

10 Digit ACGME Program I.D. #:

Program Name:

PROGRAM INFORMATION FORM TRANSITION DOCUMENT

Provide responses to the following, print and append to the completed program information form.

PROGRAM DIRECTOR INFORMATION

Does the program director approve the selection of program faculty as appropriate? (X) YES () NO

Does the program director evaluate the faculty and approve the continued participation of program faculty based on evaluation? (X) YES () NO

Does the program director comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents? (X) YES () NO

Is the program director familiar with and does he/she comply with ACGME and RC policies and procedures as outlined in the ACGME Manual of Policies and Procedures? (X) YES () NO

THE EDUCATIONAL PROGRAM

GENERAL COMPETENCIES

Practice-based Learning and Improvement

Examples of Learning Activities: (e.g., didactic session, assigned reading, seminar, self-directed learning module, conference, small group discussion, workshop, online module, journal club, project, case discussion, one-on-one mentoring)

- 1a. Describe one learning activity in which residents engage to identify strengths, deficiencies, and limits in their knowledge and expertise (self-reflection and self-assessment); set learning and improvement goals; identify and perform appropriate learning activities to achieve self-identified goals (life-long learning).

Limit your response to 400 words.

The pulmonary critical care program has regularly scheduled Clinical Case Conferences. Presentation of cases is assigned to the fellows on a rotating basis. The fellow assigned to run the conference is responsible to identify a clinical case of interest for presentation and frank, open group discussion. The salient issue could be a diagnostic dilemma, a therapeutic quandary, or unusual or unforeseen turn of clinical events. The fellows select cases with elements of uncertainty. The act of choosing an appropriate case for discussion at the Clinical Case Conference engages the fellows to identify a set of circumstances beyond their current level of knowledge and expertise. The topic to be presented is reviewed with a faculty member prior to presentation. The venue is an interactive format between the fellows and faculty. The presenting fellow facilitates the discussion of the case, and is encouraged to provide the results of literature searches and to prepare a formal Power Point presentation for the group. After presentation of the case, the faculty and fellows engage in ad hoc analysis of the case, during which problematic issues are recognized. The fellows develop an appreciation about which levels of their dynamic cognitive process offer opportunity for improvement. During the course of discussion, issues for

further investigation and study are identified. Various methodologies for self improvement are identified and set into motion. These include, but are not limited to further literature searches and assignment of topics for Grand Rounds presentation. We ensure closure by requiring follow-up concerning the case and specific issues raised at subsequent case conferences or at journal club. Further, the Power Point presentations created by the fellows are posted on the division's web site. Alternatively, discussion at the Clinical Case Conference may lead to the formulation of research questions, in which case the fellow has an opportunity to develop a research project. We believe this format offers an excellent venue for the fellows to identify strengths and weakness, and to develop strategies to improve their dynamic cognitive process, it is where we help the fellows learn to learn.

b. Describe one example of a learning activity in which residents engage to develop the skills needed to use information technology to locate, appraise, and assimilate evidence from scientific studies and apply it to their patients' health problems. The description should include:

- (1) locating information
- (2) using information technology
- (3) appraising information
- (4) assimilating evidence information (from scientific studies)
- (5) applying information to patient care

Limit your response to 400 words.

All fellows organize and conduct a mandatory weekly "case conference" throughout the 3 year fellowship, one fellow is responsible for each week. Fellows and faculty are required to attend these. Fellow identifies a specific case from their clinical practice that has management features of interest and has controversy (ICU, hospital consult service, or outpatient clinics). Fellow pulls all the patient data together including presentation, labs, actual imaging studies, PFTs, and subsequent clinical course (and possibly outcome). Most, if not all, of this data is in disparate electronic medical record repositories and the fellow learns proficiency in bringing this data together (quite different from the paper charts and hard films). In our specialty reviewing primary imaging data is a crucial skill. Fellow identifies specific issues for discussion and solicits group input. In addition, prior to the actual case conference, the fellow independently searches the published literature in attempting to identify what exists in the literature that speaks to the issues at hand. An important part of this task is to critically learn how to quickly scan a large medical literature that is increasingly on electronic platforms rather than conventional textbooks. These include PubMed, Up-To-Date, but also other cross references as appropriate. The expectation is for the fellow to review and synthesize this information and find gaps in existing knowledge, the relevance of the literature to the case at hand, impact on our current practice. Needless to say, this intellectual exercise "spills over" to other forums that fellows are involved in including journal club and research-in-progress. The complete exercise gives an excellent opportunity for the fellow to learn to use all available resources, including faculty, to apply the latest science AND art of medicine into patient care.

- c. Give one example and the outcome of a planned quality improvement activity or project in which at least one resident participated in the past year that required the resident to demonstrate an ability to analyze, improve and change practice or patient care. Describe planning, implementation, evaluation and provisions of faculty support and supervision that guided this process.

Limit your response to 400 words.

The Pulmonary and Critical Care Medicine section is actively involved in a multi-center research project involving the instruction of basic bronchoscopy skills (bronchoscopy education project). One fellow (currently a third year) has been involved as a sub-investigator in this project since its inception. One or more senior faculty members have been involved as investigators. Other fellows have been involved as research subjects. The project aims to discover if a particular predefined curriculum, *The Virtual Bronchoscopist, developed by Dr. Heni Colt at UCLA* (both cognitive knowledge of the procedure as well as practical skills) is better than current standard practice (i.e apprentice model of informal teaching) at improving the trainees' bronchoscopy skills. Trainees are evaluated by both written exams, as well as proctored procedural exams. We are currently in the data collection mode for the cohort that is being taught with the standardized curriculum. The fellow who is the sub-investigator has been involved with the project's design, as well as its implementation. He currently is active in proctoring the exams given to the other trainees, as well as presenting at local and national meetings (i.e abstract being presented at the upcoming national CHEST meeting in 10/07). In addition to this project, all fellows attend and participate in a day long bronchoscopy training course at the beginning of the academic year (in July) at Duke University Medical Center (organized by Dr. Momen Wahidi).

- d. Describe how residents:

- (1) develop teaching skills necessary to educate patients, families, students, and other residents;
- (2) teach patients, families, and others; and
- (3) receive and incorporate formative evaluation feedback into daily practice. (If a specific tool is used to evaluate these skills, please have it available for review by the site visitor.)

Limit your response to 400 words.

Pulmonary and Critical Care fellows develop their teaching skills from direct observation of P&CCM faculty teaching sessions. Fellows are allowed to teach medical students, and various levels of residents on both the MICU service and Pulmonary Consult service teaching rounds. It is expected that as each fellow is promoted from year 1 through year 3 of the fellowship, that they take a greater role in teaching rounds. Fellows are also expected to teach in various core lecture series of medical students and residents. Fellows are proctored by P&CCM faculty, who provide feedback and instruction. Fellows play an active role in the instruction of performing procedures relevant to the specialty (central lines, art lines, thoracentesis, intubations) routinely on all services. This is usually hands-on instruction with feed-back. Fellows also participate in the skills clinic for medical students (this is a new workshop). Third year fellows actively participate in instructing introduction to bronchoscopy to first year fellows. As the fellow progresses through the fellowship, less and less active supervision is required by the teaching faculty. Fellows teach patients and families in both the inpatient services (including end-of-life discussions), as well as their outpatient continuity clinic. These sessions are supervised by faculty.

Interpersonal and Communication Skills

- a. Describe one learning activity in which residents develop competence in communicating effectively with patients and families across a broad range of socioeconomic and cultural backgrounds, and

with physicians, other health professionals, and health related agencies.

Limit your response to 400 words.

End of life discussions with families is a critical skill that intensivists routinely engage in; this activity requires competence in effective communication of difficult concepts at the level of patients & families. Pitt County Memorial Hospital's Medical Intensive Care Unit (MICU) serves a large and splendidly diverse population (by age, ethnicity, socioeconomic status, and comorbid disease). The pulmonary critical care fellows are taught the skills needed to effectively and humanely communicate with this culturally and ethnically diverse population and their families concerning end of life issues. Typical discussions might involve medical futility and withdrawal of care, brain death and organ donation, appropriateness of performing dialysis or other resource intensive organ support in setting of multiorgan illness, decision to perform tracheostomy for long term support, etc. Fellows are closely monitored and permitted progressive, graded responsibility in communicating with patients and families concerning palliative care at the end of life in the MICU. These issues are reviewed at formal didactic sessions offered by the palliative care team.

The fellows are offered ample opportunity to actively participate in ethical discussions with the multidisciplinary team of critical care providers including the palliative care nurse. They eventually progress from the passive role of observer to team leader. Under close monitoring and with ample feedback of their performance, they learn how to coordinate end of life, palliative care in the intensive care unit. They are taught how to listen to the thoughts of the critical team, and to integrate these points of view into a palliative care plan. The fellows assume greater levels of responsibility in coordinating the palliative care plans.

The goal of this experience is to learn how to set realistic and humane goals of care at the end of life. This is an incredibly rich learning experience, as the fellows are exposed to an exceptionally varied mosaic of patients and families from a very ethnically and socioeconomically diverse population. Often the best teachers in this regard are the families and patients themselves.

When they demonstrate the requisite skills of empathetic listening and communication at the end of life, the fellows are progressively expected to take on more of a supervisory role for the resident housestaff. This transition from learner to teacher is crucial. The fellows learn to help the resident housestaff to become proficient and acquire confidence in this most crucial set of skills. The faculty closely monitors this process with input from the critical care nursing staff.

- b. Describe one learning activity in which residents develop their skills and habits to work effectively as a member or leader of a health care team or other professional group. In the example, identify the members of the team, responsibilities of the team members, and how team member communicate to accomplish responsibilities.

Limit your response to 400 words.

Care of patients in the intensive unit is dependent on the interrelated professional activities of a multidisciplinary team of critical care providers. Learning how to function as an effective member of the multidisciplinary critical care team, and eventually to lead this team are crucial skill sets for the fellows. Over a three year period, the fellows are progressively allotted more supervisory and functional responsibilities. The members of the team include the attending physician, fellows, interns, upper level residents, nurses, pharmacologists, respiratory therapists, case managers and others. The members of the team pool their expertise, in hopes of offering efficient and compassionate care.

As a member of this team, the fellow learns to be respectful, to listen to and consider the opinions and advice of other professionals. Communication amongst these providers occurs at different formal and informal venues. The fellows learn how to effectively communicate in more public

venues such as formal rounds, and on a more informal basis. The fellow learns how to integrate the input from these different sources into a cogent care plan for the patients. A key responsibility for the fellow is attendance multidisciplinary care rounds. At these rounds the fellow is afforded to opportunity to interface with allied health professionals, and formalize plans in respect to acute care and long term issues.

Further, the fellow learns how to be a role model for the more junior physicians in training. We expect the fellows to assist with housestaff orientation, education, clinical supervision and evaluation. Eventually the fellow is expected to function as leader of the team. Leadership demands excellent communication skills, and we closely monitor the trainee's performance as he or she assumes these higher levels of responsibility.

The intensivist must learn how to coordinate the care of critically ill patients suffering from a plethora of organ failures. Frequently the expertise of multiple consultants is required. The fellows learn how to communicate with, and integrate the opinions of multiple physician subspecialist into a cogent treatment plan. This requires much training, practice and supervision, and here again, learning to communicate well and effectively is of paramount importance.

Finally, the discharge of a patient from the intensive care unit engages a complex set of hierarchical steps which must be skillfully coordinated. The fellow learns these skills, and eventually rises to the level of planner and coordinator of this activity.

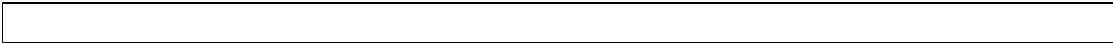
- c. Explain (a) how the completion of comprehensive, timely and legible medical records is monitored and evaluated, and (b) the mechanism for providing residents feedback on their ability to competently maintain medical records.

Limit your response to 400 words.

The medical chart documentation methods are evolving at our institution for both outpatient charting as well as in-patient at PCMH. The hand written notes and order writing are gradually being replaced by electronic formats. Effective July 1, 07 a new in-patient electronic medical record has been deployed at the hospital (Epic or Health Span). All fellows completed 8 hours of self-directed learning and computer lab training prior to the implementation of Health Span. Essentially, all orders (written by housestaff or attendings) are now electronically entered. The progress notes are the only element that remains in paper format, but this is scheduled to go electronic before end of 2007. Therefore the issue of legibility will hopefully disappear. The monitoring of completion of charting in any format is a joint responsibility of the medical records dept and the staff support office at PCMH as well as the attendings. There are pre-established thresholds for various components to be completed or face suspension at the attending level. For example, procedure notes and admit H & Ps need to be completed within 24 hours, and discharge summaries within 7 days. There is a 1 week grace period of "pre-suspension" followed by 1 week prior to "suspension" of privileges. One example is the bronchoscopy note, this is routinely dictated by the fellow. If the note is not in the system within 48 hours, the chart is listed as "delinquent" in the attending's list (an unusual occurrence). The typical approach is for the attending to notify the fellow of this lapse and this is usually adequate for proper completion.

As to fellow daily charting, the expectation is for all new consults and new MICU admits to have a fellow note. This is reviewed by the attending within 24 hours during daily rounding. The expectation for a "fellow note" is different than an "intern note" with greater emphasis on the big picture and plan of care. The quality of the notes as well as presentation skills are discussed during daily rounds.

The outpatient charting system currently is electronic (Centricity / Logician), but is scheduled to migrate to Health Span within the year. The expectations for charting are as noted above.



Professionalism

- a. Describe at least one learning activity, other than lecture, by which residents develop a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Limit your response to 400 words.

Our fellows are expected to behave and participate in the specialty & profession of pulmonary & critical care medicine by discharging all responsibilities and act according to widely expected ethics (as described in the ABIM policy on professionalism). They are encouraged / expected to become affiliate members (at discounted fees) in the professional societies (i.e. ACCP, ATS, SCCM, and NC medical society). This enables them to receive journals and all correspondence from these organizations. In addition, they are encouraged (expected) to attend at least 2 national meetings within the 3 year fellowship, preferably as an active presenter and also in a more focused way attend sessions devoted to fellows in training, etc. Each of our recent graduates and several of our current fellows have done so and this is an excellent method to network and build a sense of belonging. One of our fellows will be presenting data on a bronchoscopy education project at ACCP in 10/07. One of our current fellows regularly attends the GME committee meetings where training issues are vigorously discussed. Two of our fellows have taken the initiative to identify a "difficult airway skills" course and are planning attendance. One of our fellows is a member of an institutional initiative called the "rapid response team" geared for in-patient care for semi-urgent scenarios comprised of a physician, a nurse, and a respiratory therapist. Overall, these are some specific examples of activities and opportunities that our trainees participate in to develop a culture of contribution and professionalism.

- b. How does the program promote professional behavior by the residents and faculty?

Limit your response to 400 words.

Our fellows participate in a Research and Professional Skills series organized by our Family Medicine dept. These are very interactive sessions with specific fellow projects and there are several sessions devoted to professionalism. This topic was discussed in an interactive session in our division conducted by the GME office (May '07). As part of the evaluation process, we have instituted a 360-degree evaluation of each fellow by designated leaders/educators in a variety of key areas (our outpatient clinic, bronchoscopy suite, the medical intensive care unit, and respiratory therapy). This standardized evaluation form gives an opportunity for feedback from a variety of disciplines that will be shared by the program director with each fellow confidentially. Routine clinical care as organized in our medical intensive care unit is multi-disciplinary. The faculty role model an approach to interacting with a variety of physician and non-physician providers including nurses, RTs, etc. This routinely demonstrates how to be inclusive, how to communicate, how to resolve conflict, how to show respect and worth of various disciplines. The fellow has an opportunity to observe this and then incorporate it into their approach.

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- c. How are lapses in these behaviors addressed?

Limit your response to 400 words.

We have a multi-tiered system to address lapses in professional conduct. The system starts with direct interaction between the fellow and pulmonary/ critical care faculty and Program Director. The issue may rise to the level of the GMEC and perhaps fall under the purview of the Medical Staff Bylaws. Further, North Carolina State Statute 90-14 addresses the state's authority to revoke, suspend, annul or deny licensure and delineates the Medical Board's authority to investigate allegations of substance abuse. The Graduate Medical Education Committee (GMEC) has an official policy addressing Reappointment, Disciplinary Actions and Grievance. The mechanisms for due process in the event of non-reappointment, summary suspension, and disciplinary actions are

clearly delineated. Further, the appeals process is also outlined in this document. The GMEC has official policy documents addressing due process in the event of allegation of Sexual Harassment, Substance Abuse and relations with the Pharmaceutical Industry. The faculty, GMEC and hospital administration take allegations of professional misconduct, ethical transgression, sexual harassment and substance abuse very seriously. The first tier of adjudication takes place between the fellow and program director. If case of serious breeches and repeat offenses, the GMEC may get formally involved in the process according to the official GMEC policy documents. The Medical Staff Bylaws are also quite clear concerning due process in the event of professional misconduct. We believe strongly in rehabilitation, and fortunately we have several mechanisms to assist our fellows. The hospital has a formal Employee Assistance Plan. Further, a formal counseling program is available, and accepts referrals from the faculty. The State of North Carolina has a very successful Physician Health Program (NCPHEP). The NCPHEP accepts self- as well as anonymous referrals for physicians with issues of substance abuse, disruptive behavior or sexual misconduct.

Systems-Based Practice

- a. Describe the learning activity(ies) through which residents achieve competence in the elements of systems-based practice: work effectively in various health care delivery settings and systems, coordinate patient care within the health care system; incorporate considerations of cost-containment and risk-benefit analysis in patient care; advocate for quality patient care and optimal patient care systems; and work in interprofessional teams to enhance patient safety and care quality.

Limit your response to 400 words.

The medical intensive care unit is a key area where pulmonary/ccm fellows spend a great deal of time. Over the 3 years, the fellows receive instruction and develop skills for graded increase in responsibility culminating in a junior attending role by 2nd and 3rd years. A busy MICU at an 800 bed tertiary medical center (i.e. PCMH) is a "bottleneck" in the flow of patients in the region. Patients maybe admitted from the ED, regional hospitals / ICUs, and cardiopulmonary arrests on the floor. The fellow acts in a pivotal triage role fielding requests for beds and transfers in a system with high bed occupancy on most days. There are competing demands by referring physicians, nursing staff, attendings from various services, and hospital administration. Efficient disposition of patients into and out of the MICU is immensely important for both the safety of individual patients (i.e. shorter time on the ventilator or in the unit lowers nosocomial infections and complications) as well as the overall functioning of the "health care system" (i.e. appropriate transfer of critically ill patients from smaller outlying facilities without specific expertise to PCMH is best utilization) In this context, the fellow closely works with the housestaff, attending, charge nurse, discharge planners/social workers, as well as the floor services. This milieu represents the ultimate experience for fellows to learn and develop many disparate skills related to 1. the ethics of prioritizing and triaging patients in setting of limited beds, 2. making judgments of patient length of stay in the ICU (as opposed to step-down units or subacute acute care facilities), 3. making evidence-based decisions re. the risk-benefit of various decisions for acute support, 4. communicating with a variety of professional providers including non-physicians, and 5. keeping families in the loop re. this complexity. There are dedicated learning activities that teaches fellows how to develop competence in this particular systems-based practice (i.e. ICU triage and prioritizing patients). For example, at specific case conferences involving ICU patients, these issues are discussed as a group. The discipline of "severity scoring indices" (i.e. APACHE) for ICU patients is routinely discussed in several forums including journal clubs, fellow-driven grand rounds, and research-in-progress sessions. The ICU fellow and the ICU attending frequently discuss outside phone calls soliciting patient transfers, these are placed in a "waiting list", and appropriate disposition and criteria are discussed. The overall impact of all this on the health care system is

substantial and goes way beyond the particular hospital.

- b. Describe an activity that fulfills the requirement for experiential learning in identifying system errors.

Limit your response to 400 words.

The reduction of errors in the ICU is a major safety initiative endorsed by many professional organizations including the Agency for Healthcare Research and Quality. Experiential learning implies learning through action, where teachers provide meaningful experience. As faculty we purposefully engage with the fellows in direct experience and focused reflection in order to increase awareness of system errors in the ICU, and help them acquire the knowledge and skills to reduce these errors. During their ICU experience the fellows have ample opportunity to help identify and participate in reducing the occurrence of medical errors. Often this is part of a larger process, whereby the fellows become aware of a new idea or concept at pulmonary critical care journal club, and then help translate this information into evidence based clinical practice. The following are prime examples of how our fellows have used experiential learning to identify and help reduce system errors. 1) Maintenance of euglycemia is a major safety initiative shown to reduce mortality. After review of the literature concerning glycemic control and review of practice patterns, a significant fellow-driven initiative helped standardize a successful protocol for maintenance of euglycemia. The fellows reviewed data concerning glycemic control, insulin orders and protocols, interviewed nurses, pharmacologists and subspecialty physicians. This led to the institution of a successful action plan thus avoiding a significant error omission. We are proud of this instance of democratic experiential education. 2) Low tidal volume ventilation is crucial to optimizing outcome in ARDS. Faculty and fellows have worked closely together and with respiratory therapy to introduce the use of a computerized closed looped ventilator to minimize errors in mechanical ventilation. The fellows have been instrumental in this regard, as they recognized the serious nature of this common error, and have been actively engaged in helping to introduce this new technology into the ICU. They have been very energetic as champions of this new technology. 3) Adequate communication among team members during hand off of patient care is paramount to patient safety. As part of the critical care team, our fellows have identified opportunities for improvement, and have taken deliberate steps to insure patient safety. These measures include reviewing care plans with the on-call housestaff, and evening rounds when needed.

RESIDENT DUTY HOURS

Briefly describe how the faculty provides appropriate supervision of residents in patient care activities.

Clinical care is rendered in several settings in our pulmonary fellowship program including the medical intensive care unit, in-patient general floors, the outpatient clinic, and the bronchoscopy procedure suite. The details of supervision are different based on the specific settings. However, every in-patient that is seen by a fellow is also seen by the attending daily. **In the MICU**, the attending rounds with the entire team (including housestaff as well as the fellow) 7 days per week, sees every patient at the bedside, and writes a hand-written note daily. All bronchoscopies that are performed on any patient always occur with the attending present at the bedside (in fact, procedures do not begin without bedside presence of the attending). Based on the level of the fellow, the attending plays a variable role in the actual procedure. For example, for 1st year fellows the attending directly assists with all specimen collections (lavage, brushings, biopsies), and for 2nd and 3rd years the attending is present but plays a small role depending on the fellow proficiency. TBNAs and stents are generally reserved for the senior fellows. Supervision for the other critical care procedures is more variable but the fellows do log in all procedures on an online system ("new innovations" website). **In the outpatient clinic**, each fellow has a half day clinic for all weeks not assigned to the MICU. A specific faculty is assigned to each fellow clinic and the faculty is physically present in the clinic. All new patients are evaluated by a fellow first and presented to the attending with review of all available data (including radiographs). Both the attending and fellow subsequently interview and exam the patient and a plan of care is communicated to the patient. The fellow is fully responsible for implementation of the plan, including follow-up for all diagnostic studies, referrals, writing scripts, etc. All telephone calls from the patients are triaged by the clinic nurse to the appropriate fellow (and not the attending). All procedures on fellow patients are performed by the fellow (with attending supervision).

Does the program have approval from the Review Committee for an exception to the 80-hour per week duty hour limit? () YES (X) NO

If yes, provide the date of the approval. _____

If yes, provide a description of the exception (e.g. specific rotations, program-wide)

If yes, and the program is requesting continued approval of the exception, complete the following:

Patient Safety: Describe how the program and institution have monitored, evaluated, and ensured patient safety with the extended resident work hours.

Educational Rationale: Describe the educational rationale for the exception in relation to the program's stated goals and objectives for the particular assignments, rotations, and level(s) of education.

Moonlighting Policy: Describe the program's moonlighting policies for residents who have the duty hour exception.

Call Schedules: Describe the resident call schedules during the times specified for the exception.

Faculty Monitoring: Describe the faculty development activities about the effects of resident fatigue and sleep deprivation.

Please have the following documents available for the site visitor:

1. Files for current residents/fellows
2. Current Program Letters of Agreement (PLAs)
3. Files of residents/fellows who have transferred into the program (if applicable), including documentation of previous experience and competency-based performance evaluation for actively enrolled residents accepted as transfer residents.
4. Program Policy Manual, including:
 - a. policy for resident appointment, eligibility, selection, and promotion
 - b. policies for supervision of residents
 - c. policies and procedures for resident duty hours and the working environment
 - d. moonlighting policy
5. The resident supervision policy that addresses the following:
 - a. Residents' responsibilities for patient care,
 - b. Progressive responsibility for patient management, and
 - c. Supervision of patient care.
6. Documentation of resident duty hours
7. Institutional policy for remediation and dismissal of residents, including due process
8. Documentation of internal review (date, participants' names and titles, type of data collected, when reviewed by GMEC)
9. Overall educational goals for the program are required.
10. Written competency-based goals and objectives for each experience at each educational level are required. (RRCs that wish to see a sample, will ask for an example to be appended to the PIF).
11. Documentation of resident evaluation including:
 - a. A final (summative) evaluation for each resident must document the resident's performance during the final period of education and verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. Have copies of these evaluations for the most recent year's graduates available for review by the site visitor.
 - b. Resident evaluation at the end of each learning experience; and
 - c. Written or electronic semiannual evaluation of the resident with feedback;
12. Completed evaluations of the faculty by the residents
13. Completed evaluations of the program by the residents
14. The written improvement action plan the program prepared after a review of the aggregated results of residents' performance and/or other program evaluation results.
15. Documentation of conference attendance, if applicable
16. For those institutions which are either a single-program institution (e.g., medical genetics only), or an institution with multiple residencies accredited by the same RRC: A copy of the resident contract/agreement with the items required by the ACGME numbered according to the Institutional Requirements. (Institutional Requirements II.D.