LEAVE OF ABSENCE
MATERNITY/PATERNITY LEAVE
EDUCATIONAL LEAVE
FAMILY LEAVE
SICK LEAVE
HURRICANE "CODE GRAY" POLICY
PAGERS
MONITORING PAGERS
COMPUTER E-MAIL REGISTRATION
PARKING
DRESS CODE
SUBPOENAS
EDUCATIONAL RESOURCES
HEALTH INSURANCE
DISABILITY INSURANCE
DISABILITY POLICY
REQUIRED IMMUNIZATIONS AND
VACCINATIONS
LAB COATS, MEALS, NIGHT CALL
MALPRACTICE INSURANCE
DEA NUMBERS
MOONLIGHTING
MOONLIGHTING REQUISITION REQUEST
LSU INSTITUTIONAL POLICY ON DUTY HOURS
SIX GENERAL COMPETENCIES
CAMPUS ASSISTANCE PROGRAM (CAP)
RESTRICTIVE COVENANTS
COMMITTEE AND OTHER SERVICE
DRUG TESTING REQUIREMENT (PRE-EMPLOYMENT)
OCCUPATIONAL INJURY/DISEASE PROCEDURES
LSUHSC NEEDLE STICK INSTRUCTIONS
POLICY ON HOLIDAY SCHEDULE
MEDIA POLICY
VENDOR/INDUSTRY RELATIONS POLICY
NEW INNOVATIONS MEDICAL EDUCATION MANAGEMENT SUITE
CLIQ AND SMARDI
USMLE PART III AND COMLEX LEVEL POLICIES
HONESTY, INTEGRITY AND TRUSTWORTHINESS
PROFESSIONALISM AND LEARNING ENVIRONMENT

RESIDENT RESPONSIBILITIES

INCOMPLETE MEDICAL RECORDS

GUIDELINES FOR SUPERVISION OF RESIDENTS

LSU PM & R POLICY ON MANDATORY NOTIFICATION OF FACULTY

ATTENDANCE REQUIREMENTS

SIGN OUT POLICY

POLICY ON EFFECTIVE TRANSITIONS

SIGN OVER TRANSITION TEMPLATE

POLICY ON DOCUMENTING ATTENDANCE AT AFFILIATED FACILITIES

PROGRAM CLOSURE OR REDUCTION

PROGRAM OVERVIEW

OVERALL PROGRAM GOALS AND OBJECTIVES

ROTATIONAL GOALS AND OBJECTIVES

TOURO INPATIENT REHABILITATION
TOURO BRAIN INJURY REHABILITATION
MCLNO - UNIVERSITY HOSPITAL CONSULTS ROTATION
MCLNO - UNIVERSITY HOSPITAL CLINICS ROTATION
OCHSNER INPATIENT REHABILITATION
OCHSNER INTERVENTIONAL PAIN ROTATION
OCHSNER CARDIAC REHABILITATION
CHILDREN’S PEDIATRIC REHABILITATION
OCHSNER PEDIATRIC REHABILITATION AND SPORTS MEDICINE ROTATION
ORTHOTICS AND PROSTHETICS ROTATION
VETERANS ADMINISTRATION PM&R CLINICS ROTATION
VETERANS ADMINISTRATION PAIN ROTATION
CHABERT MEDICAL CENTER CLINICS ROTATION
PEDIATRIC NEUROLOGY ROTATION
BATON ROUGE GENERAL BURN REHABILITATION
EAST JEFFERSON PAIN ROTATION
SCHOLARLY ACTIVITY – RESEARCH

EVALUATIONS

EVALUATION FORMS

Lecture and Speaker Evaluation Form
Resident Evaluation by Faculty Forms
Peer Review House Officer Form
Faculty Evaluation by Resident Form
Resident Evaluation Form from Nursing, Therapists, and Clerical Staff
Resident Evaluation by Patient Form
Program Evaluation by Resident Form
Duty Hours Log
Semiannual Evaluation Form
Clinical Competency Evaluation Form (Mock Standardized Patient)
American Board of PM&R Final Evaluation Form
Lecture attendance sign-in sheet
Resident Observation and Competency Assessment (ROCA)
Resident Self Evaluation Form
Rotational Evaluation Form

READING LIST
ATTESTATION SHEET - PM&R House Officer Manual
ATTESTATION SHEET – LSU House Officer Manual
INTRODUCTION

Founded in 1973, the Physical Medicine and Rehabilitation (PM&R) Residency Program at the Louisiana State University Health Sciences Center (LSUHSC) is dedicated to providing superior, comprehensive training in rehabilitation care. PM&R residents work closely with skilled, experienced physicians in a variety of practice settings, including acute medical/surgical units, sub-acute rehabilitation facilities and outpatient rehabilitation clinics. Under faculty guidance, our residents care for a diverse patient population and gain in-depth exposure to a range of physical medicine and rehabilitation areas, including musculoskeletal medicine, spine care, chronic pain, spinal cord injury, foot problems due to diabetes, neuromuscular disorders, joint replacement, disuse atrophy, brain injury, occupational injuries, sports medicine, stroke rehabilitation, electrodiagnostics and prosthetics. PM&R faculty members encourage residents to make independent decisions on patient care, treatment, and management, yet provide appropriate guidance and supervision.

We emphasize the development of superb diagnostic skills through detailed attention to the patient history and physical examination, supplemented by electrodiagnostic studies when appropriate. Our physicians also are committed to devising ways to improve patients' quality of life through treatment that includes therapeutic exercise and the use of appropriate assistive devices. PM&R residents gain skills in formulating such treatments and learn to work with a comprehensive team of health care professionals to provide first-rate rehabilitation care. Clinical research is also a crucial component of the PM&R training program, and residents undertake clinical research under the guidance of faculty mentors. Through a balanced curriculum of didactics and clinical experience, PM&R residents graduate with the confidence, clinical skills, and knowledge they need to practice in the setting of their choice.

DEFINITIONS

For purposes of this Manual, the following terms shall have the meaning ascribed thereto unless otherwise clearly required by the context in which such term is used.

**House Officer** - The term “House Officer” shall mean and include interns, residents and fellows.

**Program** – The term “Program” shall mean a Resident and Fellow Training Program of Louisiana State University School of Medicine in New Orleans.

**Dean** - The term “Dean” shall mean the Dean of the Louisiana State University School of Medicine in New Orleans or his “designee”.

**Academic Dean** – The term “Academic Dean” shall mean the Dean of Academic Affairs of the Louisiana State University School of Medicine in New Orleans or his “designee”.

RESIDENT ELIGIBILITY AND SELECTION

Our House Officer selection criteria conforms to the guidelines of the Accreditation Council for Graduate Medical Education (ACGME) General Requirements. Potential residents submit an application through the Electronic Residency Application Service (ERAS). Members of the section of Physical Medicine and Rehabilitation review the files and select applicants for on-site interviews. Interviews are conducted from November through February of each year. The applicants meet with the program director, section administrator, faculty members, chief resident, and several residents, and are given a guided tour of the main campus and facilities. The Section of Physical Medicine and Rehabilitation meets several times
throughout the interviewing season and prepares the final match list after all interviews are conducted.

LSU School of Medicine ensures that its training programs select from eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs do not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.

House Officers must be

(1) graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME) or
(2) graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA) or
(3) graduates of medical schools outside the United States who have a currently valid certificate from the Education Commission for Foreign Medical Graduates or have a full and unrestricted license to practice medicine in a United States licensing jurisdiction or
(4) graduates of medical schools outside the United States who have completed a Fifth Pathway Program by an LCME-accredited medical school.

All House Officer trainees must have a valid license or permit to practice medicine in the State of Louisiana. Beginning with medical graduates of 1992, all Louisiana licensure examination is through the United States Medical Licensing Examination (USMLE) three-step pathway. The Louisiana State Board of Medical Examiners will confer unlimited licensure only after the candidate successfully completes the post-graduate year I level and passes the USMLE Step examinations 1 through 3. The examination of the National Board of Osteopathic Examiners and the LMCC Canada examination are not currently accepted by the Louisiana licensing Board.

The Louisiana State Board of Medical Examiners issues temporary training permits to qualified post-graduate year I level trainees. Temporary permits (Visiting Resident Permits) also may be issued for certain foreign medical graduates entering the U.S. on J-1 visas. Foreign citizen trainees must have standard Educational Commission for Foreign Medical Graduates (ECFMG) certification. They must pass the Foreign Medical Graduate Examination in the Medical Sciences (FEMGEMS) and the ECFMG English test.

House Officers are appointed for one year. Contract renewal is subject to mutual written consent of the Department Head and the House Officer. This renewal must be made in a timely manner in accordance with dates set by the GME Office.

**LSU HOUSE OFFICER MANUAL**

In addition to this PM&R specific manual, all house officers must abide by everything contained in the current LSU House Officer Manual. This can be found online at:
http://www.medschool.lsuhsn.edu/medical_education/graduate/HouseOfficerManual.asp

**COMPENSATION**

Compensation is provided consistent with the pay scale determined by the managing entity of Louisiana's Charity Hospital System.

**HOUSE OFFICER SUPPORT**

The mission of the Graduate Medical Education Office is to support the House Officers and the training programs of the School of Medicine. The Office of Graduate Medical Education (GME) offers House Officers the opportunity to participate in group long term disability coverage. In the event a House Officer experiences a loss of income as a result of an emergency, the House Officer should contact the Associate Dean for Academic Affairs for possible avenues of assistance.

In order to enhance the House Officer’s training experience, the Office of Graduate Medical Education has developed a series of Core Curriculum On-line Modules. This series of modules includes topics such as: Competencies Overview, Recognizing Signs of Fatigue, Impaired Physicians, Professionalism-Parts I and II, Medical Errors-Parts I and II, Breaking Bad News, Patient Safety, Interpretation of Diagnostic Screening Tests, How to Read a Clinical Trial, Into to Evidence Based Medicine, Study Design I and II, Risk Management and Quality Assurance, Introduction to Biostatistics, and EMTALA. The Office of Graduate Medical Education administers the House Officer Payroll; processes education loan deferment certifications, applications for Internship Registration and Verification of Internship forms for the Louisiana State Board of Medical Examiners; and coordinates House Officer Orientation LSBME License Application Day and Residency Fair Day.

**INSTITUTIONAL HOUSE OFFICER POLICIES**

The LSU School of Medicine – New Orleans (School of Medicine) is responsible for supervising House Officer training programs. This responsibility is delegated to individual departments and is fulfilled by the medical faculty. The level of supervision must be commensurate with the House Officer's level of training and the House Officer's individual level of clinical skills. On-call schedules for faculty are designed so that supervision and/or consultation are readily available at all times to House Officers on duty. Each Department has established policies for House Officers that will be consistent with the ACGME General Requirements and Special Requirements of each program.

At the beginning of each academic year, each House Officer Program should provide the House Officer an outline of specific rotations and regularly scheduled lectures, conferences and seminars. House Officers should be informed about departmental duties and disciplinary policies during orientation and/or by written guidelines. These policies should describe training goals and expectations, program evaluation methods, possible basis for adverse actions such as probation or dismissal, and due process procedures.

The educational effectiveness of each House Officer Program should be periodically reviewed by departmental faculty. Reviews should include resident evaluations of faculty and the House Officer Program and faculty evaluations of program effectiveness.

**EVALUATION AND PROMOTION OF HOUSE OFFICERS**

Records of House Officer evaluations are to be maintained by the Departmental Program Directors. These files will generally be available to the individual trainees, training faculty, Program Director, and other University personnel as may be required by the House Officer Program, School Of Medicine, or University. House Officers will be formally evaluated no less than twice a year, however, more frequent feedback is encouraged. Both strengths and weaknesses should be documented and discussed in the
evaluation process as well as plans to remediate any deficiencies.

Evaluation of House Officers ideally should include comments by multiple evaluators such as the Program Director, ward and/or clinic faculty, chief resident, and others. Additionally, each House Officer is expected to participate in departmental self-assessment when applicable.

Residents are required to take the annual American Academy of Physical Medicine & Rehabilitation Self-Assessment Examination for Residents (SAE-R) administered nation-wide usually on the last Friday of January. Examination results received the last week of March include a percentile ranking within the examinee’s peer group for his/her post-graduate year of training. Residents are also required to take weekly quizzes given on Friday afternoons. At least 75% of all quizzes are required for advancement to the next level of training and failure is grounds for non-renewal of the house officer’s contract. **A minimum average test score is required for advancement to the next level or for graduation: PG1 – 65%, PG2 – 70%, and PG3 and PG4 – 75%**. Test scores will be averaged from July to December for the PG1 academic year, and similarly for the PG2 level for house officers starting at a PG2 level. Test scores will otherwise be averaged from January to December (i.e. from six months prior to the start of the academic year to six months into the academic year). The minimum test score requirement can be waived if the house officer attains an SAE-R score that academic year that is at least at the 25th percentile for their PG level. If a house officer does not attain the minimum quiz test score requirements a second time in their residency program, then this is grounds for non-renewal of the house officer’s contract. **NOT WRITING ANY EXAM FOR ANY REASON WILL RESULT IN A SCORE OF 0**. A minimum of 75% of all didactic sessions, lectures, and formal teaching sessions is required. Failure to attain this 75% attendance is grounds for probation or other disciplinary measures.

**MEDICAL SPECIALTY BOARD INFORMATION**

Residents are directed to the American Board of Physical Medicine and Rehabilitation web site (https://www.abpmr.org/index.html) regarding qualifications and requirements to sit for their specialty boards.

**PRELIMINARY INTERVENTION**

Substandard disciplinary and/or academic performance is determined by each Department. Corrective action for minor academic deficiencies or disciplinary offenses which do not warrant remediation as defined below, shall be determined and administered by each Department. Corrective action may include oral or written counseling or any other action deemed appropriate by the Department under the circumstances. Corrective action for such minor deficiencies and/or offenses are not subject to appeal.

**PROBATION**

House Officers may be placed on probation for, among other things, issuance of a warning or reprimand; or imposition of a remedial program. Remediation refers to an attempt to correct deficiencies which if left uncorrected may lead to a non-reappointment or disciplinary action. In the event a House Officer’s performance, at any time, is determined by the House Officer Program Director to require remediation, the House Officer Program Director shall notify the House Officer in writing of the need for remediation. A remediation plan will be developed that outlines the terms of remediation and the length of the remediation process. Failure of the House Officer to comply with the remediation plan may result in termination or non-renewal of the House Officer’s appointment.

A House Officer who is dissatisfied with a departmental decision to issue a warning or reprimand, impose a remedial program or impose probation may appeal that decision to the Department Head informally by meeting with the Department Head and discussing the basis of the House Officer’s dissatisfaction within ten (10) working days of receiving notice of the departmental action. The decision of the Department Head shall be final.
TERMINATION, NON-REAPPOINTMENT, AND OTHER ADVERSE ACTION

A House Officer may be dismissed or other adverse action may be taken for cause, including but not limited to: i) unsatisfactory academic or clinical performance; ii) failure to comply with the policies, rules, and regulations of the House Officer Program or University or other facilities where the House Officer is trained; iii) revocation or suspension of license; iv) violation of federal and/or state laws, regulations, or ordinances; v) acts of moral turpitude; vi) insubordination; vii) conduct that is detrimental to patient care; and viii) unprofessional conduct.

The House Officer Program may take any of the following adverse actions: i) issue a warning or reprimand; ii) impose terms of remediation or a requirement for additional training, consultation or treatment; iii) institute, continue, or modify an existing summary suspension of a House Officer’s appointment; iv) terminate, limit or suspend a House Officer’s appointment or privileges; v) non-renewal of a House Officer’s appointment; vi) dismiss a House Officer from the House Officer Program; vii) or any other action that the House Officer Program deems is appropriate under the circumstances.

DUE PROCESS

All communication regarding due process will occur by either official campus email, certified letter, or hand delivery Dismissals, non-reappointments, non-promotion or other adverse actions excluding probation which could significantly jeopardize a House Officer’s intended career development are subject to appeal and the process shall proceed as follows:

Recommendation for dismissal, non-reappointment, or other adverse action which could significantly threaten a House Officer’s intended career development shall be made by the Program Director in the form of a Request for Adverse Action. The Request for Adverse Action shall be in writing and shall include proposed disciplinary action, a written statement of deficiencies and/or charges registered against the House Officer, a list of all known documentary evidence, a list of all known witnesses and a brief statement of the nature of testimony expected to be given by each witness. The Request for Adverse Action shall be delivered in person to the Department Head. If the Department Head finds that the charges registered against the House Officer appear to be supportable on their face, the Department Head shall give Notice to the House Officer in writing of the intent to initiate proceedings which might result in dismissal, non-reappointment, summary suspension, or other adverse action. The Notice shall include the Request for Adverse Action and shall be sent by campus email, certified mail to the address appearing in the records of the Human Resource Management, or may be hand delivered to the House Officer.

Upon receipt of Notice, the House Officer shall have five (5) working days to meet with the Department Head and present evidence in support of the House Officer’s challenge to the Request for Adverse Action. Following the meeting, the Department Head shall determine whether the proposed adverse action is warranted. The Department Head shall render a decision within five (5) working days of the conclusion of the meeting. The decision shall be sent by campus email, certified mail to the address appearing in the records of the Human Resource Management, or hand delivered to the House Officer and copied to the Program Director and Academic Dean.

If the House Officer is dissatisfied with the decision reached by the Department Head, the House Officer shall have an opportunity to prepare and present a defense to the deficiencies and/or charges set forth in the Request for Adverse Action at a hearing before an impartial Ad Hoc Committee, which shall be advisory to the Academic Dean. The House Officer shall have five (5) working days after receipt of the Department Head’s decision to notify the Academic Dean in writing or by email (revised 12/15/2009) whether the House Officer would challenge the Request for Adverse Action and desires an Ad Hoc Committee be formed. If the House Officer contends that the proposed adverse action is based, in whole or in part on race, sex (including sexual harassment), religion, national origin, age, Veteran status, and/or disability discrimination, the House Officer shall inform the Academic Dean of that contention. The Academic Dean shall then invoke the proceedings set out in the Section entitled
“Sexual Harassment Policy” of this Manual. The hearing for adverse action shall not proceed until an investigation has been conducted pursuant to the Section entitled “Sexual Harassment Policy.” The Ad Hoc Committee shall consist of three (3) full-time (75% or greater effort) clinical faculty members who shall be selected in the following manner:

The House Officer shall notify the Academic Dean of the House Officer’s recommended appointee to the Ad Hoc Committee within five (5) working days after the receipt of the decision reached by the Department Head. The Academic Dean shall then notify the Department Head of the House Officer’s choice of Committee member. The Department Head shall then have five (5) working days after notification by the Academic Dean to notify the Academic Dean of his recommended appointee to the Committee. The two (2) Committee members selected by the House Officer and the Department Head shall be notified by the Academic Dean to select the third Committee member within five (5) working days of receipt of such notice; thereby the Committee is formed. Normally, members of the committee should not be from the same program or department. In the case of potential conflicts of interest or in the case of a challenge by either party, the Academic Dean shall make the final decision regarding appropriateness of membership to the ad hoc committee. Once the Committee is formed, the Academic Dean shall forward to the Committee the Notice and shall notify the Committee members that they must select a Committee Chairman and set a hearing date to be held within ten (10) working days of formation of the Committee. A member of the Ad Hoc Committee shall not discuss the pending adverse action with the House Officer or Department Head prior to the hearing. The Academic Dean shall advise each Committee member that he/she does not represent any party to the hearing and that each Committee member shall perform the duties of a Committee member without partiality or favoritism. The Chairman of the Committee shall establish a hearing date. The House Officer and Department Head shall be given at least five (5) working days notice of the date, time, and place of the hearing. The Notice may be sent by campus email, certified mail to the address appearing in the records of the Human Resource Management, or may be hand delivered to the House Officer, Department Head, and Academic Dean. Each party shall provide the Academic Dean five copies of the witness list, a brief summary of the testimony expected to be given by each witness, and a copy of all documents to be introduced at the hearing at least three (3) working days prior to the hearing. The Academic Dean will assure that all parties will receive the other parties documents.

The hearing shall be conducted as follows:

The Chairman of the Committee shall conduct the hearing. **The hearing shall include the following persons: the resident appealing the action, the members of the AdHoc Committee, the Program Director with or without the Department Head, counsel if present and any other persons deemed by the Chairman of the Ad Hoc Committee to carry out the hearing.** Each party shall have the right to appear, to present a reasonable number of witnesses, to present documentary evidence, and to cross-examine witnesses. The parties may be excluded when the Committee meets in executive session. The House Officer may be accompanied by an attorney as a nonparticipating advisor. Should the House Officer elect to have an attorney present, the program may also be accompanied by an attorney. The attorneys for the parties may confer and advise their clients upon adjournment of the proceedings at reasonable intervals to be determined by the Chairman, but may not question witnesses, introduce evidence, make objections, or present argument during the hearing. However, the right to have an attorney present can be denied, discontinued, altered, or modified if the Committee finds that such is necessary to insure its ability to properly conduct the hearing. Rules of evidence and procedure are not applied strictly, but the Chairman shall exclude irrelevant or unduly repetitious testimony. The Chairman shall rule on all matters related to the conduct of the hearing and may be assisted by University counsel. There shall be a single verbatim record, such as a tape recording, of the hearing (not including deliberations). Deliberations shall not be recorded. The record shall be the property of the University. Following the hearing, the Committee shall meet in executive session. During its executive session, the Committee shall determine whether or not the House Officer shall be terminated, or otherwise have adverse actions imposed, along with reasons for its findings; summary of the testimony presented; and
any dissenting opinions. The Academic Dean shall review the Committee’s report and may accept, reject, or modify the Committee’s finding. The Academic Dean shall render a decision within five (5) working days from receipt of the Committee’s report. The decision shall be in writing and sent by campus email or certified mail to the House Officer, and a copy shall be sent to the Department Head and Dean.

If the Academic Dean’s final decision is to terminate or impose adverse measures and the House Officer is dissatisfied with the decision reached by the Academic Dean, the House Officer may appeal to the Dean, with such appeal limited to alleged violations of procedural due process only. The House Officer shall deliver Notice of Appeal to the Dean within five (5) working days after receipt of the Academic Dean’s decision. The Notice of Appeal shall specify the alleged procedural defects on which the appeal is based. The Dean’s review shall be limited to whether the House Officer received procedural due process. The Dean shall then accept, reject, or modify the Academic Dean’s decision. The decision of the Dean shall be final.

A House Officer who at any stage of the process fails to file a request for action by the deadline indicates acceptance of the determination at the previous stage.

Any time limit set forth in this procedure may be extended by mutual written agreement of the parties and, when applicable, the consent of the Chairperson of the Ad Hoc Committee.

**SUMMARY SUSPENSIONS**

The House Officer Program Director, or designee, or the Department Head or designee shall have the authority to summarily suspend, without prior notice, all or any portion of the House Officer’s appointment and/or privileges granted by University or any other House Officer training facility, whenever it is in good faith determined that the continued appointment of the House Officer places the safety of University or other training facility patients or personnel in jeopardy or to prevent imminent or further disruption of University or other House Officer training facility operations.

Within two (2) working days of the imposition of the summary suspension, written reason(s) for the House Officer’s summary suspension shall be delivered to the House Officer and the Academic Dean. The House Officer will have five (5) working days upon receipt of the written reasons to present written evidence to the Academic Dean in support of the House Officer’s challenge to the summary suspension. A House Officer who fails to submit a written response to the Academic Dean within the five (5) day deadline, waives his/her right to appeal the suspension. The Academic Dean shall accept or reject the summary suspension or impose other adverse action. Should the Academic Dean impose adverse action that could significantly threaten a House Officer’s intended career, the House Officer may utilize the due process delineated above.

The Department may retain the services of the House Officer or suspend the House Officer with pay during the appeal process. Suspension with or without pay cannot exceed 90 days, except under unusual circumstances.

**OTHER GRIEVANCE PROCEDURES**

Grievances other than those departmental actions described above or discrimination should be directed to the Program Director for review, investigation, and/or possible resolution. Complaints alleging violations of the LSUHSC EEO policy or sexual harassment policy should be directed to the appropriate supervisor, Program Director, Director of Human Resource Management and EEO/ AA Programs, or Ms. Flora McCoy, Labor Relations Manager (504-568-8742). Resident complaints and grievances related to the work environment or issues related to the program or faculty that are not addressed satisfactorily at the program or departmental level should be directed to the Associate Dean for Academic Affairs. For those cases that the resident feels can’t be addressed directly to the program or institution s/he should contact the LSU Ombudsman.
OMBUDSMAN

Dr. Joseph Delcarpio, Associate Dean for Student Affairs is available to serve as an impartial, third party for House Officers who feel their concerns cannot be addressed directly to their program or institution. Dr. Delcarpio will work to resolve issues while protecting resident confidentiality. He can be reached at 504-568-4874.

REVIEW OF TRAINING PROGRAMS

Each House Officer Program at the LSU School of Medicine-New Orleans will be reviewed regularly between accreditation site visits and in accordance with the ACGME guidelines. The Institutional Graduate Medical Education Committee (IGMEC) is a standing school committee charged with the oversight of Graduate Medical Education. Program evaluation is accomplished by a detailed internal site visit process quite similar to the regular ACGME site visit.

At the conclusion of the IGMEC review, the committee should make recommendations, formulate a suggested action plan if necessary, and summarize its findings for each program reviewed. Minutes and summary reports should be filed in the GME Office. Serious programmatic problems should be brought to the attention of the Department Head and the Dean.

POLICY REGARDING VISITING PHYSICIANS/HOUSE OFFICER ROTATIONS

Visiting Physicians/House Officers may be allowed to rotate on the School of Medicine clinical services on a case by case basis. Visiting Physicians/House Officers do not need a valid license to simply observe. However, to participate in patient care these Visiting Physicians/House Officers must have a valid Louisiana license/permit. To obtain licensure Visiting Physicians/House Officers should contact the Louisiana State Board of Medical Examiners http://www.lsme.org/ (phone# 504-568-6820), 630 Camp Street or PO Box 30250, New Orleans, LA 70190-0250. A letter must be submitted by the LSU Program Director to the State Board of Medical Examiners requesting temporary licensure for the Physician/House Officer as a Visiting Physician/House Officer. The letter should include the dates of the rotation; a statement that the sponsoring physician will be responsible for all patient care; the anticipated responsibilities of the Visiting Physician/House Officer, the sites at which the Visiting Physician/House Officer will be practicing, and verification that the Visiting Physician/House Officer is the holder of valid licensure in another state.

In order to be covered for malpractice, a letter must be sent to Mr. Ron Gardner, Vice Chancellor of Administrative, Community and Security Affairs, stating the dates and locations of the Visiting House Officer’s rotation; the anticipated responsibilities of the Visiting House Officer and the Visiting House Officer’s licensure status in Louisiana.

OUT OF STATE SERVICE POLICY

House Officers shall comply with the rules, regulations, and bylaws of the facilities at which House Officers are assigned as part of their prescribed training in the House Officer Program. House Officers assigned to facilities outside the state of Louisiana must provide additional professional liability coverage (other than coverage provided under LSA-R.S. 40:1299.39) with indemnity limits set by the House Officer Program Director.

Out of state rotations necessary for fulfillment of educational goals of the House Officer Program may be permitted after being approved by the appropriate Program Director or Department Head. Except in unusual circumstances that would require perspective approval by the Academic Dean, use of state salary lines will not be permissible.

EEO POLICY
The Louisiana State University Health Sciences Center is committed to providing equal opportunity to all members of the Health Sciences Center Community. LSUHSC will take reasonable steps to ensure that 1) employment decisions are made so as to further the principles of equal employment opportunity; and 2) all personnel actions, such as compensation, tenure, benefits, transfers, layoffs, recall from layoffs, education, tuition assistance, social and recreation programs are administered without reared to race, color, religion, sex, age, national origin, or handicap/veteran status.

Implementation, coordination, and monitoring of this policy is the responsibility of the Department of Human Resource Management. No person who complains about a violation of this policy shall be subjected to intimidation or retaliation. Any persons having questions or complaints regarding this policy should contact the Director of Human Resource Management and EEO Programs at (504) 568-8742. The matter will be investigated using the same procedure contained in the sexual harassment policy contained in this Manual.

SEXUAL HARASSMENT POLICY

Louisiana State University Health Sciences Center is committed to providing a professional work environment that maintains equality, dignity, and respect for all members of its community. In keeping with this commitment, the Health Sciences Center prohibits discriminatory practices, including sexual harassment. Any sexual harassment, whether verbal, physical or environmental, is unacceptable and will not be tolerated.

Sexual harassment is illegal under federal, state and local laws. It is defined as any unwelcome advance, request for sexual favors, or other verbal or physical conduct of a sexual nature when:

1. Submission to the conduct is made either explicitly or implicitly a term or condition of an individual’s employment;

2. Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting the individual; or

3. The conduct has the purpose or effect of unreasonably interfering with the individual’s performance or of creating an intimidating, hostile or offensive working environment.

Types of behavior that constitute sexual harassment may include, but are not limited to:

- Unwelcome sexual flirtations, advances or propositions; derogatory, vulgar, or graphic written or oral statements regarding one’s sexuality, gender or sexual experience; unnecessary touching, patting, pinching or attention to an individual’s body;

- Physical assault;

- Unwanted sexual compliments, innuendo, suggestions or jokes; or

- The display of sexually suggestive pictures or objects.

Any House Officer who has a workplace sexual harassment complaint has the right and obligation to bring the problem to LSUHSC’s attention. Further, any House Officer who witnesses such conduct or receives a complaint of such conduct, must report the incident to Human Resource Management (HRM); the Department Head; Program Director; or other member of the faculty.

A House Officer who believes he/she has been sexually harassed or wishes to report a violation of this policy should immediately report the incident to the labor relations manager of Human resource
Management (504/568-8742), Department Head, Program Director, or Academic Dean. Any recipient of such complaint shall notify (HRM).

The Department of Human Resources Management will be responsible for investigating complaints of sexual harassment occurring between House Officers; House Officers and staff members; House Officers and students; and complaints made by House Officers against other third parties. HRM will investigate and/or assist those responsible for investigating complaints made by House Officers against faculty members in accordance with the terms of the faculty handbook.

Actions taken to investigate and resolve sexual harassment complaints shall be conducted confidentially to the extent practicable and appropriate in order to protect the privacy of persons involved. An investigation may include interviews with the parties involved in the incident, and if necessary, with individuals who may have observed the incident or conduct or who have other relevant knowledge. The individuals involved in the complaint will be notified of the results of the investigation.

There will be no discrimination or retaliation against any individual who makes a good-faith sexual harassment complaint, even if the investigation produces insufficient evidence to support the complaint. There will be no discrimination or retaliation against any other individual who participates in the investigation of a sexual harassment complaint. If the investigation substantiates the complaint, appropriate corrective and/or disciplinary action will be swiftly pursued.

If a House Officer’s complaint is found to be valid, and the accused harasser is a member of the faculty, staff, or is a student, that complaint will be addressed in accordance with the procedures contained in the applicable faculty handbook; student bulletin; or staff policy.

If a complaint made against a House Officer is found to be valid, the offender may be directed to appropriate counseling, discipline, or dismissed, depending on the degree of seriousness of the offense. In the event that the House Officer involved as the accused disagrees with the conclusions recommended as a result of the investigation, and such conclusion results in dismissal, non-renewal, or any adverse action which could significantly jeopardize a House Officer’s intended career development, he/she may invoke the procedures set out in the Due Process section of this House Officer Manual. If allegations of harassment or discrimination are first raised as a part of an appeal by a House Officer, that is, prior to an investigation of the complaint by Human Resource Management, the Program Director shall refer the complaint to HRM for investigation in accordance with this section. No due process hearing shall proceed until an investigation has been conducted and a report of the investigation has been submitted to the Program Director.

**DRUG-FREE WORKPLACE POLICY**

Louisiana State University Health Sciences Center (LSUHSC) is governed by and complies with the provisions of the Drug Free Workplace Act of 1988. The applicable provisions are as follows:

The unlawful manufacture, distribution, dispensing, possession and/or use of unlawful drugs at any facility of the Louisiana State University Health Sciences Center is prohibited.

Penalties for violation of this policy could result in written disciplinary action, suspension, demotion, and/or immediate dismissal depending on the severity of the circumstances; or criminal prosecution.

Further, all employees are required to notify the Director of Human Resource Management of any drug related criminal conviction which occurs in the workplace within five (5) days following conviction. The
Director will notify the Grants Office so that they may comply with the provision for notice to the federal funding agency within ten (10) days. Notice to the federal contractor should include the sanctions imposed on the employee convicted of a drug work-related crime.

Campus/Employee Assistance Program (C/EAP) is available to all House Officers of LSUHSC.

Abiding by this policy and any other drug policy established by LSUHSC or other House Officer training facility, regardless of when promulgated, is a condition of the House Officer’s employment with LSUHSC.

**POLICY ENSURING RESIDENTS HAVE ADEQUATE REST**

In order to ensure residents have adequate rest between duty periods and after on–call sessions we adopt the following policies:

1. Our Duty Hours Policy contains the following relevant language:
   a. PGY-1 resident should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

   b. Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

   c. Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

1. Circumstances or return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

   All of this is in the context of the other duty hours requirements.

2. All employees of LSUHSC are under **Chancellors Memorandum 37** which is the LSHSC Fitness for Duty Policy. This describes the expectations for employees to report to work fit and safe to work. It further defines what are considered unsafe/impaired behaviors, the requirement for self or supervisor referral to the Campus Assistance Program, and what steps are taken thereafter.

3. The institutional Policy of Professionalism and Learning Environment further amplifies the expectations for residents to be fit for duty and to take it upon themselves to be well rested with the following language:

   Residents must take personal responsibility for and **faculty must model** behaviors that promote:
   1. Assurance for fitness of duty.
   2. Assurance of the safety and welfare of patients entrusted in their care.
   3. Management of their time before, during and after clinical assignments.
   4. Recognition of impairment (e.g. illness or fatigue) in self and peers.
   5. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

4. The moonlighting policy anticipates potential trouble areas and describes a method for monitoring the
effects of moonlighting on residents.

5. Adequate sleep facilities are in place at each institution and our alertness management / fatigue mitigation policy and process encourages good sleep hygiene as well as recommending such strategies and pre-call strategies, strategic napping and post-call naps.

6. Foremost our Professionalism and Learning Environment Policy requires faculty to model behaviors that encourage fitness for duty as noted above and our Supervision Policy requires faculty to observe for signs of fatigue especially during transitions.

**ALERTNESS MANAGEMENT/ FATIGUE MITIGATION STRATEGIES**

Residents and faculty are educated about alertness management and fatigue mitigation strategies via on line modules and in departmental conferences. Alertness management and fatigue mitigation strategies are outlined on the pocket cards distributed to all residents and contain the following suggestions:

1. **Warning Signs**
   a. Falling asleep at Conference/Rounds
   b. Restless, Irritable w/ Staff, Colleagues, Family
   c. Rechecking your work constantly
   d. Difficulty Focusing on Care of the Patient
   e. Feeling Like you Just Don’t Care
   f. Never drive while drowsy

2. **SLEEP STRATEGIES FOR HOUSESTAFF**
   a. Pre-call Residents
      1. Don’t start Call w/a SLEEP DEFICIT – GET 7-9 ° of sleep
      2. Avoid Heavy Meals / exercise w/in 3° of sleep
      3. Avoid Stimulants to keep you up
      4. Avoid ETOH to help you sleep
   b. ON Call Residents
      1. Tell Chief/PD/Faculty, if too sleepy to work!
      2. Nap whenever you can á > 30 min or < 2°)
      3. BEST Circadian Window 2PM-5PM & 2AM- 5AM
      4. AVOID Heavy Meal
      5. Strategic Consumption of Coffee (t ½ 3-7 hours)
      6. Know your own alertness/Sleep Pattern!
   c. Post Call Residents
      1. Lowest Alertness 6AM –11AM after being up all night
      2. Full Recovery from Sleep Deficit takes 2 nights
      3. Take 20 min. nap or Cup Coffee 30 min before Driving

In addition programs will employ back up call schedules as needed in the event a resident can’t complete an assigned duty period.

**How Monitored:**

The institution and program monitor successful completion of the on line modules. Residents are encouraged to discuss any issues related to fatigue and alertness with supervisory residents, chief residents, and the program administration. Supervisory residents will monitor lower level residents during any in house call periods for signs of fatigue. Adequate facilities for sleep during day and night periods are available at all rotation sights and residents are required to notify Chief Residents and program administration if those facilities are not available as needed or properly maintained. At all transition periods supervisory residents
and faculty will monitor lower level residents for signs of fatigue during the hand off. The institution will
monitor implementation of this indirectly via monitoring of duty hours violations in New Innovations, the
Annual Resident Survey (administered by the institution to all residents and as part of the annual review of
programs) and the Internal Review process.

**FITNESS FOR DUTY POLICY**

The Louisiana State University Health Sciences Center (LSUHSC) promotes and protects the well being
of faculty, staff, residents, students, and patients.

Any individual who works or is enrolled at Louisiana State University Health Sciences Center (LSUHSC)
is expected to report to work/school in a fit and safe condition. An individual who has an alcohol, drug,
psychiatric, or medical condition(s) that could be expected to impair their ability to perform in a safe
manner must self report their medical status to their supervisor and provide a signed medical release
indicating their fitness for work/school to the Campus(Employee Assistance Program (C/EAP).

LSUHSC requires all faculty, staff, residents, students or other LSUHSC workers who observe an
individual who is believed to be impaired or is displaying behavior deemed unsafe at work/school to
report the observation(s) to their supervisor for appropriate action. Supervisors are then required to make
an administrative referral to the Drug Testing Program and C/EAP. An individual who is referred to
C/EAP and found to be impaired must provide C/EAP, prior to returning to work, with a signed medical
release indicating they are fit to resume their work or school responsibilities at LSUHSC. LSUHSC will,
as a condition of continued employment/enrollment, require an “at risk” individual to maintain a
continued care plan either recommended or approved by C/EAP and sign a Continuation of
Employment/Enrollment Contract.

This policy applies to all faculty, staff, residents, students, contract and subcontract workers, medical
staff, volunteers, laborers, or independent agents who are conducting business on behalf of, providing
services for (paid or gratis), or being trained at LSUHSC.

**LEAVE**

House Officers are granted leave benefits as described in this manual. Each type of leave will be
monitored and granted in accordance with this policy, the needs of the program, and the provisions of
applicable law. Whether training time missed as a result of extended leave can be made up by the House
Officer is determined by the Department Head and/or Program Director in accordance with the
requirements of the LSU PM&R program, The American Board of Medical Subspecialties and the
provisions of applicable law.

**VACATION LEAVE**

Vacation leave is leave with pay granted a House Officer for the purpose of rehabilitation, restoration and
maintenance of work efficiency, or transaction of personal affairs. House Officers at post-graduate year 1
(PGY 1) are entitled to three (3) weeks, twenty-one (21) days including weekends, of non-cumulative vacation leave per year. House Officers at post-graduate year 2 (PGY2) and levels above are entitled to four (4) weeks, twenty-eight (28) days including weekends, of non-cumulative vacation leave per year.

The Program recognizes vacation leave is most efficiently administered in seven (7) day blocks. However, in deference to the needs of our House Officers, the Program may grant leave in shorter increments. The Program will not, however, grant to a PGY 1 House Officer vacation leave in excess of fifteen (15) weekdays, Monday through Friday, or grant to a PGY 2 House Officer, and those at a higher levels, vacation leave in excess of twenty (20) weekdays, Monday through Friday, during any contract year. House Officers opting for vacation leave in increments of less than seven (7) days forfeit the privilege of requesting specific dates for weekend leave which will be assigned according to the needs of the Program and to assure appropriate administration of payroll accounts. Vacation leave should normally be taken during training on the home service, not during brief rotations to other services. Vacation leave should not ordinarily be requested before or after scheduled holidays.

All vacation leave must be requested in wiring on the Section form provided for that purpose and approved by the Chief Resident, attending service and the Program Director. No vacations will be approved at the time scheduled for the American Board of Physical Medicine and Rehabilitation Self Assessment Examination held annually usually late in the month of January. And vacations will not be approved for PGY 3 House Officers at the time scheduled for the American Board of Neuromuscular & Electrodiagnostic Medicine Self Assessment Examination held annually usually late in the month of May.

Vacation leave must be used during the contract year. The Program does not permit carry forward or accumulation of unused vacation leave. Any unused vacation leave will be forfeited at the end of the contract year.

**PROSPECTIVE JOB INTERVIEWS**

Fellows and final year House Officers, who need to go for interviews for potential employment or fellowships, must use vacation days for this purpose.

**MILITARY LEAVE**

If called to active duty, House Officers are permitted fifteen (15) days of paid military leave. Additional or other military leave, paid or unpaid, will be granted in accordance with applicable law.

**LEAVE OF ABSENCE**

A leave of absence may be granted subject to Program Director approval and as may be required by applicable law for illness extending beyond available sick leave; for academic remediation; to address licensing problems; and/or for family or personal emergencies. To the extent that such leave exceeds available vacation and/or sick leave, any leave granted will be without pay. The House Officer will make arrangements to makeup missed training with the Program Director in accordance with the requirements of the Board of the effective specialty.

**MATERNITY/PATERNITY LEAVE**
In order to receive paid maternity leave, a House Officer must utilize available vacation leave and sick leave. Paid and unpaid maternity leave for up to six (6) weeks or extended unpaid maternity leave may be granted by the Department Heads as appropriate and as required by applicable law. A House Officer wishing to receive paid paternity leave must utilize available vacation leave. Under special circumstances and/or as required by applicable law, extended leave without pay may be granted.

**EDUCATIONAL LEAVE**

House Officers are permitted five (5) days (including weekends) of educational leave to attend or present at medical meetings. However, educational leave is not a right, but a privilege which may be granted contingent upon the House Officers’ standing in the Program and the ability to benefit from the extramural educational opportunity. Education Leave can be requested to attend PM & R related courses such as Board Review and Interventional Pain topics/techniques or to attend and/or present papers or posters at PM & R or GME related academic organization conferences such as ABPMR, AAP, AAPMR and ACGME. Education leave can also be requested to sit for required board exams and LSBME required orientation classes. Internet/online courses will not be approved for educational leave. Final approval for educational leave for a PM & R House Officer rests with the Program Director who will weigh the clinical, educational and research needs of the section and the House Officer.

For any education leave requested prior to July 1st of the start of the new academic year, all House Officers are required to submit documentation (to the Program Director via the Chief Resident) of registration and course curriculum or conference agenda at least 30 days in advance of the actual start date of the education leave. For USMLE and COMLEX exams or LSBME orientation, House Officers must submit documentation of registration 30 days in advance as well.

In addition, the VA Medical Center requires submission of any request for education leave to include the above noted documentation and prior approval from Dr. Kathy Lazarus (GME VA) at least 45 days in advance of the dates of the leave for residents taking leave while on rotation at the VA.

If the House Officer requests additional educational leave or changes to their original education leave requests, they must submit a leave form and all the above mentioned documentation at least 45 days in advance for approval by the Attending Physician on the rotation, the Chief Resident and finally the Program Director.

**FAMILY LEAVE**

All House Officers who have worked for LSUHSC for twelve (12) months and 1,250 hours in the previous twelve (12) months, may be eligible for up to twelve (12) weeks of unpaid, job-protected leave in each twelve (12) month period, in accordance with the requirements of the Family Medical Leave Act of 1993 (FMLA). See the FMLA information attached to this manual for further details.

**SICK LEAVE**

House Officers are permitted fourteen (14) days (including weekends) of paid sick leave per year. Sick leave is leave with pay granted to a House Officer who is unable to perform their usual duties and responsibilities due to a disability resulting from accident, illness, or childbearing, or who requires medical, dental, or optical consultation or treatment. Sick leave is not vacation and may not be used for that purpose. Sick leave may not be accumulated or carried forward into subsequent calendar years. Extended sick leave without pay is allowable at the discretion of the Program, or as may be required by applicable law. A written certification from a licensed physician or other acceptable proof of disability is required for sick leave of ten (10) or more consecutive workdays.
A sick leave request form must be completed for every period of sick leave taken. When a House Officer is unavailable for their duties due to sick leave it is their responsibility to inform the Section Office, their attending and the Chief Resident as early as possible, preferably before the start of the workday. Daily notification is required for any period of extended sick leave.

**HURRICANE “CODE GREY” POLICY**

Program Director and Chief Resident Responsibilities:

The residency program director and chief resident are responsible for declaring code grey status after being informed by hospital administration or department chairs. The chief resident will assure that an adequate number of house staff are on duty at each hospital. The chief resident will identify the on call teams and will provide this information to the medical director via fax or if after hours via phone and fill out the on call form.

Call rooms will be assigned by the medical director. Assigned physicians will be allowed to park 1 (one) vehicle on campus. Family members will be limited to immediate family only (spouse/significant other and children) absolutely no pets will be allowed. Food, clothing, medications, blankets, pillows, and water are the responsibility of the individuals. The hospital will do its best to supply food and water but in an extended disaster this may not be possible. The LSUHSC campus facilities will not be available as an emergency shelter for anyone including faculty, staff, students or the general public in the event of a hurricane. This will be strictly enforced by the University Police. Only essential and approved persons/personnel will be allowed on campus. All parking garage privileges will be suspended at all locations for the duration of the emergency. Emergency/Disaster parking will be available for essential personnel only with appropriate passes and approvals.

**PAGERS**

House Officers pagers are provided and managed by the Office of Graduate Medical Education and funded by the Residents training hospitals. Should a House Officer have a problem with his/her pager, the House Officers should contact the Program Coordinator (Kim Cannon) at the Office of Graduate Medical Education (504-568-2468), located at 2020 Gravier Street, 6th floor, Room 619. If a pager is malfunctioning while a resident is rotating in Baton Rouge or Lafayette, he/she should contact the Office of Graduate Medical Education, Cynthia Scott, 504-568-9632. The following information is necessary to swap the broken pager: House Officer’s name, Department, Pager number, specific description of the activity of the pager, training facility, contact person and phone number of contact person. We will arrange to overnight another pager to the training facility’s LSU unit. The malfunctioning pager should be returned to GME within 72 hours.

This $40.00 fee is charged for each incident. Please note that Water Damage cannot be repaired. The procedure for collecting the $40 fee is as follows—you should complete an Internal Transfer form and write your department account number under “debit” and the GME office will fill in the “credit” portion with our account number. Departments should collect the $40 charge from their residents. Resident should make their check payable to LSU Medical Center. The residency coordinator (or resident) should bring the completed form with the resident’s check to the GME Office to receive a new pager.

Each department residency coordinator should collect pagers from your outgoing residents each year and assign those pagers to your incoming residents. If additional pagers are needed at the end of the year, you should contact our office. If residents complete their training and do not return their pager to their training program, the pager will be reported as LOST and the procedure for the lost pager charge will be followed. If a resident decides to switch training programs, his pager should be returned to the program he is leaving and his new training program should issue him one of their
pagers. This will ensure proper tracking of resident pagers.

If pagers are lost, stolen, or damaged Beyond Repair the insurance deductible fee is $40.00. This $40.00 fee is charged for each replaced pager. Upon receiving the replacement pager, the fee should be submitted in the form of check or money order, made payable to the LSU Health Sciences Center.

We emphasize to all residents that they should take proper care of their assigned pagers. Please maintain a fresh battery in your pager at all times.

**Monitoring Pager**

Your contract for employment requires your availability to the program seven (7) days per week. Monitoring your pager responsibly assures your availability when needed. At a minimum, house officers will monitor their pager during normal working hours, on all rotations, at all times when on call and on weekends that involve clinical responsibilities. House officers may choose not to monitor their pager while on leave and on weekends free of clinical responsibilities. However, clinical responsibilities always have precedence. Any house officer following a patient who requires close monitoring will respond to their pager at all times, except when on leave.

**COMPUTER E-MAIL REGISTRATION**

All House Officers are required to register at LSU to get a LSUHSC e-mail address. All House Officers are required to check their e-mail accounts at least twice weekly.

**PARKING**

Parking is available to House Officers for a nominal annual fee through the LSUHSC Parking Services (504-568-4884).

**DRESS CODE**

House Officers shall comply with the “dress code” of the Hospital service to which they are assigned and present at all times an appropriate and professional appearance.

**SUBPOENAS**

Any House Officer receiving a subpoena must call Ron Gardner’s office before contacting any attorney’s office or reporting for trial. Ron Gardner’s office number is 568-4810. Come to the PM&R office if you have any questions on how to proceed.

**EDUCATIONAL RESOURCES**

Training programs have access to the general education resources of the Health Sciences Center. These include: the audio, video, slide, poster, and other services of the Department of Learning Resources (568-4840); lecture rooms, conference rooms, and auditorium facilities; and interdepartmental laboratories, computers, and educational devices. Library facilities of the Health Sciences Center (504-568-6100), and individual Departments are available to all House Officers.

**HEALTH INSURANCE**
House Officers are eligible to enroll in the state employees health insurance or state managed health care options (HMO's etc) through Employee Benefits (504-568-7780), or LSUHSC student/resident health insurance Gallagher Benefit Services, Inc., 235 Highlandia Drive, Suite 200, Baton Rouge LA 70810, contact: Michele Prudhomme Coordinator, phone# (225) 292-3515 or Fax (225) 296-3998. If desired, other health insurance may be chosen and must be paid for individually by the House Officer. House Officer agrees to maintain one of these plans or another plan with equal or better benefits.

**DISABILITY INSURANCE**

The opportunity to participate in-group long-term disability coverage may be available through the GME Office.

**DISABILITY POLICY**

Please refer to Chancellor Memonandum-26 on www.lsuhs.edu

**REQUIRED IMMUNIZATIONS AND VACCINATIONS**

Incoming House Officers are required to provide proof of the following Immunizations / Vaccinations as conditions of employment:

- TB/PPD skin test or blood test within 4 months prior to start date
- Rubella immunity proven by titer or documentation of two injections of MMR vaccine
- Mumps immunity proven by titer or documentation of two injections of MMR vaccine
- Measles immunity proven by titer or documentation of two injections of MMR vaccine
- Varicella (chickenpox) immunity proven by titer, two injections of varicella vaccine, or reliable history of past varicella infection
- Hepatitis B immunity proven by proof of antibodies to Hepatitis B or documentation of Hepatitis B vaccine
- Td/Tdap vaccination within the past 10 years

Continuing House Officers are required to provide ongoing documentation of the following immunizations to continue employment and be appointed to the next House Officer level:

- Annual TB/PPD skin test or blood test
- Maintenance of Td/Tdap vaccination as needed

Annual TB test results must be turned in on the specified LSU TB form with the House Officer Contract. All vaccination records will be maintained and monitored by the Student Health Department.

**LAB COATS, MEALS, NIGHT CALL**

Availability of housing, meals, lab coats, etc. will vary among the hospital to which House Officers are assigned. Lab coats will be provided (903-0229) and laundered (903-2133) for House Officers training at the Medical Center of Louisiana, New Orleans (MCLNO) by MCLNO. Meals will be provided for House Officers while on call in house at MCLNO. Adequate sleeping accommodations will be provided by MCLNO for House Officers assigned to night call at MCLNO.

**MALPRACTICE INSURANCE**
The State of Louisiana provides professional liability coverage pursuant to LSA-R.S. 40:1299.39 et seq. to House Officers when acting within the course and scope of their training or staff appointments in and under the supervision of a state hospital or other health care facility to which they are assigned as part of their prescribed training, regardless of where the services are performed. However, House Officers assigned to a health care facility outside the state of Louisiana may be required to provide additional professional liability coverage with indemnity limits set by the House Officer Program Director.

House Officers are not provided professional liability coverage under LSA-R.S. 40:1299.39 et seq. when engaging in professional activities outside the scope of the House Officer Program, unless the professional services are performed at a public charity health care facility.

All professional liability matters should be directed to Ron Gardner, Vice Chancellor of Administrative, Community and Security Affairs (504-568-4810).

A Summary of the Coverage Includes: Insurance Carrier: State of Louisiana is self insured through a State Health Care Provider Fund Policy Number/State Provision Number: LA R.S. 40:1299.39.1 et seq Liability Coverage Limit: $500,000.00 per occurrence Aggregate: $500,000.00 per occurrence Tail Coverage: Yes, tail coverage continues to apply to any incidents during the physician’s employment with the LSUHSC. Coverage Terminates only at the end of employment with the LSUHSC.

DEA NUMBERS

All temporary DEA Numbers issued at MCLNO are valid from the date issued thru the house officers period of training. Use of this temporary DEA number is restricted to prescriptions written only for
MCLNO patients on the MCLNO Prescription Form # MCL 12/95 (blue). Violators will be reported to the Medical Director and DEA for appropriate disciplinary action.

Once the house officer receives the LSBME license, he/she is eligible to apply for his/her permanent DEA License. The application process takes 3-6 months to complete, therefore, it is recommended that physicians begin this process before their temporary DEA Number expires.

MOONLIGHTING

Professional activity outside of the scope of the House Officer Program, which includes volunteer work or service in a clinical setting, or employment that is not required by the House Officer Program (moonlighting) shall not jeopardize any training program of the University, compromise the value of the House Officer’s education experience, or interfere in any way with the responsibilities, duties and assignments of the House Officer Program. It is within the sole discretion of each Department Head and/or Program Director to determine whether outside activities interfere with the responsibilities, duties and assignments of the House Officer Program. House Officers must not be required to moonlight. Before engaging in activity outside the scope of the House Officer Program, House Officers must receive the written approval of the Department Head and/or Program Director of the nature, duration and location of the outside activity. All moonlighting activities must be tracked in New Innovations Software Program. PGY1’s may not moonlight. All internal and external moonlighting must be counted in the 80 hour maximum weekly hour limit. Resident must not schedule moonlighting that will cause the 80 hour maximum. Residents who schedule moonlighting activities resulting in violation of the 80 hour work rule will be subject to disciplinary action including but not limited to loss of moonlighting privileges. The house officers’ performance will be monitored for the effect of these moonlighting activities upon performance and that adverse effects may lead to withdrawal of permission to continue. All documentation will be kept.
in the house officer’s program file. House Officers, while engaged in professional activities outside the scope of the House Officer Program, are not provided professional liability coverage under LSA-R.S.40:1299.39 et seq., unless the professional services are performed at a public charity health care facility. A House Officer providing services outside the scope of the House Officer Program shall warrant to University that the House Officer is and will remain insured during the term of any outside professional activities, either (1) insured against claims of professional liability under one or more policies of insurance with indemnity limits of not less than $500,000 per occurrence and $1,000,000 in the aggregate annually; or (2) duly qualified and enrolled as a health care provider with the Louisiana Patient’s Compensation Fund pursuant to the Louisiana Medical Malpractice Act, LSA-R.S. 40:1299.41 et seq. or (3) that the House Officer is provided such coverage by the person or entity who has engaged the House Officer to provide the outside professional services.

House Officers shall not provide outside professional activities to any other state agency (e.g., Department of Health and Hospitals, Department of Public Safety and Corrections, Office of Mental Health, etc.) by means of a contract directly between the House Officer and the other state agency. Should a House Officer desire to provide outside professional services to another state agency, the contract must be between the LSU School of Medicine in New Orleans and the other state agency for the House Officer’s services, and the House Officer will receive additional compensation through the LSU payroll system. House Officers should speak with the Departmental Business Administrator of the House Officer Program to arrange such a contract.

House Officers may not moonlight at any site without a full and unrestricted license. Occasional exceptions may be granted by the LSBME only after a specific request by a program and are largely limited to moonlighting which is in the same institution as the program, is under the supervision of program faculty and similar to activity the trainee might have in the program. In addition, residents on J-1 visas may not moonlight.

The LA State Board and the DEA will independently investigate and prosecute individual residents if they so desire regarding the following:

To moonlight all house officers must be fully licensed and have their own malpractice and DEA number.

Moonlighting in pain and weight loss clinics is not allowed by the LSBME. Pre-signing prescriptions is illegal.

Using MCLNO prescriptions outside MCLNO is prohibited – your “MCLNO” number is site specific.

Don't ever sign anything saying you saw a patient if you didn't see the patient

All narcotics prescriptions must be put in the patient's name and address plus the date

don’t "let the nurse do it"

House officers are held accountable for things all things signed - read the fine print

Follow accepted practice guidelines for everything especially weight loss and pain patients

All house officers should be cognizant of Medicare fraud and abuse guidelines.

LSU PRESIDENT'S MEMORANDUM 11 (PM-11) form for approval of all outside activities must be signed and approved prior to commencing any moonlighting.
REQUEST FOR MOONLIGHTING

I, ______________________________________ request permission to seek extra employment (moonlighting) outside of my full time position as an LSU Resident. The time frame requested is from ____________________ to ____________________.

I am seeking employment at ___________________________________ and understand this agreement is only for this assignment. I understand I cannot contract with another state agency and to the best of my knowledge; this is not a state agency. My duties will be:

And I will work approximately __________ HOURS per month. I understand I need to obtain my own insurance for malpractice. A COPY OF THE MALPRACTICE INSURANCE MUST BE PRESENTED WITH THIS REQUEST. This privilege may be withdrawn by the Program Director without notice or cause at any time. I will report any changes to the Program Director.

Sincerely,

__________________________________________
Name

__________________________________________
Signature

Discussed and approved on_______________________
Date

___________________________________________
Stephen Kishner, M.D.
LSU HSC PM & R Residency Program Director
INSTITUTIONAL POLICY ON DUTY HOURS

The institution through GMEC supports the spirit and letter of the ACGME Duty Hour Requirements as set forth in the Common Program Requirements and related documents July 1, 2003 and subsequent modifications. Though learning occurs in part through clinical service, the training programs are primarily educational. As such, work requirements including patient care, educational activities, administrative duties, and moonlighting should not prevent adequate rest. The institution supports the physical and emotional well being of the resident as a necessity for professional and personal development and to guarantee patient safety. The institution will develop and implement policies and procedures through GMEC to assure the specific ACGME policies relating to duty hours are successfully implemented and monitored. These policies may be summarized as:

Maximum Hours of Work Per Week

Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Duty Period Length

Duty periods of PGY-1 residents must not exceed 16 hours in duration. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:

appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Minimum Time Off between Scheduled Duty Periods

PGY-1 resident should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-
off in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances or return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than four nights of night float per academic year.

Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

At-Home Call

Time spent in the hospital by residents on at-home call must count towards the 80-hours maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for on-day-in-seven free of duty, when averaged over four weeks. At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

Residents are required to log all duty hours in New Innovations Software Program or its replacement program. Those who fail to log duty hours or log erroneous duty hours are subject to disciplinary action.

The institution as well as each program is required to monitor and document compliance with these requirements for all trainees. This policy applies to every site where trainees rotate.

SIX GENERAL COMPETENCIES

Moving towards a competency based education; the ACGME has implemented the requirement of six general competencies into the curriculum of all accredited programs.

1. **Patient care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
2. **Medical knowledge** about established and evolving biomedical, clinical, and cognate (eg, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
3. **Practice-based learning and improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
4. **Interpersonal and communication skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
5. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
6. **Systems-based practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.
In addition, as accredited programs work to expose trainees to the six general competencies, house officers should be mindful of this and work with the programs to accomplish these educational objectives. Furthermore, during the programs ACGME accreditation site visits, house officers will be asked questions regarding the six general competencies and their implementation on the program level.

**CAMPUS ASSISTANCE PROGRAM (CAP)**

A physician who works at the LSU School of Medicine New Orleans is expected to report to work in a fit and safe condition. A House Officer who is taking prescription medication(s) and/or who has an alcohol, drug, psychiatric or medical condition(s) that could impair his/her ability to perform in a safe manner should contact the Campus Assistance Program.

The LSUHSC Campus/Employee Assistance Program (C/EAP) is a free service provided by LSU Health Sciences Center to assist faculty, staff, residents and students in the resolution of personal problems.

C/EAP offers a multidisciplinary team with medical backup. The staff is equipped to assist you with an array of problems, issues or stressors. All services are confidential, and all client records are limited to C/EAP staff. If you or a family member need C/EAP services call 568-3931. A C/EAP counselor will be happy to answer any questions you may have about their services or schedule an appointment. (Revised January 15, 2002 by the Campus Assistance Program Office, CM-23)

**RESTRICTIVE COVENANTS**

The ACGME does not allow restrictive covenants.

**COMMITTEE AND OTHER SERVICE**

It is expected residents will serve on school and hospital committees as part of their education. Residents bring special expertise to these committees and these experiences will prepare residents for their professional careers. Residents are encouraged to self nominate to committees of interest by contacting the GME office at 568-8686. Each year the House Staff Organization will be asked to submit resident nominees for all committees. If the House Staff Organization is unable to make nominations, the Chief Residents will be asked to poll their residents for nominees. A partial list of committees includes:

<table>
<thead>
<tr>
<th>Department/Section</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen Copping Teaching Award Nomination Committee</td>
<td></td>
</tr>
<tr>
<td>Curriculum Oversight Committee</td>
<td></td>
</tr>
<tr>
<td>Curriculum Development Committee</td>
<td></td>
</tr>
<tr>
<td>Curriculum Evaluation Committee</td>
<td></td>
</tr>
<tr>
<td>Committee on Excellence in Teaching</td>
<td></td>
</tr>
<tr>
<td>Institutional Graduate Medical Education (IGMEC)</td>
<td></td>
</tr>
<tr>
<td>Committee on Women’s Affairs</td>
<td></td>
</tr>
<tr>
<td>Ethics Committee</td>
<td></td>
</tr>
<tr>
<td>Quality Assurance</td>
<td></td>
</tr>
</tbody>
</table>

**DRUG TESTING REQUIREMENT (Pre-Employment)**

As per Chancellor’s Memorandum (CM38-Substance Abuse Policy and Procedures LSUHSC New Orleans Campus) effective November 1, 1999 all newly hired faculty, staff, residents and student workers of LSU Health Sciences Center New Orleans will be required to undergo drug testing as a condition of employment.
Drug testing may also be required during employment for reasonable suspicion or post accident for cause and for individuals who have signed Fitness For Duty and/or Drug Testing Continuation of Employment contracts.

A prospective employee undergoing post-job offer drug testing and who declines to consent to testing or who receives a confirmed positive drug test result shall have the conditional offer of employment withdrawn and shall be subject to disqualification from employment consideration for a period of one year from the date of the drug test. (Page 6, 7 LSUHSC Substance Abuse Policy. The complete policy can be viewed at www.lsumc.edu/policy/cm/cm38.htm)

In order for incoming house officers to be paid through the Payroll system they must undergo drug testing (urine) prior to their Start date.

Incoming house officers must go to the LSUHSC Lions Clinic, Worksite Health Services, 2020 Gravier Street, 5th floor, Room 511B for drug testing between the hours of 9 a.m. – Noon and 1:30pm - 4:30 p.m. Monday through Friday. House officers should bring with them: (1) a valid driver’s license, or valid state ID with photo or a passport; (2) any prescription medication that they are currently taking; (3) a completed Agreement to Submit to Drug Testing/Release of Test Results Form.

The telephone number for LSUHSC Worksite Health Services is (504) 568-4933. Off-site testing can be arranged through Worksite Health Services.

**OCCUPATIONAL INJURY/DISEASE PROCEDURES**

The procedure for an occupational injury/disease is as follows:  (1) The house officer should report immediately to the training hospital’s Employee Health Department for initial treatment.  (2) He should notify his training program director of the occupational injury/disease.  (3) The house officer should notify LSUHSC Human Resource Management, Labor Relations (Paulette Albera at 568-3916) about the occupational injury/disease within 30 days of the injury/disease to be eligible for Workman’s Compensation benefits.  Ms. Albera will send the house officer a Employee’s Report of Occupational Injury/Disease form to be completed.  The occupational Health forms are also located in the Graduate Medical Education.

If there is no Employee Health Department at the training facility where the injury/disease occurred, the house officer can go to any medical facility for treatment.  House officers can also receive initial medical treatment and follow-up care at Concentra Medical Center.  The addresses and phone numbers for the Concentra Medical Center locations are listed below.

318 Baronne St.  2460 Veterans Memorial Blvd.  4015 Jefferson Hwy.  3225 Perkins Road
New Orleans, LA 70112  Metairie, LA 70062  Jefferson, LA 70121  BR, LA 70808
(504) 561-1051  (504) 456-9014  (504) 837-6447  (225) 387-3030

The house officer can also contact the on call Infectious disease fellows at MCLANO (903-3000) for their recommendations concerning the occupational injury/disease.

**LSUHSC NEEDLE STICK INSTRUCTIONS**

If a needle stick incident should occur, follow the steps below:

1.  Go immediately to the ER
2. Within thirty (30) days of the injury, contact Paulette Albera in Human Resources to report the incident and complete mandatory paperwork. An injured employee must give notice to the employer within thirty (30) days of the injury to be eligible for Worker’s Compensation benefits.

To view the LSU Health Sciences Center Policy on Worker’s Compensation in its entirety, visit the following link:

www.lsuhsc.edu/no/administration/hrm/relations/wrkcomp.aspx

The following two (2) forms must be completed and faxed or emailed to Ms. Albera within thirty (30) days of the injury:

. Worker’s Comp E-1 Form www.doa.louisiana.gov/orm/formsCR.htm
. Incident/Accident Investigation Form DA 2000 www.doa.louisiana.gov/orm/lpforms.htm

To report an injury or to gain further information on the program, please contact Paulette Albera at (504) 568-3916.

Paulette M. Albera
Human Resource Management
433 Bolivar Street, Room 603
New Orleans, LA 70112
(504) 568-3916 Phone
(504) 568-8350 Fax
palber@lsuhsc.edu

POLICY ON HOLIDAY SCHEDULE

House Officers will follow the holiday schedules of the entities (hospitals, etc.) where they are assigned to work and train. They are not to adhere to the LSU system holiday schedule.

MEDIA POLICY

The Office of Information Services is charged with the responsibility for releasing information about Health Science Center programs, emergencies, crimes, controversies, the official position on issues involving the Health Science Center, and other events to which the press has a reasonable claim. LSUHSC personnel shall not release information about programs, events and other activities to the media independent of the Office of Information Services. All questions from the media should be directed to Leslie Capo in the Office of Information Services.

VENDORS/INDUSTRY RELATIONS POLICY

Relations to vendors and all other private entities are covered by the Code of Government Ethics and the policies promulgated by the LSUHSC Conflict of Interest Committee via various Chancellors Memoranda. All state employees are bound by the ethics statutes with the most relevant being Louisiana Code of Governmental Ethics Title 43, Chapter 15 number 6 page 14 – Gifts. To paraphrase - “no public 27 employee shall solicit or accept directly or indirectly anything of economic value as a gift or gratuity from any person if the public employee does or reasonably should know such a person conducts activities or operations regulated by the public employees agency or has substantial economic interests which may be substantially affected by the performance or nonperformance of the public employees duty. “ When in the various training sites the resident is further bound by the rules and policies of that institution.

AMA Code of Medical Ethics, Opinion 8.061, “Gifts to Physicians from Industry.”
Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members. (2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (e.g., pens and notepads). (3) The Council on Ethical and Judicial Affairs defines a legitimate "conference" or "meeting" as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made. (4) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference. (5) Subsidies from industry should be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses. (6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional, or specialty medical associations. (7) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

NEW INNOVATIONS MEDICAL EDUCATION MANAGEMENT SUITE

The Institution has chosen the New Innovations Medical Education Management Suite to provide residency management software for management of program requirements. House Officers will have access to rotation schedules and information, electronic evaluations, and other academic resources through New Innovations.

House Officers will be required to comply with the institutional policy regarding duty hours monitoring / recording through the use of the New Innovations. House Officers must record their duty hours for ACGME compliance by entering the data in the Duty Hours Module of New Innovations on a weekly basis. Periodic monitoring will be done to ensure that duty hours are being logged into the system and compliance with ACGME guidelines. Failure to comply with this policy may result in formal disciplinary action being taken, up to and including possible dismissal from the program.

How to Log Duty Hours on New Innovations

**Purpose:** How to add Duty Hour logs, log Vacation Hours, view/edit Duty Hours and approve hours.

**Requirements:** Administrators must have level 5 or 6 privileges in Duty Hours and the module must be configured to allow level 5 users to add or edit hours on behalf of others. Residents and fellows must have level 2 privileges in Duty Hours to log hours.
Adding Duty Hours
1. Go to Select Main > Duty Hours > Log My Hours
2. The default data entry view as configured by the administrator is displayed although any other method of logging may be chosen.

Graphical Entry
Make selections from the start page:
1. Choose timeline increment of 15 minutes, 30 minutes or 60 minutes
2. Choose horizontal or vertical grid
3. Select the date to start logging
4. To skip this page, check the box ‘Next time, bypass this page and take me straight to the timeline’
5. Click Continue

Log hours:
1. Click on the Duty Type or Assignment Definition from the list on the right side of the page
2. Choose Training Location (if required)
3. Record details of the duty hour entry by clicking and dragging the cursor over the cells that represent the time worked.
4. Erase mistakes by dragging the cursor back over the painted cells.
5. Cells with previously saved entries display with hash marks through them.
6. Click Save

Multi-Day Entry
1. Select either the Duty Type or Assignment Definition
2. Select Training Location (if required)
3. Enter the Start time
4. Enter the Duration of the duty
5. Select the days on the calendar that apply to the duty entry (Hold the Ctrl key for multiple selections)
6. Click Add Hours to save the entry
7. Log entries are displayed directly below the entry form.

Single-Day Entry
1. Select either the Duty Type or Assignment Definition
2. Select Training Location (if required)
3. Select either the Duration or Start/Stop entry option and detail the time worked.
4. Click Add Hours to save each entry
5. Log entries will be displayed directly below the entry form.

Logging Vacation Hours
1. Go to My Duty Hours > Add Hours > Vacation/Leave
2. Select the first day of the vacation from the calendar on the left
3. Select the last day of the vacation from the calendar on the right.
4. Select a start date on the calendar on the left only for single day vacation
5. Click Save

Edit a Single Duty Hour Log
1. Go to My Duty Hours > View My Hours
2. Click Edit next to the entry to be modified
3. Make necessary edits
4. Click Approve button to confirm and save changes
**Edit Multiple Entries**
1. Go to *My Duty Hours > View My Hours*
2. Click the *Edit In Bulk* button
3. From the dropdown list, select an *action*
4. Make necessary edits
5. Click *Save* or *Save and Go to Next Week*

**Approving Duty Hours**
1. Go to *My Duty Hours > Approve My Hours*
2. Select the date range to view
3. Click the *Update* link
4. Put a check beside the entries to approved
5. Click *Approve Selected Entries* or *Did Not Work*

**CLIQ AND SMARDI**

Clinical InQuiry (CLIQ) and the Shared Medical Record Data Infrastructure (SMaRDI) represent initial steps in moving to a comprehensive electronic health record for the Public Hospital system. CLIQ is a Web-based results reporting application with a graphical user interface that provides efficient and easy access to a longitudinal record of patient information. CLIQ organizes test result and clinical/procedural report data from disparate legacy systems in a clinically intuitive, patient-centric format, permitting access to all electronically available clinically relevant patient information in a single location. CLIQ access to patient demographic / registration data, visit history, general laboratory and microbiology results, pathology, radiology, cardiology and electromyography reports, admission history and physical notes and discharge summaries, operative notes, outpatient consultation notes from selective clinics and a record of outpatient pharmacy prescriptions. CLIQ can be accessed from web-enabled computers. SMaRDI represents the technical information system foundation on which CLIQ is built.

For additional information about CLIQ and SMaRDI, and other medical informatics activities underway at LSU Health Sciences Center, please see: [http://medinfo-telemed.lsuhsc.edu](http://medinfo-telemed.lsuhsc.edu)

**USMLE PART III and COMLEX LEVEL POLICIES**

Residents enrolling in the Physical Medicine and Rehabilitation program as PGY-1 house officers must take the USMLE Step 3, or, if an Osteopathic physician, the COMLEX Level 3 examination during their first year of training. If a passing score is not achieved, the test must be retaken. A copy of the USMLE Certified Transcript of Scores, or NBOME Transcript indicating achievement of a Step/Level 3 passing score must be available to the program director or program coordinator by December 1st of the PGY-2 year. If a resident can not provide the required evidence of passing USMLE Step 3/COMLEX Level 3, his/her contract of employment will not be renewed on expiration of the current year in training.

Residents enrolling in the program as PGY-2 house officers must provide to the program director or program coordinator by December 1 of the PGY-2 year a copy of the USMLE Certified Transcript of Scores, or, if an Osteopathic physician, NBOME Transcript, indicating achievement of a Step 3/Level 3 passing score. If a passing score in USMLE Step 3/COMLEX Level 3 is not achieved by December 1 of the PGY-2 year, the resident’s contract of employment will not be renewed on expiration of the current year in training.

Residents dis-enrolled due to an action taken under this policy who subsequently become eligible for enrollment may reapply for admission

**HONESTY, INTEGRITY AND TRUSTWORTHINESS**

The Program subscribes to the concept that Honesty, Integrity and Trustworthiness must be core values of
any candidate recommended to the American Board of Physical Medicine and Rehabilitation for certification. Therefore, any misrepresentation of facts or self including presentation of the work of others as one’s own; fabrication of information; misrepresentation of attendance at work, lectures or other educational programs; or attempts to deceive others may result in probation, termination of contract or immediate dismissal

**POLICY ON PROFESSIONALISM AND LEARNING ENVIRONMENT**

The LSU PM & R Program wishes to ensure:

1. Patients receive safe, quality care in the teaching setting of today.
2. Graduating residents provide safe, high quality patient care in the unsupervised practice of medicine in the future.
3. Residents learn professionalism and altruism along with clinical medicine in a humanistic, quality learning environment.

To that end we recognize that patient safety, quality care, and an excellent learning environment are about much more than duty hours. Therefore, we wish to underscore any policies address all aspects of the learning environment not just duty hours. These include:

1. Professionalism including accepting responsibility for patient safety
2. Alertness management
3. Proper supervision
4. Transitions of care
5. Clinical responsibilities
6. Communication / teamwork

Residents must take personal responsibility for and faculty must model behaviors that promote:

2. Assurance for fitness of duty
3. Assurance of the safety and welfare of patients entrusted in their care
4. Management of their time before, during, and after clinical assignments
5. Recognition of impairment (e.g. illness or fatigue ) in self and peers
6. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data

The institution further supports an environment of safety and professionalism by:

1. Providing and monitoring a standard Transitions Policy as defined elsewhere.
2. Providing and monitoring a standard policy for Duty Hours as defined elsewhere.
3. Providing and monitoring a standard Supervision Policy as defined elsewhere.
4. Providing and monitoring a standard master scheduling policy and process in New Innovations.
5. Adopting and institution wide policy that all residents and faculty must inform patients of their role in the patient’s care.
6. Providing and monitoring a policy on Alertness Management and Fatigue Mitigation that includes:
   a. On line modules for faculty and residents on signs of fatigue.
   b. Fatigue mitigation, and alertness management including pocket cards, back up call schedules, and promotion of strategic napping.
7. Assurance of available and adequate sleeping quarters when needed.
8. Requiring that programs define what situations or conditions require communication with the attending physician.

**Process for implementing Professionalism Policy**

The program and institution will assure effective implementation of the Professionalism Policy by the following:
1. Program presentations of this and other policies at program and departmental meetings.
2. Core Modules for faculty and residents on Professionalism, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and Substance Abuse and Impairment.
3. Required LSBME Orientation.
4. Institutional Fitness for Duty and Drug Free Workplace policies.
5. Institutional Duty Hours Policy which adopts in toto the ACGME Duty Hours Language.
7. Comprehensive Moonlighting Policy incorporating the new ACGME requirements.
8. Orientation presentations on Professionalism, Transitions, Fatigue Recognition and Mitigation, and Alertness Management.

Monitoring Implementation of the Policy on Professionalism

The program and institution will monitor implementation and effectiveness of the Professionalism Policy by the following:

1. Evaluation of residents and faculty including:
   a. Daily rounding and observation of the resident in the patient care setting.
   b. Evaluation of the residents’ ability to communicate and interact with other members of the health care team by faculty, nurses, patients where applicable, and other members of the team.
   c. Monthly and semi-annual competency based evaluation of the residents.
   d. By the institution in Annual Reviews of Programs and Internal Reviews.
   e. By successful completion of modules for faculty and residents on Professionalism, Impairment, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and others.
   f. Program and Institutional monitoring of duty hours and procedure logging as well as duty hour violations in New Innovations.

RESIDENT RESPONSIBILITIES

1. Attend all clinics and scheduled conferences. Attendance is mandatory and will be traced. Tardiness will not be tolerated.
2. Dictating History and Physical and Discharge Summaries, write a detailed resident acceptance note on each patient, and a concise progress notes.
3. Take responsibility for admitting patients to the ward service.
4. The resident will contact the staff physician for any emergencies or major problems.
5. Student education.

6. Residents must document all procedures in their logbook. Residents must bring their logbook completely up to date to their semiannual and year-end evaluation. Failure to due so will be reflected negatively in that evaluation. Furthermore, noncompliance is referred to the Faculty for consideration during their quarterly review of House Officer performance. In addition residents must turn their completed Logbook in by the end of the academic year (June 30th) to successfully
complete the program.

7. Check mailbox and email at least twice weekly.

8. Turn in anonymous faculty, fellow, rotation and peer evaluations every month.

9. Take the American Board of Physical Medicine and Rehabilitation in-service exam every year (January) and the American Board of Electrodiagnostic Medicine in the junior year.

10. Go to medical records every (2) two weeks to complete your charts.

11. In the event you cannot fulfill your duty because of death in the family, sickness, etc. you must contact the Program Coordinator, supervising faculty, and chief resident immediately.

12. Any house officer taking time off during the day for personal reasons (family emergency, doctor appointment, etc.) must have this approved by their faculty, residency coordinator, and the chief resident in advance.

INCOMPLETE MEDICAL RECORDS

Accurate and complete medical record documentation is essential professional behavior for any successful physiatric practice. The consequences of incomplete medical records include suspension of hospital medical staff privileges and possible criminal liability for fraudulent billing. As a resident, your medical record keeping directly affects the practice of PM&R faculty who has assumed responsibility for your actions. Residents are therefore required to complete medical records for patients seen during a rotation within four (4) weeks of the end date for that rotation. Non-Compliance will result in an unsatisfactory rotation evaluation which maybe remediated only be repeating the rotation in its entirety. Your program completion date will be adjusted to accommodate the additional time needed to fulfill your training requirements. Unsatisfactory rotation evaluations for incomplete medical records may be avoided by including a visit to the Medical Record Department of your hospital at the end of a rotation to handle any outstanding medical record issues.

GUIDELINES FOR SUPERVISION OF RESIDENTS AND PROGRESSIVE RESPONSIBILITY

Most rotations have one resident being supervised directly by one faculty. Occasionally there are more than one resident on the same service and they may be of different training levels. Both residents will report directly to the same or different faculty. However, the more senior resident will help the more junior resident.

To further address this issue we have added the following policy:

Policy on PM&R Resident Supervisory Role

The purpose of this policy is to ensure adequate supervision of PM&R resident physicians involved in postgraduate medical training in the Department of Physical Medicine and Rehabilitation. This policy is designed to facilitate the educational and clinical progression and maturation of the resident from intern or PGY2, to senior resident. The following are general guidelines for the supervision of Physical Medicine and Rehabilitation residents in clinical settings.

For the purposes of this policy, a senior resident is one who is at least one year in training ahead of the resident that is being supervised. In any setting, unusual findings or complicated questions should be directed to the faculty attending for that service. Supervision of junior residents and medical students by senior residents is an integral part of the residency program, and this helps junior residents and students to learn and to improve the teaching skills of senior residents. In all settings, the ability of the senior resident to competently supervise the junior resident will be based upon the context of the specific activity and the senior resident’s skill in that area, as documented by procedure logs. Although it is an expectation of the
program that senior residents will supervise junior residents, it is always at the discretion of the faculty to
decide whether or not a senior resident is competent to supervise others. In addition, there are some
activities that must always have staff in attendance.

• All patient care must be supervised by qualified faculty.
• The Program Director must ensure, direct, and document adequate supervision at all times.
• Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
• Faculty schedules must be structured to provide residents with continuous supervision and consultation.
• Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to
prevent and counteract the potential negative effects.
• Residents will be given the opportunity to evaluate patients in each clinical setting and formulate a
treatment plan. The attending physician must confirm and document the key elements of the history,
physical examination, and medical decision-making. The attending physician will review all pertinent
clinical findings with the resident and instruct the resident on related examination techniques. The
attending physician will discuss treatment options with the resident and then approve the treatment plan.
• Attending physicians are encouraged to review with the resident his or her performance midway through
the rotation and provide constructive comments.
• At the completion of the rotation, a resident evaluation form should be completed, reviewed with the
resident, and then submitted to the residency program director.
• The attending physician must continue to provide supervision of residents in all clinical settings.
However, PM&R residents are allowed increasing autonomy as they progress through their residency
training and begin to develop a sound foundation for clinical decision-making. Initially, the attending
physician will demonstrate appropriate history taking and examination skills and discuss their assessment
and recommendations. As the residents progress through the clinical rotations and training years, they will
be provided with increasing opportunity to formulate a preliminary assessment and treatment plan which
is then reviewed with the attending physician. The intent is to prepare residents to be independent and
skilled practitioners of the specialty of Physical Medicine and Rehabilitation upon completion of their
residency-training program.
• The senior resident on the consultation service teaches the importance of teamwork, and how to
determine whether a patient is a candidate for acute inpatient rehabilitation.
• The senior PM&R resident will assist the attending in teaching and training the junior resident in the use
of the electrodiagnostic equipment and procedures.
• The senior resident will supervise the junior resident during history taking, physical examination and
electrodiagnostic evaluation. The senior resident also will practice with the junior resident new
procedures previously taught by the attending physician.
• As the PM&R residents progress through the PM&R residency training program, they will be given the
opportunity to both supervise and instruct more junior residents and medical students. Senior residents
will provide direct supervision of junior residents on the electrodiagnosis service. Faculty will
demonstrate teaching techniques and provide appropriate educational oversight. Residents will also
provide backup coverage and be available to assist in the supervision of more junior residents while on
call. Residents will present journal articles to other residents at Journal Club. The attending physicians
will assist, advise, and supervise as well as teach how to most effectively give a scientific talk to small as
well as large audiences
• Senior residents will act as role models for the ideal patient encounter.
• Residents will be given the opportunity to observe mannerism and the general approach to patient care,
interaction with other team members, and interaction with patients’ families.
• The more senior resident will model important humanistic qualities to the residents such as kindness,
understanding, supportive and positive attitudes that induce hope and trust in the patients and their
families. He/she will also stress the need for patience, responsiveness, availability, and emotional stability
in the handling of patient problems.
• The importance of cooperation and interacting in a professional manner with colleagues, peers, nurses,
therapists, and other allied health professionals will also be stressed.
• In addition, leadership qualities need to be nurtured in order to prepare for the appropriate role within
the team.
• When the resident is ready to perform these functions independently, he/she will be supervised,
corrected, and/or counseled by the attending physician to assure that the proper professional behavior is
modeled.

Policy and Process:

LSU PM&R residents rotate at eight different facilities which include various types of rotation settings such as in patient rehabilitation, ambulatory care clinics (Pain and PM & R), in patient consults and interventional pain clinics. The general policies for supervision at all rotations are as follows.

Faculty Responsibilities for Supervision and Graded Responsibility:

Residents must be supervised in such a way that they assume progressive responsibility as they progress in their educational program. Progressive responsibility is determined in a number of ways including:

1. GME faculty on each service determines what level of autonomy each resident may have that ensures growth of the resident and patient safety.
2. The Program Director and Chief Residents assess each resident’s level of competence in frequent personal observation and semi-annual review of each resident.

The expected components of supervision include:

1. Defining educational objectives.
2. The faculty assessing the skill level of the resident by direct observation.
3. The faculty defines the course of progressive responsibility allowed starting with close supervision and progressing to independence as the skill is mastered.
4. Documentation of supervision by the involved supervising faculty must be customized to the settings based on guidelines for best practice and regulations from the ACGME, JACHO and other regulatory bodies. Documentation should generally include but not be limited to:
   a. progress notes in the chart written by or signed by the faculty
   b. addendum to resident’s notes where needed
   c. counter-signature of notes by faculty
   d. a medical record entry indicating the name of the supervisory faculty.
5. In addition to close observation, faculty are encouraged to give frequent formative feedback and required to give formal summative written feedback that is competency based and includes evaluation of both professionalism and effectiveness of transitions.

The levels of supervision are defined as follows:

- Direct Supervision by Faculty - faculty is physically present with the resident being supervised.
- Direct Supervision by Senior Resident – same as above but resident is supervisor.
- Indirect with Direct Supervision IMMEDIATELY Available – Faculty – the supervising physician is physically present within the hospital or other site of patient care and is immediately available to provide Direct Supervision.
- Indirect with Direct Supervision IMMEDIATELY Available – Resident - same but supervisor is resident.
- Indirect with Direct Supervision Available - the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

**LSU PM & R Policy on Mandatory Notification of Faculty**

**Policy and Process**

In the PM & R resident program, the residents are rotating at sites with a one on one or one to three supervision ratio of residents to faculty members and rarely would be in a situation where the below conditions would occur without faculty directly present. In addition, the below conditions are mainly found on inpatient primary care rotations. PM & R residents are only assigned to primary care rotations during their intern year on general medicine rotation usually done with the LSU Internal Medicine program. While on these Internal Medicine rotations, the residents are required to know and follow the specific department policies on mandatory notification established in Internal Medicine.

In certain cases faculty must be notified of a change in patient status or condition. The table below outlines those instances in which faculty must be called by PGY level.

<table>
<thead>
<tr>
<th>Condition</th>
<th>PGY 1</th>
<th>PGY 2</th>
<th>PGY 3 and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of complex patient</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transfer to ICU</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>DNR or other end of life decision</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Emergency surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Acute drastic change in course</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Unanticipated invasive or diagnostic procedure</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Add more as needed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How monitored**

Chief Residents, faculty, and the program will monitor by checking for proper implementation on daily rounds, morning reports, and other venues as well as solicitation of reports from faculty on lack of appropriate use of the policy.

**ATTENDANCE REQUIREMENTS FOR EDUCATIONAL PROGRAMS**

For the purpose of this requirement an educational program is defined as any educational event scheduled by the Residency Program on Fridays from 1200 until end time. Attendance at eighty-five per cent (85%) of Program scheduled events, including quizzes, is considered satisfactory performance. Absences include all leave; i.e. annual, educational, sick and without pay; excused absences and unexcused absences. Notification of absence by telephone at 897-8948 at least sixty (60) minutes before the start of the event is sufficient for an excused absence. Notification must be given to an Administrative staff member. A telephone message is not acceptable. In addition, House Officers who will not attend an educational program must also notify the Chief or Associate Resident by phone.
Absence for urgent clinical responsibilities, verified by the Attending, will not be used in calculating performance under this provision. An unexcused absence is one where required notification is not given, the House Officer fails to personally sign all attendance records provided for an educational program or the House Officer fails to complete and turn in a scheduled test.

Unsatisfactory performance will be administered in the following manner. The Faculty may: on the first unexcused absence send a letter of warning; on the second unexcused absence send a letter of reprimand and on the third unexcused absence place the House Officer on probation. House Officers failing to maintain eighty-five percent (85%) attendance for the year may be placed on probation.

**Sign-Out Policy**

- Sign-out policy to be implemented at inpatient rotations
- Sign-out to be done DAILY
- Verbal sign-out to on-call resident to be done in person or via phone.
- Written patient list to be handed in person or via email to on-call resident.
- Residents should send a written patient list via email to faculty on-call on FRIDAYS.
- Inpatient residents are responsible for their patients until 5 pm. Afterwards, the on-call resident is responsible for all patient care.
- Written patient list/sign-out MUST include:
  - Patient name
  - Medical Record number
  - Diagnosis
  - Problem list
  - To do list
  - Code Status (i.e DNR)

**Example**

<table>
<thead>
<tr>
<th>Name</th>
<th>MR</th>
<th>DX</th>
<th>Problems</th>
<th>To Do:</th>
<th>Code Status</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. JR</td>
<td>0000000</td>
<td>CVA/LHP</td>
<td>HTN, CAD</td>
<td>Check BMP</td>
<td>DNR</td>
<td></td>
</tr>
</tbody>
</table>

**POLICY ON EFFECTIVE TRANSITIONS**

The transitions policy is created in recognition that multiple studies have shown that transitions of care create the most risk or medical errors (ACGME teleconference July 14, 2010.) In addition to the below specific policies, promotion of patient safety is further ensured by:

1. Provision of complete and accurate rotational schedules in New Innovations
2. Presence of a back up call schedule for those cases where a resident is unable to complete their duties.
3. The ability of any residents to be able to freely and without fear of retribution report their inability to carry out their clinical responsibilities due to fatigue or other causes.

**Policy and Process**

Residents receive educational material on Transitions in Orientation and as a Core Module. In the PM & R resident program, there is no in house call, only at home call on the two inpatient rehab rotations (Touro
Inpatient Rehab and Ochsner Inpatient Rehab). There are only three rotations where transitions of patients occur: Touro Inpatient Rehab, Ochsner Inpatient Rehab and ILSUPH/MCLNO Inpatient consults. The other rotations are all outpatient clinic or outpatient procedure type rotations where a transition between residents of patient care does not occur. The residents developed a common form to be used at all three of the previous mentioned rotations which is attached to this policy.

In any instance where care of a patient is transferred to another member of the health care team an adequate transition form (see attached example form) must be used. Although transitions may require additional reporting than in this policy a minimum standard for transitions must include the following information:

1. Demographics
   a. Name
   b. Medical Record Number
   c. Unit/room number
   d. Age
   e. Attending physician – Phone numbers of covering physician
   f. Weight
   g. Gender
   h. Allergies
   i. Admit date

2. History and Problem List
   a. Primary diagnosis(es)
   b. Chronic problems (pertinent to this admission/shift)

3. Current condition/status

4. System based
   a. Pertinent Medications and Treatments
   b. Oral and IV medications
   c. IV fluids
   d. Blood products
   e. Oxygen
   f. Respiratory therapy interventions

5. Pertinent lab data

6. To do list: Check x-ray, labs, wean treatments, etc - rationale

7. Contingency Planning – What may go wrong and what to do

8. ANTICIPATE what will happen to your patient. Ex:
   a. “If patient seizes > 5 minutes, give him Ativan 0.05mg/kg. If he still seizes load him with 5mg/kg of fosphenytoin.”

9. Code status/family situations

10. Difficult family or psychosocial situations

11. Code status, especially recent changes or family discussions

This information is found on pocket cards delivered to each house officer. The process by which this information is distributed is via Core Modules and Orientation presentations to residents and via a Compliance Module for faculty. In addition this information is presented in program/departmental meetings.

As of July 2011, The Program Director delegates the responsibility to periodically sample transitions at the three sites (Touro Rehab, Ochsner Rehab and ILSUPH/MCLNO consults) to the supervising faculty at those sites. This sampling includes review of samples of patient charts and interviews of incoming residents to ensure the key elements are transmitted and have been understood. The supervising faculty then provides a written report back to the Program Director on a semiannual basis on the outcome of his or her sampling.

How monitored:

Faculty are required to answer a question on effectiveness of witnessed transitions on each evaluation. The process and effectiveness of each program’s system is monitored through the Annual Program Review and the Internal Review process. The institution and program will monitor this by periodic sampling of
transitions, as part of the Annual Review of Programs and as part of the Internal Review Process. Senior residents and supervising faculty on the three inpatient rotations where transitions of patients occur (Touro Rehab, Ochsner Rehab and ILSUPH/MCLNO consults), routinely witness in person some transitions and review completed forms weekly while on those rotations. The Program Director reviews the completed forms twice annually prior to the midyear review with each resident and addresses any discrepancies at the midyear review meetings.

**SIGN OVER TRANSITION TEMPLATE**

<table>
<thead>
<tr>
<th>Date: <em><strong><strong>/____/</strong></strong></em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Physician:</td>
</tr>
<tr>
<td>Resident Physician:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Room Number</th>
<th>Meds</th>
<th>Allergies</th>
<th>Precautions</th>
<th>Anticoagulation</th>
<th>Age</th>
<th>Gender</th>
<th>Date of Onset</th>
<th>Date of Admission</th>
<th>Tentative discharge date</th>
<th>Diagnosis</th>
<th>Comorbidities</th>
<th>Medications</th>
<th>Consulting Services</th>
<th>Medical and non-medical issues to be observed and addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROGRAM CLOSURE OR REDUCTION**

In the event of any reduction in the number of residents trained in the program, it is the intent of the program to implement this reduction by reducing the number of incoming new residents. If the ACGME withdraws accreditation of the program residents will be notified of this action. (The program director will notify the residents in writing of any confirmed adverse accreditation action). Withdrawal of accreditation generally permits the completion of the training year in which the action becomes effective. The program will help in placing residents in other programs so that they can complete any remaining
years of training. In the event of program closure, resident records will be available at the university or other designated facility to ensure future credentialing needs.

**POLICY ON DOCUMENTING ATTENDANCE AT AFFILIATED FACILITIES**

Residents are paid by and receive benefits through LSUHSC. However, LSUHSC is reimbursed for these expenses through contractual relationships with affiliate facilities where resident training occurs. All affiliated facilities have established procedures to verify on-site resident attendance which must be verified before funds flow to LSUHSC for reimbursement of costs for resident salaries, benefits, etc. It is the resident’s responsibility to know and comply with procedures established for this purpose. Failure to do so is a grievous breach of administrative responsibility and will result in the following actions.

The first occurrence of undocumented attendance at an affiliated facility will result in three (3) months probation for failure to comply with administrative procedures. The second occurrence will result in six (6) months probation. With Faculty approval, the third occurrence will result in the resident being terminated from the program at a date no earlier than four (4) months after the resident receives official notice of the infraction.
**PROGRAM OVERVIEW**

Louisiana State University Physical Medicine and Rehabilitation 4-Year Program

<table>
<thead>
<tr>
<th>PG 1</th>
<th>PG 2</th>
<th>PG 3</th>
<th>PG 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Medicine Rotations at Touro, East Jefferson, or Ochsner</td>
<td>Medicine Rotations at Touro, East Jefferson, or Ochsner</td>
<td>VA Hospital - PM&amp;R Clinics, EMG, Geriatrics, Consults</td>
<td>Baton Rouge General - Burn Rehab, Research</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Medical Center of Louisiana - Consult Service</td>
<td>Children's Hospital Pediatric Rehabilitation Inpatient and Outpatient</td>
<td>Ochsner Inpatient Rehabilitation</td>
<td>East Jefferson General Hospital - Pain Management</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>VA Hospital - PM&amp;R Clinics, EMG, Geriatrics, Consults</td>
<td>Ochsner Inpatient Rehabilitation</td>
<td>Ochsner - Physical Medicine and Pain Management</td>
<td>L.J. Chabert - EMG and PM&amp;R Clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ochsner - Cardiopulmonary Rehab, Orthotics and Prosthetics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>VA Hospital PM&amp;R Clinics and EMG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Touro Inpatient Rehabilitation</td>
</tr>
</tbody>
</table>

The 4-year program incorporates twelve (12) months of non-Physical Medicine and Rehabilitation rotations to satisfy the fundamental clinical skills described by the ABPM&R. There is flexibility in these rotations that can be individualized with the House Officer, however, the 12-months of training must meet the program requirements set by the American Board of Physical Medicine and Rehabilitation and the ACGME. Recommended rotations include: Medicine, and Medicine Subspecialties, Emergency Room, Rheumatology, Neurology and Neurosurgery, and Orthopedics.

If 12 months of fundamental clinical skills have been satisfactorily completed prior to starting this PM&R program, then the 12 months of fundamental clinical skills will be omitted from the above four-year program so that it can be completed in 3 years.

These rotations are designed to meet the program requirements for residency training set by the American Board of PM&R and the ACGME. The program calls for progressive responsibilities by residents in their training program.
LSU PM & R  Overall Goals and Objectives

Over the course of the three year residency training program, residents will acquire the knowledge and skills required to be competent practitioners of Physical medicine and rehabilitation (PM&R), a medical specialty concerned with diagnosis, evaluation, and management of persons of all ages with physical and/or cognitive impairments and disability. This specialty involves diagnosis and treatment of patients with painful or functionally limiting conditions, the management of comorbidities and coimpairments, diagnostic and therapeutic injection procedures, electrodiagnostic medicine and emphasis on the prevention of complications of disability from secondary conditions. Residents are trained in the diagnosis and management of impairments of the neurologic, musculoskeletal (including sports and occupational aspects) and other organ systems and the long-term management of patients with disabling conditions. Residents will acquire the skills to provide leadership to multidisciplinary teams concerned with maximal restoration or development of physical, psychological, social, occupational and vocational functions in persons whose abilities have been limited by disease, trauma, congenital disorders or pain.

I. Patient Care

Residents will be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents will develop the attitudes and psychomotor skills required to:

- take a medical history which includes the recognition of functional abilities, and physical and psychosocial impairments which may cause functional disabilities
- perform the general and specific physiatric examinations, including electromyography, nerve conduction studies, and other procedures common to the practice of physical medicine and rehabilitation
- make sound clinical judgments
- design and monitor rehabilitation treatment programs to minimize and prevent impairment and maximize functional abilities
- prevent injury, illness and disability

Residents will attain competence in the following areas:

- history and physical examination pertinent to physical medicine and rehabilitation
- assessment of neurological, musculoskeletal and cardiovascular-pulmonary systems
- assessment of disability and impairment and familiarity with the ratings of disability and impairment
- data gathering and interpreting of psychosocial and vocational factors
Residents will gain proficiency in diagnosing, assessing, and managing the conditions commonly encountered by the physiatrist in the rehabilitative management of patients of all ages in the following areas:

- acute and chronic musculoskeletal syndromes, including sports and occupational injuries
- acute and chronic pain management
- congenital or acquired myopathies, peripheral neuropathies, motor neuron and motor system diseases and other neuromuscular diseases
- hereditary, developmental and acquired central nervous system disorders, including cerebral palsy, stroke, myelomeningocele, and multiple sclerosis
- rehabilitative care of traumatic brain injury
- rehabilitative care of spinal cord trauma and diseases, including management of bladder and bowel dysfunction and pressure ulcer prevention and treatment
- rehabilitative care of amputations for both congenital and acquired conditions
- sexual dysfunction common to the physically impaired
- postfracture care and rehabilitation of postoperative joint arthroplasty
- cardiac and pulmonary rehabilitation
- pulmonary, cardiac, oncologic, infectious, immunosuppressive and other common medical conditions seen in patients with physical disabilities
- diseases, impairments and functional limitations seen in the geriatric population
- rheumatologic disorders treated by the physiatrist
- medical conditioning, reconditioning and fitness
- tissue disorders such as burns, ulcers and wound care

II. Medical Knowledge

Residents will demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.
Residents will demonstrate knowledge about the diagnosis, pathogenesis, treatment, prevention, and rehabilitation of those neuromusculoskeletal, neurobehavioral, cardiovascular, pulmonary, and other system disorders common to this specialty in patients of both sexes and all ages.

Residents will demonstrate knowledge in the principles of bioethics as applied to medical care, and the residents must participate in decision-making involving ethical issues that arise in the diagnosis and management of their patients.

Residents will demonstrate knowledge in the basic sciences relevant to physical medicine and rehabilitation such as anatomy, physiology, pathology and pathophysiology of the neuromusculoskeletal, cardiovascular and pulmonary systems, kinesiology and biomechanics, functional anatomy, electrodiagnostic medicine, fundamental research design and methodologies, and instrumentation related to the field.

Residents will demonstrate the ability to order and review appropriate laboratory and imaging studies for the patient.

Residents will demonstrate fundamental understanding of orthotics and prosthetics, including fitting and manufacturing, through instruction and arrangements made with appropriate orthotic-prosthetic facilities.

Residents will demonstrate knowledge of the principles of pharmacology as they relate to the indications for and complications of drugs utilized in physical medicine and rehabilitation.

III. Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Residents are expected to develop skills and habits to be able to meet the following goals:

- identify strengths, deficiencies, and limits in one’s knowledge and expertise
- set learning and improvement goals
- identify and perform appropriate learning activities
- systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
- incorporate formative evaluation feedback into daily practice
- locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
- use information technology to optimize learning
participate in the education of patients, families, students, residents and other health professionals

IV. Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents will demonstrate the ability to:
- communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
- communicate effectively with physicians, other health professionals, and health related agencies
- work effectively as a member or leader of a health care team or other professional group
- act in a consultative role to other physicians and health professionals
- maintain comprehensive, timely, and legible medical records
- develop the necessary written and verbal communication skills essential to the efficient practice of physiatry
- have training in counseling of patients and family members
- have instruction in medical administration and teaching methodology

V. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents will demonstrate:
- compassion, integrity, and respect for others
- responsiveness to patient needs that supersedes self-interest
- respect for patient privacy and autonomy
- accountability to patients, society and the profession
- sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
- participation in community service, professional organizations, or institutional committee activities
- an appropriate professional attitude and behavior toward colleagues
- a spirit of collegiality and a high standard of moral behavior within the clinical setting in the care of patients, in the education of residents, and in conducting research
- recognition of the importance of personal, social and cultural factors in the disease process and clinical management
VI. Systems-based Practice

☐ Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care.
☐ Residents will demonstrate the ability to:
☐ Work effectively in various health care delivery settings and systems
☐ Coordinate patient care within the health care system
☐ Incorporate considerations of cost awareness and risk-benefit analysis
☐ Advocate for quality patient care
☐ Work in interprofessional teams
☐ Participate in identifying system errors and implementing potential systems solutions
☐ Gain fundamental understanding in the continuum of rehabilitative care
Location: Touro Infirmary, New Orleans, LA
Attendings: Gary Glynn, M.D., Kathleen Barfoot, M.D., Farohk Contractor, M.D., Diane Mayer, M.D., Mark Rosenbloom, M.D.

General Description:

Residents will be exposed to and integrally involved with the management of a population of individuals on this unit which is a general rehabilitation unit with a predominantly neurological population including stroke, spinal cord injury (SCI), degenerative and other neurological conditions. All aspects of brain injury rehabilitation are to be addressed on this rotation. Knowledge of the epidemiology and assessment of traumatic brain injury, as well as the specialized history and physical, is essential to the proper management of this patient population. There will also be an opportunity for exposure to a variety of orthopedic type problems including multiple trauma, fractures, total joint replacements and arthridites.

Knowledge of special complications related to this population includes: seizures, spasticity, swallowing disorders, pressure ulcers, hydrocephalus, contractures, nutritional complications, neurogenic bowel and bladder management, DVT and heterotopic ossification to include a few. Detailed knowledge such as precautions for various orthopedic conditions; DVT assessment and prophylaxis and treatment; ASIA classification of SCI, including functional outcomes and prognosis; evaluation and treatment of depression; and pain management techniques appropriate to various conditions will be learned.

An emphasis is on communication and teamwork among the team leader physiatrist, case manager, rehab nursing, PT, OT, TR, nutritional services, psychology, neuropsychology, rehab counseling and chaplaincy in this facility known for this approach. A stable and regular team of experienced full time physiatrists staff this rotation. Hospital consultation skills are also learned. Radiology and Physiatric staff will provide regular film reading sessions with emphasis on the most useful imaging techniques to physiatric practice.

GOALS AND OBJECTIVES:

Patient Care

Residents are expected to:
• Perform a rehabilitation medicine focused admission history and physical examination.
• Diagnose physical, cognitive, and psychosocial impairments in rehabilitation patients with acute and chronic medical problems, musculoskeletal injuries, and disabilities.
• With attending supervision, admit and function as the primary care provider for inpatients on the rehab unit. Residents are responsible for all administrative care related to their patients including but not limited to daily progress notes, discharge summaries, team rounds summaries, daily patient medication orders, comprehensive therapy orders, and family conference summaries.
• Create a differential diagnosis appropriate to the physical findings and history.
• Generate a comprehensive problem list.
• Incorporate pertinent medical issues into therapy orders in order to precisely define patient precautions.
• Select appropriate orthotics, prosthetics, and durable medical equipment for inpatient rehabilitation patients.
• Utilize consultants to help manage acute and chronic medical problems.

Medical Knowledge

Residents are expected to:
• Explain indication and techniques for:
  * Central venous catheter placement
  * Lumbar puncture
  * Nasogastric tube placement
  * Bladder catheterization
  * Obtaining arterial blood gases and venous samples of blood
  * Paracentesis (diagnostic and therapeutic)
  * Thoracentesis
  * PICC lines

  * Define the ASIA scale and be able to apply it given patient data.
  * Define the ASIA scale and use in prediction of recovery from TBI.
  * Define other problems in spinal cord injury:
    - Heterotopic Ossicication
    - Pain
    - Thermoregulations
    - Syringomyelia
    - Reflex Sweating
    - Autonomic Hyperreflexia

  * Define respiratory problems in spinal cord injury:
    - Phrenic nerve pacing
    - Ventilator dependency
    - Restrictive pulmonary disease

• Design a rehab program for a patient with CHF, CABG, Cardiac valve replacement, or s/p MI.
• Design a rehab program for a patient with COPD, Cancer, and other conditions causing medical debility.
• Indicate when a cardiac rehab inpatient is safe for discharge to an outpatient cardiac rehab program.
• State the relative and absolute contraindications to inpatient exercise.
• Order appropriate parameters for CPM following total knee arthroplasty.
• Prescribe precautions to prevent dislocation following total hip arthroplasty.
• Prescribe appropriate anticoagulation for the post op arthroplasty patient.
• Manage blood sugars and blood pressures appropriately on the rehabilitation unit.
• Read an EKG in a patient with acute chest pain.
• Diagnose and treat acute chest pain.
• Characterize the benefits and specific risks of medications used in geriatric patients.
• Prescribe pain medications for patients cared for on the comprehensive rehabilitation service, including post-operative patients.
• Demonstrate how to treat bowel dysfunction in patients who are not suffering from neurogenic bowel.
• Demonstrate how to treat bladder dysfunction in patients who are not suffering from neurogenic bladder.
• Diagnose and treat sources of fever, wound drainage, chest pain, shortness of breath, and Post-operative pain.

**Practice-Based Learning and Improvement:**

Residents are expected to:
• Evaluate their own exam skills and knowledge and incorporate feedback from others.
• Investigate and apply evidence from scientific studies to enhance patient care throughout the rotation.
• Use information technology (computers, journals, etc.) to access and manage patient information and support their own education and treatment decisions.
• Review the literature for “Best Practices” in the above areas of Medical Knowledge and Patient Care.
• Contribute their findings to discussions on the care of the patient with other health care professionals.
• Save their reports from early in the rotation and compare them to those done later in the rotation.
• Investigate the outcomes of their treatment decisions.
• Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
• Facilitate the learning of students, more junior residents, and related allied health care professionals.

**Interpersonal and Communication Skills**

Residents are expected to:
• Establish trust and maintain rapport with patients and family. Serve as primary source of information for family.
• Complete all chart notes and dictations in a timely manner.
• Present material clearly and accurately to patients and family.
• Effectively communicate verbally and in writing patient needs to all staff and referring physicians involved with the patient.
• Utilize effective listening skills.
• Participate in rounds and discussions.
• Present findings clearly and concisely to supervising faculty so management can be discussed.
• Demonstrate appropriate interpersonal skills, compassion, and leadership skills in the patient care conference and multidisciplinary team conference.
• Write adequately detailed therapy prescriptions that are based on functional goals for physiatric management.
• Discuss issues such as prognosis, and address return to work/home issues with families and patients.
• Lead an interdisciplinary team, formulate goals, and care plans.
• Complete medical records in a timely manner.
• Develop effective listening skills.
• Communicate with the cardiac rehab patient and their family regarding diet, exercise, and activity recommendations.

**Professionalism**
Residents are expected to:
* Promote respect, dignity, and compassion for patients
* Demonstrate a commitment to ethical principles and confidentiality of patient information by understanding and adherance to HIPPA regulations
* Demonstrate reliability and punctuality by being on time for clinic and lectures
* Dress and behave in a highly professional manner at all times in the clinic
* Demonstrate the ability to interact well with attendings, other residents, nurses and other administrative and technical support personnel.
* Accept responsibility for their own actions and decisions

**System-Based Practice**
Residents are expected to:
• Demonstrate patient advocacy, yet showing the ability to recognize situations in which progress is no longer occurring and problem solving these situations.
• Collaborate and work effectively with other health professionals and maintain appropriate behaviors.
• Assess how their decisions affect others – patients, family, and other health care professionals.
• Integrate care of patients across hospital and community settings.
• Learn when tests are appropriate or may be under-or over-utilized.
• Identify the cost of the treatments and diagnostic tests that are ordered.
• Advocate for patients who need tests and treatment that might be inappropriately denied.
• Recognize requirements as they relate to documentation, elements of the exam, and billing procedures and codes.
• Understand the unique needs of geriatric patients as they transition to home, Assisted Living facilities, or Skilled Nursing facilities.
• Describe the role of Hospice and how rehabilitation can fit in with a patient who may ultimately be discharged to hospice.
• Explain the role of the Functional Independence Measure (FIM) in the context of inpatient rehabilitation, research goals, and third party payors.
• Describe the outcome parameters used by third party payers.
• Learn how to apply the Prospective Payment System (PPS) system.
• Learn how rehabilitation units function and maintain fiscal stability.
• Realize the limitations on the ability of geriatric patients to pay for their medications.
• Discuss code status and advance directives with patients.
• Understand the use of “CMS 13” diagnosis, why they are used, how they are applied, and the meaning of these diagnoses to the inpatient rehabilitation program.
• Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
• Describe the factors involved in the decisions on length of stay, disposition, and insurance coverage.
• Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.
Location: Touro Infirmary, New Orleans, LA
Attendings: Gary Glynn, M.D., Kathleen Barfoot, M.D., Farokh Contractor, M.D., Diane Mayer, M.D., Mark Rosenbloom, M.D.

General Description:

All aspects of brain injury rehabilitation are to be addressed on this senior level rotation. Knowledge of the epidemiology and assessment of traumatic brain injury, as well as the specialized history and physical, is essential to the proper management of this patient population. The team approach to inpatient management, which is always important, is especially essential in this population.

Knowledge of special complications related to traumatic brain injury includes seizures, spasticity, swallowing disorders, post-traumatic hydrocephalus, heterotopic ossification, autonomic disturbances, endocrinologic complications, and gastrointestinal and genitourinary complications and an unusually large exposure to tracheotomy patients.

Detailed knowledge of the neuropsychiatric evaluation and assessment outcome scales also is very important. These scales include the Coma/Near Coma, Glasgow Coma Scale, Ranchos Las Amigos Levels of Cognitive Function, among others.

Close communication between the neuropsychologist, physical therapist, occupational therapist, speech pathologist, recreational therapist, physiatrist, and other medical specialties is essential in the ultimate appropriate disposition of these individuals. This rotation offers a unique venue to learn management methods for this very complex patient population. Hospital consultation skills will also be developed. Radiology and Physiatric staff will also provide regular film reading sessions with emphasis on the most useful imaging techniques to physiatric practice.

GOALS AND OBJECTIVES:

Patient Care:

Residents are expected to:

- Perform a rehabilitation medicine focused history and physical.
- Generate a comprehensive problem list.
- Incorporate pertinent medical issues into therapy orders in order to precisely define patient precautions.
- Select appropriate orthotics and durable medical equipment for patients with brain disorders.
- Define short and long term goals for patients.
- Demonstrate proficiency in performing a neurologic examination.
- Observe a neuropsychological evaluation.
- Observe a bedside swallow and video fluoroscopic modified barium swallow evaluation.

Medical Knowledge:

Residents are expected to:

- Describe common neurosurgical disease processes, including aneurysms, tumors, arteriovenous malformations, and traumatic brain injuries and their prognoses.
- Recognize when neuro-stimulants are appropriate, and how to choose an appropriate medication.
- Determine how to evaluate a patient for returning to safe driving.
- Diagnose and treat agitation by using environmental manipulation and medications.
- Describe the role and duration of use of anti-epileptic medications in the acquired brain injury population.
- Describe the Rancho Los Amigos cognitive scale and the GOAT and how they are used in patient assessment.
- Outline the diagnosis and prognosis of traumatic brain injury using variables such as extent of injury, Glasgow coma scale, trauma scores, age, premorbid function, and somatosensory evoked potentials.
- Outline the prognosis for right vs. left CVA, hemorrhagic vs. embolic stroke, and include factors such as age and co-morbidities that may affect outcome.
- Develop a treatment plan for patients with brain disorders who have:
  - Mental status changes
  - Limited joint range of motion
  - Pain in an extremity
  - Spasticity
  - Bowel/bladder dysfunction
  - Fevers
  - Skin breakdown
- Identify candidates for neurolytic procedures and intrathecal baclofen.
- Describe the therapeutic approaches (Bobath, Brunnstrom, Forced use, Proprioceptive neuromuscular facilitation) used with patients with neurological dysfunction.
- Describe the clinical characteristics of the common aphasic syndromes.

Practice Based Learning and Improvement:

Residents are expected to:

- Read pertinent articles from recent evidence-based medical literature on the assessment and/or treatment of brain injury and apply this knowledge to the current care of the patient.
- Present a lecture to the attending and other residents on an aspect of interest to you in the assessment and/or treatment of brain injury.

Discuss with the attending and other residents the limitations in the current knowledge
Discuss with the attending and other residents the limitations in the current knowledge
knowledge in this area.

Interpersonal and Communication Skills:

Residents are expected to:

☐ Communicate effectively with patients and families from a broad range of socio-economic and cultural backgrounds.
☐ Communicate effectively with physicians, other health professionals, and health related agencies.
☐ Work effectively as a member or leader of a health care team or other professional group.
☐ Act in a consultative role to other physician and health professionals.
☐ Maintain comprehensive, timely, and legible medical records.
☐ Develop the skills to interview cognitively impaired patients.
☐ Recognize how to implement safe techniques during an encounter with an agitated patient.
☐ Perform an interview of the patient and family members with special attention to the psychosocial aspects of the patient and family unit.
☐ Lead a family and team conference in a manner that optimizes the contributions of each team member and coordinates their individual roles.

Professionalism:

Residents are expected to:

☐ Participate in rounds and discussions.
☐ Respect patient privacy and autonomy.
☐ Be on time to lectures and rounds.
☐ Apply sound ethical principles in practice including patient confidentiality, informed consent and provisions of withholding care.
☐ Demonstrate sensitivity to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
☐ Demonstrate sensitivity to the patient and family members, and respect the psychosocial impact of brain injury on the family unit.
☐ Develop an attitude of interdisciplinary cooperation with physical, occupational therapies, and speech-language pathology, social work, psychology, and nursing.
☐ Function as a team leader and teacher for the more junior residents.

Systems Based Practice:

Residents are expected to:

☐ Coordinate patient care within the health care system.
☐ Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care.
- Discuss with the attending and other residents the limitations in the current knowledge.
- Advocate for quality patient care and optimal patient care systems.
- Participate in identifying system errors and implementing potential systems solutions.
- Identify the resources in the community after discharge from hospital, including post-acute rehab facilities, vocational rehabilitation, group homes, and day programs.
- State the criteria for state-funded vocational rehabilitation services.
- Understand how complex social issues and limited resources can affect the patient’s rehabilitation and outcome.
General Description:

During this rotation, PM&R residents learn to evaluate patients in an acute care setting, determine their rehabilitation needs, the appropriate setting for rehabilitation (acute inpatient rehabilitation, sub-acute rehabilitation, day rehabilitation, outpatient rehabilitation, and home health services) and make recommendations regarding therapies and modalities. Residents learn how to minimize complications that can occur from long hospitalizations such as DVT, contractures, pressure ulcers and deconditioning. The resident will perform a chart review, examine the patient and document their findings. The resident will then discuss the patient with the attending faculty physician and recommendations will be formulated. Throughout this rotation, the resident will be introduced to a wide variety of patients including those with spinal cord injuries, burns, amputations, multiple trauma, traumatic brain injury and stroke. A major goal of this rotation is to learn to work as a part of the team on the acute services, particularly with the trauma team.

GENERAL OBJECTIVES:

Upon completion of this experience, the resident should demonstrate advanced knowledge in the evaluation of acute care patients and determine their rehabilitation needs.

COMPETENCY BASED SPECIFIC GOALS AND OBJECTIVES:

Patient Care

Residents are expected to:

- Obtain essential and accurate information and present it in a concise but thorough format
- Perform a rehabilitation medicine focused consultation history and physical which reflects the patient’s abilities and inabilities
- Generate a focused problem list
- Determine appropriate rehabilitation services for patients and assist in placement to inpatient rehabilitation, skilled nursing facilities, long term acute care centers, home health care, or hospice care
- Expeditiously facilitate patient transfers from acute hospitalizations to other settings
- Prevent long-term complications from immobility and improve recovery in acutely hospitalized patients
- Accurately define short and long term goals for their patients
- Incorporate pertinent medical issues in their therapy orders in order to precisely define patient precautions
- Select appropriate orthotics, prosthetics, and durable medical equipment for acutely hospitalized patients
- Identify which acutely ill hospitalized patients should not participate in therapy
- Recognize how pain may limit participation in therapy and provide recommendations to the primary team on how to control pain during therapies
Understand when therapies are not medically necessary for a patient

Medical Knowledge

Residents are expected to:

- Follow the acute management and rehabilitation needs of patients with spinal cord injury, cancer, organ transplant, amputations, stroke, multiple trauma, brain injury, and general disability from acute medical illnesses
- Outline prognosis for right vs. left CVA, hemorrhagic vs. embolic stroke, and include various factors such as age and comorbidities which may affect outcome
- Discuss the physiologic changes associated with acute traumatic brain injury and spinal cord injury
- Discuss the diagnosis and prognosis of traumatic brain injury using variables such as extent of injury, Glasgow coma scale, trauma scores, age, premorbid function, and somatosensory evoked potentials
- Classify brain injured patients according to the Rancho Los Amigos Medical Center Levels of Cognitive functioning
- Design a treatment plan to assist the primary team in managing the agitated brain injured patient
- Discuss the diagnosis, prognosis, and treatment of pain in the acute spinal cord injured patient
- Perform a comprehensive neuromuscular and ASIA exam on selected patients
- Design a plan for the neurogenic bladder and bowel in the acute care setting
- Discuss standard amputation indications and post operative management including transfemoral, transtibial and Symes
- Distinguish between dementia and delirium; describe the reversible causes of delirium
- Identify five common comorbid diagnoses of geriatric patients and describe their impact on rehabilitation
- Demonstrate understanding of the mechanisms of the following complications of immobility in a patient in the acute hospital setting and outcome strategies for prevention and management:
  - Pressure ulcers
  - Deep venous thrombosis
  - Contracture
    - Malnutrition
    - Constipation
    - Pneumonia/Atelectasis
    - Heterotopic Ossification
    - Urinary tract infection
    - Hypercalcemia
- Understand the estimation of burn depth and body surface area
techniques to avoid these

- Discuss types of hip fractures, possible complications, fixation and arthroplasty alternatives and mortality
- Assess cardiovascular and pulmonary systems for effects on impairment and disability
- Identify contraindications or precautions for exercise in patients with cardiac or pulmonary conditions
- Formulate a rehabilitation plan for patients with poor endurance
- Identify risk factors for aspiration

Practice-Based Learning and Improvement

Residents are expected to:

- Assess appropriateness of diagnostic testing and how it affects patient treatment, outcomes, and overall patient management in today’s health care environment
- Use information technology to access and manage patient information and support their own education and treatment decisions
- Evaluate and improve patient care practices using information technology, practical clinical experience, and evidence-based medicine
- Coordinate rehabilitation with the needs and concerns of the primary physician
- Facilitate learning by students, fellows, allied health professionals, and the rehabilitation team

Interpersonal and Communication Skills

Residents are expected to:

- Communicate effectively with the patient, the patient’s family, and other health care services regarding rehabilitation diagnosis, treatment plans, prognosis, and patient management issues
- Demonstrate sound clinical judgment in patient management and respond to patients and their families in a compassionate and respectful way
- Counsel patients and their families on the goals of inpatient rehabilitation. Know when to ask for formal psychological support.
- Participate in rounds and discussions
- Utilize effective listening skills

Professionalism

Residents are expected to:
Describe the common contractures that develop after burns and the appropriate
Maintain a strong personal integrity and responsibility to the patient and other disciplines with whom they are involved
Be sensitive to the cultural differences of their patients and the health care team
Be a strong patient advocate and assist them with their interactions with other health care systems in order to yield maximum patient and health care benefit
Be on time to lectures and rounds
Accept responsibility for their actions and decisions
Apply sound ethical principles in practice including patient confidentiality, informed consent, and provisions of withholding care
Follow the institutional policies such as clinical industry interactions, conflict of interest, and infection control
Assist with the administrative functions of the rotation and monitor work flow
Function as a team leader for more junior residents
Assist with coverage for resident vacations

Systems – Based Practice
Residents are expected to:
Understand how complex social issues and limited resources can affect the patient’s rehabilitation and outcome
Assess benefit, risk, and resource allocation when making prescription and test recommendations
Advocate for patients who need tests and treatments that might be inappropriately denied
Learn Medicare/Medicaid requirements for documentation (elements of the history, review of systems, physical exam, billing, and procedure codes)
Learn how Medicare/Medicaid determines physician reimbursement for inpatient consults
Understand the role of an Inpatient medical director
Describe the contraindications set by various hospitals to exclude patients from acute inpatient rehabilitation
Understand the difference between for-profit and not-for-profit Rehabilitation facilities
Location: Interim LSU Public Hospital Clinic – New Orleans
Attending: Stephen Kishner, M.D., Dr Harry J. Gould, III, M.D., PhD.

General Description:

This is a one month rotation for PGY 2 - 4 residents working as a team at the Interim LSU Public Hospital outpatient Clinic, New Orleans, LA. ILSUPH is a member of the LSU Health Care Services Division. The eight member hospital system provides training and health care services to the underinsured population of the state of Louisiana. In this rotation the resident should strive to achieve an intermediate to advanced knowledge of the management of neuromusculoskeletal disorders, electrodiagnostic testing and pain management disorders. The weekly clinic schedule is as follows:

Monday – PM & R clinic 8 -1 / EMG clinic 1-5

Tuesday – EMG clinic 8 -1 / Pain clinic 1 -5 (residents work under the supervision of the pain fellow and Dr. Gould

Wednesday – Pain clinic all day - (residents work under the supervision of the Pain Fellow and Dr. Gould

Thursday – PM & R clinic 8 – 1 / EMG clinic 1 -5

Friday – Pain Medicine Conference 8 -10 / PM & R lecture series 12 – 5

GOALS AND OBJECTIVES: Patient Care:

The resident is expected to:

- Develop a differential diagnosis for common problems including pain in the wrists, elbows, shoulders, hips, knees, ankle, foot, and spine based on the results of the history and physical
- Evaluate and manage patients with common musculoskeletal problems in an outpatient clinic
- Learn to assess how pain has had an impact on someone’s life and determine treatment recommendations through a comprehensive pain management team approach, which includes:
  - Psychological interview and treatment
  - Physiatric evaluation
LSU PM & R – PM & R / Pain Medicine and Electrodiagnostic Medicine Outpatient Clinic Rotation – PGY1-2

- Vocational evaluation
- Physical capacity evaluation
- Work hardening
- Inclusion of family and workplace issues

☐ Perform brief neurologic and physical examinations prior to EMG testing
☐ Demonstrate skills necessary to maximize rehabilitation health care outcomes for pain conditions
☐ Demonstrate the ability to evaluate and manage musculoskeletal pain syndromes as well as neuromuscular disorders
☐ Perform a comprehensive electrodiagnostic evaluation of each patient and to provide a concise diagnosis and plan for further treatment
☐ Describe a variety of conditions frequently encountered in electrodiagnostic medicine
☐ Develop an extensive knowledge base of neuromuscular anatomy
☐ Familiarize oneself with the EMG/NCS machine and be able to troubleshoot common errors and problems encountered in EMG/NCS testing
☐ Obtain appropriate informed consent for the procedures
☐ Describe the variety of conditions frequently encountered in electrodiagnostic medicine
☐ Determine a logical approach of testing for each individual condition

Medical Knowledge:

The resident is expected to:

☐ Define the components of the motor unit
☐ Draw the Brachial Plexus, including the terminal nerves
☐ List the nerve root level and peripheral nerve innervation of upper and lower extremity muscles
☐ Describe the nerve root and peripheral nerve innervation of the skin in both the upper and lower extremity
☐ Describe the response of the peripheral nervous system to injury
☐ Describe the purpose of the EMG/NCV recording device
☐ Identify the relative contraindications to electrodiagnosis
☐ Identify the complications of electrodiagnosis
☐ List the components of the EMG machine and their purpose
☐ Discuss the concept of differential amplification and the purpose of G1 and G2 electrodes
☐ Define sensitivity and gain
☐ List at least three ways to reduce stimulus artifact
Discuss the effects of inadequate or excessive stimulus intensity
Demonstrate the proper placement of recording, reference and ground electrodes
proper stimulation sites; measure the latencies and calculate conduction velocities
State the various physiological factors, which can influence the electrodiagnostic results, e.g., age, body
temperature, volume conduction, electrical interferences, and measurement error
Memorize normal values for distal latencies evoked response amplitudes and conduction velocities of
different nerves
Measure sensory latencies and amplitudes of median, ulnar, radial, superficial peroneal, dorsal ulnar
cutaneous nerve, and medial antebrachial cutaneous nerves.
Measure motor latencies, amplitude and conduction velocities of median, ulnar, radial, peroneal, tibial
nerves, and musculocutaneous nerves
Distinguish between the late responses (H, F, A) waves, their etiology and clinical significance
Demonstrate the ability to perform H reflex and F wave studies and interpret the results.
Differentiate between axon loss and conduction block
Demonstrate the ability to perform and diagnose upper and lower extremity nerve entrapments and
radiculopathies
Differentiate axonal versus demyelinating type of peripheral neuropathies
Demonstrate the ability to diagnose neuropraxia versus axonotmetic and neurotmetic nerve lesion in
mononeuropathies
Analyze a normal motor unit potential’s morphology (shape, size, and phases) and recruitment pattern on
needle EMG exam
Define the diagnostic significance of these potentials: miniature endplate potentials, end plate
potentials, fibrillations, positive waves, fasciculations, myotonia, myokymia, complex repetitive
discharges
Explain the reason why fibrillations and positive sharp waves are commonly seen in myopathy
Describe typical electromyographic findings in muscle disease
Describe the electromyographic findings in neuropraxia, axonotmesis, and neuronotmesis
Know key muscles for cervical and lumbar radiculopathy

Practice-Based Learning and Improvement
The resident is expected to:
Utilize the library and Internet to perform literature searches upon which to base their treatment of
patients
Develop skills to apply knowledge of study designs and statistical methods to appraisal of clinical studies
Review the literature for electrodiagnostic medicine “Best Practices” for neuromuscular disorders
Disseminate these “Best Practices” to patients, consultants, and staff

Interpersonal and Communication Skills
The resident is expected to:
* Interact with patients in a sensitive manner
Demonstrate effective listening skills
Communicate on a given patient’s intellectual/educational level
Produce concise, accurate documentation of the consultation, electrodiagnostic findings, and complete all
chart notes in a timely manner
Promote respect, dignity, and compassion for patients
Accept responsibility for their own actions and decisions
Professionalism
The resident is expected to:
- Demonstrate sensitivity and responsiveness to age, culture, disability and gender of patients and colleagues.
- Consider effects of personal, social and cultural factors in the disease process and patient management.
- Demonstrate reliability, punctuality, integrity and honesty in all interactions with patients and colleagues.
- Accept personal responsibility for own actions & decisions.
- Apply sound ethical principles in practice (e.g., informed consent, confidentiality, veracity, provision or withholding of care).

System Based Practice
The resident is expected to:
- Appreciate when electrodiagnostic medicine procedures are most appropriately rendered to maximize information gain and patient outcome.
- Appreciate when electrodiagnostic medicine procedures are not cost-effective for the patient and health care system.
- Understand where electrodiagnostic medicine testing “fits” in the continuum-of-care for persons with neurologic disorders.
- Recognize drug formulary and treatment limitations imposed by some health insurance plans.
- Become aware of public and private support organizations for persons with musculoskeletal disorders.
- Develop the concept of how a well run outpatient practice clinic should function.
The residents work with Dr. Saucier who is Chairman of the PM&R Department at Ochsner, as well as other PM&R physicians at Ochsner. Areas of knowledge to be acquired are related to the patient base. Typically, this includes orthopedic rehabilitation (e.g. amputees, arthritis, joint replacements, fractures), as well as neurological conditions (e.g. stroke, brain injury, neuromuscular disorders, myelopathy).

This rotation should also help the resident understand many of the administrative aspects of managing inpatient rehabilitation admissions including the Health Care Finance Administrations rules on inpatient rehabilitation for Medicare patients. Residents work closely with nursing, physical therapy, occupational therapy, speech therapy, recreation therapy, social work, and vocational rehabilitation. Also, the residents learn how to communicate effectively with the patient’s family members, as family conferences are held to clarify medical and psychosocial issues prior to discharge.

General Objectives:
Upon completion of the experiences in this rotation, the resident will be able to demonstrate proficiency in managing an inpatient rehabilitation unit and to be the “team leader” for the many members of the inpatient rehabilitation team.

Upon completion of this residency experience, the resident will be able to demonstrate competency in obtaining a thorough physiatric history, perform a comprehensive PM&R physical exam for orthopedic rehabilitation patients, including total joint replacements and post-fracture patients, as well as stroke rehabilitation patients and apply this evaluation to formulate and direct an interdisciplinary rehabilitation program.

Upon completion, the resident will be able to access and manage the major potential medical complications that commonly arise on a rehabilitation unit.

Competency Specific Goals and Objectives

Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Residents are expected to:

☐ communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
 Residents must demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate knowledge of the basic and clinical sciences supporting current treatment strategies for common rehabilitation diagnoses, including Spinal Cord Injury, Traumatic Brain Injury, stroke, cardiopulmonary compromise, amputation, and major trauma
- demonstrate understanding of physiology and pathophysiology as they pertain to their patients and how this will effect treatment
- demonstrate understanding of elements of complete physiatric assessment and how these contribute to generation of an overall plan for patient treatment

Interpersonal and communication skills

Residents must be able to demonstrate interpersonal and communication skills that results in effective information exchange and teaming with patients, their patient families, and professional associates. Residents are expected to:

- create and sustain therapeutic and ethically sound relationships with patients
- facilitate communication among the various disciplines involved in patient care, acting as liaison and leader
- demonstrate ability to document current assessment, patient progress, and treatment plan effectively in the medical record (including computer system)
- work effectively with others as a member or leader of a health care team or other professional group
Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Residents are expected to:

☐ demonstrate respect, compassion, and integrity in dealing with patients, families, and staff
☐ demonstrate ethical behavior with respect to patient privacy, confidentiality, informed consent, and patient participation in generation of treatment plan
☐ demonstrate sensitivity to a patient’s culture, ethnicity, gender, age, and impairment/disability

present themselves in professional manner with respect to appearance and behavior

Practice-based learning and improvement

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Residents are expected to:

☐ locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
☐ apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
☐ participate in weekly rounds, presenting materials for recent literature on the management and research related to diagnoses related to those found in the current patient population

Systems-based practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Residents are expected to:

☐ demonstrate knowledge/understanding of health care issues affecting the care and decision-making as they pertain to their patients
☐ know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
☐ practice cost-effective health care and resource allocation that does not compromise quality of care
☐ advocate for quality of patient care
☐ work effectively with case managers to bring about the most appropriate long term treatment plan for patients
Location: Ochsner Clinic Foundation Hospital – Baptist Center  
Attendings: Hazem Eissa, M.D., Eric Royster, M.D., Ali Khan, M.D.

General Description: This is a 2 month long rotation with generally one resident (PGY1-4) and one Pain Fellow assigned together with the Pain fellow supervising the junior resident along with the attending. This rotation combines outpatient pain management with fluoroscopic-guided injection techniques. Residents learn a thorough history and physical, including range of motion, sensation, strength and gait. They also learn the indications for specialized testing such as EMG, MRI, CT scans, bone scans and discography. A major goal of this rotation is the performance of techniques such as epidural steroid injections, sympathetic blocks, and EMG-guided botox injections, Hyalgan injections using fluoroscopy, joint injections, and other advanced techniques. Residents will learn how to appropriately select patients for such injections, and perform appropriate follow-up exams and post-intervention management for the patients. Residents will also learn how to integrate medication management with therapeutic techniques and interventional pain procedures.

GOALS AND OBJECTIVES:  
Patient Care  
Residents are expected to:
- Perform a focused PM&R related History and Physical exam for patients with chronic pain, with special attention to the musculoskeletal and nervous systems
- Elicit information using effective questioning and listening skills
- Diagnose physical, cognitive, and psychosocial impairments in patients with acute and chronic pain
- Demonstrate a differential diagnosis appropriate to the physical findings
- Demonstrate caring, compassion, and respectful behaviors (verbal and non-verbal) towards patients with chronic and often incurable pain
- Learn what tests are appropriate in patients who complain of pain, based upon the differential diagnosis
- Learn to interpret the findings of the ordered tests
- Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians
- Integrate the findings to recommend rehabilitation treatment based upon the examination findings
- Outline the typical management of an acute and chronic pain patient and be aware of the different approaches and differing concerns for each

Residents are expected to become proficient in:
- Demonstrating competency skills in conducting and administering diagnostic and therapeutic injections procedures
- Demonstrating performance skills specifically for epidural steroid, facet, SI, bicipital tendon, intra-articular glenohumeral, carpal tunnel and subacromial injections
- Understanding, recognizing, assessing and managing secondary problems of pain patients

Medical Knowledge  
Residents are expected to:
- Define the term “pain” according to the IASP Pain classification system
- Learn the physiology and basic science behind pain syndromes
Understand the theories behind common pain generators and their implication on management
Learn the difference between neuropathic pain and nociceptive pain and be able to describe the mechanisms

Discuss the modalities available to treat musculoskeletal pain. Discuss the mechanism of action, indications, and contraindications for each. (e.g., TENS, hot/cold modalities such as ultrasound, diathermy, icing)
Be able to define and understand the difference between management, as well as clinical implications, of acute and chronic pain syndromes
Discuss fibromyalgia, its diagnosis, and management
Understand the concept and principles of Failed Back Syndrome
Describe the common psychosocial consequences of chronic pain

Residents should know:

Anatomy as it relates to regional anesthesia and main nerve blocks:

- Autonomic: stellate, celiac, lumbar sympathetic
- Head and neck: cervical plexus
- Extremities: brachial plexus, ulnar, radial, median, sciatic, femoral, lateral femoral cutaneous, obturator, ilioinguinal, lumbar plexus
- Trunk – intercostals, paravertebral somatic
- Spine – epidural, caudal, intrathecal

Procedures, methods, and techniques for regional anesthesia and main nerve blocks

- Peripheral and autonomic nerve blocks – indications, contraindications, techniques, clinical assessment, complications
  - IV regional – mechanism, agents, indications, contraindications, techniques, complications

Painful disease states and their management
Types of pain – cutaneous, deep somatic, visceral, central
Specific pain syndromes – sympathetic dystrophy, phantom limb, low back pain, intractable cancer pain, causalgia, post-herpetic neuralgia, trigger points, fibromyalgia

Treatment
Drugs – analgesics, sedatives, stimulants, anticonvulsants, antidepressants, corticosteroids, capsaicin
Nerve block, epidural steroid injections
Others – transcutaneous nerve stimulation, acupuncture, spinal cord stimulators and pumps
Surgical and chemical neurolysis

Practice-Based Learning and Improvement

Residents are expected to:
Critically review and analyze appropriate literature regarding pain management and pain management techniques.

Be familiar with the literature on interventional pain management techniques.

Become proficient with the use of the hospital’s computer system in order to obtain medical records, lab results, imaging study results, and other ancillary notes.

Prepare lectures for the didactic lecture series to further enhance PM&R knowledge.

Educate and supervise junior residents, rotators and medical students who are spending time on the rotation.

Evaluate their own exam skills and pain medicine knowledge and incorporate feedback from others.

Use information technology (computers, journals, etc.) to access and manage patient information in order to support the resident’s education and treatment decisions.

Contribute their findings to discussions on the care of the patient with other healthcare professionals.

Attend and participate in conferences and rounds in order to facilitate such discussions.

Investigate the outcomes of pain management treatments.

**Interpersonal & Communication Skills**

Residents are expected to:

- Establish trust and maintain rapport with patients and family.
- Explain basic pain management techniques to patients and families.
- Educate patients and families about possible risks, complications, and benefits associated with pain management techniques.
- Identify techniques in interacting with the patient with pain complaints who exhibits non-compliance with the prescribed therapeutic plan and/or has a history of substance abuse.
- Appropriately convey medical and prognostic information to the patient, the patient's family and allied health staff.
- Write reports with a clear diagnosis and plan.
- Complete all chart notes and dictations in a timely manner.
- Develop effective presentation and listening skills.
- Develop appropriate communication skills when working with medical/surgical consultants from other specialties.
- Develop skills in team management and leadership while working with the team members caring for the patient with pain.
- Work as a part of the referral development team to enhance the efficiency of the admission process.
- Identify and overcome obstacles to effective communication and care with the elderly pain patient.
- Identify and overcome obstacles to effective communication and care for non-English speaking patients and patients of differing cultures.

**Professionalism**

Residents are expected to:

- Promote respect, dignity, and compassion for patients.
- Demonstrate a commitment to ethical principles and confidentiality of patient information by understanding and adherence to HIPPA regulations.
- Demonstrate reliability and punctuality by being on time for clinic and lectures.
- Dress and behave in a highly professional manner at all times in the clinic.
Demonstrate the ability to interact well with attendings, other residents, nurses and other administrative and technical support personnel.
Accept responsibility for their own actions and decisions

**Systems-Based Practice**
Residents are expected to:

Outline a program of non-surgical rehabilitation management for chronic low back pain that incorporates system resources such as case management and vocational rehabilitation
Learn when to refer to a multi-disciplinary pain management clinic, the costs and settings of such treatment, and what the outcomes might be
Describe the components of a pain contract and the requirements for success in a large system of care
Be familiar with referral options to specialists for more complex patients with pain
Discuss the requirements for Pain Medicine Certification
Understand what physicians are involved in the treatment of pain and what their role is
Understand management limitations and when to request appropriate medical/surgical consultations from other specialties
Advocate for patients who need tests and treatments that might be inappropriately denied
Advocate for all patients equally within the healthcare system
Recognize medical/legal issues with regards to prescribing chronic narcotics
Integrate care of patients across hospital and community settings
Learn when tests and pain procedures are appropriate or may be under- or over- utilized
Understand the cost of the treatments and diagnostic tests that are ordered
Understand documentation requirements and learn how to complete insurance paperwork
General Description:
This is a one-month rotation for senior residents at the Ochsner Heart and Vascular Institute in Metairie to provide clinical exposure to a comprehensive cardiac rehabilitation unit. Residents rotate along with Cardiology Fellows from Ochsner and will be formally taught how to assess patients for cardiac rehabilitation, enact and monitor cardiac rehab and write exercise prescriptions. Residents will also learn to educate patients regarding secondary or primary prevention. The Cardiovascular Health Center’s cardiac rehabilitation program is nationally accredited and focuses on exercise and education as the foundation for improved health.

GOALS AND OBJECTIVES:

Patient Care:
Competency: Provides compassionate, appropriate, and effective health care.
1) Gathers essential and accurate information about the patient through interviews, examination, and complete history and by appropriately accessing adjunctive sources of information to this obtained from the patient and/or family members.
2) Makes informed diagnostic and therapeutic decisions based on patient information, current scientific evidence, clinical judgment, and patient preference.
3) Carries out patient management plans based on age, diagnosis and psychosocial issues, including, but not limited to, management of patients with ischemic heart disease, congestive heart failure, valvular heart disease, and disorders of cardiac rhythm.
4) Demonstrates the clinical skills necessary to safely perform and select patients for cardiac rehabilitation.

Medical Knowledge:
Competency: Demonstrates knowledge of concepts involved in patient selection for rehabilitation, contraindications to rehabilitation, stepwise phases of rehabilitation, and writing an exercise prescription.
1) List the indications and contraindications for cardiac rehabilitation.
2) Demonstrate knowledge of the phases of cardiac rehabilitation.
3) Demonstrate knowledge of how to write an exercise prescription.

Practice Based Learning:
Competency: Evaluates each new patient individually and addresses new problems/questions encountered through assimilation of scientific evidence as part of improving care practices.
1) Uses feedback to identify areas for improvement.
2) Seeks opportunities to strengthen deficits in knowledge/skills.
3) Demonstrates initiative in researching current scientific evidence and applying it to problems encountered during daily practice.
Interpersonal and Communication Skills:
Competency: Demonstrates interpersonal and communication skills that result in effective information exchange with patients, their families and professional associates.
1) Communicate effectively with other members of a multi-disciplinary team, working effectively with others as a leader of the health care team, member or consultant.
2) Maintains comprehensive, timely and legible medical record demonstration and correspondence related to patient care activities.
3) Provides accurate and timely feedback to referring physician.
4) Actively listens and elicits appropriate information from the patient and/or family members and colleagues.

Professionalism:
Competency: Demonstrate commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.
1) Recognizes ethical dilemmas and utilizes / seeks out appropriate consultation where needed.
2) Obtains informed consent from patient and/or family member/legal guardian.
3) Adheres to the laws and rules governing the confidentiality of patient information.
4) Engages in ethical business practices and adheres to the institution’s Code of Conduct.

Systems Based Practice:
Competency: Demonstrate awareness and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
1) Understands, accesses, utilizes and evaluates effectiveness of resource providers, and systems to provide optimal cardiac rehabilitation therapy.
2) Understands different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
3) Practices quality, cost-effective health care.
4) Advocates and facilitates patient advancement through the health care system.
General Description:
This is a rotation for the PGY3 or PGY4 resident for a pediatric rehabilitation experience at the Gilda Trautman Newman Rehabilitation Center at Children’s Hospital in New Orleans. The Gilda Trautman Newman Rehabilitation Center at Children’s Hospital provides comprehensive interdisciplinary, team-oriented, family-centered inpatient services to patients from birth through 21 years. Accredited by the Commission of Accreditation of Rehabilitation Facilities (CARF), the unit specializes in treating patients with brain injury, cerebral palsy, developmental disability, feeding disorder, limb deficiency, myelodysplasia, neuromuscular disease, rheumatic disease, seizure disorder, spinal cord injury, stroke, ventilator dependence, and other congenital or acquired disabling disorders.

During this rotation the resident will follow and participate in the care of both inpatients and outpatients under the supervision of Dr. Tilton. During this rotation the resident will attend and participate in a variety of rehabilitation specialty outpatient clinics, including extensive experience in chemodenervation for spasticity.

GOALS AND OBJECTIVES:

Patient Care

Residents are expected to:
* Perform a comprehensive physiatric physical examination on infants and young children adapted to the child’s varying degree of ability to cooperate and follow commands.
* Demonstrate performance of an age-appropriate neurological examination including techniques for the assessment of motor strength, coordination, balance, mobility, tone, cognition and speech.
* Develop an interdisciplinary rehabilitation program to maximize a child’s function and incorporates family and school environment.
* Generate a comprehensive problem list.
* Define short and long term goals for pediatric patients.
* Demonstrate proficiency in the performance of an age-appropriate developmental examination of a child.
* Assess swallow and suck in small infants.
* Understand principles of neurotoxin therapy in pediatric patients with spastic hypertonia.
* Counsel parents on prognosis following an acute brain or spinal cord injury.

Medical Knowledge

Residents are expected to:
* Identify treatment goals for inpatient pediatric rehabilitation admission.
* Describe the pathophysiology and principles of medical treatment for the major pediatric rheumatologic disorders.
* Describe the ASIA scale and be able to apply it given patient data.
* Demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and how to apply this knowledge to direct patient care.
* Demonstrate knowledge of the pathophysiology, biochemistry, genetics and clinical presentation of the patient’s neurological disease.
* Recognize and interpret abnormal neurological findings.
* Demonstrate the ability to present medical knowledge background for each case to the attending physician by correctly utilizing medical references, journal articles and information technology.

Practice-Based Learning and Improvement:

Residents are expected to:
* Use information technology (computers, journals, etc.) to access and manage patient information and support their own education and treatment decisions.
* Review the literature for “Best Practices” in the above areas of Medical Knowledge and Patient Care.
* Contribute their findings to discussions on the care of the patient.

Interpersonal and Communication Skills

Residents are expected to:
• Establish trust and maintain rapport with patients and family.
• Complete all chart notes and dictations in a timely manner.
• Present material clearly and accurately to patients and family.
• Effectively communicate verbally and in writing patient needs to all staff and referring physicians involved with the patient.
• Utilize effective listening skills.
• Participate in rounds and discussions.
• Present findings clearly and concisely to supervising faculty so management can be discussed.
• Demonstrate appropriate interpersonal skills, compassion, and leadership skills in the patient care conference and multidisciplinary team conference.
• Discuss issues such as prognosis, and address return to home issues with families and patients.
• Complete medical records in a timely manner.
• Develop effective listening skills.

Professionalism

Residents are expected to:
* Promote respect, dignity, and compassion for patients
* Demonstrate a commitment to ethical principles and confidentiality of patient information by understanding and adherence to HIPPA regulations
* Demonstrate reliability and punctuality by being on time for clinic and lectures
* Dress and behave in a highly professional manner at all times in the clinic
*Demonstrate the ability to interact well with attendings, other residents, students, nurses and other administrative and technical support personnel.

*Accept responsibility for their own actions and decisions

**System-Based Practice**

Residents are expected to:

• Demonstrate patient advocacy, yet showing the ability to recognize situations in which progress is no longer occurring and problem solving these situations.
• Assess how their decisions affect others – patients, family, and other health care professionals.
• Integrate care of patients across hospital and community settings.
• Learn when tests are appropriate or may be under-or over-utilized.
• Recognize requirements as they relate to documentation, elements of the exam, and billing procedures and codes.
• Describe the factors involved in the decisions on length of stay, disposition, and insurance coverage.
• Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.
General Description: This is a 1 month rotation with generally one resident (PGY1-2) assigned at a time. This rotation occurs in an outpatient setting. The resident will understand the anatomy and physiology of the musculoskeletal system relevant to the practice of orthopedic and sports medicine. The resident will learn the physiology of exercise and the adaptation of the body to exercise in adolescents, and children. The resident will understand the role of nutrition and supplements in sports and their role in enhancing performance. The resident will understand the function of pre-participation exam and learn to appropriately screen individuals prior to exercise. The resident will recognize the common sports injuries seen in athletes and the appropriate treatments. The resident will recognize the common medical problems seen in athletes and understand the appropriate evaluation and treatment.

GOALS AND OBJECTIVES

Patient Care

Become proficient in the evaluation and treatment of patients with sports injuries in the clinic including application of physical examination tests specific to the diagnosis.
Become highly proficient in the evaluation and treatment of injured athletes
Be able to examine the injured extremity with a high level of sophistication and detail to determine any bony or ligamentous injury, tendon injury, nerve injury, or arterial injury of the extremity.
Be able to perform a detailed clinical examination of the shoulder, elbow, knee and ankle.
Be able to order appropriate diagnostic tests and imaging studies to assist with diagnosis and accurate assessment of the level/severity of the injury.
Be able to interpret diagnostic test and imaging studies (Xrays, CT scan, MRI) to assist with diagnosis and accurate assessment of the level/severity.
Be able to perform arthrocentesis/ injections of the knee and shoulder.
Be comfortable with the diagnosis and treatment of complex knee problems such as multiple ligament injuries, recurrent patellar instability and/or degeneration, articular cartilage lesions and degenerative meniscal tears.
Be able to differentiate complex problems of the shoulder such as instability vs. impingement in the throwing athlete, rotator cuff tears, labral tears, shoulder subluxation, osteolysis of the distal clavicle, and scapulothoracic bursitis.
Be able to determine the diagnosis and treatment of complex problems of the ankle, such as post-traumatic impingement syndrome, osteochondral injuries and chronic instability.
Have an understanding of post-operative rehabilitation guidelines and restrictions for knee ligament reconstructions and repairs, rotator cuff repairs and shoulder instability reconstructions should be achieved.

Medical Knowledge
The resident will list the common symptoms, physical findings, diagnostic methods, and management of the following *acute injuries*:

- a. Rotator cuff tear
- b. Glenohumeral dislocation
- c. Acromioclavicular separation
- d. Clavicle fracture
- e. Navicular fracture
- f. Ankle sprain
- g. ACL tear
- h. MCL sprain
- i. Meniscal tear
- j. 5th metatarsal fracture

The resident will list the common symptoms, physical findings, diagnostic methods, and management (including physical therapy) of the following *chronic conditions*:

- a. Dequervain’s tenosynovitis
- b. Rotator cuff tendinitis
- c. Lateral epicondylitis
- d. Carpal tunnel syndrome
- e. Biceps tendinitis
- f. Iliotibial band syndrome
- g. Patellofemoral Stress Syndrome (PFSS)
- h. Patella tendinitis
- i. Plantar fascitis
- j. Achilles tendinitis

The resident will list the most common abnormalities discovered during the pre-participation physical of a high school athlete.
The resident will recite a classification of concussion injuries and discuss the proper return to play after a concussion.
The resident will define the role of carbohydrates, fats, and protein as energy sources for exercising persons.

**Practice-Based Learning and Improvement**

Frequent, yet focused, use of available printed textbooks, online textbooks, and Medline sources for application to specific patients. The goal is to demonstrate the ability to locate and interpret scientific studies and known medical knowledge into an appropriate knowledge base that will be of direct benefit to patients.

Use of appropriate sources (e.g. textbook, selected articles from the literature, etc.) to obtain more detailed information about a specific patient or diagnosis, based on his/her experiences on this rotation.

Demonstrate expertise in use of available information technology and hospital information systems to manage patient data (e.g. lab tests, imaging tests, etc.) and access online information that will be of direct benefit to his/her own education.

Integrate feedback from faculty to ensure that the resident is able to analyze his/her own practice experience, with the goal of improving future patient care.
Interpersonal and Communication Skills

Demonstrate the ability to interact effectively, professionally, and empathetically with patients and family members.
Demonstrate the ability to provide appropriate and detailed information to patients and family members, when appropriate.
Demonstrate the ability to develop an appropriate relationship with a patient that fosters communication, respect, and ethics of the highest degree.
Demonstrate the ability to recognize important cultural and generational differences that may affect patient care, and to apply appropriate changes in approach to these patients that respect these important differences.
Demonstrate effective listening and communication skills with patients, which may include both verbal and non-verbal skills.
Demonstrate ability to understand and respond appropriately to patient inquiries.

The resident will counsel a patient who has suffered a musculoskeletal injury in the following areas:
- Physical Management of the injury (non-surgical vs. surgical, rehab)
- Psychological effects of the injury

Professionalism

Demonstrate a strict adherence to medical/ethical principles.
Demonstrate a keen sensitivity to the differences and challenges that a diverse patient population may present.
Treat all patients with respect, empathy, and with compassionate care. All patient inquiries and requests will be considered seriously, professionally, and in a timely manner.
Recognize the important social, economic, emotional, and work-related implications that a Sports Medicine problem or injury may represent for the patient.
Maintain patient confidentiality, including strict adherence to HIPPA guidelines.
Obtain informed consent from patients in accordance with established guidelines that ensure full patient comprehension after a detailed discussion of all pertinent issues relating to patient care.
Demonstrate the ability to accommodate and adapt to differences in patients' culture, age, gender and disabilities.

Systems-Based Practice

The resident will demonstrate an awareness of the surgical vs. non-surgical approaches to musculoskeletal injuries.
The resident will demonstrate competency on knowing when to refer a musculoskeletal injury to a specialist.
Demonstrate an ability to effectively utilize hospital resources in a way that directly benefits patient care.
Develop a more detailed understanding of the differences in different payer types, such as worker's compensation, managed care, HMO, PPO, Medicare, Medicaid, and student health
insurance plans.
Develop an understanding of the necessity to provide efficient and cost-effective health care in the context of appropriate use of limited medical resources, yet without sacrificing quality of care.
Act as a patient advocate and assist patients in obtaining the necessary care, including coordination of post-discharge care if necessary (e.g. home health care, postoperative physical therapy, placement into appropriate rehabilitation facility, etc.).
General Description:
This is a part of a one-month rotation. In this senior level rotation, a detailed and advanced knowledge of orthotic and prosthetic prescription involving upper and lower extremities is expected. The resident works closely with the orthotists and prosthetists at Bayou Orthotics & Prosthetics. Experience can also be gained at the VA clinics and at Ochsner clinic. At all these venues, a team approach is emphasized. This approach provides for the inclusion of the prosthetist, the orthotist, the therapist, and the physiatrist working together to generate the proper prescription. Advanced knowledge of the kinematics of gait, biomechanics and fabrication materials is required.

GENERAL OBJECTIVES:

Upon completion of this experience, the resident should demonstrate advanced knowledge in the rehabilitation of burn patients, as well as the role of the surgeons and other providers in the burn team.

COMPETENCY BASED SPECIFIC GOALS AND OBJECTIVES:

Patient Care
Residents must be able to provide patient treatment that is effective, appropriate, and compassionate.

Residents are expected to:

☐ Counsel and educate patients and their families effectively, demonstrating caring and respectful behaviors.
☐ Gather essential, accurate, and detailed information about their patients including radiological tests as appropriate, with particular emphasis on the patients’ functional abilities, impairments, and disabilities.
☐ Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
☐ Develop and carry out patient management plans.
☐ Use information technology to support patient care decisions and patient education.
☐ Perform competently all medical and invasive procedures considered essential for the area of practice.
☐ Provide health care services aimed at preventing health problems or maintaining health.
☐ Collaborate with allied health care professionals, in oral and written format, to provide maximum patient care.
☐ Demonstrate proficiency in completing a history and focal musculoskeletal examination as appropriate.
☐ Interpret radiological investigations related to the musculoskeletal system in a systematic manner.
- Demonstrate the technique of diagnostic and therapeutic intra-articular and soft tissue injections and aspirations.
- Perform a focused PM&R related History and Physical exam for patients with amputation and dysvascular disease, detailing skin or residual limb status and neurological issues which will affect the prosthesis prescription.
- Prescribe adult and pediatric prosthetics and therapy with appropriate activity restrictions and precautions. This would include complete prosthetic prescriptions for: a young, otherwise healthy, transtibial, and transfemoral amputee and an older, dysvascular, transtibial, and transfemoral amputee
- Prescribe a pre-amputation care plan and pre-prosthetic training program
- Coordinate care with consultants (e.g., goal-directed therapy, orthotic/prosthetic prescriptions)
- Prescribe functionally and neurologically appropriate orthoses, prostheses, and durable medical equipment
- Screen patients to determine who is an appropriate candidate for a prosthetic device and the appropriate timing for prosthetic fitting
- Evaluation, identification, and management of limb deficiency / amputation
- Prescribe adult and pediatric orthoses for patients with neurological or musculoskeletal disorders
- Perform an assessment / evaluation / “check out” of an orthosis, prosthesis, wheelchair, or other durable medical equipment
- Prescribe a wheelchair / seating system for an adult and a pediatric patient with neurological or musculoskeletal disorders including hemiplegia, quadriplegia, or paraplegia
- Understand, recognize, assess, and manage the following secondary problems of amputees:
  - Phantom sensation
  - Phantom pain
  - Choking phenomenon of the distal residual limb

Medical Knowledge

Residents are expected to:

- Indicate the indications, contraindications, potential benefits, evaluation and limitations of upper extremity orthoses.
- Explain the principles of the biomechanics of upper limb functions, the abnormalities of function associated with specific diseases, the principles of upper extremity bracing, static orthoses, dynamic orthoses, fabrication and components, training, problems of gadget tolerance, and costs.
- Indicate the indications, contraindications, potential benefits, evaluation and limitations of lower extremity orthoses.
- Explain the principles of the biomechanics of lower limb functions, the abnormalities of function associated with specific diseases, the principles of lower extremity bracing,
static orthoses, dynamic orthoses, fabrication and components, training, problems of
gadget tolerance, and costs.

☐ Indicate knowledge of anatomy and biomechanics of lower extremity function and
abnormalities of function associated with specific diseases, such as hind foot problems,
mid foot problems, forefoot fractures, stress fractures, medial tibial stress syndrome, knee
pain, hip pain, back pain secondary to foot disorders.

☐ Indicate knowledge of knee orthoses to prevention of deformity, for example, genu
recurvatum = Swedish knee, extension/flexion contracture (varus/valgus), weakness and
control of motion due to ligamentous insufficiency (AC, PCL, ML instability.

☐ Show understanding of the use of continuous passive motion.

☐ Indicate the indications, contraindications, potential benefits, fabrication, evaluation and
limitations of lower extremity orthoses.

☐ Describe the use of lower extremity orthoses for paralytic problems of lower extremity,
non-paralytic joint disorders, fracture orthoses, energy requirements for ambulation with
braces, contraindications for bracing, cost of lower extremity orthoses and functional
electrical stimulation.

☐ Demonstrate an understanding of the biomechanics of the spine.

☐ Describe the indications, contraindications, effectiveness and specific types of cervical
and spinal orthotics, such as collars, corsets, belts, molded jackets, etc.

☐ Demonstrate a knowledge of wheelchair prescription where the following factors are
considered: user's age, size, weight, disability, prognosis, functional skills, preferences,
indoor/outdoor use, portability/accessibility, reliability/durability, cosmetic features,
options available, service, cost, level of acceptance (total environment).

☐ Learn to evaluate and prescribe assistive devices and technology, including: orthotics,
prosthetics, wheelchairs and positioning, ADL aids, interfaces and environmental
controls, augmentative/alternative communication, environmental accessibility, electrical
stimulation, and dynamic splinting.

☐ Discuss the epidemiology & common causes of limb amputation

☐ Discuss indications for amputation and the process of determining the amputation level,
including hip disarticulation, AKA, BKA, and Symes, and review basic aspects of pre-
and post-op surgical care.

☐ Discuss the various components of an upper extremity and lower extremity prosthesis and
the indications/contraindications for the use of each component.

☐ Explain the purpose of a removable rigid dressing.

☐ Understand and outline the steps in the fabrication of a prosthesis.

☐ Explain the benefits of early prosthetic fitting and ambulation.

☐ Discuss the timing of prosthesis for congenital and acquired pediatric amputees.

☐ Discuss the differences between a pediatric and adult amputee.

☐ Discuss ambulatory prognosis based upon level of amputation.

☐ Discuss life expectancy and causes of death after amputation.

☐ Demonstrate knowledge of the rehabilitation management of edema.

Interpersonal and communication skills
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.

Residents are expected to:

- Communicate a patient's diagnosis, diagnostic plan, and treatment plan in a manner that is easily understood by the patient and/or their family.
- Communicate with other medical staff, in oral and written format, a detailed but concise patient history, problem list, differential diagnosis, diagnostic plan and treatment plan.
- Demonstrate reliable and conscientious professional conduct in all aspects of patient care.
- Demonstrate a commitment to the application of exemplary bio-ethical standards to clinical practice.
- Create and sustain a therapeutic and ethically sound relationship with patients.
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.
- Explain basic residual limb management techniques to patients and families.
- Educate patients and families about possible complications associated with amputations (contractures, contralateral foot ulcers, etc.)
- Appropriately convey medical and prognostic information to the patient, the patient's family, and allied health staff.
- Communicate with the orthotist / prosthetist regarding appropriate orthotic / prosthetic treatment plans.
- Develop skills in team management and leadership while working with the consult team members, pediatric team members and while participating in the various team and family conferences.
- Identify and overcome obstacles to effective communication and care with the elderly rehabilitation patient.
- Identify and overcome obstacles to effective communication and care for non-English speaking patients and patients of differing cultures.

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Residents are expected to:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
- Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities lead a team conference in a manner that optimizes the contributions of each team member and coordinates their individual roles.
Demonstrate professional and courteous communication to the patient, the patient's family, referring physicians and allied health staff.

Demonstrate ability to serve non-English speaking and English speaking patients equally through the use of interpreters when needed.

Recognize cultural / ethnic diversity and how that reflects differences in prosthetic and orthotic management.

Demonstrate understanding of cultural, age, religion, and gender differences in patients

Understand and adhere to HIPPA regulations.

Demonstrate understanding of cultural, age, religion, and gender differences in pediatric and adolescent patients

Understand the ethical principles involved in managing children who have congenital disease or trauma

Demonstrate traits of reliability and punctuality

Demonstrate sensitivity to patients’ perception of disability

Practice-based learning and improvement

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Residents are expected to:

- Demonstrate a patient-centered approach to health care with emphasis on limiting disability and handicap.
- Demonstrate progress and acquisition of knowledge as a result of self-evaluation, formative feedback, clinical instruction and self-directed study.
- Demonstrate a compassionate and empathetic interest and overall understanding in all aspects of patients’ care, including gender, social, cultural, psychological, and medical health.
- Analyze practice experience and perform practice-based improvement activities using a systematic methodology
- Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- Use information technology to manage information, access on-line medical information; and support their own education
- Facilitate the learning of students and other health care professionals
- Demonstrate progressive acquisition of knowledge as a result of self-evaluation, formative feedback, clinical instruction and self-directed study.

Systems-Based Practice
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Residents are expected to:

- Understand Medicare and insurance guidelines for prosthetic prescriptions.
- Understand vocational rehabilitation services available for amputees.
- Discuss vocational outcome and issues after amputation.
- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice.
- Recognize the value of continuing medical education; reflection on practice and use of evidence based medicine in providing optimal patient care.
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
- Practice cost-effective health care and resource allocation that does not compromise quality of care.
- Advocate for quality patient care and assist patients in dealing with system complexities.
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.
LSU PM & R – PM & R Outpatient Clinic Rotation – PGY1-PGY2

Revised: January 2010

Location: Southeast Louisiana Veterans Health Care System (SLVHCS) – New Orleans

Attendings: Robert Mipro, M.D., Kiersta Kurtz-Burke, M.D.

General Description:

During this rotation, the residents learn appropriate therapeutic modalities, write therapy orders, and work on gait training programs. Extensive knowledge as to the management of acute and chronic musculoskeletal conditions is emphasized. This experience is gained in the Physical Medicine and Rehabilitation clinics that are held every day except Friday. All aspects of neurologic, musculoskeletal, and rheumatologic patient care are observed and taught during these clinics. Joint aspirations, joint injections, trigger point injections, exercise prescriptions, and long term follow up of patient conditions are also emphasized.

Residents gain experience in writing orthotic, prosthetic, and wheelchair prescriptions during this rotation. As intermediate level residents typically in their second and third year of residency are scheduled on this rotation, an intermediate understanding of this subject matter is expected. These clinics are held every other Thursday morning. Experience in the pre and post prosthetic management of amputees is also addressed during this rotation, both in the clinics noted above and during inpatient consultations.

Durable medical equipment clinics also occur every other Thursday, and appropriate management of these equipment needs is also taught. In the above durable medical, prosthetic, and orthotic clinics, the resident should review the chart and follow the patient as a consultant prior to the clinic. The resident also gains experience in management as the prosthetist, orthotist, therapist, and the physician discuss the patient as a group in the clinic setting.

The spinal cord clinic held every Friday morning affords the resident the opportunity to diagnose, treat, and follow up acute and chronic injuries. All aspects of spinal cord injury and management are taught. This includes an understanding of the epidemiology, mechanisms of injury, ASIA classification, and evaluation of stability of spinal cord injuries. The affect of injuries on the pulmonary, cardiovascular, genitourinary, gastrointestinal, and integumentary systems is also emphasized. Functional assessment and management of common complications including orthostatic hypotension, pulmonary embolism, and autonomic dysreflexia are also learning goals. Management of genitourinary problems, such as detrusor spinster dyssynergia, and gastrointestinal problems, such as constipation, are also emphasized. Integumentary issues of decubitus prevention and management are managed. Issues of the musculoskeletal and neuromusculoskeletal systems such as spasticity management, and syrinx diagnosis and treatment, are also learning objectives. Pain management issues are also addressed. In addition to normal clinic follow-up, a comprehensive “anniversary” evaluation including all aspects of spinal cord injury is performed on every patient annually.
EMG clinics are held on Monday and Tuesday afternoons. Referrals are for a wide variety of diagnoses, including peripheral neuropathy, radiculopathy, mononeuropathy, myopathy, plexopathy, ALS, and HSMN Types I and II.

GOALS AND OBJECTIVES:

Patient Care:

The resident is expected to:

- Develop a differential diagnosis for common problems including pain in the wrists, elbows, shoulders, hips, knees, ankle, foot, and spine based on the results of the history and physical
- Evaluate and manage patients with common musculoskeletal problems in an outpatient clinic
- Learn to assess how pain has had an impact on someone’s life and determine treatment recommendations through a comprehensive pain management team approach, which includes:
  - Psychological interview and treatment
  - Physiatric evaluation
  - Vocational evaluation
  - Physical capacity evaluation
  - Work hardening
  - Inclusion of family and workplace issues
- Perform brief neurologic and physical examinations prior to EMG testing
- Demonstrate skills necessary to maximize rehabilitation health care outcomes for pain conditions
- Demonstrate the ability to evaluate and manage musculoskeletal pain syndromes as well as neuromuscular disorders
- Perform a comprehensive electrodiagnostic evaluation of each patient and to provide a concise diagnosis and plan for further treatment
- Describe a variety of conditions frequently encountered in electrodiagnostic medicine
- Develop an extensive knowledge base of neuromuscular anatomy
- Familiarize oneself with the EMG/NCS machine and be able to troubleshoot common errors and problems encountered in EMG/NCS testing
- Obtain appropriate informed consent for the procedures
☐ Describe the variety of conditions frequently encountered in electrodiagnostic medicine

☐ Determine a logical approach of testing for each individual condition

Medical Knowledge:

☐ Identify the role, function, and expertise of physical, occupational and speech therapists, psychologists, and vocational counselors in the comprehensive management of the rehabilitation patient using a variety of therapeutic modalities.

☐ Supervise allied health professionals in their use of physical modalities and exercises

☐ Discuss the following agents with reference to their distinguishable characteristics and features, and mechanism of action:
  o heating modalities
  o cryotherapy modalities
  o electrotherapy modalities
  o traction
  o manipulation
  o massage

☐ Describe the clinical indications, contraindications, precautions, risks and side effects for the above modalities.

☐ Demonstrate proper prescription writing skills appropriate to the patient for therapeutic modalities, therapeutic exercises and testing conducted by physical therapists, occupational therapists, and speech/language pathologists.

☐ Evaluate the multiple options available in therapeutic modalities to judge appropriate patient candidates and treatment strategies.

☐ Determine appropriate thermal and electrical modalities justified by the patient's impairments, medical condition, comorbidity, cost effectiveness, quality, utilization, patient satisfaction and prescribe a safe and effective course of treatment to achieve measurable goals.

☐ Discuss the reliability and validity of testing commonly used by rehabilitation professionals, including manual muscle testing, goniometry, dynamometry, and isotonic and isokinetic functional capacity evaluations.

☐ Integrate and interpret therapeutic modality results with input and feedback from a multidisciplinary team process to design an effective management program.

☐ Describe the relevant characteristics and features of the nervous, musculoskeletal, cardiovascular, pulmonary systems in response to strengthening and endurance exercise programs.

☐ Discuss and differentiate the following categories of exercise therapy:
  o ROM/flexibility
  o static resistance
  o dynamic resistance
- aerobic coordination
- relaxation

- Review and describe the basic anatomy, physiology, pathology and pathophysiology of the musculoskeletal system.
- Obtain, produce/record and present a comprehensive, reliable, concisely organized and written PM&R history focusing on acute musculoskeletal pain syndromes.
- Demonstrate performance skills in obtaining, recording/documenting and presenting a thorough, reliable, and concisely organized physical examination with emphasis on the diagnosis of musculoskeletal pain, including the following components:
  - inspection/palpation
  - ROM/flexibility
  - strength (manual testing)
  - structural stability
  - pain level evaluation (palpation/mobilization)
  - neurologic examination
  - functional evaluation

- Evaluate diagnostic indications for pain, including radiologic and other imaging techniques such as CT and MRI, and discuss their limitations.
- Evaluate diagnostic indications for pain, including neurodiagnostic testing such as EMG/INCS and SEP, and discuss their limitations.
- Apply information obtained from physiatric musculoskeletal history and physical to formulate and support a functional and medical assessment for the patient with acute musculoskeletal disorder.
- Record and present in case summary format the significance of history and physical findings on functional impairments.
- Determine and prescribe appropriate physical therapy modalities for pain including heat/cold, TENS, rest, exercise, structural protection/energy conservation, mobilization and stretching.
- Prescribe orthotic and/or prosthetic devices to meet treatment plan objectives to protect/immobilize and/or maximize functional abilities.
- Understand the rehabilitation principles of amputee care:
  - Perioperative stump management and fabrication of rigid dressing
  - Principles of appropriate prosthetic prescription
  - Follow-up complications
  - Learn principles of evaluation and prescription writing for orthotics.
  - Understand basic amputee gait patterns
  - Evaluate abnormal gait with methods of correcting gait deviations
Learn the energy expenditure in amputees
Learn the management of upper limb amputees
Be able to diagnosis and treat phantom pain and sensation

- Describe demographic and epidemiologic trends in the U.S. population, and relate this to prevalence, impairment and disability as effected by aging, as well as the impact on the health care system.
- Assess support systems of the older adult, describing how that effects rehabilitative management.
- Review and discuss common physiological changes and disease processes in the major organ systems with aging, listed below, and their implications for the rehabilitation process:
  - hematological
  - renal
  - pulmonary
  - cardiovascular
  - immunological
  - endocrine
  - thermoregulatory
  - neurologic
  - genitourinary systems
- Discuss modifications in therapy to determine strategies to optimize rehabilitation of geriatric patients, and of geriatric patients with multiple underlying/coexisting disorders
- Compare and contrast various presentations of neurological disorders in the older adult vs. younger adult, including dementia, and communicate results to the treatment team.
- Discuss changes in pharmacokinetics associated with aging, including factors contributing to adverse drug reactions in the elderly, and demonstrate avoidance of adverse drug reactions through appropriate management techniques.
- Describe the history, clinical signs and symptoms, and physical findings; laboratory and imaging studies; the onset, course and degree of impairment; the differential diagnosis; and the treatment, management and prognosis for each of the following conditions:
  - osteoarthritis
  - rheumatoid arthritis
  - juvenile rheumatoid arthritis
  - systemic lupus erythematosus
  - polymyalgia rheumatica
o psoriatic arthritis

o scleroderma

o polymyositis

o ankylosing spondylitis

o infection

o post infectious arthritis

o undifferentiated connective tissue disease

Practice-Based Learning and Improvement
The resident is expected to:

☐ Utilize the library and Internet to perform literature searches upon which to base their treatment of patients

☐ Develop skills to apply knowledge of study designs and statistical methods to appraisal of clinical studies

☐ Review the literature for electrodiagnostic medicine “Best Practices” for neuromuscular disorders

☐ Disseminate these “Best Practices” to patients, consultants, and staff

Interpersonal and Communication Skills
The resident is expected to:

* Interact with patients in a sensitive manner

☐ Demonstrate effective listening skills

☐ Communicate on a given patient’s intellectual/educational level

☐ Produce concise, accurate documentation of the consultation, electrodiagnostic findings, and complete all chart notes in a timely manner

☐ Promote respect, dignity, and compassion for patients

☐ Accept responsibility for their own actions and decisions

☐ Demonstrate reliability and punctuality

☐ Understand and adhere to HIPPA regulations

Professionalism
The resident is expected to:

☐ Demonstrate sensitivity and responsiveness to age, culture, disability and gender of patients and colleagues.

☐ Consider effects of personal, social and cultural factors in the disease process and patient management.

☐ Demonstrate reliability, punctuality, integrity and honesty in all interactions with patients and colleagues.

☐ Accept personal responsibility for own actions & decisions.

☐ Apply sound ethical principles in practice (e.g., informed consent, confidentiality, veracity, provision or withholding of care).
☐ Abide by the SLVHCS rules and regulations concerning internet security and professional behavior.
☐ Complete all required SLVHCS training in a timely fashion.

System Based Practice

The resident is expected to:

☐ Appreciate when electrodiagnostic medicine procedures are most appropriately rendered to maximize information gain and patient outcome
☐ Appreciate when electrodiagnostic medicine procedures are not cost-effective for the patient and health care system
☐ Understand where electrodiagnostic medicine testing “fits” in the continuum-of-care for persons with neurologic disorders
☐ Recognize drug formulary and treatment limitations imposed by the VA Health Care system.
☐ Become aware of government and private support organizations for persons with musculoskeletal disorders
☐ Develop the concept of how a well run outpatient practice clinic should function
LSU PM & R / VA Pain Management Outpatient Clinic Rotation – PGY1-2

Revised: May 2010

Location: Southeast Louisiana Veterans Health Care System (SLVHCS) – New Orleans

Attendings: Robert Mipro, M.D., Kiersta Kurtz-Burke, M.D.

General Description:
This is an introductory pain management rotation for PM&R residents. During this rotation residents are exposed to comprehensive pain evaluation and management. During this rotation interventional pain procedures are introduced, with hands on experience gained.

GENERAL OBJECTIVES:
Upon completion of this experience, the resident should be able to understand the basic concepts of pain, and how to evaluate and treat chronic pain.

COMPETENCY BASED SPECIFIC GOALS AND OBJECTIVES:
Patient Care
Residents are expected to:

☐ Perform a focused PM&R related History and Physical exam for patients with chronic pain, with special attention to the musculoskeletal and nervous systems
☐ Elicit information using effective questioning and listening skills
☐ Diagnose physical, cognitive, and psychosocial impairments in patients with acute and chronic pain
☐ Create a differential diagnosis appropriate to the physical findings
☐ Demonstrate caring, compassion, and respectful behaviors (verbal and non-verbal) towards patients with chronic and often incurable pain
☐ Learn what tests are appropriate in patients who complain of pain, based upon the differential diagnosis
☐ Learn to interpret the findings of the ordered tests
☐ Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians
☐ Integrate the findings to recommend rehabilitation treatment based upon the examination findings
Outline the typical management of an acute, subacute, and chronic pain patient and be aware of the different approaches and differing concerns for each.

Become proficient in:
- Writing appropriate therapy prescriptions for adult and pediatric pain patients that would also include appropriate activity restrictions and precautions.
- Writing appropriate pain medication regimens including the use of long-acting and short-acting narcotics.
- Coordinating care with consultants (e.g., goal-directed therapy, injections, medication prescriptions).
- Prescribing functionally and neurologically appropriate orthoses, assistive devices and durable medical equipment.
- Screening patients to determine who is appropriately using pain meds and who is addicted to or diverting medications.
- Evaluation, identification, and management of various different pain syndromes including sympathetically maintained pain (including CRPS / RSD), neuropathic pain, musculoskeletal pain and fibromyalgia / myofascial pain syndromes.
- Instituting and using a pain contract.
- The laws associated with prescribing Schedule II medications (also called controlled substances, class 2 or CII agents).

Understand, recognize, assess and manage the following secondary problems of pain patients:
- Addiction, pseudo-addiction, and tolerance.
- Bowel management programs.
- Contractures.
- Depression and adjustment disorder.

Identify important considerations in the evaluation and management of the geriatric pain patient.

Obtain informed consent and document appropriate procedure note.

Perform epidural steroid injections, facet joint injections, sacroiliac joint injections, medial branch blocks, sympathetic blocks (stellate ganglion and lumbar sympathetic), and intravenous regional blocks.

Learn about the role of a pain psychologist and when to refer to them.

Medical Knowledge

Residents are expected to:

- Learn the physiology and basic science behind pain syndromes.
Understand the theories behind common pain generators and their implication on management

Learn the difference between neuropathic pain and nociceptive pain

Discuss the modalities available to treat musculoskeletal pain. Discuss the mechanism of action, indications, and contraindications for each. (e.g., TENS, hot/cold modalities such as ultrasound, diathermy, icing)

Be able to define and understand the difference between management, as well as clinical implications, of acute, subacute, and chronic pain syndromes

Outline "The Gate Theory" of pain described by Melzack and Wall

Discuss fibromyalgia, its diagnosis, and management

Describe the common psychosocial consequences of chronic pain

Discuss the following medications, their mechanism of action, side effects, and indications/contraindications in patients with pain:

- Tricyclic antidepressants (e.g., amitriptyline)
- Anticonvulsants (e.g., Neurontin, Lyrica, Zonegran, and SSRIs) (e.g., Cymbalta, Effexor)
- Benzodiazepenes (e.g., clonazepam)
- Opiates, long-acting and short-acting (e.g., morphine, oxycodone, hydrocodone, fentanyl, methadone, Suboxone) and be familiar with the various methods of delivery
- Non-steroidal anti-inflammatories (NSAIDS)
- Others such as clonidine, Ultram, acetaminophen, capsaicin, Lidoderm patch

Understand the indications for intrathecal pump placement for management of severe chronic pain. Describe the medications typically utilized, potential complications, contraindications, and efficacy.

Discuss indications for axial steroid injections, the various techniques utilized, the potential complications, and efficacy. Be familiar with the medical literature describing these techniques.

Understand the indications for implantation of a spinal stimulator and describe the mechanism for action, risks, benefits, costs, and efficacy in different populations with pain.

Residents should know:

- Autonomic: stellate, celiac, lumbar sympathetic
- Head and neck: cervical plexus
- Extremities: brachial plexus, ulnar, radial, median, sciatic, femoral, lateral femoral cutaneous, obturator, ilioinguinal, lumbar plexus
- Trunk – intercostals, paravertebral somatic
- Spine – epidural, caudal, intrathecal
Procedures, methods, and techniques for regional anesthesia and main nerve blocks

Peripheral and autonomic nerve blocks – indications, contraindications, techniques, clinical assessment, complications

Painful disease states and their management

Types of pain – cutaneous, deep somatic, visceral, central

Specific pain syndromes – sympathetic dystrophy, phantom limb, low back pain, intractable cancer pain, causalgia, post-herpetic neuralgia, trigger points, fibromyalgia

Treatment

- Drugs – analgesics, sedatives, stimulants, anticonvulsants, antidepressants, corticosteroids, capsaicin
- Nerve block, epidural steroid injections
- Others – transcutaneous nerve stimulation, acupuncture, spinal cord stimulators and pumps
- Surgical and chemical neurolysis

Practice-Based Learning and Improvement

Residents are expected to:

- Critically review and analyze appropriate literature regarding pain management and pain management techniques
- Be familiar with the literature on interventional pain management techniques
- Become proficient with the use of the hospital’s computer system in order to obtain medical records, lab results, imaging study results, and other ancillary notes
- Prepare lectures for the didactic lecture series to further enhance PM&R knowledge
- Educate and supervise junior residents, rotators and medical students who are spending time on the rotation
- Evaluate their own exam skills and pain medicine knowledge and incorporate feedback from others
- Use information technology (computers, journals, etc.) to access and manage patient information in order to support the resident’s education and treatment decisions
- Contribute their findings to discussions on the care of the patient with other health care professionals
- Attend and participate in conferences and rounds in order to facilitate such discussions
- Investigate the outcomes of pain management treatments
Interpersonal & Communication Skills

Residents are expected to:

- Establish trust and maintain rapport with patients and family
- Explain basic pain management techniques to patients and families
- Educate patients and families about possible risks, complications, and benefits associated with pain management techniques
- Identify techniques in interacting with the patient with pain complaints who exhibits non-compliance with the prescribed therapeutic plan and/or has a history of substance abuse
- Appropriately convey medical and prognostic information to the patient, the patient's family and allied health staff
- Write reports with a clear diagnosis and plan
- Complete all chart notes and dictations in a timely manner
- Develop effective presentation and listening skills
- Develop appropriate communication skills when working with medical/surgical consultants from other specialties
- Develop skills in team management and leadership while working with the team members caring for the patient with pain
- Work as a part of the referral development team to enhance the efficiency of the admission process
- Identify and overcome obstacles to effective communication and care with the elderly pain patient
- Identify and overcome obstacles to effective communication and care for non-English speaking patients and patients of differing cultures

Professionalism

Residents are expected to:

- Demonstrate professional and courteous communication to the patient, the patient's family, referring physicians, and allied health staff
- Demonstrate ability to serve non-English speaking and English speaking patients equally through the use of interpreters when needed
- Recognize cultural/ethnic diversity and how that is reflected in the different pain management strategies
- Understand and adhere to HIPPA regulations
- Demonstrate understanding of cultural, age, religion, and gender differences in pediatric and adolescent patients
☐ Understand and demonstrate the ethical principles involved in managing patients with chronic pain
☐ Demonstrate reliability, integrity, honesty, and punctuality
☐ Demonstrate respect for the dignity of patients and colleagues
☐ Learn how to legally and appropriately terminate a patient from your practice

Systems-Based Practice

Residents are expected to:

☐ Outline a program of non-surgical rehabilitation management for chronic low back pain that incorporates system resources such as case management and vocational rehabilitation
☐ Learn when to refer to a multi-disciplinary pain management clinic, the costs and settings of such treatment, and what the outcomes might be
☐ Describe the components of a pain contract and the requirements for success in a large system of care
☐ Be familiar with referral options to specialists for more complex patients with pain
☐ Discuss the requirements for Pain Medicine Certification
☐ Understand what physicians are involved in the treatment of pain and what their role is
☐ Understand management limitations and when to request appropriate medical/surgical consultations from other specialties
☐ Advocate for patients who need tests and treatments that might be inappropriately denied
☐ Advocate for all patients equally within the healthcare system
☐ Recognize medical/legal issues with regards to prescribing chronic narcotics
☐ Integrate care of patients across hospital and community settings
☐ Learn when tests and pain procedures are appropriate or may be under- or over- utilized
☐ Understand the cost of the treatments and diagnostic tests that are ordered
☐ Understand documentation requirements and learn how to complete insurance paperwork
LSU PM & R – Electrodiagnostic Medicine Rotation – PGY3-4

Revised: January 2010

Location: Leonard J. Chabert Medical Center, Houma, LA
Attending: Mary Mathai, M.D., Stephen Kishner, M.D.

General Description:
This is a four month long rotation for 2 PGY3 or 4 residents at the Leonard J. Chabert Medical Center in Houma, LA which is a member of the LSU Health Care Services Division. The eight member hospital system provides training and health care services to the underinsured population of the state of Louisiana. In this senior level course, an advanced understanding of electrodiagnostic studies is expected. The residents work together to observe and perform electrodiagnostic studies in daily clinics under the supervision of either Dr. Mathai or Dr. Kishner. The residents are given the option to stay in Houma at designated LSU apartments for free while on this rotation.

GOALS AND OBJECTIVES:

Patient Care

Residents are expected to:

☐ Review the objectives for the beginner EMG rotations at the VA and ILSUPH Clinics and ensure all were met and mastered
☐ Perform at least 4 – 6 Electrodiagnostic medicine evaluations per day with limited faculty supervision
☐ Determine a logical approach of testing for each individual condition
☐ Characterize the electrophysiology of common normal and abnormal findings encountered in EMG/NCS
☐ Build on their knowledge base of neuromuscular anatomy
☐ Troubleshoot common errors and problems encountered in EMG/NCS testing
☐ Identify patient and family concerns associated with the testing process as well as the results
☐ Learn the patient safety issues with EMG/NCS including proper maintenance, inspection of the machine, and risk of blood borne pathogen exposure
☐ Obtain appropriate informed consent for the procedure
☐ Respect that the patient is experiencing an uncomfortable procedure
☐ Communicate with tech support personnel when a machine is not functioning
☐ Review inpatient and outpatient Electrodiagnostic medicine consults to determine medical necessity and the best time frame to perform the exam
☐ Develop enough speed to complete the exam in the allotted time frame

Medical Knowledge

Residents are expected to:

Anatomy & Physiology:

☐ Outline the events occurring at the neuromuscular junction
☐ Review the course and muscles supplied by the facial, phrenic, suprascapular, axillary, and spinal accessory nerves
☐ Review the anatomy of the lumbar and brachial plexus
Discuss myopathic and neuropathic biopsy findings

Describe anomalous innervations including the Martin-Gruber anastomosis and accessory deep peroneal nerve

List the most common forms of muscular dystrophy, motor neuron diseases (e.g., Amyotrophic lateral Sclerosis (ALS), Spinal Muscular Atrophy (SMA), hereditary motor/sensory neuropathies (HMSN), and myopathies and be familiar with their genetics, incidences, ages of onset, evaluation (to include electrodiagnostic studies), treatment options, and recommendations and prognosis.

Differentiate muscular dystrophy/congenital myopathy from kalemic and metabolic myopathies

Describe the findings of stiff man syndrome and other diseases of continuous muscle activity

Understand the anatomy of the blink reflex

Instumentation:

Describe the effect of changes in the high and low frequency filters on the sensory nerve action potential (SNAP) and compound muscle action potential (CMAP) latencies and amplitudes

Describe the effect of changes in the high and low frequency filters on the motor unit action potential (MUAP)

Describe the technical difficulties of performing Electrodiagnostic testing in the ICU setting

Nerve Conduction Studies (NCS):

Perform lateral femoral cutaneous, plantar, saphenous, spinal accessory, and supra scapular nerve studies

 Demonstrate the ability to evaluate Neuromuscular junction disorders with repetitive stimulation testing

Evaluate and perform testing to diagnose patients with lumbar and brachial plexopathy

Evaluate an inpatient with generalized weakness or difficulty weaning off the ventilator

List the disease categories associated with axonal and demyelinating neuropathies

Identify common reasons for utilizing Somatosensory Evoked Potentials (SSEP). State the limitations and the pathophysiology behind their generation. Have a basic understanding of interpretation.

Interpret the blink reflex in a normal patient, and in a patient with trigeminal and facial nerve involvement

Describe the sensitivity and specificity of the various studies to diagnose median neuropathy

Describe the combined sensory index (CSI) for diagnosing median neuropathy

Electromyography (EMG)

List the common forms of voluntary and spontaneous activity seen with muscle disease

Be familiar with and apply the grading systems available for documenting the extent of spontaneous activity

Describe the effects of muscle disease on MUAP morphology

Give the differential diagnosis of an abnormal interference pattern

Discuss single fiber electromyography (SFEMG) and its possible uses

Define jitter and fiber density based on SFEMG usage

Discuss when not to perform electromyography as part of the testing

State the indications for anal sphincter EMG and how to perform the exam

Practice-Based Learning and Improvement:
Residents are expected to:

- Review the American Association of Neuromuscular and Electrodiagnostic Medicine’s (AANEM) Recommended Policy for Electrodiagnostic Medicine
- Review AANEM practice parameters for Electrodiagnostic studies in carpal tunnel syndrome, ulnar neuropathy at the elbow, and peroneal neuropathy

**Interpersonal and Communication Skills**

Residents are expected to:

- Interact with patients in a sensitive manner
- Communicate on a given patient’s intellectual/educational level
- Produce concise, accurate documentation of the consultation, electrodiagnostic findings, and recommendations
- Complete all chart notes in a timely and accurate manner
- Participate in teaching discussions

**Professionalism**

Residents are expected to:

- Promote respect, dignity, and compassion for patients
- Accept responsibility for their own actions and decisions
- Demonstrate reliability and punctuality
- Understand and adhere to HIPPA regulations

**System-Based Practice**

Residents are expected to:

- Appreciate when electrodiagnostic medicine procedures are most appropriately rendered to maximize information gain and patient outcome
- Appreciate when electrodiagnostic medicine procedures are not cost-effective for the patient and health care system
- Understand where electrodiagnostic medicine testing “fits” in the continuum-of-care for persons with neurologic disorders
LSU PM & R – Pediatric Neurology – PGY 1 - 2 Revised: January 2010

Location: Children’s Hospital, New Orleans, LA
Attending: Ann Tilton, M.D.

General Description:
This is a one-month rotation at Children’s Hospital in New Orleans, including its Gilda Trautman Newman Rehabilitation Center. The Gilda Trautman Newman Rehabilitation Center at Children’s Hospital provides comprehensive interdisciplinary, team-oriented, family-centered inpatient services to patients from birth through 21 years. Accredited by the Commission of Accreditation of Rehabilitation Facilities (CARF), the unit specializes in treating patients with brain injury, cerebral palsy, developmental disability, feeding disorder, limb deficiency, myelodysplasia, neuromuscular disease, rheumatic disease, seizure disorder, spinal cord injury, stroke, ventilator dependence, and other congenital or acquired disabling disorders. During this rotation the PGY1 or PGY2 resident is introduced to pediatric neurology as part of the 12 months of their general medicine internship year. They will round with Dr. Tilton’s team on inpatients and also participate in various out patient clinics.

GOALS AND OBJECTIVES:

Patient Care

Residents are expected to:
* Provide patient care that is compassionate, appropriate and effective for the treatment of neurological health problems and the promotion of health in newborns, infants, children and adolescents.
* Demonstrate competency in gathering essential and accurate information about the patient.
* Perform a comprehensive history and obtain detailed information regarding birth and developmental history as age appropriate.
* Perform a fundamental pediatric neurological examination.

Medical Knowledge

Residents are expected to:
* Demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and how to apply this knowledge to direct patient care.
* Demonstrate knowledge of the pathophysiology, biochemistry, genetics and clinical presentation of the patient’s neurological disease.
* Recognize and interpret abnormal neurological findings.
* Demonstrate the ability to present medical knowledge background for each case to the attending physician by correctly utilizing medical references, journal articles and information technology

Practice-Based Learning and Improvement:

Residents are expected to:
* Use information technology (computers, journals, etc.) to access and manage patient information and support their own education and treatment decisions.
* Review the literature for “Best Practices” in the above areas of Medical Knowledge and Patient Care.
* Contribute their findings to discussions on the care of the patient.

**Interpersonal and Communication Skills**

Residents are expected to:
- Establish trust and maintain rapport with patients and family.
- Complete all chart notes and dictations in a timely manner.
- Present material clearly and accurately to patients and family.
- Effectively communicate verbally and in writing patient needs to all staff and referring physicians involved with the patient.
- Utilize effective listening skills.
- Participate in rounds and discussions.
- Present findings clearly and concisely to supervising faculty so management can be discussed.
- Demonstrate appropriate interpersonal skills, compassion, and leadership skills in the patient care conference and multidisciplinary team conference.
- Discuss issues such as prognosis, and address return to home issues with families and patients.
- Complete medical records in a timely manner.
- Develop effective listening skills.

**Professionalism**

Residents are expected to:
* Promote respect, dignity, and compassion for patients
* Demonstrate a commitment to ethical principles and confidentiality of patient information by understanding and adherence to HIPPA regulations
* Demonstrate reliability and punctuality by being on time for clinic and lectures
* Dress and behave in a highly professional manner at all times in the clinic
* Demonstrate the ability to interact well with attendings, other residents, students, nurses and other administrative and technical support personnel.
* Accept responsibility for their own actions and decisions

**System-Based Practice**

Residents are expected to:
- Demonstrate patient advocacy, yet showing the ability to recognize situations in which progress is no longer occurring and problem solving these situations.
- Assess how their decisions affect others – patients, family, and other health care professionals.
- Integrate care of patients across hospital and community settings.
- Learn when tests are appropriate or may be under-or over-utilized.
- Recognize requirements as they relate to documentation, elements of the exam, and billing procedures and codes.
- Describe the factors involved in the decisions on length of stay, disposition, and insurance coverage.
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system
performance.
Location: BATON ROUGE GENERAL MEDICAL CENTER

Attending: Andrew Hargroder, M.D.

General Description:
This is a one-month rotation for senior residents. The burn rehabilitation rotation takes place at the major regional burn center in the area at Baton Rouge General Medical Center. The rotation consists of making multidisciplinary burn rounds on the burn unit, attending the adult and pediatric burn clinic, possibly attending surgical burn cases and observing burn rehabilitation therapies.

GENERAL OBJECTIVES:
Upon completion of this experience, the resident should demonstrate advanced knowledge in the rehabilitation of burn patients, as well as the role of the surgeons and other providers in the burn team.

COMPETENCY BASED SPECIFIC OBJECTIVES:

PATIENT CARE:
Residents must be able to provide patient care that is compassionate, appropriate, patient centered and effective for the rehabilitative treatment of burns.

- Resuscitation
- Nutrition
- Infection control
- Evaluation for surgical management
  - Debridement
  - Skin grafting
- Psychological / Depression management
- Positioning
- Splinting
- Pain control
- Pressure garments
- Range of motion

MEDICAL KNOWLEDGE:
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

Residents are expected to be able to:
- Learn assessment and classification of burn wounds, including estimation of burn size and depth and prediction of related morbidity and mortality.
Gain appreciation of stress response to acute burn injuries, including hemodynamic, metabolic, nutritional support, wound care and ventilator management.

Learn initial management of the acute burn patient, including fluid resuscitation, nutritional support, wound care and ventilator management.

Learn wound management of burn patients, including an understanding of wound healing, wound sepsis, topical and antimicrobial agents, biological dressings and skin substitute and skin grafts.

Develop fundamental skills in the basic evaluation and treatment of burn rehabilitation patients.

Gain appreciation for burn rehabilitation, including physical and occupational therapy, psychosocial support and reconstructive needs.

Learn principles of management of special problems, including inhalation injuries, chemical burns, electrical injuries and toxic epidermal necrolysis.

The residents are expected to understand:

- Pathophysiology of acute burns
- Pathophysiology of burn scar hypertrophy, heterotopic ossification and contractures
- Overview of early acute and chronic care problems and management
  - Pain
  - Pruritis
  - Contractures
  - Scar hypertrophy
  - Psychological problems
  - Associated injury to nerves and joints
- Orthotic devices
  - Dynamic/resting splints
  - Adaptive devices
  - Prosthetics
  - Environmental modifications

Practice- Based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

Residents are expected to develop skills and habits to be able to:

- Evaluate one’s own knowledge, incorporating feedback from others
- Modify self-directed learning appropriately including feedback provided from the faculty attending and peers.
- Appraise and assimilate evidence from scientific studies to enhance patient care, especially as it relates to burns-related diagnoses and treatments.
- Effectively use information technology and other resources to support one’s own ongoing self-education
o Participate in discussions concerning patient care with other health care professionals, attendings, and ancillary staff (physical therapy, dietary)
o Attend and participate in teaching conferences, didactics and rounds

**Systems Based Practice**

- Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as be able to effectively call on other resources in the system to provide optimal health care.
- Residents are expected to:
  - Collaborate with and maintain appropriate professional attitudes and behaviors toward other medical professionals and allied health personnel
  - Use diagnostic and therapeutic procedures appropriately and judiciously
  - Evaluate risks, benefits, limitations, and costs of patient care
  - Work effectively with other services, health care agencies, and case managers

**Professionalism**

- Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
- Residents are expected to demonstrate:
  - Exemplify and display an observable respect and compassion toward patients
  - Exemplify reliability, punctuality, integrity and honesty
  - Accept responsibility for one’s own actions and decisions
  - Consider the effects of personal, social, and cultural factors in the disease process and patient management
  - Demonstrate non-judgmental sensitivity and responsiveness to the age, culture, disability status, and gender of patients, families and colleagues

**Interpersonal and Communication Skills**

- Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates.
- Residents are expected to:
  - Establish trust and maintain rapport with patients and families
  - Discuss diagnoses, prognoses and treatment options clearly and accurately to patients
  - Utilize effective listening skills
  - Communicate and interact with staff/team in respectful, responsive manner
  - Be sensitive to the culture surrounding burn patients
Location: East Jefferson General Hospital – New Orleans, LA
Attendings: Eric Lonseth, M.D.

General Description: This is a 2 month long rotation with generally one resident (PGY1-4) assigned. The Pain Management Institute at East Jefferson General Hospital offers a multidisciplinary approach to the treatment of chronic pain, including a full range of interventional therapies, including physical therapy, cognitive therapy, medications and injections. The residents work one on one with Dr. Eric Lonseth, a pain boarded Anesthesiologist who is also the Medical Director for the Pain Management Institute. During this rotation, the resident will be exposed to and assist in treating a number of different conditions including but not limited to: Low back pain – Lumbar Radiculopathy, Post-operative Back pain, Degenerative Disc Disease, Sacroiliac and Facet Joint Disease and Vertebral Body compression fractures.
Neuropathic pain – Peripheral Neuralgia, Diabetic Peripheral Neuropathy, Post-Herpetic Neuralgia, Chronic Regional pain syndrome
Cancer pain – all types

GOALS AND OBJECTIVES:

Patient Care
Residents are expected to:
- Elicit information using effective questioning and listening skills
- Diagnose physical, cognitive, and psychosocial impairments in patients with acute and chronic pain
- Create a differential diagnosis appropriate to the physical findings
- Demonstrate caring, compassion, and respectful behaviors (verbal and non-verbal) towards patients with chronic and often incurable pain
- Learn what tests are appropriate in patients who complain of pain, based upon the differential diagnosis
- Learn to interpret the findings of the ordered tests
- Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians
- Integrate the findings to recommend rehabilitation treatment based upon the examination findings
- Outline the typical management of an acute and chronic pain patient and be aware of the different approaches and differing concerns for each

Residents are expected to become proficient in:
- Demonstrating competency skills in conducting and administering diagnostic and therapeutic injections procedures
- Demonstrating performance skills specifically for epidural steroid, facet, SI, bicipital tendon, intra-articular glenohumeral, carpal tunnel and subacromial injections
- Understanding, recognizing, assessing and managing secondary problems of pain patients

Medical Knowledge
Residents are expected to:
- Define the term “pain” according to the IASP Pain classification system
- Learn the physiology and basic science behind pain syndromes
- Understand the theories behind common pain generators and their implication on management
Learn the difference between neuropathic pain and noioceptive pain and be able to describe the mechanisms.

Discuss the modalities available to treat musculoskeletal pain. Discuss the mechanism of action, indications, and contraindications for each. (e.g., TENS, hot/cold modalities such as ultrasound, diathermy, icing)

Be able to define and understand the difference between management, as well as clinical implications, of acute and chronic pain syndromes

Discuss fibromyalgia, its diagnosis, and management

Understand the concept and principles of Failed Back Syndrome

Describe the common psychosocial consequences of chronic pain

Residents should know:

Anatomy as it relates to regional anesthesia and main nerve blocks:

- Autonomic: stellate, celiac, lumbar sympathetic
- Head and neck: cervical plexus
- Extremities: brachial plexus, ulnar, radial, median, sciatic, femoral, lateral femoral cutaneous, obturator, illoinguinal, lumbar plexus
- Trunk – intercostals, paravertebral somatic
- Spine – epidural, caudal, intrathecal

Procedures, methods, and techniques for regional anesthesia and main nerve blocks

- Peripheral and autonomic nerve blocks – indications, contraindications, techniques, clinical assessment, complications
- IV regional – mechanism, agents, indications, contraindications, techniques, complications

Painful disease states and their management

Types of pain – cutaneous, deep somatic, visceral, central

Specific pain syndromes – sympathetic dystrophy, phantom limb, low back pain, intractable cancer pain, causalgia, post-herpetic neuralgia, trigger points, fibromyalgia

Treatment

- Drugs – analgesics, sedatives, stimulants, anticonvulsants, antidepressants, corticosteroids, capsaicin
- Nerve block, epidural steroid injections
- Others – transcutaneous nerve stimulation, acupuncture, spinal cord stimulators and pumps
- Surgical and chemical neurolysis

**Practice-Based Learning and Improvement**

Residents are expected to:

Critically review and analyze appropriate literature regarding pain management and pain management techniques
Be familiar with the literature on interventional pain management techniques
Become proficient with the use of the hospital’s computer system in order to obtain medical records, lab results, imaging study results, and other ancillary notes
Prepare lectures for the didactic lecture series to further enhance PM&R knowledge
Educate and supervise junior residents, rotators and medical students who are spending time on the rotation
Evaluate their own exam skills and pain medicine knowledge and incorporate feedback from others
Use information technology (computers, journals, etc.) to access and manage patient information in order to support the resident’s education and treatment decisions
Contribute their findings to discussions on the care of the patient with other health care professionals
Attend and participate in conferences and rounds in order to facilitate such discussions
Investigate the outcomes of pain management treatments

Interpersonal & Communication Skills

Residents are expected to:
Establish trust and maintain rapport with patients and family
Explain basic pain management techniques to patients and families
Educate patients and families about possible risks, complications, and benefits associated with pain management techniques
Identify techniques in interacting with the patient with pain complaints who exhibits non-compliance with the prescribed therapeutic plan and /or has a history of substance abuse
 Appropriately convey medical and prognostic information to the patient, the patient's family and allied health staff
Write reports with a clear diagnosis and plan
Complete all chart notes and dictations in a timely manner
Develop effective presentation and listening skills
Develop appropriate communication skills when working with medical/surgical consultants from other specialties
Develop skills in team management and leadership while working with the team members caring for the patient with pain
Work as a part of the referral development team to enhance the efficiency of the admission process
Identify and overcome obstacles to effective communication and care with the elderly pain patient
Identify and overcome obstacles to effective communication and care for non-English speaking patients and patients of differing cultures

Professionalism

Residents are expected to:
Promote respect, dignity, and compassion for patients
Demonstrate a commitment to ethical principles and confidentiality of patient information by understanding and adherence to HIPPA regulations
Demonstrate reliability and punctuality by being on time for clinic and lectures
Dress and behave in a highly professional manner at all times in the clinic
Demonstrate the ability to interact well with attendings, other residents, nurses and other administrative and technical support personnel.
Accept responsibility for their own actions and decisions
Systems-Based Practice
Residents are expected to:

Outline a program of non-surgical rehabilitation management for chronic low back pain that incorporates system resources such as case management and vocational rehabilitation
Learn when to refer to a multi-disciplinary pain management clinic, the costs and settings of such treatment, and what the outcomes might be
Describe the components of a pain contract and the requirements for success in a large system of care
Be familiar with referral options to specialists for more complex patients with pain
Discuss the requirements for Pain Medicine Certification
Understand what physicians are involved in the treatment of pain and what their role is
Understand management limitations and when to request appropriate medical/surgical consultations from other specialties
Advocate for patients who need tests and treatments that might be inappropriately denied
Advocate for all patients equally within the healthcare system
Recognize medical/legal issues with regards to prescribing chronic narcotics
Integrate care of patients across hospital and community settings
Learn when tests and pain procedures are appropriate or may be under- or over- utilized
Understand the cost of the treatments and diagnostic tests that are ordered
Understand documentation requirements and learn how to complete insurance paperwork
SCHOLARLY ACTIVITY - RESEARCH

SCHOLARLY ACTIVITY - RESEARCH GOALS AND OBJECTIVES

Our mission is to promote and motivate our residents in research and scholarly activities. We expect residents to demonstrate their achievements in these activities by performing meaningful investigative research. There is a desire to complete at least one piece of scholarly activity during their training years. To accomplish these goals a time frame for these activities for each academic year is summarized below.

Research activity will consist of acquiring knowledge and understanding of the role of research in clinical care as evidence based. The development of investigative research should include, but not limited to: developing hypothesis, writing protocol, study design, data collection, obtaining approvals from institutional review board and closely working with statistician during the process of analysis.

Requirements:

☐ Faculty approval and mentor supervision. A mentor can be from within or outside the section of PM&R.

☐ The Residency Program Director must approve research proposals.

☐ Maximum of two residents on one project or study.

☐ Repetition of an already presented project is not acceptable, unless significant new work or findings are to be presented.

Scholarly activity is an oral, poster or written presentation that reflects a thorough and critical collection of knowledge. This may include writing abstracts and manuscripts for publication, preparation of a book or e-book chapter, slide and poster presentations for local, regional or national meetings.
EVALUATIONS

1. Lecture and Speaker Evaluation Form
2. Resident Evaluation by Faculty Forms
3. Peer Review House Officer Form
4. Faculty Evaluation by Resident Form
5. Resident Evaluation Form from Nursing, Therapists, and Clerical Staff
6. Resident Evaluation by Patient Form
7. Program Evaluation by Resident Form
8. Duty Hours Log
9. Semiannual Evaluation Form
10. Clinical Competency Evaluation Form (Mock Standardized Patient)
11. American Board of PM&R Final Evaluation Form
12. Lecture attendance sign-in sheet
13. Resident Observation and Competency Assessment (ROCA)
14. Resident Self Evaluation Form
15. Rotational Evaluation Form
# Lecture Series Evaluation Form

**Name:**

**Date:**

**Signature:**

**House Officer**

**Faculty**

**Fellow**

**Student**

**Other**

<table>
<thead>
<tr>
<th>Speaker 1</th>
<th>Speaker 2</th>
<th>Speaker 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic</td>
<td>Topic</td>
<td>Topic</td>
</tr>
</tbody>
</table>

- **Rating for this speaker:**
  - 1=Poor, 5=Excellent
  - Content: 1 2 3 4 5
  - Presentation: 1 2 3 4 5
  - Audio-Visual: 1 2 3 4 5
  - Handout Quality: 1 2 3 4 5

- **Please list one or two relevant points that you consider the principal message(s) from this speaker.**

- **If you rated this speaker poorly, please explain.**

- **Did this presentation meet the stated objectives?**

- **Comments:**

---

<table>
<thead>
<tr>
<th>Speaker 1</th>
<th>Speaker 2</th>
<th>Speaker 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic</td>
<td>Topic</td>
<td>Topic</td>
</tr>
</tbody>
</table>

- **Rating for this speaker:**
  - 1=Poor, 5=Excellent
  - Content: 1 2 3 4 5
  - Presentation: 1 2 3 4 5
  - Audio-Visual: 1 2 3 4 5
  - Handout Quality: 1 2 3 4 5

- **Please list one or two relevant points that you consider the principal message(s) from this speaker.**

- **If you rated this speaker poorly, please explain.**

- **Did this presentation meet the stated objectives?**

- **Comments:**

---

<table>
<thead>
<tr>
<th>Speaker 1</th>
<th>Speaker 2</th>
<th>Speaker 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic</td>
<td>Topic</td>
<td>Topic</td>
</tr>
</tbody>
</table>

- **Rating for this speaker:**
  - 1=Poor, 5=Excellent
  - Content: 1 2 3 4 5
  - Presentation: 1 2 3 4 5
  - Audio-Visual: 1 2 3 4 5
  - Handout Quality: 1 2 3 4 5

- **Please list one or two relevant points that you consider the principal message(s) from this speaker.**

- **If you rated this speaker poorly, please explain.**

- **Did this presentation meet the stated objectives?**

- **Comments:**
**Louisiana State University Health Science Center**  
School of Medicine, Department of Internal Medicine  
Section of Physical Medicine & Rehabilitation

**Resident Evaluation by Faculty Form**

<table>
<thead>
<tr>
<th>Resident’s Name</th>
<th>Rotation Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending’s Name</td>
<td>Rotation Dates</td>
</tr>
<tr>
<td>PGY Level</td>
<td>Evaluation Date</td>
</tr>
</tbody>
</table>

Evaluate the resident’s ability to carry out the following clinical tasks. Few individuals will merit a rating of either superior or very poor. Most will receive an average rating. Use the following scale: 9 = Superior; 8 = Outstanding; 7 = Excellent; 6 = Above Average, Exceeds Expectation; 5 = Average, Expected Level of Performance; 4 = Marginal, Approaching Expectations; 3 = Unsatisfactory, Needs Attention; 2 = Poor, 1 = Very Poor.

### 1. Patient Care

Superb, accurate, comprehensive medical interviews, physical examinations, review of other data, and procedural skills; always makes performance of essential diagnostic and therapeutic decisions based on available evidence, sound judgment and patient preferences.

- **9 8 7 6 5 4 3 2 1**
- Performance needs attention
- Insufficient contact to judge
- Incomplete, inaccurate physical examinations, and procedures; fails to analyze patient preferences.

### 2. Medical Knowledge

Exceptional knowledge of basic and clinical sciences; highly resourceful development of learning; does comprehensive understanding of complex relationships and mechanisms of disease.

- **9 8 7 6 5 4 3 2 1**
- Performance needs attention
- Insufficient contact to judge
- Limited knowledge of basic sciences; minimal interest in complex mechanisms of disease.

### 3. Practice-Based Learning & Improvement

Constantly evaluates own performance, evaluation; lacks incorporation of feedback into improvement or ignores activities; effectively uses technology to manage information for patient care and care or pursue self-improvement.

- **9 8 7 6 5 4 3 2 1**
- Performance needs attention
- Insufficient contact to judge
- Fails to perform self-insight and initiative; resists feedback; fails to use technology to enhance patient self-improvement.

### 4. Interpersonal and Communication Skills

| 9 8 7 6 5 4 3 2 1 |


Establishes a highly effective therapeutic relationship with patients and families; demonstrates excellent relationship building ability to through listening, narrative and nonverbal skills; excellent education and counseling of does not patients, families, and colleagues; always counseling to patients, “interpersonally” engaged.

5. **Professionalism**

Always demonstrates respect, compassion, integrity, honesty; teaches/role models self-responsible behavior; total commitment to acknowledge errors; self-assessment; willingly acknowledges patients, errors; always considers needs of patients, families, and colleagues.

<table>
<thead>
<tr>
<th>9 8 7 6 5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance needs attention</td>
</tr>
<tr>
<td>Insufficient contact to judge</td>
</tr>
</tbody>
</table>

Lacks respect, compassion, honesty; disregards leads for assessment; fails to does not consider needs of families, colleagues; does not responsible behavior.

6. **Systems-Based Practice**

Effectively accesses/utilizes out resources; outside resources; effectively uses systematic approaches to improve systems of reduce errors and improve patient care; approaches to enthusiastically assists in developing patient care. systems’ improvement.

<table>
<thead>
<tr>
<th>9 8 7 6 5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance needs attention</td>
</tr>
<tr>
<td>Insufficient contact to judge</td>
</tr>
</tbody>
</table>

Unable to access/mobilize actively resists efforts to care; does not use systematic reduce error and improve

7. **Overall Clinical Competence**

Outstanding overall clinical competence.

<table>
<thead>
<tr>
<th>9 8 7 6 5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance needs attention</td>
</tr>
<tr>
<td>Insufficient contact to judge</td>
</tr>
</tbody>
</table>

Very poor overall clinical

8. **Physiatric Knowledge**

Up-to-date, extensive, well integrated and applied organized and Self-motivated to acquire knowledge; recognizes motivation to acquire and responds to psychosocial aspects of illness recognize or respond to illness.

<table>
<thead>
<tr>
<th>9 8 7 6 5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance needs attention</td>
</tr>
<tr>
<td>Insufficient contact to judge</td>
</tr>
</tbody>
</table>

Limited, fragmented, poorly applied; insufficient knowledge; does not psychosocial aspects of
9.
Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Resident Signature ________________________  Attending Signature

________________________________________________________________________

Return to LSU PM&R Residency Office, Touro Infirmary, 1401 Foucher St., Suite 10012, New Orleans, LA 70112. Fax 504-897-7145
Evaluate the resident's ability to carry out the following clinical tasks. Few individuals will merit a rating of either superior or very poor. Most will receive an average rating. Use the following scale: 9 = Superior; 8 = Outstanding; 7 = Excellent; 6 = Above Average, Exceeds Expectation; 5 = Average, Expected Level of Performance; 4 = Marginal, Approaching Expectations; 3 = Unsatisfactory, Requires Attention; 2 = Poor, 1 = Very Poor.

1. Patient Care
Superb, accurate, comprehensive medical interviews, physical examinations, review of other data, and procedural skills; always makes diagnostic and therapeutic decisions based on available evidence, sound judgment and patient preferences.

2. Medical Knowledge
Exceptional knowledge of basic and clinical sciences; highly resourceful development of knowledge; comprehensive understanding of complex relationships and mechanisms of disease.

3. Practice-Based Learning & Improvement
Constantly evaluates own performance, incorporates feedback into improvement activities; effectively uses technology to manage information for patient care and self-improvement.

4. Interpersonal and Communication Skills
Establishes a highly effective therapeutic relationship with patients and families; demonstrates excellent relationship building through listening, narrative and nonverbal skills; excellent education and counseling of patients, families, and colleagues; always "interpersonally" engaged.
5. **Professionalism**
Always demonstrates respect, compassion, integrity, honesty; teaches/role models responsible behavior, total commitment to self-assessment; willingly acknowledges errors; always considers needs of patients, families, and colleagues.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Performance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>987654321</td>
<td>D Performance needs attention</td>
<td>Lacks respect, compassion, integrity, honesty; disregards leads for self-assessment; fails to acknowledge errors; does not consider needs of patients, families, colleagues; does not display responsible behavior.</td>
</tr>
<tr>
<td>D Insufficient contact to judge</td>
<td>Insufficient contact to judge</td>
<td></td>
</tr>
</tbody>
</table>

6. **Systems-Based Practice**
Effectively accesses/utilizes out resources; effectively uses systematic approaches to reduce errors and improve patient care; enthusiastically assists in developing systems' improvement.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Performance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>987654321</td>
<td>D Performance needs attention</td>
<td>Unable to access/mobilize outside resources; actively resists efforts to improve systems of care; does not use systematic approaches to reduce error and improve patient care.</td>
</tr>
<tr>
<td>D Insufficient contact to judge</td>
<td>Insufficient contact to judge</td>
<td></td>
</tr>
</tbody>
</table>

7. **Overall Clinical Competence**
Outstanding overall clinical competence.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Performance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>987654321</td>
<td>D Performance needs attention</td>
<td>Very poor overall clinical competence.</td>
</tr>
<tr>
<td>D Insufficient contact to judge</td>
<td>Insufficient contact to judge</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Resident Signature _________________________  Evaluator Signature ____________________________

Return to LSU PM&R Residency Office, Touro Infirmary, 1401 Foucher St., Suite 10012, New Orleans, LA 70015. Fax 504-897-7145
### FACULTY EVALUATION

Faculty Member(s): 

Rotation: 

Dates on Service: 

Year of Training: 

1. **Availability**

   - Always available
   - Seldom available

   | 5 | 4 | 3 | 2 | 1 |

2. **Orientation/attitude toward teaching**

   - Enthusiastic
   - Negative

   | 5 | 4 | 3 | 2 | 1 |

3. **Time devoted to teaching – approximate hrs/week**

4. **Perceived quality of teaching**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

5. **Level of supervision**

   - Excessive
   - Just Right
   - Too Little

   | 5 | 4 | 3 | 2 | 1 |

6. **Professional Behavior**

   **A. Punctuality**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

   **B. Reliability**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

   **C. Courtesy**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

   **D. Directness**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

   **E. Conscientiousness**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

   **F. Teamwork**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

   **G. Team Leadership**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

   **H. Patient relations**

   - High
   - Average
   - Low

   | 5 | 4 | 3 | 2 | 1 |

7. **Comments/suggestions (Use back if necessary)**
LSU Health Sciences Center  
Physical Medicine & Rehabilitation  
360° Global Ranking Evaluation Form For Evaluating PM&R Residents by Nurses, Therapists, and Clerical Staff

**360 Global Evaluations:** Nurses, therapists, clerks, and other clinical staff evaluate residents from different perspectives using similar rating forms. These ratings should be analyzed and summarized for feedback to residents and faculty by a medical or outside source.

Please return to Maggie Niles, Program Coordinator, LSU PM&R. Fax 504-897-7145

Name of physician being evaluated: ____________________________
Location of Facility: ____________________________
Evaluator’s Name: (optional): ____________________________
Evaluator’s Signature :(optional): ____________________________ Date: __________
For Period: ____________________________
Evaluator’s Position: Nurse _______ Clerk_______ Therapist _______

Please circle the extent to which you agree with each of the items below using the rating schedule.

N/A = Not Applicable; 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Somewhat Agree; 5 = Agree; 6 = Strongly Agree

**Patient Care:**
1. Resident demonstrates caring and respectful behavior when interacting with patients and their families N/A 1 2 3 4 5 6
2. Physician counsels and educates patients and patients’ families N/A 1 2 3 4 5 6

**Practiced-Based Learning and Improvement:**
3. Resident facilitates the learning of students and other health care professionals N/A 1 2 3 4 5 6

**Interpersonal and Communication Skills:**
4. Resident creates and sustains a therapeutic and ethically sound relationship with patients. N/A 1 2 3 4 5 6
5. Resident uses effective listening skills and elicits and provides information using effective, nonverbal, explanatory and written skills. N/A 1 2 3 4 5 6

**Professionalism:**
6. Resident demonstrates respect, compassion and integrity and a responsiveness for the needs and security that supersedes self interest. N/A 1 2 3 4 5 6
7. Resident demonstrates a commitment to ethical principals. N/A 1 2 3 4 5 6
8. Resident demonstrates sensitivity and compassion to patient’s color, age, gender and disability. N/A 1 2 3 4 5 6

**System-Based Practice:**

9. Resident is an advocate for quality patient care and assists patient in dealing with system complexities. N/A 1 2 3 4 5 6

**SUGGESTIONS FOR IMPROVEMENT:**

**MAJOR STRENGTHS:**

**OVERALL EVALUATION:**

( ) 5 Outstanding  
( ) 4 Above Average  
( ) 3 Average  
( ) 2 Below Average  
( ) 1 Unsatisfactory

Evaluator’s Name: (optional) __________________________
LSU PM&R PATIENT/CARE-GIVER SATISFACTION RATING FORM

Please answer these questions so that we may help the doctor- in-training who took care of you (or your family member) know how she/he did in giving care. Your thoughts will help our doctors learn to give the best care to patients and families.

Please do not put your name on this form only the name of the doctor you are evaluating.

The Name of Your Physical Medicine & Rehabilitation Resident (Doctor-in-Training) (Please print) ____________________________

<table>
<thead>
<tr>
<th>THE DOCTOR:</th>
<th>Can’t tell</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduced him-/her-self to me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduced other members of the health care team to me if they were in the room with us</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respected my privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spoke to me and/or other members of my family so we could understand what was going on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asked questions in a way that let me tell my concerns and feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt like the doctor listened to me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt like the doctor took enough time with me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt like the doctor was interested in my problems and concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>He/she gave me instructions on how to treat my problem by either telling me or giving me something in writing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: Please tell us why you answered “no” to any of the questions.

Thank you for doing this. Please return this form to the person who gave it to you.
Program Evaluation by Resident

Year of training: Date:

1. How well did you think the program prepared you for a career in PM&R?
   Well --------------------------------- Poor
   5  4  3  2  1

2. How well did you think the program prepared you for your board examinations?
   Well --------------------------------- Poor
   5  4  3  2  1

3. Did you think that all important areas of the specialty were covered?
   Well --------------------------------- Poor
   5  4  3  2  1

4. Did you feel competent in your procedures?
   Well --------------------------------- Poor
   5  4  3  2  1

5. How did you rate the didactic lectures?
   Well --------------------------------- Poor
   5  4  3  2  1

6. How did you rate the faculty supervision?
   Well --------------------------------- Poor
   5  4  3  2  1

7. How well did you rate the facilities you worked in?
   Well --------------------------------- Poor
   5  4  3  2  1

8. Was the workload excessive?
   Well --------------------------------- Poor
   5  4  3  2  1

9. Did you feel there was the right balance of teaching to workload?
   Well --------------------------------- Poor
   5  4  3  2  1

10. Were there ample evaluations for appropriate feedback?
    Well --------------------------------- Poor
        5  4  3  2  1

11. Please describe any changes you would suggest in the program.
    Name: ____________________________
<table>
<thead>
<tr>
<th>Date</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time arrived at work</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Time left work</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>In-house call (hours)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Called back from home (hrs) Moonlighting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total daily hours</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>
### Louisiana State University Health Science Center
#### School of Medicine, Department of Internal Medicine
#### Section of Physical Medicine & Rehabilitation

**Semi-Annual Resident Evaluation Form**

<table>
<thead>
<tr>
<th>Resident’s Name</th>
<th>Evaluation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PGY Level</th>
<th>Evaluation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Evaluate the resident’s ability to carry out the following clinical tasks. Few individuals will merit a rating of either superior or very poor. Most will receive an average rating. Use the following scale: 9 = Superior; 8 = Outstanding; 7 = Excellent; 6 = Above Average, Exceeds Expectation; 5 = Average, Expected Level of Performance; 4 = Marginal, Approaching Expectations; 3 = Unsatisfactory, Needs Attention; 2 = Poor, 1 = Very Poor.

1. **Patient Care**
   - 9 8 7 6 5 4 3 2 1
   - Performance needs attention
   - Incomplete, inaccurate
   - Interview, physical examinations, review of other data, and procedural skills; always makes performance of essential diagnostic and therapeutic decisions based on clinical data and available evidence, sound judgment and patient when making preferences.

2. **Medical Knowledge**
   - 9 8 7 6 5 4 3 2 1
   - Limited knowledge of basic sciences; minimal interest in procedures; fails to analyze
   - Exceptional knowledge of basic and clinical sciences; highly resourceful development of learning; does not understand complex relationships and mechanisms of disease.

3. **Practice-Based Learning & Improvement**
   - 9 8 7 6 5 4 3 2 1
   - Fails to perform self-
   - Constantly evaluates own performance, evaluation; lacks feedback into improvement or ignores activities; effectively uses technology to manage information for patient care and care or pursue self-improvement.

4. **Interpersonal and Communication Skills**
   - 9 8 7 6 5 4 3 2 1
   - Does not establish even therapeutic relationships with patients and families; patients and
   - Establishes a highly effective therapeutic relationship with patients and families;
demonstrates excellent relationship building and demonstrates ability to build relationships through listening, narrative and nonverbal listening, skills; excellent education and counseling of patients, families, and colleagues; always provides education or counseling to patients, families, and colleagues; “interpersonally” engaged.

5. Professionalism
Always demonstrates respect, compassion, integrity, honesty; teaches/role models self-responsible behavior; total commitment to acknowledge errors; self-assessment; willingly acknowledges patients, errors; always considers needs of patients, display families, and colleagues.

5. Performance needs attention
- Insufficient contact to judge
- Insufficient contact to judge
Lacks respect, compassion, honesty; disregards leads for assessment; fails to do not consider needs of families, colleagues; does not responsible behavior.

6. Systems-Based Practice
Effectively accesses/utilizes out resources; outside resources; effectively uses systematic approaches to improve systems of reduce errors and improve patient care; approaches to enthusiastically assists in developing patient care. systems’ improvement.

6. Performance needs attention
- Insufficient contact to judge
Unable to access/mobilize actively resists efforts to care; does not use systematic reduce error and improve

7. Overall Clinical Competence
Outstanding overall clinical competence.

7. Performance needs attention
- Insufficient contact to judge
Very poor overall clinical

8. Physiatric Knowledge
Up-to-date, extensive, well integrated and applied organized and Self-motivated to acquire knowledge; recognizes motivation to acquire and responds to psychosocial aspects of illness recognize or respond to illness.

8. Performance needs attention
- Insufficient contact to judge
Limited, fragmented, poorly applied; insufficient knowledge; does not psychosocial aspects of

9. Comments:
Resident Signature ______________________  Program Director
____________________________
### Clinical Competency Evaluation

<table>
<thead>
<tr>
<th>Clinical Skills</th>
<th>Satisfactory</th>
<th>Improvement Needed</th>
<th>Not Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Interviewing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Studies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop management plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsel patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possess appropriate fund of medical knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate compassion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate responsibly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respect patients’ dignity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal + Communication Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicate effectively with patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System-Based Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incorporate risk-benefit analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocate for quality care in interest of one's patient</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### General Rating of Performance

Comments:

__________________________  _______________________
Date                                      Examiner

09/12/03 - gld
I. Background and Training

Program name: 
Resident name: 
Social Security#: 

Instructions:
This form should be completed by the program director at the end of each 12-month period that the resident is in the program. Completed forms must be returned to the ABPMR office within 30 days of that date.

If an unsatisfactory rating (1, 2, or 3) is assigned in any of the essential components the program director must complete the Change of Resident Status form to indicate the areas of deficiency, the plan for addressing any deficiency, and the extent to which the deficiency was addressed. The Change of Resident Status form should be submitted to the ABPMR.
If a resident receives credit for fewer than 46 weeks the Change of Resident Status form must be submitted to ABPMR.
This form is strictly confidential and will be used by the ABPMR for monitoring resident progress toward completion of certification requirements. The program director must retain copies for their files.

II. Evaluation of Essential Components

<table>
<thead>
<tr>
<th>PATIENT CARE</th>
<th>Superior</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>General skills</td>
<td>9 8 7 6 5 4 3 2 1</td>
<td>• Lacks proficiency or is awkward when obtaining patient history</td>
<td>• Unskilled in performing physical exams</td>
</tr>
<tr>
<td>• Proficient at obtaining patient history</td>
<td>• Skilled at performing physical exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treated patient's modality prescription</td>
<td>• Functional evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Demonstrates proficiency in:</td>
<td>• Lacks proficiency in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Functional evaluation</td>
<td>• Exercise and modality prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Therapeutic and diagnostic injections</td>
<td>• Therapeutic and diagnostic injections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Electrodiagnosis</td>
<td>• Electrodiagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ineffective clinician and problem solver</td>
<td>• Medical equipment prescriptions (e.g., prosthetic, orthotic and wheelchair)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Limited knowledge base</td>
<td>• Does not infer relationship between medical knowledge and clinical data; indiscriminate use of diagnostic and therapeutic procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does not respond to psychosocial aspects of illness and functional limitations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL KNOWLEDGE</th>
<th>Superior</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>General knowledge</td>
<td>9 8 7 6 5 4 3 2 1</td>
<td>• Ineffective clinician and problem solver</td>
<td>• Limited knowledge base</td>
</tr>
<tr>
<td>• Exceptional knowledge base</td>
<td>• Well integrated with practice</td>
<td>• Not integrated with practice</td>
<td></td>
</tr>
<tr>
<td>• Well integrated with practice</td>
<td>• Limited knowledge base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does not respond to psychosocial aspects of illness and functional limitations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physiatric knowledge</th>
<th>Superior</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exceptional knowledge base</td>
<td>• Well integrated with practice</td>
<td>• Limited knowledge base</td>
<td></td>
</tr>
</tbody>
</table>

n/a
PRACTICE-BASED LEARNING & IMPROVEMENT

• Excellent ability to analyze his/her practice for needed improvements
• Outstanding use of evidence-based medicine
• Appropriate application of research and statistical methods
• Appropriate use of information technology
• Facilitates education of students and other professionals
• Eagerly accepts feedback

INTERPERSONAL & COMMUNICATION SKILLS

• Communicates clearly and accurately to patients, families and health professionals
• Medical records are timely, complete and legible
• Works effectively with others
• Excellent listening skills

PROFESSIONALISM

Professional attitudes
• Reliable and punctual
• Shows integrity, initiative, and leadership
• Cooperative, promotes teamwork and mutual respect
• Accepts responsibility for own actions

Humanistic qualities
• Establishes a therapeutic and ethically sound relationship with patients
• Demonstrates compassion, sensitivity to and respect for the dignity of patients, families and colleagues as persons including their age, culture, disabilities, ethnicity, gender, and sexual orientation
• Respects patient confidentiality

SYSTEMS-BASED PRACTICE

• Excellent knowledge of practice and delivery systems
• Fully evaluates risks, benefits, limitations and costs of available resources
• Improves system of care by integration of his/her practice within the larger system

III. Overall Clinical Competence

Outstanding overall clinical competence

At the completion of training, this physician demonstrated sufficient professional ability to practice competently and independently in the specialty of PM&R (applicable to residents in their final year of training): Yes No

IV. Electronic Signature

Your electronic signature (below) serves as acknowledgement that the person signing this resident evaluation is authorized to complete this evaluation for the resident and that all information is true, correct, and complete. To complete this evaluation, please type your electronic signature in the box below and submit the evaluation.

The resident has reviewed this evaluation: Yes No

Program Director ___________________________ Date ____________
### 2012-2013 LECTURE SIGN-IN SHEET LSU HSC PM & R

**Date:** ______________  
**Topic:** ____________________________________________  
**Time:** ______________  
**Speaker:** ____________________________________________  
**Attendance verified:** ____________________________________________

<table>
<thead>
<tr>
<th>NAME</th>
<th>TIME IN</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian Clasby, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rachel Treuting, D.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amy Authement, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jacques Courseault, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicholas Goyeneche, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patrick Mahaney, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinton McCready, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jared Rochelle, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brian Koch, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justin Black, D.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lindsay Imhoff-Elliot, D.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diana Mekler, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan Morello, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chad Murphy, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navneet Sharma, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adam Shomstein, D.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benjamin Baronne, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christine Cao, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alexander Drakh, D.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jerry Miller, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>William David Rogenmoser, D.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael Voorhies, M.D.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other faculty, students, guests

<table>
<thead>
<tr>
<th>Name/Department – print clearly</th>
<th>Time In</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gary Glynn, MD (Faculty)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stephen Kishner, MD (Faculty)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kiersta Kurtz-Burke, MD (Faculty)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Mathai, MD (Faculty)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robert Mipro, MD (Faculty)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quan Le, MD (Faculty)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Randy Roig, MD (Faculty)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Instructions for Evaluator

The RO&CA evaluation is a brief (10-20 minute) spot check of resident clinical skills followed by immediate feedback. Directly observe a focused exam, a complete exam, a procedure or another resident-patient encounter, or a formal teaching experience by the resident with students or other health care professionals. Complete the assessment and give feedback to the resident immediately after the observation. Base your evaluation on only 1 observation, not on a composite of encounters. It is not necessary to observe and rate all these competencies during the evaluation.

Use the ratings: NA=not assessed at this observation. 1=unsatisfactory. 2=marginal but satisfactory performance. 3=satisfactory. 4=superior.

<table>
<thead>
<tr>
<th>Patient Name: ___________________________</th>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>PGY4</th>
<th>Date:________________________</th>
</tr>
</thead>
</table>

Patient diagnosis (for this observation):____________________________________________________ |

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Inpatient Consult</th>
<th>Outpatient Clinic</th>
<th>EMG</th>
<th>Procedure</th>
</tr>
</thead>
</table>

**PATIENT CARE**

**Interviewing Skills:** gathers essential and accurate information that identifies impairments/diagnoses and functional impact on patient; efficient.  
**Physical Exam Skills:** proficient, thorough, elicits subtle findings; sensitive to patient comfort and modesty  
Complete exam ___ Focused exam: check all that apply  
Neuro exam ___ MMT ___ Spine exam ___ Upper limb mus/skel ___  
Mental Status exam ___ ROM ___ Neck exam ___ Lower limb mus/skel ___  
ASIA exam (SCI) ___ Mobility/gait ___ Other (specify) ______________________________________ |

**Procedure Skills:** proficient; safe; uses equipment correctly; minimizes patient risk or discomfort  
Procedure observed (e.g. electrodiagnosis, injection): ______________________________________ |

**PROFESSIONALISM**

**Informed consent:** obtains informed consent including explanation of risks, benefits, and alternate methods of treatment prior to procedures  
**Sensitivity:** demonstrates sensitivity and responsiveness to patient’s culture, age, gender, disability, and tolerance to exam/procedure  

**INTERPERSONAL AND COMMUNICATION SKILLS**

**Listening skills:** uses effective listening skills, elicits information using effective questioning and nonverbal skills  
**Counseling Skills:** counsels and educates patient/family/caregiver; presents rationale for tests or treatment clearly and logically and appropriate to patient’s level of understanding; elicits patient confidence and cooperation  

**SYSTEMS-BASED PRACTICE**

**Efficient use of resources:** develops cost effective diagnostic or treatment or discharge plan of care, using services in the continuum of care; does not compromise quality of care  

**PRACTICE BASED LEARNING AND IMPROVEMENT**

**Teaching skills:** facilitates the learning of students and other health care professionals  
Title of resident presentation observed: ___________________________________________________ |

Strengths or Areas Needing Improvement: For scores of 1 or 2, comments must include areas for remediation.

Attending Signature:________________________

Resident Signature:__________________________
### LSU New Orleans
### Physical Medicine and Rehabilitation
### Annual Resident Self-Evaluation

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>PGY</th>
</tr>
</thead>
</table>

**PLEASE RATE YOURSELF ON THE FOLLOWING SCALE:**

Never -- -------------------------------------------------- Always

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Adaptability &amp; Initiative</th>
<th>Please give specific details as to why if you chose the rating of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adhere to time and attendance guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Flexible in view of interruptions, emergencies and schedule changes, including call</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anticipate needs of patients/visitors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prepare for conference and rotations through both case preparation and general reading</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Appropriately utilize literature (primary and reference) to work through difficult and puzzling cases, including protocols and interpretation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Communication and Relations with Others</th>
<th>Please give specific details as to why if you chose the rating of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Possess a collaborative, cooperative and hospitable working relationship with all members of the PM&amp;R Department.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Demonstrate competence, professionalism, and respect for patients including privacy and confidentiality.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Make suggestions for improvement in the residency program.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Make suggestions for improvement in the PM&amp;R department</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Act as mentor/teacher to students and rotating residents while promoting a positive learning environment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Communicate effectively with patients and family members by educating and reassuring them.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Present a professional image in attire and demeanor. Wear ID badge.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Quality of Work</th>
<th>Please give specific details as to why if you chose the rating of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Recognize normal and abnormal findings and generate a differential diagnosis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Understand and properly utilize equipment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Appropriately recommend follow-up examinations, understanding impact on costs and information gained</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dictations are clear and succinct</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Record keeping completed in a timely manner</td>
<td></td>
</tr>
</tbody>
</table>
### Productivity

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Please give specific details as to why if you chose the rating of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work efficiently with staff, therapists, nurses, and clerical staff to minimize report turnaround time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understand how to use various equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Familiar with routine protocols and understand when they must be altered to answer specific questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilize staff, therapists, and nurses to aid in planning for difficult or puzzling cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ask for help when needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good steward of hospital resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Development of PM&R Knowledge

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Please give specific details as to why if you chose the rating of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly read reference textbooks in preparation for rotations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regularly read primary literature to expand knowledge beyond texts and apply to individual cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify areas of weakness and adjust study habits to address those problem areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attend all conferences and maximize time spent in conferences. Incorporate this knowledge into everyday patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Please use additional space if necessary.

Provide an example where you felt you made a conscious ethical decision and/or handled a difficult patient situation: What did you learn from the experience?

What would you like to do better the next time?

What plan do you have in place to accomplish this change?

Strengths:

Areas for improvement:

Plan to make these improvements:

Signature/Date
ROTATION EVALUATION

ROTATION:

Year of Training:

General:

1. Learning Goals:

<table>
<thead>
<tr>
<th>Clear</th>
<th>Average</th>
<th>Ambiguous</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

2. How well was the rotation structured to enable you to meet the learning goals?

<table>
<thead>
<tr>
<th>Very well</th>
<th>Average</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

3. Rate this rotation in terms of how you perceive its value in preparing you (1) for a career in PM&R:

<table>
<thead>
<tr>
<th>High</th>
<th>Average</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

(2) for passing your boards:

<table>
<thead>
<tr>
<th>High</th>
<th>Average</th>
<th>Low</th>
</tr>
</thead>
</table>

4. Rate this rotation as compared to other rotations as a learning experience.

<table>
<thead>
<tr>
<th>The Best</th>
<th>Average</th>
<th>Low</th>
</tr>
</thead>
</table>

Specific Areas:

1. Teaching

A. Hours per week (est., exclude Fri. Afternoons) __________
B. Regular teaching scheduled? ________________
C. Perceived quality of teaching:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Average</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

2. Supervision

A. Hours per week of direct staff contact (include teaching time above) __________
B. Level of supervision

<table>
<thead>
<tr>
<th>Too Much</th>
<th>Above Right</th>
<th>Too Little</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

C. Resident responsibility for care

<table>
<thead>
<tr>
<th>Too Much</th>
<th>Above Right</th>
<th>Too Little</th>
</tr>
</thead>
</table>
D. Supervisory staff available 24hrs/day, 7-days/week? ________________

3. Clinical material
   A. Rate rotation in terms of new/novel clinical problems seen:
      Many new experiences-------------------------------------------------seen it all before
      5 4 3 2 1

   B. Rate rotation in terms of clinical procedures performed:
      Many---------------------------------------------------------------few or none
      5 4 3 2 1

   C. List procedures performed:

4. Workload/Learning Ratio:
   Excessive-----------------------------Just Right------------------------Too Little
   5 4 3 2 1

5. What were the best features of this rotation? Should they be enhanced or expanded in any way?

6. What needs to be improved on this rotation?
PM&R’s Suggested Reading List

An overview of suggested reading materials and educational goals for our residents include beginner, intermediate and advanced classifications. These reading suggestions are further broken down into subsections as designated by the self assessment exam (SAE). Beginning reading materials are relevant for the intern and early PGY2 years. Intermediate may extend through PGY3 year. Advanced are for Senior residents, and for continued education beyond residency. All discussed materials are available to our residents at no cost. The materials may be in the main (Ische) Library at the MEB. Several volumes of relevant physiatric materials are available at the program office (room 602) for checkout. Additionally, our resident have access to the learning resource computers on the first floor of the LSU Medical School Building 24-hours a day with the completion of a computer account application.

Three major textbooks currently exist in our field, authored respectively by Braddom, Delisa, and Grabois. It is essential that each resident review at least one of these major texts during their residency. Additionally, study guides are annually published and revised by the Archives of PM&R. The previous five years of these publications contain the most recently updated 10 subjects. Two new subjects are revised annually. Although these study guides are expressly produced for the use of practicing physicians (post residency), several of our residents have found them to be very useful in the past. Also, previous SAE exams are available. The value of this review is to determine what type of information is tested in these examinations, and to concentrate more directly on the type of information that is ultimately tested on board examinations. Other general basic texts which are valuable especially in the early years of training are the Secrets of Physical Medicine and Rehabilitation (which recently has been updated), and the Handbook of Physical Medicine and Rehabilitation Basics. (Orthotics and Prosthetics-PGY1 (Garrison, PM&R Basics) has a fine introductory chapter #3) on this subject. (This is a good book for interns to acquire).

PGY2&3 (Grabois, PM&R text) chapters 29-32 (most residents have the disc version of this text, the chapters tend to be smaller and more numerous than other texts).
Braddom PM&R text chapters 13-18 (some have found the sections 4.3-4.4 in the Practical Manual of Physical Medicine and Rehabilitation by Jackson Tan helpful. Study Guide of the Archives of PM&R, 2001 was dedicated to Limb Deficiency and Vascular Rehabilitation

PGY4 and beyond - Northwestern University publishes an excellent Orthotic and Prosthetic review. (This is a testing center for certification for orthotists and prosthetists) Also, the American Academy of Orthopedic Surgeons publishes an Atlas of Orthotics, and an Atlas of Prosthetics. These may prove to be fine reference books for prosthetic and orthotic questions, and they are available in our resident library.

INDUSTRIAL MEDICINE

PGY1 - Secrets of PM&R contains several easily accessible chapters related to this topic
PGY2&3 - Study guide of the Archives of PM&R, 2002 was dedicated to Industrial Medicine and Acute Musculoskeletal Rehabilitation
PGY4 - AMA Guide to the evaluation of Permanent Impairment provides a standard reference tot his topic.
CARDIOVASCULAR/PULMONARY/CANCER REHABILITATION

PGY1 - Garrison, Handbook of Physical Medicine & Rehabilitation Basics contains two fine chapters, 6 on Cancer rehabilitation, and 7 on Cardiovascular rehabilitation
PGY2&3 - Grabois, Chapters 79, 80 on cardiopulmonary rehabilitation respectively, and chapter 91 on cancer rehabilitation
PGY4 - The study guide of the Archives of PM&R, 2001 was dedicated to Cardiopulmonary Rehabilitation and Cancer Rehabilitation.

JOINT AND CONNECTIVE TISSUE DISORDERS

PGY1 - Doherty, “Clinical Examination in Rheumatology” (this may no longer be in print, but the office should have a copy of it).
PGY2&3 - Paget, “Manual of Rheumatologic and Outpatient Orthopedic Disorders” (this book offers succinct reviews of relevant subjects). Anderson, “Office Orthopedics for Primary Care” (this book provides a number of basic injection techniques and rehabilitation protocols, it could also be listed under the Musculoskeletal Medicine Section). Grabois, Chapter 82; Braddom, Chapter 36; and the study guide of the Archives of PM&R, 2000 was dedicated to Rehabilitation of Orthopedic and Rheumatologic disorders.
PGY4 - Klipple, J, Dieppe, “Practical Rheumatology” (this text contains excellent graphs and photographs, it is the basic edition of the above named Rheumatology textbook “The Arthritis Foundation, Primer on the Rheumatic Diseases

NEUROMUSCULAR

PGY1 - Garrison, “Handbook of Physical Medicine and Rehabilitation Basics”, Chapter 11. (This large basic chapter is a good introduction).
PGY2&3 - “Neurology Secrets” (updated 2001) is an extremely useful and accessible review of neurology. Chapter 5 is dedicated specifically to neuromuscular diseases. Grabois , Chapter 89
PGY4 - “The Archives of PM&R” dedicated its 2000 study guide to Neuromuscular Rehabilitation and Electrodiagnosis

MUSCULOSKELETAL MEDICINE

PGY1 - Grabois, Chapter 5 has a good review of clinical examination (not limited to musculoskeletal); Braddom, Chapter 1; Hoppenfeld, “Physical Exam of Spine and Extremities” (classic text, some regard as too detailed); Buschbacher, “Musculoskeletal Disorders” (written by a physiatrist, this book is easy to read and covers basic musculoskeletal topics well
PGY2&3 - Mercier, “Practical Orthopedics” (also covers basic musculoskeletal topics in an easy to read format); “Orthopedic Secrets” (nearly all of this book is important to review during your residency.); Grabois, Chapters 59-60, and 65-71; Braddom, Chapters 37-40.
PGY4 - “Archives of PM&R study guide in 2000 and 2002 reviewed the topics of Orthopedic and Acute Musculoskeletal Rehabilitation respectively.
TBI/STROKE

PGY1 - Neurology House Officer Series contains a good review of basic stroke issues. Garrison - Chapter 20 of this basic text contains an excellent review of TBI management.

PGY2&3 - Grabois, Chapter 72 (TBI) and Chapter 74 (CVA); Braddom Chapter 49 (TBI) and 50 (CVA); Archives of PM&R study guides 1998 (Brain Injury) and 1999 (Stroke Rehabilitation)

PGY4 - Horn, “Medical Rehabilitation of Traumatic Brain Injury” (this is a reference text for TBI management)

PEDIATRIC REHABILITATION


PGY2 – Carry the Journal: Developmental Medicine and Child Neurology

PGY3 - Grabois, Chapter 95; Braddom Chapters 48, 53, and 54

PGY4 - “Molnar Pediatric Rehabilitation” provides a good reference book for this topic

SPINAL CORD INJURY

PGY1 - Garrison, Chapter 17, this is an excellent review of spinal cord injuries, and quite comprehensive for an introduction; “International Standards for Neurological Classification of Spinal Cord Injury (2000). Published by ASIA (American Spinal Injury Association)

PGY2&3 - Grabois, Chapter 73; Braddom, Chapter 55; Archives of PM&R study guide 2002

PGY4 - “Rehab Institute of Chicago Procedure Manual” provides a good reference text on this subject; Spinal Cord Medicine Clinical Practice Guidelines are available on the topics of Pressure Ulcers, Management of Autonomic Dysreflexia, Prevention of Thromboembolism, Outcomes following traumatic spinal cord injury, Neurogenic Bowel Management, and Depression in spinal cord injuries

EMG

PGY1 - The Electromyographer’s Handbook, by Thompson. This is a small soft cover book that gives an excellent overview of EMG. This book should be read more than once.


PGY3 - One of the case studies book, such as Principles of Clinical Electromyography Case Studies, by Shin Oh; or Peripheral Neurology by Lweson and Spielholz; AAEM Minimonograph Series

PGY4 - Review one of the reference textbooks on EMG e.g. Electrodiagnostic medicine by Dumitru. Others are available by other authors, e.g. Johnson; Kimura; Oh; Aminoff.
ATTESTATION SHEET

I acknowledge receiving the LSU Physical Medicine and Rehabilitation House Officer Manual. By this attestation, I will abide by the rules and regulations. I understand that I will be accountable for conducting duties in the workplace in accordance with the information contained in this manual.

______________________________
Print Name

______________________________
Signature

______________________________
Date
Charles W. Hilton, MD  
Associate Dean for Academic Affairs  
Office of Graduate Medical Education  
2020 Gravier Street, Suite 602  
New Orleans, LA 70112

I hereby certify that I have received the mandatory 2012-13 House Officer Manual. I understand that I will be accountable for conducting duties in the workplace in accordance with the information contained in this manual. I understand that additional information is available through the LSUHSC-NO website; http://www.lsuhsc.edu/no/Administration; http://www.lsuhsc.edu/no/administration/hrm; http://www.medschool.lsuhsc.edu/medical_education/graduate; LSU Bylaws and Regulations, LSU System Policies, LSUHSC Policies and GME Policies. I understand that these rules and policies are subject to change and the latest revision of this manual is at http://www.medschool.lsuhsc.edu/medical_education/graduate/HouseOfficerManual.asp.

Print Name ________________________________  AY 2012-2013 ________________________________  Department ________________

HO Level ________________________________  Date ________________________________  SSN or EMPLID ________________________________

Signature ________________________________  Date ________________________________  SSN or EMPLID ________________________________

Return this form to Program Coordinator