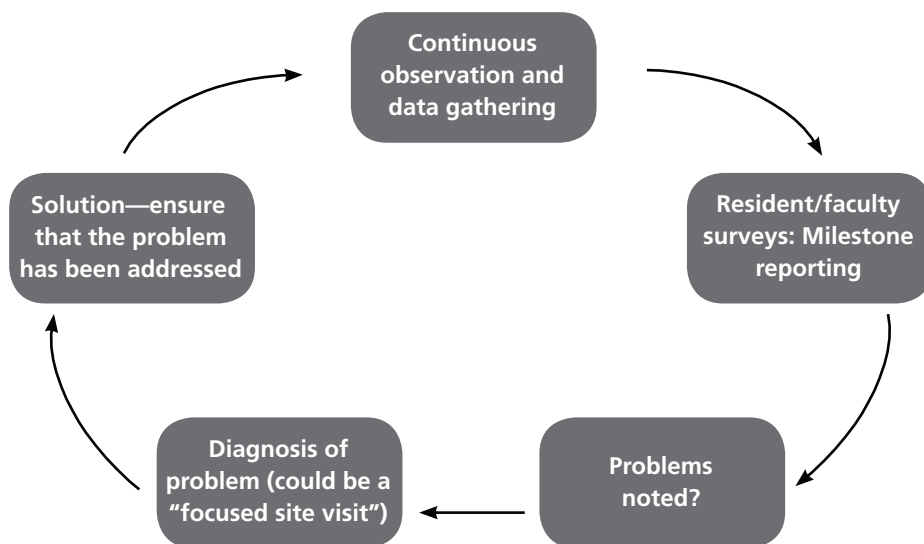
The Program Accreditation Process Overview

As mentioned in Chapter 1, in 2012, the Accreditation Council for Graduate Medical Education (ACGME) shifted away from the linear-style accreditation process.

The linear system was very rule-based. The residency review committee (RRC) would first review the program information form to ensure that all answers were considered correct and that all common program and applicable specialty requirements were met. It would also review the site visitor's report. Once the RRC had gathered this information, it would issue a letter to the program outlining citations and assigning a cycle length between one and five years, and the cycle would start over.

When the current accreditation system was implemented in 2013 (see Figure 2.1), there was a major shift toward an ongoing review of programs with a continuous improvement cycle.

Figure 2.1: Current accreditation process



their responsibility to know the extent of the liability insurance provided by the external facility. It is within ACGME guidelines for sponsoring institutions and individual programs to not allow moonlighting.

Clinical and educational work hour restrictions

The sponsoring institution and program director must mandate that their trainees comply with clinical and educational work hours limitations and immediately address rotations and duties that cause noncompliance. All residents should have a copy of the program's policy regarding clinical and educational work hours restrictions and violations. This topic warrants repetition in resident education and faculty development sessions, typically at the request of the program director. Although the main reason for clinical and educational work hours restrictions is to ensure patient safety, they are also required to support resident wellness as well as to monitor fatigue and prevent burnout.

Reminder: The ACGME has replaced the term *duty hours* with *clinical and educational work hours*.

Counseling services for residents

Depression and anxiety among residents are common, and Goebert et al. (2009) reported depressive symptoms in more than 20% of their medical student and resident study participants. Additionally, according to a meta-analysis by Schernhammer and Colditz (2004), the rate of suicide among physicians is moderately higher for men and substantially higher for women than it is in the general population.

Because rates of depression and suicide are high among physicians and residents, the sponsoring institution must have counseling and mental health resources available. These services should remain confidential; however, a mental health professional may provide information to the program regarding the resident's safety and ability to provide quality patient care. Resident wellness programs are an emerging solution to mitigate the effects of stress during residency training, and program directors should strongly consider them. Resident wellness and strategies to promote it are described in more detail in Chapter 9.

Leave of absence

Program and institutional policies regarding vacation and leave of absence (LOA) must be consistent with applicable federal laws, namely those from the United States Department of Labor. The most common LOAs for residents are related to maternity and paternity leave. Note that a prolonged LOA may extend the period of a resident's training and affect their eligibility for subspecialty board examinations, and the institution's policy must ensure that residents are

If a program can support a chief resident's attendance at a national ACGME or specialty-specific meeting that provides an informational session about the chief resident's role, it may be well worth the cost and effort.

FIGURE 4.2: Sample list of chief resident duties

- I. Administration**
 1. Create schedules
 - a. Residents' master rotation schedule for the academic year
 - b. Monthly on-call schedule
 - c. Vacation schedule
 - d. Didactic conference schedules
 2. Assist with quality improvement projects
 3. Organize morbidity, mortality, and improvement conferences
 4. Act as a liaison between nurses and residents
 5. Participate in committees
 - a. Program evaluation committee
 - b. Resident selection committee
 - c. Others
 6. Assist with resident retreat planning
 7. Assist with graduation planning
 8. Assist with interview season
- II. Teaching**
 1. Resident didactic lectures
 2. Board review
 3. Grand rounds
 4. Journal club monitor
 5. Medical student didactic lectures
- III. Clinical responsibilities**
- IV. Scholarly pursuits**

Source: Department of Pediatrics, West Virginia University School of Medicine, Morgantown, West Virginia. Reprinted with permission.

Liaison

For certain specialties—pediatrics, for example—there must be a liaison included in program leadership to assist in the duties of maintenance of certification. As the term implies, a liaison interfaces between the residents and the program office. The specific duties of a liaison will vary depending upon the program's needs. Program directors must know whether the appointment of a liaison is a requirement for their specific specialty.

Departmental Chair and Vice Chair

Departmental leadership, such as the chair and the vice chair of education, must certainly add support to the residency program and strive for excellence in all aspects of resident education. Consultation with these department leaders will provide guidance to the program director,

Residents should evaluate and provide feedback on each didactic session they attend. This information can be used for formative feedback, which is an important aspect of the promotion and tenure process for teaching faculty. See Figure 6.2 for a sample resident conference evaluation.

FIGURE 6.2: Sample resident conference evaluation

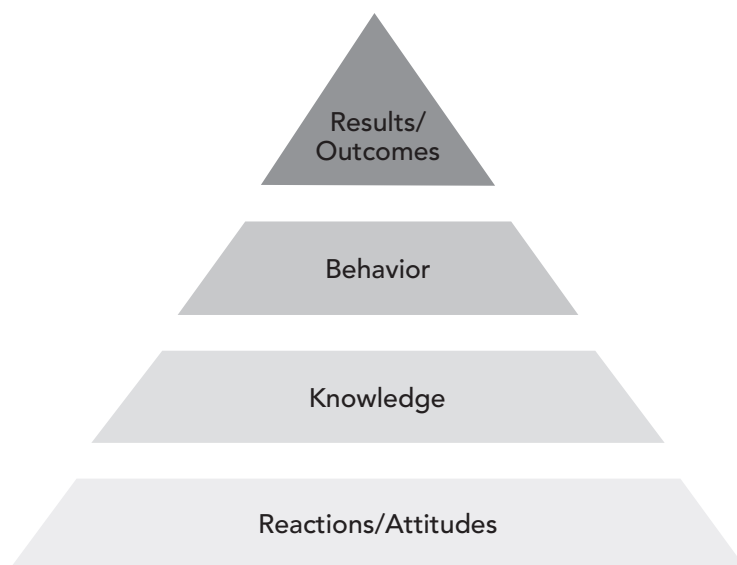
RESIDENT EVALUATION OF LECTURE & LECTURER				
Name of lecturer:			Date:	
Topic/Event:				
In order to help us continue offering high-quality lectures along with high-quality lecturers, please share your opinion about the lecture content and lecturer instruction. Your comments are important to us.				
	Excellent	Good	Fair	Poor
About the lecture:				
Lecture organization				
Lecture content				
Lecture material: clear, helpful, & useful				
Lecture length				
Overall quality of lecture				
About the lecturer:				
Lecturer's knowledge				
Lecturer's enthusiasm				
Opportunity for questions				
Lecturer's helpfulness				
Overall quality of lecturer				
Other comments:				

Source: Department of Pediatrics, University of Louisville School of Medicine, Louisville, Kentucky. Reprinted with permission.

Following the prescription writing learning event, the program director can track the residents' written prescriptions to determine whether they applied what they learned. An additional evaluation could be utilized to determine whether the learning affected patient safety.

Because the end goal of every residency is to produce competent physicians, each learning event should have an associated patient outcome. For example, after the prescription-writing learning event, it would be critical to monitor any adverse events in patient care that were related to incorrectly written prescriptions, near misses, and/or full-blown medical errors. Ideally, adverse outcomes should be reduced as a result of any educational intervention.

Figure 6.4: Kirkpatrick hierarchy of outcomes



The most common method of measuring a program's strengths and weaknesses is a survey. After an individual lecture, learners can easily provide their opinion and constructive suggestions through a single session evaluation. As previously mentioned, it is recommended that residents complete an evaluation for every scheduled learning activity in which they participate. Valuable information about resident reactions can be gleaned from rotation evaluations, as residents are required to evaluate their clinical rotation (Figure 6.5), their teaching faculty members (Figure 6.6), and the stressors associated with the rotation (Figure 6.7). ACGME and institutional surveys, as well as annual program evaluations, can provide additional global information regarding the program's educational curriculum quality. Finally, graduate surveys can provide perspective on opportunities to improve the residents' preparedness for practice. For more information on graduate surveys, see Chapter 15.

Additional Resources

- Johns Hopkins Medicine and the Resident Wellness Program. (2013). Resident Wellness Toolkit, a prototype. <https://christianacare.org/documents/medical-dental%20staff/ResidencyWellnessToolkit-Prototype-Dec17.pdf>
- Andolsek, K. (2016). The Life Curriculum. <https://sites.duke.edu/thelifecurriculum/2016/12/05/new-acgme-am-society-for-suicide-prevention-and-mayo-clinic-resources>

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Pincavage, A., & Poston, J. (2017). Addressing wellness in residency: Ready, set, go! Retrieved from https://resident360.nejm.org/content_items/addressing-wellness-in-residency-ready-set-go

Sen, S., Kranzler, H. R., Krystal, J. H., Speller, H., Chan, G., Gelernter, J., & Guille, C. (2010) A prospective cohort study investigating factors associated with depression during internship. *Archives of General Psychiatry, 67*, 557–565. doi:10.1001/archgenpsychiatry.2010.41.

13

Evaluations

The program director is charged with the duty of upholding high-quality healthcare delivery by his or her trainees. To ensure that this duty is fulfilled, the success of the residents, faculty, and the program must be monitored and evaluated on a routine basis.

Residents

In response to the public's concerns about physician skills and patient safety issues, the Accreditation Council for Graduate Medical Education (ACGME) enacted the requirement to assess residents' abilities in the six core competencies: patient care, interpersonal and communication skills, medical knowledge, professionalism, practice-based learning and improvement, and systems-based practice.

The ACGME Common Program Requirements (2019) include the need for both formative and summative evaluation. *Formative evaluation* refers to assessments by multiple evaluators completed in a timely manner for each clinical rotation or assignment (see Figures 13.1–13.3 for sample formative evaluations). The definition of a formative evaluation also includes the semi-annual feedback that the program director provides to the resident about overall skills and progression of performance regarding specialty-specific milestones.

Summative evaluation refers to the program director's overall assessment of the trainee upon completion of the residency, and it should indicate that the trainee is capable of practicing in the specialty without supervision. See Figure 13.4 for a sample summative evaluation.

The clinical competency committee (CCC) aids the program director in the resident evaluation process. Appointed by the program director, members of this committee must review all resident evaluations on a semiannual basis, advise the program director of each resident's progress, and ensure the reporting of milestone data to the ACGME. The CCC and the program director use many tools to assess the resident's performance in the six competencies. The tools

listed in the ACGME and American Board of Medical Specialties' (ABMS; ACGME and ABMS, 2000) assessment toolbox consist of but are not limited to the following:

- Chart reviews
- Checklists
- Conference attendance and participation
- In-training examinations
- Mini-clinical examination exercises
- Mock board examinations in the form of multiple-choice questions
- Nurse evaluations
- Patient/family evaluations
- Peer evaluations
- Procedure and case logs
- Recorded participation in scholarly activity
- Self-evaluations
- Simulation performance
- Written attending evaluations

Using multisource feedback, such as a 360-degree evaluation that involves the input of all individuals who work with the resident, can be an effective way to assess the resident's performance in the ACGME competencies, especially patient care, interpersonal and communication skills, professionalism, and systems-based practice. See the Additional Resources box at the end of this chapter for further information about multisource feedback.

Results of the assessment tools used to evaluate residents should be available in each resident's electronic portfolio. This confidential portfolio should include a collection of the resident's accomplishments that documents achievements in the training process. A sample list of headings and subheadings in the portfolio is included in Figure 13.5. The resident, program director, and members of the CCC should have access to information included in the electronic portfolio.

Assessment tools recommended by the ACGME and ABMS (2000) that are most useful or applicable to evaluate each specific competency are as follows:

- **Patient care:** Chart review, checklist, standardized patient, observed standardized clinical examination (OSCE), mini-clinical examination exercise, simulation, 360-degree evaluation, portfolio, oral examination, procedure or case log, and patient survey
- **Interpersonal and communication skills:** Checklist, standardized patient, OSCE, 360-degree evaluation, and patient survey

- **Medical knowledge:** Chart review, simulation, multiple-choice question examination, and oral examination
- **Professionalism:** Checklist, OSCE, simulation, 360-degree evaluation, portfolio, oral examination, and patient survey
- **Practice-based learning and improvement:** Chart review, checklist, standardized patient, OSCE, simulation, 360-degree evaluation, portfolio, multiple-choice question examination, oral examination, procedure or case log, and patient survey
- **Systems-based practice:** Chart review, checklist, OSCE, 360-degree evaluation, portfolio, multiple-choice question examination, and patient survey

Figure 13.1: Sample form for competency-based evaluation of resident

Resident's Name: _____

Evaluator (Circle one): Attending Nurse Peer Other

Rating key: Rate resident for each subcompetency

N/A or N/O—Not applicable or not observed

Unsatisfactory (1)—Never. Usually falls short of minimal expectations for level of training.

Marginal (2)—Sometimes. Meets minimum expectations for level of training.

Satisfactory (3)—Half of the time. Meets reasonable expectations for level of training.

Satisfactory (4)—Most of the time. Usually exceeds reasonable expectations.

Satisfactory (5)—Always. Far exceeds reasonable expectations for level of training.

Competency/Subcompetency	Rating
Patient care	
Appropriately prioritizes patient problems	
Shows compassion for patients and their families	
Responds to patient's/family's need for information and encouragement	
Professionalism	
Demonstrates respect for the patient's gender/culture/disability	
Demonstrates respect for nursing and support staff	
Demonstrates respect for peers	
Answers pages or messages in a timely fashion	
Practice-based learning improvement	
Seeks appropriate help/consultation/supervision	
Functions effectively as a member of the team	
Medical knowledge	

whereas an institutional survey can be directed toward more specific aspects of the individual program. See Figures 15.1 and 15.2 for examples of these evaluations. The components of these evaluations are not prescribed and thus can be tailored to the needs of or issues faced by your program. Often, they can coincide with the annual performance evaluation, but be careful that they do not overlap or interfere with ACGME survey completion.

Figure 15.1: Sample institutional resident survey

How satisfied are you with the following aspects of our training program?

	Extremely satisfied	Very satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied	Extremely dissatisfied
Overall educational curriculum						
Service-education balance						
Overall quality of rotations						
Resources for education						
Resources for patient care						
Teamwork within the program						
Program leadership						
Preparation for board exam						

1. Name up to two rotations that you feel could benefit the most from improvement in the educational curriculum or structure, and describe a potential solution.

2. Choose up to two rotations that you feel provide the overall best educational experience and explain why.

3. Additional comments:

Source: Department of Pediatrics, University of Louisville School of Medicine, Louisville, Kentucky. Reprinted with permission.

16

Electronic Resources

Over the past several years, managing a residency or fellowship program has become easier in the sense that most residency professionals can manage their programs without a lot of paper. There are several resources in use for programs that are managed completely electronically. Learning how to use these programs and their benefits is key.

ACGME's Accreditation Data System

The Accreditation Data System (ADS) is the web-based program into which most program accreditation information is entered, updated, and stored for sponsoring institutions and programs. ADS is the key system that the Accreditation Council for Graduate Medical Education (ACGME) and residency review committees use to communicate with programs.

The following are contained within the ADS:

- Due dates/expected dates for the following:
 - Self-study reports
 - Clinical Learning Environment Review visits
 - Annual program updates
 - Site visits
 - Faculty and resident surveys
- Reviews of the following:
 - Resident and faculty survey results
 - Letters of notification
 - Historical data concerning any letters of notification and responses to citations that programs have received

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THIRD EDITION

Linda S. Nield, MD
Jennifer L. Reemtsma, M.Ed

Residency program directors, who are full-time physicians themselves, are tasked with splitting their time between teaching residents, practicing medicine, and fulfilling their administrative duties. Understanding this to be no small task, authors **Linda S. Nield, MD**, and **Jennifer L. Reemtsma, M.Ed.**, crafted *The Residency Program Director's Handbook, Third Edition*, to be an on-the-job manual for residency program directors and administrators.

Perfect for both new and seasoned program directors, this updated edition includes tips and best practices for developing a disciplinary policy, measuring outcomes, evaluating residents and faculty, assessing a curriculum, and understanding the program accreditation process. Nield and Reemtsma have revised this resource to keep pace with the challenges that residency program directors face today. New to this edition is important information on the single accreditation system, the All-In Policy and waiver application processes, and managing physician and resident wellness, as well as practical tips for residency recruitment.

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