

Physical Medicine & Rehabilitation
Residency Program Director's Manual
May 2011

This is the third edition of a program director's manual sponsored by the Association of Academic Physiatrists. It is a practical guide to working with the organizations governing residency programs, preparing for an accreditation site visit, and managing the year-round activities of recruitment and training. It refers to the program requirements effective as of July 2007. It is written specifically for directors of PM&R residency programs, but some sections may be useful to directors of fellowships in SCI medicine, pain management or pediatric rehabilitation medicine.

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AANEM: American Association of Neuromuscular & Electrodiagnostic Medicine
Sponsors electrodiagnostic self-assessment examination
<http://www.aanem.org>

AAMC: Association of Academic Medical Colleges
Association of medical schools, teaching hospitals, and academic medical societies. Sponsors an annual meeting on education issues. Publishes the monthly journal Academic Medicine.
<http://www.aamc.org>

AAMC STAT: weekly on-line newsletter. STAT summarizes the latest AAMC initiatives, policy statements, and other activities, plus relevant national news. To subscribe to AAMC STAT, send an email to majordomo@aamcinfo.aamc.org, typing only the words "subscribe aamcstat" in the body, not the subject of the email message.

Clinicalmail: summary of news reports related to medicine from around the country. Send an e-mail to majordomo@aamcinfo.aamc.org. Leave the subject line blank. In the first line of the body of the e-mail, type the following: subscribe CLINICALMAIL [followed by your e-mail address]

Find a resident: website to advertise open positions:
<http://www.aamc.org/audiencefindaresident.htm>

GME Track: national GME census conducted with the AMA
<https://services.aamc.org/gme/admin/login/index.cfm>

MedEdPORTAL: website to share peer-reviewed educational material
<http://www.aamc.org/mededportal>

AAP: Association of Academic Physiatrists
Information about the council for program directors; directory of training programs and directors; fellowships listings; sites for medical student clerkships; white papers on educational issues; sample goals and objectives for rotations
<http://www.physiatry.org>
aap@physiatry.org

AAPMR: American Academy of PM&R
Membership benefits for residents and medical students; resident physician council programs and services; meeting dates; roster of members
<http://www.aapmr.org>
info@aapmr.org

ABEM: American Board of Electrodiagnostic Medicine
Information about board exam requirements, maintenance of certification, and listing of diplomates
<http://www.abemexam.org/>

ABPMR: American Board of Physical Medicine and Rehabilitation
Information about registration and annual evaluation of residents, listserv for sending messages to all current program directors, board examination dates, maintenance of certification requirements, and statistics about diplomates certified
<http://www.abpmr.org/index.html>
info@abpmr.org

ACGME: Accreditation Council for Graduate Medical Education

The current residency program training requirements as developed by the PM&R Residency Review Committee (RRC) and the Program Information Form (PIF) can be downloaded from this site. Residency programs must complete the common PIF on-line and maintain annual resident rosters.

<http://www.acgme.org>

ECFMG: Educational Commission for Foreign Medical Graduates

Certifies foreign medical graduates to enter US ACGME approved residencies; explains requirements for medical school certification and exams required; J-1 visa sponsor

<http://www.ecfm.org>

ERAS: Electronic Residency Application Service

Information about the electronic residency application service; frequently asked questions; how to obtain technical support

<http://www.aamc.org/audienceeras.htm>

FREIDA: Fellowship and Residency Electronic Interactive Database Access

Place to list your residency, consulted by medical students; information about ACGME accredited residencies; physician workforce statistics; summaries by specialty of resident work hours, compensation, number of training programs

<http://www.ama-assn.org/ama/pub/category/2997.html>

GME e-Letter: monthly publication by AMA on news and updates about GME

<http://www.ama-assn.org/ama/pub/category/7669.html>

NRMP: National Resident Matching Program

Policies of the match; data tables from the most recent match; how the matching algorithm works

<http://www.nrmp.org>

USMLE: United States Medical Licensing Examination

Provides performance data on the exams and information to program directors about Step 3, which many residents will need to take during the PM&R residency

<http://www.usmle.org>

I. INTRODUCTION

A. Qualifications of the Program Director

At a minimum, the program director must have 4 years experience in clinical care, administration and teaching after residency, be licensed to practice medicine in the state where the program is located (unless a federal employee) and be certified by the ABPMR or possess suitable equivalent qualifications. There must be a single program director responsible for the program, but it may be practical to have a co-director as well. The program director's appointment should be at a major participating site, defined as an institution in which residents train for 6 months or more (PDs can petition the RRC for an exemption to this expectation.)

Key personal qualities include: enthusiasm for teaching; leadership skills; efficiency; attention to detail; and the ability to play well with others.

B. Duties of the Program Director

The goal of residency training is to provide an educational experience to prepare graduates to attain the competence needed for enter physiatric practice without direct supervision. In this context, two broad duties of the program director are:

- ◆ To ensure that trainees who complete the program meet criteria to take the ABPMR part 1 (written) and part 2 (oral) exams.
- ◆ To ensure that the program meets accreditation criteria according to the common ACGME requirements and the specialty specific requirements for PM&R residency training

The actual activities throughout an academic year include those listed below and are described in further detail in the section on "Year Round Activities"

- Developing appropriate clinical rotations for the residents
- Enrolling and orienting new residents and verifying their credentials
- Ensuring faculty evaluate residents
- Evaluating clinical competence of residents
- Monitoring resident stress
- Developing and monitoring remediation plans when needed
- Meeting with residents twice a year to review performance
- Ensuring residents evaluate faculty
- Developing and monitoring appropriate didactic and clinical training
- Promoting and monitoring resident involvement in a scholarly activity
- Evaluating the program's effectiveness
- Providing annual evaluations to the Board
- Recruiting new residents
- Selecting/electing one or more chief residents
- Developing and maintaining written policies and procedures
- Providing references for residents
- Providing a final written evaluation for each senior resident
- Maintaining required data for the accreditation site visit, completion of the PIF
- Assuring sufficient resources for the program
- Participating in institutional GME committees
- Oversight of fellowship directors
- Maintaining program letters of agreement

C. Resources for the Program Director

This list represents some of the resources a program director may need to lead and manage the residency program.

- **A program coordinator** is essential to handle mail, paperwork, resident and on-call schedules; track sick days and vacation days; maintain records of performance; schedule interviews and coordinate the application process; advocate for residents and be the front-line person for information about the program.
- **A personal computer** for the director and another for the coordinator, each capable of handling the ERAS files. You will need 100MB of hard disk space for the server and an additional 8 MB of space for each expected applicant. Get a very large monitor to read the files. ERAS is not designed for Macintosh computers.
- **Secure space** to maintain resident files and a storage system for long-term storage of records of those who have graduated. Records of graduates must be kept in perpetuity. It is helpful to design and maintain a database of resident demographic information: dates of training and any adverse actions to enable efficient completion of credentialing documents.
- **Office space** at the main institution if the program director is located at another institution.
- **A committee of faculty** dedicated to education to assist in evaluation of the program, faculty, and residents; recruitment; and program development. It may be helpful to designate faculty as associate program directors for specific activities, such as evaluation, research or scholarly activity support, or recruitment.
- **Administrative support** for gathering the program information form (PIF) data from various institutions in preparation for the accreditation site visit.
- **A web site** to advertise the program. An internal, password protected website for the residency which may include: rotation schedules, didactic schedules, on call schedules, policies and procedures, commonly used forms, educational items such as lecture notes or readings, resident CVs and photos, facility phone numbers, and links to other websites such as for evaluations, reporting duty hours or electronic medical records.
- **The support of the department chair.** Try to decide lines of authority, and what issues need approval of the chair, or a training committee or the faculty as a whole. Set up quarterly (or more frequent) standing meetings to update the chair on residency issues.
- **A budget** to run the daily activities of the program: e.g. telephone expenses, photocopying, food for recruitment meals, lab coats, pagers, office supplies, software and hardware upgrades, fees for the self-assessment exams (AAPMR and AAEM), travel for residents presenting at meetings, a graduation event.
- **Funding** to attend the annual Association of Academic Physiatrists meeting and the Residency Program Directors' Council at that meeting.
- **Protected TIME!** This will vary throughout the year, with the recruitment and interview months being the most time-consuming (next to preparation of the PIF). For medium and large programs, a program director could spend up to 20-30% of the week on residency issues.

II. WHO MAKES THE RULES?

A. Overview

Program directors answer to both the Accreditation Council for Graduate Medical Education via the PM&R Residency Review Committee and to the American Board of PM&R. Become familiar with the websites for ACGME and ABPMR. One of the first things you should do as a new program director is read the most recent Board requirements outlined in their annual booklet of information and the RRC requirements.

Graduates of residency programs are certified by the American Board of PM&R. The Board's role is to certify individuals in PM&R or the subspecialties of Hospice and Palliative Care, Neuromuscular Medicine, Pain Medicine, Pediatric Rehabilitation Medicine, Spinal Cord Injury Medicine, or Sports Medicine once he/she has satisfactorily completed residency or fellowship training.

Residency Programs are accredited by the ACGME. The ACGME is responsible for establishing requirements for institutions sponsoring residencies and for specialty requirements. The ACGME's member organizations are the American Board of Medical Specialties, the American Hospital Association, the AMA, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. The ACGME delegates authority to accredit residency programs to the Residency Review Committees. The constituencies which elect members to the RRC for PM&R include the American Board of PM&R, the American Academy of PM&R (often in consultation with the Association of Academic Physiatrists), and the Council of Medical Education of the AMA. A resident representative is also appointed. The RRC meets twice a year in February and August. The RRC develops and proposes program requirements. Residency and fellowship programs are given the opportunity to suggest revisions as well. Program requirements are typically revised about every 5 years. The RRC reviews individual residency and fellowship programs to determine their compliance with the program requirements. Based on this review, the RRC determines an accreditation status for each program:

- full accreditation up to 5 years (although statistically most programs receive 3 years)
- probationary accreditation for programs failing to be in substantial compliance
- withdrawal of accreditation for noncompliant or inactive programs
- initial accreditation for new programs
- withhold accreditation for a new program that does not substantially comply

B. ABPMR

All of the ABPMR "publications" are available on their website. The ABPMR publishes a booklet of information each year outlining the requirements and qualifications for physicians to take the written and oral examinations (www.abpmr.org/boi/Cert_BOI.pdf). Important information in this booklet for program directors includes:

- the "internship" year
- the minimum amount of time to be spent in inpatient and outpatient care
- credit for other specialty training
- absence from training
- information to be submitted to the Board for each resident including: registration, verification of medical training, annual evaluation, remedial action plan for any resident on probation
- combined training in pediatrics or internal medicine
- the clinical investigator pathway (integrated PM&R and research training)

Annually in July, the ABPMR publishes a Program Director Newsletter available at: (www.abpmr.org/candidates/newsletters.html) The ABPMR also maintains a Program Director Manual that may be accessed through Program Directors Homepage under the "Download Documents" section.

The residency program director and coordinator will interact with the ABPMR throughout each year, much of it on-line. Your program will have a different login and password than your personal ABPMR account.

- Notify the Board whenever a new residency program director or program coordinator is appointed. Keep the Board apprised of changes in your mailing address, phone or fax numbers.
- Each group of new residents must be registered online with the Board by August 1 each academic year. You will need to verify that the PGY 1 year was satisfactorily completed and list the rotations completed. Be sure these meet the Board requirement for the PGY 1 year.
- Notify the Board whenever a resident transfers to or from your program. The Board needs to be able to track training and to send annual evaluations to the appropriate institution.
- At the end of each year, submit an annual resident evaluation to the Board for each resident. Each resident should be given an opportunity to review the evaluation. Final evaluations for residents taking the Part 1 examination are due July 1 each academic year. All other annual evaluations are due by August 1 each academic year. If a resident is completing training at a time of year other than June 30th (off cycle resident), the annual evaluation will be due at the time the resident completes each year of training. For example, if a resident began training on September 1st, the annual evaluation is completed at the end of August.
- If a resident has missed more than 6 weeks of training or been placed on probation, you will need to provide this information to the Board office by completing the on-line Change of Status form available on the Program Director homepage.

Contact:

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C. ACGME

The ACGME common program requirements for graduate medical education and the specific program requirements for PM&R (or any of the subspecialties) can be viewed on the ACGME website (www.acgme.org). The requirements include resources including personnel and facilities, program design and evaluation, duration of training, objectives for training, administration and organization, clinical training components, didactic components, educational policies, research and scholarly activity, and evaluation.

When developing a new program, evaluating an existing program, or preparing for a site visit for accreditation, the program director should review these requirements side by side with the program information form (PIF). This is the form used by the RRC to gather data about the program. The PIF will help you interpret the RRC requirements. Also read the Program Director Guide to the Common Competencies on the ACGME website; it will help you understand what the ACGME views as an ideal response on the PIF. The program director also needs to be familiar with the ACGME Institutional requirements and their institution's accreditation status. Program directors should also become familiar with the contents of the resident survey. This will be administered annually beginning in 2009, and the data is available to the site visitor and the review committee when the program comes up for accreditation.

ACGME sponsors workshops for program directors and institutional graduate medical education (GME) directors who are preparing for an accreditation site visit. These workshops are very informative

and can be very helpful to new program directors. These are listed on their website. These workshops often fill early, so it is best to register as soon as possible.

Other resources on the ACGME website include descriptions of the competencies and ways to educate faculty about them under the Outcomes Project. On the Program Directors' and Coordinators' sites, there are FAQs about common issues and links to the resident survey and the procedure log systems.

You must notify the executive director of the RRC immediately (within one month) whenever there is a change in program director. Enclose a copy of the new program director's curriculum vitae. Also notify the executive director of the RRC for any major change that may affect the educational experience for the residents, including:

- Changes in resident complement
- Major changes in program structure or length of training
- Changes in department leadership

Whenever you contact the RRC, for these issues, or for responses to progress reports, you must have the signature of your Institution's Designated Institutional Official. Check in Web ADS to see if you should submit information on line or by paper.

In addition to finding information on the ACGME website, programs must input information into WebADS each year. This includes a roster of new residents, identifying any residents who have left the program, and status of residents who completed training. At the time of each site visit, there is also an online portion of the PIF to complete in WebADS, which has information about participating institutions, faculty CVs, evaluation of the competencies, and responses to previous citations.

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III. YEAR ROUND ACTIVITIES

This section contains hints and suggestions for managing year round activities, with attention to the PM&R program requirements defined by the RRC (effective July 2007). Each program will develop and implement these activities depending on available local resources.

A. Competency Based Curriculum

You need to write a curriculum based on the six core competencies. There must be written educational goals and objectives for each major rotation by level of resident training and for each assignment. The goals and objectives should clearly demonstrate that residents are given increasing responsibility as they progress through training. (Note that even in the case that two levels of resident rotate on the same rotation with the same responsibilities, they will require different goals and objectives that reflect progress through training.) The written goals and objectives must be provided to the residents and discussed by the supervising faculty at the start of each rotation. It is advised that you develop a system documenting that this occurs. A useful resource can be found on the ACGME website (http://www.acgme.org/outcome/e-learn/e_powerpoint.asp).

It can be challenging to understand what is expected for some of the competencies. A very useful resource is The ACGME's Program Director Guide to the Common Requirements (http://www.acgme.org/acWebsite/navPages/nav_commonpr.asp)

There are many ways to structure teaching for residents. These can include bedside rounds, tutorials with allied health professionals, lectures, courses, hands-on experiences, peer teaching (by residents), and board review courses. The RRC requires the program to bring all the residents together at frequent and regular intervals for educational experience. The faculty must be active participants in these didactics.

In addition to tracking the didactic lectures for a whole cycle and the case conferences for the year prior to the site visit, you need to track the number of formal resident presentations per year for five years prior to the visit. It is a good idea to monitor attendance at didactics, although our RRC does not currently require them. The RRC requires that basic teaching aids such as computers, projection equipment and videotape or digital recording resources be available for residents and staff.

1. Patient Care

The choice and structure of clinical rotations is determined by RRC requirements, individual program goals and objectives, and local resources. It is helpful to develop a block outline of the typical resident assignments for all the years of training. Ensure that residents receive a minimum each of 12 months of "direct and complete responsibility for inpatient management" and 12 months of "outpatient experience that must include significant experience in the care of patients with musculoskeletal disorders." The latter excludes time spent in EMG training. You will need to supply such a block outline and the actual schedules of 2 senior residents in your PIF for your next accreditation review.

If your program offers a PGY-1 year, be sure the rotations offered meet the RRC requirements. Six months of the year must be in some combination of inpatient family practice, internal medicine, ob-gyn, pediatrics or surgery. In the remaining six months, any specialty or subspecialty rotation must be at least 4 weeks long, and residents may not be assigned more than 8 weeks of non-direct patient care experiences. The 12 months of fundamental training can be offered as a traditional PGY-1 year, or can be integrated with PM&R over the first 2 years of residency. It can be difficult to fund the PGY-1 year, since the residents are not doing much training in your own department. You do not need to offer all your trainees a PGY-1 position. For instance, if your PGY-2, 3, and 4 years each have 6 residents, you can

offer just a few PGY-1 positions, and the other residents who will eventually be in that class can do their PGY-1 year elsewhere.

Inpatient residents must care for a minimum census of 8 patients. If the average daily census is less than 8 per resident at each site, the resident should spend a proportionate amount of time in some other activity, such as clinics or EMGs. Faculty must make bedside teaching rounds 5 days per week on inpatient services. You will need to document how residents manage usual medical conditions or complications in their patients. Residents should have the opportunity to review imaging materials.

Residents must be involved in 200 EMGs each (observed plus performed). They must have procedure experience with physiatric diagnostic and therapeutic injection techniques. Although the Program Requirements does not specify which injections, the program information form asks for a description of injections for spasticity management, and for pain management including joint injections, soft-tissue injections and axial injections.

Residents must have clinical experience and participation in cardiac and pulmonary rehabilitation, and pediatric rehabilitation. They must be involved in medical conditioning, reconditioning, and fitness. They must go to the therapy areas and have experience in prescribing therapy modalities throughout the duration of training.

They must have experience in the continuing care for patients with long-term disabilities through appropriate follow-up care. Residents must have the opportunity to observe the continuum of rehab care in community facilities. This means including some on-site visits or didactic lectures for places such as subacute units, skilled nursing facilities, sheltered workshops, schools for persons with multiple impairments, including deafness and blindness, independent living facilities, home health care, and community reentry services.

Residents cannot take more than six months of electives during the 3 years of PM&R training. No more than 1 month of elective time can be in a non-ACGME accredited program, unless approved in advance by the RRC and Board.

2. Medical Knowledge

The residents must have didactic instruction. While some didactics can be presented by residents, it is expected that faculty will organize and provide the bulk of the didactics. Didactics are expected to cover the diagnosis, pathogenesis, treatment, prevention, and rehabilitation of those neuromusculoskeletal, neurobehavioral, cardiovascular, pulmonary, and other system disorders common to PM&R. Residents must receive training in ethics and participate in decisions involving ethical issues. Relevant basic sciences must be included: anatomy, physiology, cardiovascular and pulmonary, and kinesiology; there must be an accessible anatomy laboratory or equivalently structured program in anatomy. Didactics in electrodiagnosis and fundamental research design are expected as well.

3. Practice Based Learning and Improvement

Residents are expected to develop skills to assess their strengths and weaknesses and actively set learning and improvement goals. One way to do this is to have residents write learning plans and assess their achievements throughout the year.

Residents need to participate in an evidence based medicine activity, such as presenting a journal club or performing a critically appraised topic.

Residents must participate in planned quality improvement projects.

Residents must have instruction in teaching skills, and be evaluated in the course of teaching patients and families, students, and other residents.

4. Interpersonal and communication skills

The program needs to have specific learning activities to teach communication skills with patients and health care providers, team management, and counseling of patients and families, including end of life issues.

5. Professionalism

The program needs to have learning activities to help residents develop a commitment to professional responsibility and adherence to ethical principles. It is expected that this is taught by some means other than lecture. The program needs to teach residents about the personal, social and cultural factors in the disease process.

6. Systems Based Practice

PM&R has a distinct advantage in addressing this competency, as so much of our work involves coordination of care across settings and team work. Residents must be trained in identifying system errors and proposing solutions to them. This should not be an ad hoc process, but a formal experience such as M&M reviews.

B. Promoting and monitoring resident involvement in a scholarly activity

You are required to offer teaching in fundamental research design. A committee for the AAP has written a document on a research curriculum for residency training programs, which should be helpful for programs getting started in this area. Residents should also have the opportunity to participate in research training. The RRC considers it desirable that residents publish a peer reviewed paper during residency. You will need to track the percent of residents engaged in research, and resident publications. Residents may take up to 6 months of research time during the 36 months of PM&R training.

Many residents may express an interest in research but have no idea how to begin. It can be helpful to have one person on the faculty serve as a research advisor to connect residents with appropriate faculty members. Develop a timeline for when projects must be completed or presented to the department and outline consequences for failure to meet guidelines. Even if the resident has a research advisor, it is helpful for the program director to also monitor progress toward goals.

Other scholarly activities include critical reviews of the literature and presentations at professional meetings.

C. Evaluating clinical competence of the residents

Programs will need to have a formal system for evaluation of the clinical competence of residents. This is in addition to in-service examinations, the self-assessment exam, or post-rotation evaluations. The program must use “dependable measures” to assess competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. These 6 areas must be included in the goals and objectives in the curriculum. More detailed descriptions of these categories can be viewed from the ACGME website (<http://www.acgme.org/Outcome/>)

The use of multiple evaluation methods is required. Listed below are some common types of evaluation tools and what they might be used to measure. This list is derived from materials provided by the ABMS-ACGME joint initiative. Consult the Program Director Guide to the Common Program Requirements to see what ACGME expects in the way of evaluations for specific competencies.

- **Record review:** Using patient records to compare a resident's plan to standard of care; examples might be completeness of data gathering, developing management plans, practice cost effective care, evaluation of writing/dictating skills
- **Global rating of performance:** Typically what is used at the end of a rotation; examples might be performance of procedures, use of scientific evidence related to patient care, facilitating learning of students and other health care professionals, commitment of ethical principles for informed consent
- **Patient survey questionnaire:** Patients evaluate resident care; examples might be counsel and educate families and patients, caring and respectful behaviors, listening skills, advocate for patients
- **Multiple choice examination:** An example is the self-assessment exam; examples for use might be knowledge and application of basic and clinical sciences, knowledge of how types of medical practice and delivery systems differ from one another
- **Procedure or case logs:** Residents track educational experiences; examples might be performance of procedures or EMGs, facilitating learning of others by presentations
- **Checklist evaluation of live or recorded performance:** a single interaction or procedure is evaluated using a checklist; examples might be patient interviewing, procedures or EMGs. A group of program directors developed and validated an evaluation tool specifically for PM&R, called ROCA (Resident Observation and Competency Assessment) and is available on the ABPMR website, once you have logged in as a program director (www.abpmr.org).
- **Oral examination:** Use of structured cases to assess clinical decision-making; examples might be demonstrating knowledge of basic and clinical sciences, investigatory and analytical thinking, practice of cost-effective care
- **Portfolio:** Project reports prepared by the resident, documenting projects completed in residency; examples might be analyzing practice experience in a systematic manner, assessing progress toward goals by year of training or rotation; use of scientific evidence from studies to prepare a journal club presentation
- **360 Global rating evaluation:** Staff, peers, students, and allied health professionals evaluate residents from their own perspective using similar rating forms; examples might be work within the team, facilitating learning of others, sensitivity to and responsiveness to patients' culture, age, gender and disabilities, advocate for patients (see reference section for one program's (Massagli and Carline) 360 evaluation.
- **Simulations and models:** Simulations are computer based programs to assess knowledge and models are simulations using models or props to assess procedural skills or interpret findings; examples might be performance of procedures, development of management plans
- **Standardized patients and OSCEs:** Standardized patients use actors trained to respond as a real patient would (or sometimes real patients). An OSCE (objective structured clinical examination) may use a series of standardized patients or other assessment tasks. The patient or a physician evaluator may rate the resident. Examples might include interviewing skills, caring and respectful behaviors, performance of physical exam, listening skills, sensitivity to cultural, age, gender or disability issues.

D. Ensuring faculty evaluate residents and the program

Decide how frequently faculty will evaluate residents. This should occur at the close of each rotation, and perhaps midway through for longer rotations. There should be opportunity for direct discussion between the faculty and the resident of each evaluation. If this does not happen, residents

need to see their evaluations in a timely manner. Decide what process you will use to determine if performance is unsatisfactory (will the responsible faculty member decide, or will this be a decision by the program director or chair, the training committee or the faculty as a whole). Evaluations and documentation about educational counseling must be maintained in a file, and the resident must have access to that file. The resident file must be kept by the institution forever.

In the PIF, you will need to document how the program director involves faculty in the evaluation of residents, including semi-annual evaluation, progressive responsibility, and final evaluation. The final evaluation must be written by the program director. It verifies whether the resident has acquired the skills, competency, knowledge and attitudes identified in the program's goals and objectives and whether the resident "has sufficient competence to enter practice without direct supervision" (use this exact language). The RRC will accept the ABPMR final evaluation as this statement. **It is the program's job to make sure a resident is competent, not the Board or any other agency.**

You need to be able to document implementation and achievement of goals and objectives. One way to do this is to include progress toward goals on your rotation evaluation forms.

You will also need to document how the faculty evaluates the effectiveness of the program.

E. Developing and monitoring remediation plans when needed

As a program director, you should encourage faculty to contact you with concerns (and praise) for residents as early as possible. If this happens by phone, or in personal conversation, make a dated and timed notation of your recall of the discussion. You need to monitor for trends that could indicate problems in performance. Notify the resident of deficiencies as soon as you can. Establish criteria for minimal performance and enforce these consistently. You should develop a plan for academic discipline for all aspects of resident training, including completion of rotations, didactic work, and a research project or scholarly activity if required by the program. When concerns arise, the plan will dictate whether the program director takes immediate action or discusses the problem further with the chairperson or training committee or faculty as a whole. It is important to be consistent in your approach to problems with performance. Follow your written policies and procedures.

In your plan for academic discipline, you may want to outline several levels of concern and the program's response to them. A minor concern might be discussed with the resident, followed by a written note from the program director documenting the concern and the expectation that it will not recur, or that an action will be completed by the resident by a certain date. A serious problem could result in academic probation. This should also be discussed with the resident. A written notation of the problem and a plan for remediation or consequences of failure to remediate should be provided to the resident. You must involve your department chairperson and the director of GME in your institution when a resident is placed on probation. When a resident is placed on probation, this must be reported to the Board, along with the remediation plan. Some licensing agencies and hospital credentials committees request information about whether a resident was ever placed on probation, so this level of discipline should be reserved for serious matters. The plan for academic discipline should also outline consequences of unsatisfactory performance that does not improve. This may include receiving no credit for the rotation and needing to repeat it (thereby extending the overall length of training), failure to advance to the next year of training and either repeating the year or not being reappointed, or termination of training. Your program must have written policies and procedures for discipline, remediation, and grievance that should be in line with those of your institution's. All residents must be given a copy of the institutional policy concerning residents' rights and due process procedures.

F. Meeting with residents twice a year to review performance

Ideally residents should be receiving a lot of feedback about their performance during and at the end of each rotation. However, residents often do not perceive that they are receiving feedback unless it is so labeled. The RRC requires that the program director or designee meet with each resident twice a

year. In a small program, the program director may be able to easily accomplish this, but in larger programs, it may be helpful to have the resident's faculty advisor conduct one of the meetings and the program director the other. In this meeting, the resident can receive feedback on performance in clinical and didactic training, and the self-assessment exam and other evaluation tools used by the program. The resident should develop a plan for self-directed learning. Other topics to discuss include progress toward any required research or scholarly activity, suggestions for improvement in the program, and career aspirations. You may want to create a competency based checklist or template for you or the faculty advisor to complete to keep as written documentation of the meeting. If this documentation is to be kept in the resident's general file, be sure what is recorded does not violate the resident's confidentiality (e.g. their candid review of personality or work load issues may not be something all faculty should have access to).

G. Providing annual evaluations to the Board

At the end of each year of training, the program director must submit a rating form to the Board documenting each resident's performance. The resident should review and sign this form. If you wait until you have received the last evaluations for your graduating residents, they may be gone by the time you complete this form. You should mail, fax, or read the form to them over the phone to get their concurrence.

To facilitate completion of this form, you may want to develop a rotation evaluation form that contains at least all the components of the Board evaluation form. (Your program may want to add additional areas of evaluation such as teaching skills, or achievement of rotation specific goals by year of training.) The ratings you provide on the Board evaluation form may be a weighted average of the rotation evaluations, and may take into account other feedback from faculty throughout the residency and performance in didactic classes. If a resident challenges your rating, you will need to explain how the value was determined.

In order to apply for Part I of the Board Certification exam, senior residents must go to (www.abpmr.org/register) to setup an ABPMR Online Services user account. This can be completed as early as September 1, in the last year of PM&R training. Through their user account, senior residents will apply for the Part I examination between November 1 and January 31.

H. Providing a final written evaluation for each senior resident

A final summary evaluation should be maintained in each resident's permanent file. This must include a review of performance in the final period of training. It should verify that the resident is able to practice competently and independently. It is the job of the program to insure that the resident is competent. The Board certifies physicians, but that certification does not prove competence.

In addition to keeping individual permanent files on each resident, it can be helpful to establish an alumni database. You can include dates of training, whether or not the resident was on probation, any projects or publications achieved, and forwarding address and phone number. Throughout the year, you will be besieged by requests for verification of training, often for physicians who completed training many years ago. It may be more efficient to consult the database than to consult the individual file each time.

I. Providing references for residents

Program directors are frequently asked to provide letters of reference for graduating residents and recent alumni. You can also assist residents in the job search by guiding them in creating an appropriate CV. It is helpful to have a central place to post job listings received by the department.

J. Monitoring resident stress and fatigue

The RRC requires that you monitor resident stress. The RRC expects that situations that consistently produce undesirable stress be evaluated and modified. This should include program wide issues, as well as individual resident concerns. These include mental or emotional conditions affecting performance or learning, and drug or alcohol related dysfunction. Many institutions have programs in place to allow residents to seek counseling at no or reduced cost, for treatment of impaired physicians, or to receive small emergency loans. In addition, residents and faculty need to receive education on stress and fatigue.

The program should have a Resident Duty Hours policy based on the similar policy found on the ACGME website (http://www.acgme.org/acWebsite/dutyHours/dh_Lang703.pdf). The program director is responsible for monitoring the residents' daily schedules at each training site to be sure duty hours are not excessive. Duty hours must be limited to 80 hours per week. On average, residents should have 1 day in 7 free of patient care duties and take call not more often than every 3rd night. They should have 10 hours off between all daily duty periods and after in house call. They need adequate on-call space for in-house night call. Moonlighting has become a fact of life for residents with large debt. The program director should monitor all moonlighting activities to make sure they are not interfering with the educational process and that they are in compliance with institutional policies on moonlighting.

K. Ensuring residents evaluate faculty and the program

The RRC requires that residents use written evaluations of the program and that the program director reviews them at least annually. This can include their clinical rotations and didactic program and review of individual faculty. Protect the residents' anonymity by providing summary feedback to faculty once or twice a year so that evaluations cannot be linked to individual residents. It takes about 7 to 9 evaluations for each faculty to really get a valid assessment of teaching skills. In addition to providing faculty with their own ratings, it can be helpful to give them a summary of ratings for all faculty, so that those who are outliers can identify themselves. The department chairperson and education committee should have access to this information to help select teaching faculty. The department should have a way of assigning faculty appropriately to teaching, clinical and research assignments (in accordance with individual competencies and weaknesses), and should help those to correct weaknesses when indicated.

L. Evaluating the program's effectiveness

It is important to take time to reflect on the performance of the program and to evaluate strengths and weaknesses. These meetings must be documented and at least one resident representative should participate in these reviews. It is expected that written evaluations by residents be used in this process. The RRC expects that the program will evaluate the extent to which educational goals are met by residents (including the competency areas), the utilization of the resources available to the program, the contribution of each institution, the financial and administrative support of the program, the volume and variety of patients, the performance of the teaching staff, and the quality of supervision of the residents. Program evaluation can also include such things as resident evaluations of the program, the institution's internal review of the program, alumni surveys, self-assessment examination results and board scores, performance in didactics, publications by residents, and employment status of graduates. A good time to analyze this type of data is in the summer, when the previous years' self-assessment exam and board scores are both available and employment outcomes of the recently graduated residents is known. It's the lull after orienting the new residents and before starting recruitment. For the self-assessment exam, it is important to remember that the exam is written anew each year. Therefore, you should look at results over several years before deciding that the program is performing very well or very poorly in any given area. The RRC expects that 75% of graduates will take the Board exam, and that in the most recent 5-year period, 75% of graduates will pass either part on the first try.

Whenever new RRC requirements are approved, the program director and education committee should review these in detail to assess what new areas of training or documentation need to be implemented by the program.

Each residency program must undergo an internal review by the institution's graduate medical education program midway between accreditation site visits. You will need to document the date of that review and the process involved in the review at your next accreditation.

M. Recruiting new residents

This is a huge job. First, some RRC requirements. Each program must have at least 2 residents per year in each year of training. The distribution of residents should be approximately equal. The program must graduate at least 80% of the residents who started the program. When taking a resident in transfer, get a written evaluation of the past performance and experience from the previous program director. Any changes in the resident complement greater than 1 position per year will have to be approved by the local sponsoring institution and the RRC.

Next, the practical components. You need to advertise the program, screen applicants, interview applicants, create a match list, and unfortunately, sometimes deal with unfilled positions (either after the match, or throughout the year). Current medical students must apply to your program only through the match. It is a violation of NRMP rules to offer medical students a position outside the match. You may be taking PGY-1 residents beginning the upcoming summer, or PGY-2 residents in a little over a year, or both. Some programs will also have vacancies they need to fill for the present or upcoming year with a PGY-2 resident or higher, and these positions are not filled through the match.

1. Advertising/marketing: A brief description of your program should be published by the AMA Directory of Graduate Medical Education Programs and listed on the AMA's FRIEDA website (www.ama-assn.org/cgi-bin/freida/freida.cgi). It should also be published in the AAP's Directory of PM&R Residency Programs, which is also available on their website (www.physiatry.org).

Your medical school may sponsor sessions for medical students to learn about various specialties; this is a great way to advertise your program locally. Regional medical student groups often invite residencies to have an exhibit at their annual meeting, but this can have a sponsorship fee associated with it. Don't forget that teaching in the basic sciences curriculum or having a PM&R clerkship is also a great way to market our field and your program.

Develop a website describing your program. Describe the training program including the clinical rotations and hospitals, the didactic curriculum, and salary and benefits. Let prospective applicants know about opportunities for PGY-1 training in your institution or city (e.g. transitional programs or preliminary medicine positions). You can provide links to your department website, medical school website, and ERAS. Do you have any special requirements concerning visas, USMLE scores, or training? What information would you like included in the application if it varies from the typical ERAS application? You may want to suggest a specific number of letters of reference and the content for the personal statement. Include a name, email address, and phone number for your program coordinator or other contact person. You can also use your website to advertise current openings for PGY-2, 3, or 4 residents.

2. Applications: If you have current openings in your program for physicians (i.e. not medical students), you can ask the applicants to mail or fax you a copy of their transcripts, dean's letter, letters of reference, USMLE scores, and a personal statement to begin your review process. All US medical students have access to ERAS through their medical schools. All foreign-trained physicians have access to ERAS through their local ECFMG office.

The information you will receive from ERAS on each applicant includes: common application form, CV, personal statement, transcript, Dean's letter, letters of recommendation, photo, USMLE transcripts, and ECFMG status reports for foreign medical graduates. Dean's letters are not released until November 1st, but you can screen any other information that has arrived prior to that time.

The ERAS program allows you to filter applications according to your specifications. It allows you to create a subset of only those candidates you want to interview. You can submit a list of names back to

ERAS with a letter inviting the candidate to schedule an interview and ERAS will distribute this by email. You can also send rejection notification in the same way.

Unfortunately, interpreting the information you receive is not always straightforward. See the reference list for recent articles documenting misrepresentation of credentials by applicants and the dishonest dean's letter. You should cross-reference dates of training in the common application form, the transcript, and the dean's letter to determine if training was extended for any reason. Compare grades noted in the transcript with comments in the dean's letter. If a histogram of grade distributions for the whole class is given, take the time to plot out each student's grades. Medical students may or not have waived their rights to see their dean's letter or letters of recommendation. You should have at least USMLE step 1 scores by the time of the initial application, and step 2 scores will appear in ERAS as they become available, so check files again before your rank list development. Note that osteopathic students can take either COMLEX or USMLE exams. If you have the time, it can be very helpful to look back at a cohort of previous residents in your program and determine what data if any identify those who will be successful and those who will not. One program's example of this is listed in the reference section.

3. Interview: It is tricky to determine how many applicants to interview. Your recent performance in the match may be a good guide for deciding how many applicants to interview per available position. With your education committee and your program coordinator, plan the interview days. You could include a general orientation session for all interviewees with the program director, several individual interviews with faculty, facility tours, participation in didactics, and time with residents. Feed the applicants breakfast, lunch, or both. Get your faculty to commit to interview dates and times as soon as possible. You may want to share this work among all faculty, or just have a core group of your education committee involved. Train the faculty in how to behave. Do you want the interviewers to grill the applicants in certain areas, explore clinical or research interests, or be recruiters for your program? Give them the answers to frequently asked questions about your program: What are the strengths of the program, can residents moonlight, can residents do research, how much elective time is there, what do residents do after graduation, how many residents pass the boards, what perks does the program offer (meetings, parking, meals, etc), how will the program change in the next 5 years, and so on. Create a form for interviewers to provide feedback to your selection committee. This could include a rating of the candidate's credentials (basic science, clerkship performance, USMLE scores), maturity (experiences besides medical school, leadership roles), exposure to and understanding of the field, research interests, clinical interests, and long term goals. Be aware, however, that researchers have failed to find much correlation between interview ratings and performance in residency. (See Langsley: How to select residents). This is one reason you may want the emphasis of the interview day to be on recruiting. Applicants expect to have time to meet with the program director or chair. Even if you are interviewing large numbers of applicants on one day, try to give each one 10 to 15 minutes with the program director. Make sure applicants have enough time to meet with residents without faculty present, so they can inquire freely about working conditions and leisure time activities. You may or not want to ask residents to provide feedback about applicants they meet. After the interview, it is a good idea for the program director or the chief resident to follow up with good candidates by phone or email.

Finally, it is hard to overemphasize the importance of a good program coordinator in this process. The applicants will have a lot of contact with the coordinator as they schedule interviews and visit your program. The coordinator should be well organized, people-oriented, and well informed about the program. How applicants behave toward the coordinator through all these processes is important information for the selection committee as well.

4. Match list: After you have completed interviews, the committee should review all the files again and interviewer comments. It is not fair to have one faculty member promote a favorite candidate unless he or she has seen all the files. Your program coordinator can enter all the candidates numbers for your rank list on line. You may receive correspondence from applicants after their interviews in which they indicate a strong interest in your program. Do not over-interpret anything they say about where they will rank your program. Neither the program nor the applicant is allowed to obtain a commitment from the other before the match.

Positions that provide all four years of training are called categorical (C) and those that are for just the 3 years of PM&R training are called specialty (S). Your program may offer both. For instance, if your usual PGY-2 class size is 6, but you only fund 3 PGY-1 positions, you are asking the match to select 3 categorical and 3 specialty residents for you. The 3 specialty residents will need to match to a PGY-1 position (e.g. transitional year, preliminary medicine or surgery) as well. In this case, you may want to indicate to the match that you are interested in a “reversion” if all of your categorical positions do not fill. You can designate these positions to “revert” to your “S” positions, so that you have a greater likelihood of filling all the PGY-2 positions with people you interviewed this year and ranked.

The couples match is designed to help couples match in the same geographic area. If you are aware that one of your applicants is “couples matching”, consider calling the program director of the other program to let them know of your interest in your candidate.

5. Unfilled positions after the match: The match typically happens on a Thursday in March. On the Monday before, unmatched students are notified as are institutions for unfilled residency programs. Unmatched students and unfilled programs can begin contacts on Tuesday. On Wednesday, programs can view their match roster via the Web and on Thursday at noon EST, all students are notified of match results. The period of contact between unmatched students and unfilled programs is referred to as the “scramble”. The program may choose to fill the rest of its positions during the scramble, or wait for inquiries from residents in other fields who wish to switch into PM&R, since the PGY-2 position you are filling is not for the upcoming year, but 15+ months later.

Several weeks after the match, the NRMP releases lots of data on trends in match results for the last several years by specialty. You can view this via the ACGME website.

6. Unfilled positions due to resident vacancy (termination, resignation): It is an unfortunate fact that not all residents who start the program will complete it. Some choose other careers, some need to transfer to another program for personal reasons (e.g. spouse’s job), and some may be terminated or not promoted by the program. It is difficult to maintain perfectly equal class sizes when such vacancies come along, because very few residents with reasonable credentials are transferring their training in the PGY 3 or 4 years. If a PGY 2 resident is not going to return the following year, your options are to find a PGY 3 resident who wants to transfer, or find someone in another field who wants to begin PM&R training as a PGY 2. One way to deal with the imbalance this can create in your class size is to have some clinical rotations that are appropriate for residents at different levels of training.

For these positions, it is usually easiest for the applicant to fax you written documents. It is very important to get feedback from the current residency program. If you are taking a medicine intern, the information from the internship program will be more current than the materials assembled for the match. If you are considering taking someone in transfer from another PM&R program, contact the other program director. This is the courteous thing to do and will also provide you with invaluable information. The RRC requires you to obtain a written evaluation of the resident’s past performance and experience from the previous program director. If a resident wants to transfer into your program at an advanced level, you are not required to accept them at that level if you feel the previous training does not meet the standards of your program. If you take a resident in transfer at a lower level of training, make sure the resident agrees to it in writing. You should also notify your department chair, your institution’s director of GME, and the Board (ABPMR).

N. Enrolling and orienting new residents and verifying their credentials

Your institution should be able to provide you and your coordinator with any paperwork that should be completed before residents begin training. This may include state licensing applications and a DEA application. You are responsible for verifying medical school training and other credentials/experience. You are responsible for verifying that the PGY-1 year was in an accredited program, that the clinical rotations of that year meet the fundamental requirements outlined by the RRC and the Board, and that the resident satisfactorily completed that year. You need to obtain a competency based summative assessment of the performance in the PGY 1 year, and copies of evaluations.

You also need to verify that international medical graduates (IMGs) have met ECFMG certification requirements as well as medical licensure and visa requirements in your state and institution. International medical graduates are those who have trained outside the US, Canada, or Puerto Rico. The ECFMG certification requires applicants to pass USMLE steps 1 and 2 CK and CS. The international medical school must be listed at the time of graduation in the World Directory of Medical Schools, published by the WHO. IMGs include US citizens who have completed their medical education outside the US, Canada, or Puerto Rico. See the ECFMG website (www.ecfm.org). Foreign born IMGs must have a J-1 (exchange visitor) or H-1B (temporary visitor) visa in addition to ECFMG certification.

O. Selecting/electing one or more chief residents

One or more chief residents can be invaluable to the program. The chief resident can represent resident views to the faculty, act as a resource to the program coordinator in daily administration of the program, participate in recruitment and selection of residents, assist with new resident orientation, assist in counseling or remediation of residents with performance problems, and teach or supervise junior residents. They can be responsible for specific tasks like developing the resident on call schedule, the resident rotation schedule, or organizing resident conferences.

A chief PM&R resident is typically a PGY-4 resident, who is adding the tasks of chief resident to the usual PGY-4 duties. Some institutions offer a supplement to the monthly salary for the chief resident. The chief may be elected by peers, selected by faculty, or some combination of the two (for instance, proposed by peers and endorsed by faculty). Qualities to consider in selecting a chief resident include the respect of peers and faculty, above average or better performance on clinical rotations and in didactics, and particular skills in organization, efficiency, communication skills, and marketing.

P. Developing and maintaining written policies and procedures

You should create and update annually a training manual that is distributed to residents and faculty alike. Post it on your internal website, so that you can update individual policies throughout the year and have it immediately available. Suggestions for content include:

- The resident's job description, including one for the chief resident
- Written goals and objectives for each major rotation by year of training (a description of the curriculum), which reflects graduated responsibilities
- Guidelines for clinical duties: rotation schedules, format for dictations or written work or orders
- Guidelines for supervision of residents including participation in team and family conferences, review of therapeutic and diagnostic problems, clinical emergencies, patient care crises and how junior residents are supervised by more senior residents.
- The processes of resident evaluation for clinical rotations, didactic work, semi-annual review, decisions for promotion, and final evaluation, including annual reporting to the Board
- A description of each of the teaching conferences, classes, lecture series; expectations for attendance and performance
- Guidelines/expectations for research work or presentations at national meetings
- Policies regarding academic discipline
- Grievance procedures
- Policies for use of Internet resources, email, and communication with patients by email
- Instructions for accessing clinical information systems at work and from home
- Policies for vacation, sick leave, other types of leave
- Duty Hours and Moonlighting policies
- Policies regarding taking call, changing on-call dates
- A list of all the residents, their pictures, CVs, email, pagers, home phone and addresses
- A list of faculty phone numbers, email addresses, pagers, research interests
- A list of faculty advisors for each resident, and a "job description" of the role

- Institutional requirements for immunizations, licensing
- Institutional resources: benefits office, emergency loans, loan deferment, parking and meal costs/benefits, and resident counseling services
- Recommended reading, department library resources

Q. Stay up to date on requirements

You should monitor changes in the institutional requirements, and the activities of the PM&R RRC. The RRC revises program requirements about every five years. They send out draft revisions to all program directors during the process and you should take the time to read them closely and give feedback. If the new revision goes into effect prior to your next site visit, read the new PIF to determine if there is any other data you should be collecting. Go to the AAP Program Director's Council workshop. A presentation by the RRC is nearly always part of the program.

R. Assuring sufficient resources for the residency program

The section at the beginning of this document titled "Resources for the Program Director" lists practical things you will need to run the program. There are other resources that you are responsible for

The RRC requires that the program director assure that residents have appropriate call rooms, conference rooms, exam rooms, and places for study. It also requires that the program director assure a sufficient number of qualified faculty. Faculty are expected to make reasonable scholarly contributions, provide quality clinical care, and participate in research and contribute to the professional literature. They are expected to actively participate in regional and national meetings. One faculty person at each training site should be designated to assume responsibility for day to day resident activities at that site. This is usually the clinical chief. Faculty are required to review the resident's history and examinations, the resident's records, and case presentations.

If your program requires residents to do a research project, you may need to identify funding sources to implement the projects.

S. Participating in your institution's GME committees

It is a good idea to participate on GME committees in your institution. These may relate to housestaff affairs, grievance committees, or ad-hoc internal review committees. By assisting in the internal review of other residencies, you can stay abreast of new institutional requirements and get ideas for how other programs are doing things. Many institutions also offer training seminars for residency program directors on resident evaluation, the impaired physician, legal issues, or other topics.

T. Oversight of fellowship directors

If your program sponsors ACGME accredited fellowship training, the core program director should oversee the activities of the fellowship(s). The core PD will have to sign off on the fellowship PIF at the time of accreditation. Fellowship directors may be responsible for 1 or several fellows, and the core PD will have invaluable advice on curriculum development, evaluation tools, interpretation of the competencies, program evaluation, and recruitment. If you have only 1 or just a few fellows, it may be helpful to have the fellow's evaluations of faculty and rotations included in the resident evaluations, to preserve confidentiality. The GME office can interview single fellows to provide feedback to the program as well.

IV. LEADER OR MANAGER?

Many of the year round activities of the program director become routine after a while, but still cannot be delegated to a chief resident or a program coordinator. It is easy to fall into a role as a manager. But the program director needs to be a leader, too, with support of the department chairperson and faculty to succeed. The process of program evaluation will help to set goals for innovations and improvements.

It is helpful to have an advisory committee to plan recruitment, evaluate problem residents, implement remediation plans, evaluate the program, and develop new ideas for teaching and evaluation. This committee should include your program coordinator, to make sure any ideas you have can be practically implemented. It should include your chief resident(s) to be sure the residents have a voice. Among the faculty, you may want: a mix of senior and junior faculty, some who trained at your institution and some who did not, a representative from each of your major institutions, or those who teach the core didactics. Choose faculty who are truly dedicated to education and whose advice you trust. Decide how you will make decisions—you may want a different plan for some scenarios. For instance, resident discipline is such a serious issue that the committee may want to act in an advisory capacity to the whole faculty. For recruitment, the committee could develop the final rank order list by majority vote, or could give input to the program director who would make the final decision.

To keep education a high priority, the committee should meet regularly throughout the year (e.g. quarterly or bimonthly or more often as needed). It is helpful to distribute minutes of the meeting to all faculty and residents to keep them up to date. Confidential discussions can be documented separately, but should be shared with the chairperson. In addition to the written minutes, review important issues at medical staff meetings. Include the chief residents at these meetings to give input and transmit information back to the residents.

The program director needs to be available to the residents. It is important to give residents a voice in program evaluation and in implementing program changes. If you have a large program with multiple institutions, regular meetings with the residents are a good idea. Even in a smaller program where a program director might see all the residents frequently, it is still helpful to devote specific times to discussion of the program.

A. Personal Development as a Program Director

Too often, program directors are “promoted” or assigned without focused preparation for the position and have on the job training. Ideally, the position should be viewed as a career path, and PDs should participate in training to enhance their effectiveness. The PD Council of AAP is a good place to start, as the annual workshops have content for both new and seasoned PDs. But there are essential competencies that PDs should acquire that may require more intensive training: formulating goals, writing a curriculum, evaluating the effectiveness of the curriculum, understanding adult teaching and learning, and giving effective feedback. The GME office of your institution may provide seminars on these topics. Many medical schools have now developed teaching scholars programs or have faculty development workshops to address these types of skills. Part of your “protected time” as PD should include being able to attend these workshops; these are valuable places to network with other educators and PDs in your institution. As you proceed in your work as a PD, it is very helpful to create a portfolio of your accomplishments as evidence of your scholarly contributions at promotion.

B. Faculty Development

The program director can and should inspire faculty to be better teachers and mentors. The program director must be a strong advocate for resident education and keep this a high priority for faculty. Maintaining a positive environment and keeping a sense of resident and faculty morale is important not only to assure ideal learning, but also for recruitment of future residents.

The PD should provide in-service training to faculty. This could be on teaching strategies, the competencies, resident evaluation, technology for teaching, or national trends in match rates or graduate

medical education funding. You don't have to provide hour long or half day retreat long presentations. Ten to 15 minutes at staff meetings devoted to a topic related to residency training can be helpful to transmit information, demonstrate a teaching technique, or discuss the value of comments on evaluation forms. As a PD, you do not have to be an expert in everything to be doing faculty development. You can initiate discussions and invite good teachers to describe how they address certain situations. Keep the E in GME; keep education on everyone's radar screen.

The program director can't fix all the problems in any residency program. Don't be discouraged by the amount of time it takes to effect change. Set reasonable goals, implement a plan, and then re-evaluate whether you met the goals. And always keep your eye on the calendar to be ready for your next accreditation site visit!

V. PREPARING FOR ACCREDITATION SITE VISIT

The preparation of the PIF is extremely time consuming. Begin work on this document several months before it is due. Enlist administrative support from your chairperson to help gather data from your various training sites, to create the faculty CVs and bibliographies, and to compile the document. Make sure you have answered every question. Follow the instructions for inserting extra pages and numbering them. Do not include any extra documents unless requested, but make sure you have everything the RRC asks you to append. At the end, you may include a brief narrative of any other plans or aspects of the program that would be pertinent to evaluation of the program.

After you have a solid draft of the document, review it with your residents. The site visitor will meet with a large proportion of your residents and will verify with them whether the information you have provided is accurate from their perspective. If you review every page with the residents, it will take several hours, so plan to do this over several sessions. This experience also helps junior residents gain perspective on the program from senior residents about rotations or experiences they have not yet encountered.

Data you should track on a continuous basis

- Resident presentations at local, regional, and national meetings: you will need to give the number for each of the last 5 years
- Publications: A list of papers published in the past 5 years with residents as author or co-author
- Curriculum: A list of didactic instruction and seminars for the entire cycle of lectures
- The number of residents taking Boards and passing Boards. It is expected that 75% of graduates will attempt the Boards, and that 75% of those taking part 1 and part 2 for the first time will pass. The Board will provide this data to the Review Committee
- Resident rotation schedules. You will need to include the actual schedules of 2 senior residents for their PGY-1 through PGY-4 years. Make sure this strongly resembles the block outline of a typical resident schedule that you will also provide. In another section of the document, you will need to break out the residents' time spent on inpatient, outpatient, consultations, and EMGs by site. **Do the math.** This needs to add up to 36 months, document 12 months of inpatient training, and 12 months of outpatient training, and should resemble both the block outline and the schedules you provided.

Data needed from the year prior to your site visit

- A list of all journal clubs, clinical case conferences, lectures by visitors for the past year, with date, title, and faculty name

Data you will need from your sponsoring institution

- The most recent letter of report from your institution's last review by ACGME. This is not for your program, but for the parent institution. You will also need to supply documentation of what the institution has done to address any citations in the report.

Data you will need from each training site to complete the PIF:

- A brief CV for all physician teachers contributing 10 or more hours per week to the program (this is entered into the electronic portion of the PIF, the Accreditation Data System on the ACGME website)
- A list of publications for the last 5 years by faculty who contribute less than 10 hours per week to the program.
- Professional staff at each institution: PTs, OTs, Speech language pathologists, therapeutic recreation specialists, clinical psychologists, social workers, and rehab nurses. You need to report the total number of FTEs.
- The total number of hospital and PM&R beds and the number assigned to residents; the average daily census; the number of admissions per year; the average length of stay; the full-time equivalent

(FTE) of residents assigned to the service, the number of admissions per FTE resident per rotation. **Do the math.** The number of admissions per year, divided by 365 multiplied by the length of stay should equal the average daily census. The average daily census divided by the FTE of residents should be 8 or more in order to call it a full time inpatient rotation. You will need to report if each institution is CARF accredited or JCAHO rehab accredited.

- The number of inpatient consultations per year, including a breakdown of adults, and children.
- The number of inpatients and outpatient consults for specific diagnoses (see below). The numbers should represent patients new to the resident; a patient seen for return visits to the same resident should be counted only once. **Do the math.** The total numbers of patients across all diagnoses should match the number of patients reported for that institution elsewhere in the PIF. The diagnostic categories are not defined in the PIF and you will need to use your judgment to decide if multiple sclerosis, for example, is included in spinal cord, brain injury, neurologic disorders, or other. The specific diagnoses include:
 - acute neuromusculoskeletal pain syndromes (including sports and industrial injuries)
 - amputation (congenital and acquired)
 - chronic pain management
 - geriatric rehabilitation for problems not listed elsewhere
 - neurologic disorders: congenital or acquired myopathies, peripheral neuropathies, motor neuron and motor system diseases and other neuromuscular diseases
 - oncological rehabilitation
 - pediatric
 - post fracture and post op joint arthroplasty
 - pulmonary and cardiac (these may be either the primary or secondary diagnosis)
 - rheumatologic disorders
 - soft tissue disorders such as burns, ulcers, and wound care
 - spinal cord (traumatic and non-traumatic and myelomeningocele,)
 - stroke
 - brain injury (traumatic and non-traumatic)
 - other

Program directors have tracked these numbers in various ways: using billing data, having residents track all their encounters, or extrapolating from quarterly samples.

- A description of on call rooms, office space for residents to use to study, access to computers, and teaching space
- Monthly calendar of specialty clinics
- Monthly calendar of formal educational activities

Documents needed at the time of the site visit (ACGME also provides a checklist):

- Four copies of the PIF; one will have been mailed to the site visitor 2 weeks before. The other 3 will be given to the site visitor on the day of the site visit.
- Current Program Letters of Agreement: must be less than 5 years old
- Policy for supervision of residents
- Policies for duty hours and work environment (institution AND program)
- Moonlighting policy

- Policy for recruitment, appointment, eligibility, and selection of residents
- Institutional policy for discipline, dismissal, and due process
- Documentation of internal review: date, participants' titles, type of data collected, and date of review by GMEC. Do NOT show the site visitor the actual internal review report.
- Overall educational goals for the program
- Competency based goals and objectives for each experience at each educational level. This includes rotations, didactics, and any other scholarly activities required of the residents.
- Files of current residents who have transferred into the program, if applicable, including documentation of previous experiences and competency based performance evaluations
- Evaluations of residents at the completion of each assignment (these are completed evaluations, not blank forms)
- Evaluations of residents showing multiple evaluators (e.g., faculty, peers, other professional staff, patients and self; these are completed evaluations, not blank forms)
- Documentation of residents' semiannual evaluations of performance with feedback.
- Final summative evaluation of residents, verifying that the resident has demonstrated sufficient competence to enter practice without supervision. Our RRC accepts the use of the ABPMR evaluation form for this final evaluation. If you use your own, make sure you include the statement verifying competence to enter practice without supervision.
- Completed annual written confidential evaluations of: 1. faculty by residents; 2. program by the residents, 3. program by faculty. These documents are reviewed primarily to ensure that they exist. Programs using computerized evaluation systems may generate and print summary reports rather than show individual records.
- Documentation of program evaluation and written improvement plan
- Documentation of resident duty hours
- Files of current residents and most recent program graduates

Documents needed at site visit if you are the only training program sponsored by your institution:

- Resident contract
- Master affiliation agreements

VI. WHAT TO EXPECT THE DAY OF THE SITE VISIT

When you get notified of the site visit:

Programs are usually notified about 90 days in advance of their site visit. If you have a conflict with the date, call Ingrid Philibert at the ACGME to reschedule the visit.

One month before the survey:

The site visitor will write to you and tell you what documentation he/she would like to have on the day of the visit, as well as a proposed agenda. If you do not receive this information, it is appropriate to write to the surveyor and ask what documentation they would like and whom they would like to meet with. Make sure that all your staff have cleared their schedule for the day of the survey. This includes attendings that are at affiliated institutions. In addition, the DIO (Designated Institutional Official or Dean) should be aware of the site visit and be prepared to meet with the surveyor.

The site visitors usually have a list of hotels that they use, but you can always ask the site visitor if he/she would like information about hotels in the area. Since the surveyor most likely does not live nearby, it may be helpful to send him/her a list of nearby hotels with their phone number, distance from your facility, and estimated cost.

Surveyors will meet with a group of your residents who have been chosen by their peers. Make sure the residents who have been selected will be available (i.e. not on vacation) and have coverage for the time they are meeting with the surveyor. Their beepers should be off during the meeting. The surveyor will want to talk to your residents privately. What they say should reflect what you have written in the PIF. It is a good idea to show your residents a copy of the PIF, and discuss any differences of opinion before the day of the site visit.

Arrange for a comfortable conference room for the day of the survey.

One week before the survey:

Make sure that everything is in order for the day of the site visit. Make sure that you have communicated to the surveyor, and that all of his/her travel arrangements have been set. By now, you should have all of your documents ready, as described above. Make arrangements for refreshments for the day of the site visit.

Ask the surveyor if they would like you to arrange for someone to pick up them up at the hotel and return them back to the hotel after the site visit.

Send the entire staff the schedule for the day of the site visit, so they are aware.

As the surveyor will have questions about the PIF, now is a good time to review what you have submitted to make sure you can answer all of his/her questions.

The day of the survey:

Relax. All of the hard work is already done. Your job today as Program Director is to make sure everything runs smoothly and to highlight your program's strengths.

Have the Program Coordinator ensure that all staff are where they are supposed to be.

Arrive early and make sure:

1. The conference room is open and all of the required documents are easily available
2. The refreshments are available
3. Everyone is aware of the schedule

REFERENCES AND RECOMMENDED READING FOR PROGRAM DIRECTORS

Academic Medicine is a journal published monthly by the AAMC that deals with medical education and academic medicine issues. To subscribe, you can email them at: publications@aamc.org

ACGME Bulletin is published quarterly and provides updates and information regarding GME issues and changes in ACGME requirements. You will receive this automatically once the RRC knows you are the program director. This is also available on the ACGME website: www.acgme.org

Andolsek K, Cefalo RC. **Learning to Address Impairment and Fatigue to Enhance Patient Safety**. Available via www.lifecurriculum.info

Two volume teachers guide with CDs on fatigue, burn out, substance abuse, disruptive behavior, instructive feedback, legal issues in residency training, generational differences, recruitment, and PD advice.

Amos DE, Massagli TL. **Medical school achievements as predictors of performance in a physical medicine and rehabilitation residency**. *Academic Medicine* 71:678-680, 1996.

One residency program evaluated which data from the application packets were correlated with strong and weak performance in the residency and on Board exams and with choice of an academic or clinical position.

Boninger ML, Chan L, Harvey R, et. al. **Resident research education in PM&R: a practical approach**. *Am J Phys Med Rehabil* 2001;80:706-12.

Outlines what residents should learn about research. AAP white paper.

Edmond M, Roberson M, and Hasan N. **The dishonest dean's letter: an analysis of 532 dean's letters from 99 US medical schools**. *Academic Medicine* 74:1033-1035, 1999.

Dean's letters frequently fail to note failing grades in preclinical courses or clinical rotations, leaves of absence or requirement to repeat an entire year of medical school!

Evaluation Methods: A resource handbook. McMaster University, 1995. Contact Program for Educational Development, McMaster University, 1200 Main St W, HSC-3N51, Hamilton, ON Canada L8N 3Z5, (905) 525-9140, ext. 23114. Information at:

http://fhs.mcmaster.ca/perd/publications/pub_evalmethods.htm

Excellent summary and critique of rating scales, oral examinations, written tests, performance tests, and assessment of skills.

Gray J. **Primer on Resident Evaluation**. *Annals Royal College Physicians Surgeons Canada*, 29 (2):91-94, 1996.

Summarizes the strengths and weakness of tools used in resident evaluation.

Irby DM, Milam S. **The legal context for evaluating and dismissing medical students and residents**. *Academic Medicine* 64:639-43, 1989.

Reviews fair and equitable treatment, due process for dismissals, documentation, libel, and defamation, in the context of actual court decisions.

Langsley DG. **How to select residents**. American Board of Medical Specialties, Evanston IL, 1988.

Includes chapters on "audition" electives, predicting residency performance using premedical or medical school performance, and the interview process (including its validity).

Lloyd JS, Langsley DG. **How to evaluate residents**. American Board of Medical Specialties, Evanston IL, 1986.

Reviews types of evaluation methods.

Massagli TL, Carline JD. **Reliability of a 360 degree evaluation to assess resident competence**. *Am J Phys Med Rehabil* 86:845-852, 2007

One program evaluated the psychometric qualities of a 360 degree evaluation of resident performance and found that reliability was adequate with as few as 5 ratings from nurses and rehab staff.

Medical Education is a journal published by the Association for the Study of Medical Education. It is an international journal, with a strong focus on medical student education.

Reyes MR, Massagli TL. **Competency based objectives for pediatric physical medicine and rehabilitation residency rotations.** *J Pediat Rehabil Med* 1:271-6, 2008

A compilation of objectives for pediatric rehab rotations based on input from about 50% of the PM&R residency programs.

Resident Observation and Competency Assessment: RO&CA

A tool developed by the ABPMR Program Director's Advisory Committee and tested for reliability by 7 residency programs. Publication pending but the RO&CA is available to all program directors at www.abpmr.org

Sekas G, Hutson WR. **Misrepresentation of academic accomplishments by applicants for gastroenterology fellowships.** *Ann Intern Med* 123:38-41, 1995.

Fellowship applicants reported research experience and publications that could not be corroborated. See also accompanying editorial: Kimball HR. Credentials misrepresentation: another challenge to professionalism. *Ann Intern Med* 123:58-9, 1995.

Sliwa JA, McPeak L, Gittler M, et al. **Clinical ethics in rehabilitation medicine: core objectives and algorithm for resident education.** *Am J Phys Med Rehabil*; 2002;81:708-17.

AAP white paper.

Teaching and Learning in Medicine is an international journal, published 4 times a year. Its focus is on applied educational research.

Walt AJ, Bashook PG, Dockery JL, Schneidman BS (eds.). **The Ecology of Graduate Medical Education.** American Board of Medical Specialties, Evanston IL, 1993.

Based on a conference on issues of balancing service and education, resident supervision, evaluation, and cultural, ethnic and gender issues.