

JACKSON MEMORIAL MEDICAL CENTER

MILLER SCHOOL OF MEDICINE/UNIVERSITY OF MIAMI

DEPARTMENT OF REHABILITATION MEDICINE

PHYSICAL MEDICINE & REHABILITATION  
RESIDENCY PROGRAM

RESIDENT'S HANDBOOK

2012-2013



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## FOREWARD

Welcome.

The entire Department of Rehabilitation team Medicine at the Leonard M. Miller School of Medicine University of Miami welcomes you to our program. Each one of us will do our best to facilitate your training in your chosen specialty and may your stay with us be rewarding and worthwhile.

This manual contains guidelines for the PMR Residency Training Program in the Department of Rehabilitation at Jackson Memorial Hospital. We ask that you read this carefully and familiarize yourself with its content. Many of the requirements you will need to fulfill are listed in this handbook. We hope this handbook will add clarity that will facilitate and enhance the performance of your duties.

Our task goes well beyond learning skills or acquiring knowledge. We have been entrusted with the care of the sick and disabled. We must work together to serve them in the most comprehensive and compassionate manner possible.

Your suggestions and constructive criticisms are welcome to ensure that you enjoy a high quality educational and personal growth experience over the next three years. For the next three years, you will become part of the “face” that this Department of Rehabilitation assumes among our colleagues in the hospital and medical school. Therefore, we only ask that as long as you also assume part of the responsibility in implementing those making changes that you suggest to improve the quality of the educational program and the reputation that this department enjoys among the other medical and surgical specialties at the University of Miami. Dr. Sherman and the Rehabilitation team will be available anytime you wish to share your thoughts with them.

Once again, welcome to our program. We look forward to working with you.

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## **INTRODUCTION TO PHYSICAL MEDICINE AND REHABILITATION**

The specialty of Physical Medicine and Rehabilitation is concerned with diagnosis, evaluation and treatment of patients with limited function as a consequence of diseases and injuries that lead to physical and emotional impairments that result in disabilities. Emphasis is placed on maximal restoration of the physical, psychological, social, and vocational functions of the person. Additionally, you are charged with providing for prevention of secondary complications of disability; maintenance of medical stability, and on alleviation of pain in your patients. Physiatrists have special training in therapeutic exercise and physical modalities; management of musculoskeletal injuries; prosthetics, orthotics, and the use of other durable medical equipment; gait analysis; diagnosis and therapeutic injections; electrodiagnostics studies; and rehabilitation management.

Rehabilitation management of chronically ill and disabled individuals, with major emphasis on the maintenance and restoration of their functional integrity, can often prevent, reduce, or postpone disability. Goals include improvement, restoration, or maintenance in functioning with or without change in underlying disease process and creation and supervision of a program of restoration. At first you may find that your input in the patient management is limited as you learn the basics of rehabilitation management and find the multidisciplinary team functions quite well on these established units. However, as you gain confidence, you will find yourself given more responsibility and ultimately become the leader of the treatment team and in charge of your patient's welfare.

As you progress through your training years, emphasis will switch from primary management of rehabilitation inpatients to outpatient care, musculoskeletal care, electrodiagnosis, and pain management. The ability to function as an independent physician in the outpatient setting is crucial to becoming an excellent physical medicine physician.

The practice of rehabilitation medicine stresses interdisciplinary team work under medical supervision. Physiatrists are trained to direct and lead a team of health related professionals that includes physical therapists, occupational therapists, speech and hearing therapists, clinical psychologists, rehabilitation counselors, nurses, social workers, and group and community workers. All of these professionals collaborate with their medical colleagues in order to fulfill the goals of comprehensive medical care. Mobilization of essential family and community resources is

emphasized. Planning and implementation of continuity of restorative care bridges the gap between intensive treatment and social re-integration.

The JMH-PHT/University of Miami Miller School residency training program is designed to fulfill these goals.

## PROGRAM DESCRIPTION AND REQUIREMENTS

The residency program in rehabilitation medicine at Jackson Memorial Hospital is a three year program of postgraduate training in physical medicine and rehabilitation that leads to eligibility for certification by the American Board of Physical Medicine and Rehabilitation. In 2009 our program was granted approval, as a fully functioning program, by the Rehabilitation Residency Committee (RRC) under the Accreditation Council for Graduate Medical Education (ACGME). In 2008 the program was reviewed, as a fully functional program, with all PGY levels filled. The RRC granted the program a 5 year accreditation, the most time granted to a program. The program trains physicians beginning at the second postgraduate year and requires a preliminary year that includes at least six months of training in one of the following areas: internal medicine, general surgery, pediatrics and/or family practice. Residents must have passed part II of the USMLE/COMLEX to begin the residency.

The objectives of the program are to provide a post-doctoral specialty training in Physical Medicine and Rehabilitation and to enable the trainee, upon completion, to undertake state-of-the-art clinical practice, perform research, and/or pursue an academic career. Towards that end, the program is structured to expose the trainee to all areas essential to the attainment of competency and expertise in the profession.

At Jackson Memorial Hospital, we have inpatient units that consist of the following number beds for each. Spinal Cord Injury/Comprehensive Rehabilitation has 26 beds, neuro-rehabilitation has 28 beds, and Pediatric Rehabilitation has 12. These patients are admitted to this service by Jackson Memorial Hospital physicians only. The mix of patients is heterogeneous, proportionately reflecting disability seen in the general population. Each resident rotates through the inpatient services a minimum of twelve months. During these rotations the resident will be responsible for the comprehensive primary medical and rehabilitative care of their patients. Residents will be given a list of comprehensive objectives for which they must show competency to pass the rotation.

The JMH rehabilitation medicine consultation service receives over 2500 annual consultations for patients on other services. Two residents rotate through this service, one performing all consultations and then presenting them to the attending physician on service and one will assist with clinics, etc. Two months of the resident's experience will be devoted to JMH Pediatric Rehabilitation, including evaluation and physiologic management of inpatients at the Jackson Memorial Hospital, consultations in the neonatal intensive care unit at Jackson Memorial Hospital, Miami Children's Hospital, and the pediatric rehabilitation in-patient wards, and outpatient exposure in the Pediatric Rehabilitation Clinics. Another JMH experience consists of Two selective months – JMH based electives – of which one must be entirely outpatient and two weeks may be “off site” experiences. The final JMH rotation is the Senior rotation which is a mix of outpatient clinics, educational and administrative opportunities, and assisting with inpatient rehabilitation care for services short of resident coverage due to vacations.

The next major rotation site is the Miami VA. At this site, currently six residents rotate. This includes a PGY 2 inpatient rotation and a PGY 2 outpatient rotation. PGY 3 consists of the EMG/neuromuscular rotation and the Research/Chronic SCI rotation. The PGY4 year consists of the Pain rotation and the specialty clinics/EMG teaching rotation.

At the University of Miami Hospital and Clinics, there is a PGY 3 MSK/Spine rotation and a PGY4 EMG/Neuromuscular disease/Spine rotation. The final rotation occurs at Mount Sinai Hospital with a 50% inpatient and 50% outpatient/hospital rotation.

Didactic course series include lectures in: prosthetics/orthotics, electrodiagnostics, anatomy and kinesiology (including cadaver prosection laboratory), physical examination, therapeutic modalities, orthopedic rehabilitation, principles of neurologic, cardiopulmonary, and musculoskeletal rehabilitation, manual medicine, neurotrauma, and pediatric rehabilitation. Regularly scheduled academic discussions and activities include: monthly journal clubs, case presentation rounds both on the inpatient unit and consultative services, mortality and morbidity conferences, program director case conferences, board review club, formal research training, and grand rounds. Interdisciplinary conferences include: spine conference, neuroradiology conference, rheumatology conferences, anatomy course with prosection laboratory, Neurosurgery grand rounds, Miami Project to Cure Paralysis lectures, Pain Fellowship conference, and Orthopedic grand rounds.

The department supports the philosophy of adult learning. A major goal of the residency is the development of sound educational habits that result in a self-generated study and continuous learning. Although the program provides an extensive variety of didactic educational tools, each resident is ultimately responsible for his/her own professional education and is expected to devote substantial time at regular intervals to reading and enhancement of his/her knowledge. Each resident will be given a mentor to guide them throughout their residency.

## **EVALUATIONS**

Resident evaluations occur every month (midpoint and final) and include formal written evaluations of the resident and face to face presentation of the evaluation. Additionally individual discussion with the Program Director occurs twice per year. Resident assessment is based on ACGME guidelines for residency programs (see Appendix). The residents also receive a written evaluation upon completion of each rotation. Conversely, residents evaluate the program and the attending physicians annually, in addition to monthly rotation evaluations. All evaluations are kept completely confidential through the web-based system, New Innovations. The Chair and Program Director use this evaluation process to optimize the resident's learning experience during the annual retreat.

## **SAE Exam**

All residents participate in the annual Self Assessment Examination administered nationally by the American Academy of Physical Medicine and Rehabilitation. The purpose of the exam is to self evaluate your ability to perform on a comprehensive written examination where the expectations are similar to - but not exactly like the board exam. Moreover, it is an opportunity for each resident to understand their strengths and deficiencies in various subspecialties of PM&R and alter their study habits accordingly. Although the SAE exam cannot be used as the sole test to decide of promotion or probation, a highly deficient score (<25%ile) creates such concern that if combined with other rotation or documented academic or professional deficiencies can serve as the impetus for initiating a remedial education plan – which if not completed successfully, would result in academic probation or dismissal. The exam, taken in aggregate (all testers) allows the program to evaluate its effectiveness in teaching these subspecialties.

## **SAE subspecialties:**

Electrodiagnosis  
Professionalism  
Musculoskeletal



Rheumatologic  
Stroke and brain Injury  
Amputee  
SCI  
Pediatrics  
Industrial Rehabilitation  
Medical Rehabilitation

Residents are expected to score ***no lower*** than the 25 percentile nationally on this examination. A score that fails to meet the expectation may result in academic remedial action. An insufficient score, by itself, will not be used as the sole reason for dismissal however.

### **Mock Oral Exam Program**

PGY 4 residents are required to participate in a Mock Oral exam program. As part of the program, each PGY 4 is required to complete a case vignette similar to that seen on the ABPM website in a topic chosen by the attending staff in charge of the program for that year. Failure to comply with the case or participate in the program will result in academic warning and/or probation. A total of 4 sessions will be held throughout the year.

### **Research**

Residents are encouraged to develop but at a minimum are required to participate in at least one original research project that will culminate in an oral presentation, at some point during or at the end of their residency. The minimum required venue for the presentation "research day", usually reserved for the third June during the PGY-4 year. The resident may use the basic tools acquired in the research lectures to produce original work.

Alternatively the resident may actively participate as an assistant in an ongoing project. Again, the background, methods, and results (if any) of the research would then be presented in oral presentation at the end of the residency on the designated PGY-4 research day program.

Additionally, all residents are required to submit at least one abstract to a national meeting during their residency. If accepted, the resident will then follow through with a poster or platform presentation. The deadline to complete the poster is by the research day of the PGY 3 year to "hang" and discuss on Research Day in June.

The meeting that residents are encouraged to target the National Academy of PM&R meeting during the fall of their PGY 4 year. Abstracts for this meeting are typically due at the end of February of the PGY-3 year. Expedited single case IRB submissions are necessary and should be planned for by with sufficient time. PGY 4 residents who submit an acceptable abstract (reviewed by the program director) will have expenses related to the academy Annual assemble meeting paid for by the department as per the department guidelines (written separately).

### **QI Projects**

Each resident will complete a QI project. An attending physician will serve as the mentor on the project. The final results of the project are required to be presented in May or June Grand Rounds of the PGY 4 year. Failure to present a QI project jeopardizes graduation status.

# EDUCATIONAL OBJECTIVES

## ***OVERALL PROGRAM OBJECTIVES***

- To provide an educational experience to enable our graduates to attain competencies necessary for entry level independent of Physical Medicine and Rehabilitation. This is accomplished through intensive study in diagnosis, pathogenesis, treatment, prevention, and rehabilitation of neuromusculoskeletal, cardiovascular, pulmonary, and other system disorders common to the specialty.
- To develop the attitudes and psychomotor skills required to:
  - Modify history taking technique to include data pertinent to functional abilities, and impairments that affect those abilities.
  - Perform physiatric examinations and 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 ability.
- To coordinate, lead, and manage an interdisciplinary team of allied rehabilitation professionals through:
  - Knowledge of each provider's role.
  - Writing of detailed, goal-based physiatric prescriptions.
  - Development of leadership and management skills.

The above concepts will be taught within the framework of the six key areas of residency teaching:

Residents must achieve competence in six key areas of physician training:

1. Patient Care
2. Medical Knowledge
3. Professionalism
4. Systems Based Practice
5. Interpersonal and Communication Skills
6. Practice Based Learning

It is expected that by achieving competence in each of the six areas, that this program will graduate complete PMR physicians, who are competent to practice in this field of PMR and can effectively compete with other physiatrists equally in an academic or private practice setting.

The global objectives that you are expected to achieve while in the PMR program are listed below:

## **GLOBAL LEARNING OBJECTIVES OF THE PMR RESIDENCY PROGRAM**

The PMR residency program at Jackson Memorial Hospital (JMH)/University Of Miami School Of Medicine will provide the intellectual environment, formal instruction, and broad experience necessary for each resident to acquire the knowledge, skills, and attitudes essential to the practice of Physical Medicine and Rehabilitation. The program will provide the facilities to accomplish the overall educational goals for each resident.

Goals: The goal of the PMR residency program at Jackson Memorial Hospital (JMH)/University of Miami School of Medicine requires that our residents attain competency and excel in the six areas identified by the ACGME and maintain a life-long commitment to continue to grow and develop in these areas. These six areas are: Patient care, medical knowledge, practice-based learning and improvement, communication and interpersonal skills, professionalism, and systems-based practice.

Residents will be expected to progress through the PGY 2, 3, and 4 years and improve their levels of competence to achieve the ability to be able to practice PMR independently without supervision in any setting. Educational programs and clinical experience provide our residents with the skills to achieve competency in these areas. The program directors have put in place assessment tools to measure residents' competency in each area, and continue to work on expanding our methods of assessment.

### **PGY-2 Resident**

The majority of the first year is devoted to inpatient medicine. The PGY-2 functions as the primary physician for his/her patients. Working closely with senior residents and attending staff, the PGY-2 is responsible for the development and implementation of each patient's multidisciplinary care plan. The PGY-2 spends their time on inpatient services 10 out of 12 months of the year rotating through SCI, Neurorehabilitation, and Comprehensive Rehabilitation services at JMH and the VAHS. Two months are spent in outpatient services at VAHS with early exposure to electrodiagnosis.

### **PGY-3 Resident**

The focus shifts during the second year of residency to more mixed schedule with the addition of outpatient musculoskeletal, spine, and pain management at UMHC. The general inpatient rotation is community based at Mount Sinai hospital. The PGY-3 resident also performs acute hospital consultations. The resident begins subspecialty training in depth in pediatrics, electrodiagnosis and neuromuscular medicine. Finally, a mixed research, advanced SCI, and MSK clinic rotation is at the VAHC.

### **PGY-4 Resident**

The PGY-4 residents has a varied experience in the PGY-4 year. They spend a great deal of time supervising and teaching other residents on the JMH consult service, and inpatient senior rotation. They also provide teaching at the VAHS outpatient service and the electrodiagnosis lab. The PGY-4 resident will also obtain advanced electrodiagnosis training at UMHC and BPEI. Elective/Selective rotations at JMH of six to eight weeks are allowed (2-4 weeks outpatient mandatory) with one full week allowed off-site (with permission and paperwork). Rotations within related departments of Orthopedics, Anesthesia Pain Management, Radiology and Rheumatology occur within the selective rotation.

An outline of the six competencies, current global objectives, and methods of assessment are discussed below:

### **Patient care:**

Residents must provide compassionate, comprehensive care to all patients. To make diagnostic and therapeutic decisions based on best available evidence, sound judgment, and patient preferences. Residents must possess comprehensive history and physical examination skills, and competence in procedural skills.

#### Education:

1. Structured inpatient and outpatient experiences provide the opportunity for residents to assess and provide care to patients with widely varying clinical problems. In the PGY-2 year, residents will see new patients in inpatient and ambulatory settings at both JMH and the VAHS, and have very close and comprehensive mentoring and supervision from both more senior residents and attending level faculty. In the PGY 3 and PGY 4 year, rotations also occur at UMHC, Mount Sinai Hospital, and elective locations.
2. In these settings, residents will participate in education based clinical care of patients in order to strengthen their ability to gather accurate data from history, physical exams, and radiographic analysis. The resident will learn to synthesize this data to develop a comprehensive plan of assessment, differential diagnosis and treatment. The residents will receive feedback on their competence and learning progression.
3. Residents are supervised in the performance of procedural skills by more senior residents or faculty, and document each procedure on-line.
4. Teaching faculty serve as role models for the provision of comprehensive, compassionate care. Dedicated PMR faculty is assigned to both the inpatient rehabilitation service and the ambulatory settings, where they review the assessment and care plan for each patient with the resident.
5. Clinical case conference is held with the program director two Fridays per month.
6. Structured musculoskeletal physical exam course taught by the Department of Physical Therapy and PGY-4 residents based upon the PASSOR competencies published on the aapmr.org website.

#### Areas of Competence (Objectives) that must be achieved:

##### PGY-2

- 1.1a Perform an expanded physiatric history, including aphasic patients.
- 1.2a Perform basic neurological, musculoskeletal, and medical physical exam that includes all aspects of the physiatric exam.
- 1.3a Perform the expanded functional exam unique to the physiatric assessment.
- 1.4a Perform the ASIA SCI examination.
- 1.5a Perform in depth musculoskeletal and neurologic system examination.
- 1.6a Learn basic procedural skills including peripheral joint injection, foley catheter placement, refill Baclofen pumps.
- 1.7a Begin to learn to perform EMG/NCV studies and Botox injections.
- 1.8a Learn how to document properly in the care of the patients with competent progress notes, discharge summaries, and team evaluation summaries.
- 1.9a Identify normal and common abnormalities on:
  - i. Brain CT, MRI
  - ii. Spine X-ray, CT, MRI
  - iii. Bone Scan
  - iv. KUB X-ray
- 1.10a Learn the aspects of caring for deep wounds and decubiti
- 1.11a Learn physical exam techniques based on the PASSOR Competencies and teach these techniques to the junior residents

##### PGY-3

- 1.1b Perform an expanded physiatric history, including aphasic patients in the setting of the acute care consultation.
- 1.2b Perform and orthopedic examination on specific areas of the body:
  - i. Shoulder
  - ii. Knee
  - iii. Spine
  - iv. Elbow
  - v. Hip
  - vi. Wrist and hand
  - vii. Ankle and foot
- 1.3b Perform an expanded history and physical exam targeted to patients with chronic pain disorders and a history of Military Service
- 1.4b Perform the necessary neurological exam that will allow for the EMG/NCS testing
- 1.5b Perform a basic NCV and EMG exam.
- 1.6b Perform joint and trigger point injections in the areas of the body mentioned above.
- 1.7b Order diagnostic tests appropriately to evaluate patients with musculoskeletal and neurological disorders.
- 1.8b Show improved abilities to read and interpret:
  - MRI, CT, X-ray, and bone scan films and reports
  - Electrodiagnostic reports
- 1.9b Begin to perform axial spine injections
- 1.10b Perform a comprehensive physiatric consultation on patients in the acute hospital.
- 1.11b Based upon comprehensive assessment, generate a differential diagnosis, begin to learn to create an appropriate rehabilitation diagnosis, treatment plan, and goal for functional outcome.

#### PGY-4

- 1.1c Master the performance and documentation of an expert comprehensive physiatric history, physical examination, and functional examination in a manner that conveys compassion, caring, and respect for the patient.
- 1.2c Based upon comprehensive assessment, show mastery of creating an appropriate rehabilitation diagnosis, treatment plan, and goal for functional outcome.
- 1.3c Show mastery of the comprehensive physiatric consultation on patients in the acute hospital.
- 1.4c On patients on whom consultation is performed, show advanced ability to decide on the need for inpatient vs. outpatient rehabilitation.
- 1.5c On patients needing inpatient rehabilitation, show advance ability to choose appropriate treatment modalities and set goals for treatment.
- 1.6c Show advanced ability to order appropriately and interpret diagnostic tests in the setting of musculoskeletal and neurologic diseases.
- 1.7c Identify detailed normal anatomy as it pertains to the nervous and musculoskeletal system on CT, MRI, myelography, bone scan, and X-ray.

- 1.8c Master the basic NCV and EMG exam such that the test can be performed independently. Begin to show proficiency and independence with advanced NCV/EMG/SEP techniques.
- 1.9c Show mastery of physical exam techniques based on the PASSOR Competencies and teaches these techniques to the junior residents

**Assessment:**

1. Residents document each procedure performed on-line.
2. Mini-CEX (clinical-evaluation exercises) exams are performed throughout each inpatient and outpatient rotation, and are reviewed with the resident by the faculty. The results of these are further reviewed with each resident at the time of each semi-annual review with the program director or associate program director.
3. Monthly evaluations are completed by the resident's attending physician, co-resident, intern and medical students and are reviewed with the resident by both his attending and program director(s).
4. Evaluations of residents in continuity clinic are completed semi-annually by their assigned attendings.
5. Evaluation of the PASSOR based physical exam course by teaching faculty with additional education given.

**Medical Knowledge:**

Residents must demonstrate knowledge of basic and clinical sciences and apply this knowledge to decisions regarding patient care. Residents obtain this knowledge through didactic lectures, case conferences, journal clubs, workshops, and direct one-on-one teaching at the patient's bedside. They will develop a comprehensive understanding of mechanisms of disease, and create the skills to obtain lifelong learning. Evaluation will occur via direct rotation grades, lecture exams, Mini-CEX and ROCA grades and SAE practice board examinations.

**Education:**

1. Resident inpatient rounds with senior residents and attending staff are held at both JMH and the VA four or five days weekly.
2. The core curriculum lecture series provides comprehensive didactics throughout the academic year, and is presented at JMH with an 18 month cycle. Residents are expected to attend 75% of lectures in order to be eligible to be promoted to their next level of training.
3. An introductory lecture block is held daily for the first month of each academic year, required for all PGY-2 residents. The block is attended and partially taught by many PGY 3 and PGY 4 residents as well, to allow them experience in teaching and promote lifelong learning and repetition of important ideals in PM&R.
4. Monthly M & M, Journal Club or Performance-Improvement conferences are held and required for all residents.
5. Monthly PMR grand rounds are given.
6. A 20 hour anatomy course is given each year by anatomy staff combined with resident lectures each year.
7. Prosthetic and Orthotics staff gives lecture series on a 1 ½ year cycle.
8. Didactics will be provided in Botox injection, joint injection, and spine injection.

9. Combined spine rounds with Neurosurgery and orthopedics each week.
10. Prosthetics and orthotics Clinic held each week
11. Neuroradiology Conference held each week combined with neurology service
12. Friday afternoon MSK teaching session

Areas of Competence (Objectives) that must be achieved:

## **PGY 2**

- 2.1a Learn the basic pathophysiology, evaluation, treatment, and inpatient rehabilitation management of the core problems of:
  - a. TBI
  - b. Stroke
  - c. SCI
  - d. Amputee
  - e. Chronic pain
  - f. Total Joint replacement
  - g. Post cardiac surgery
  - h. Debility
  - i. Inflammatory joint disease
  - j. Burn
- 2.2a Learn to prevent and then identify common and uncommon medical complications that occur in patients with disabling injuries in the inpatient rehabilitation setting including but not limited to
  - a. Decubiti
  - b. MI
  - c. Respiratory incident
  - d. Autonomic dysreflexia
  - e. Hydrocephalus
  - f. Heterotopic Ossification
  - g. DVT
  - h. Neuropathic pain
  - i. Orthopedic Pain
- 2.3a Begin to learn the pathophysiology, evaluation, treatment, and rehabilitation management of common and some uncommon problems seen in the outpatient setting including but not limited to:
  - a. Shoulder, elbow, wrist, and hand disorders
  - b. Hip, Knee, ankle, and foot disorders
  - c. Spine disorders
  - d. Chronic pain disorders
  - e. Follow up SCI, TBI, Stroke, Amputee, Total joint replacement
- 2.4a Learn the anatomy of the musculoskeletal, spine, and neurological system
- 2.5a Learn physical examination maneuvers that test the anatomy when pathology is present.
- 2.6a Learn to utilize urodynamics in the care of SCI patients
- 2.7a Learn the aspects of caring for deep wounds and decubiti

### **PGY-3**

- 2.1b Demonstrate comprehensive knowledge of common and uncommon neurologic disorders including considerations relating to age, gender, race, ethnicity, genetics, and socio-cultural factors.
- 2.2b Demonstrate knowledge of the community rehab setting – in patient, and begin to understand how private practice treatment in physiatry differs from academic center practice.
- 2.3b Show advanced knowledge of the pathophysiology, evaluation, treatment, and rehabilitation management of common and some uncommon problems seen in the outpatient setting including but not limited to:
  - a. Shoulder, elbow, wrist, and hand disorders
  - b. Hip, Knee, ankle, and foot disorders
  - c. Spine disorders
  - d. Chronic pain disorders
  - e. Post polio
  - f. Follow up SCI, TBI, Stroke, Amputee, Total joint replacement
- 2.4b Demonstrate comprehensive knowledge in psychological disorders in the context of how they impact patients with chronic disease, pain, and disability.
- 2.5b Demonstrate knowledge of healthcare delivery systems.
- 2.6b Demonstrate knowledge of the anatomy and pathophysiology of all of the common and uncommon neurological, musculoskeletal, medical, and painful disorders that a physiatrist would be expected to encounter.
- 2.7b Demonstrate the ability to competently treat all of the common and uncommon neurological, musculoskeletal, medical, and painful disorders that a physiatrist would be expected to encounter.
- 2.8b Demonstrate specific knowledge of the neurophysiology of EMG/NCS/SSEP
- 2.9b Demonstrate the knowledge of peripheral joint injection.
- 2.10b Assess a patient with amputation or limb weakness and prescribe an appropriate orthotic or prosthetic device.

### **PGY-4**

- 2.1c Show mastery of physical exam techniques based on the PASSOR Competencies and teaches these techniques to the junior residents
- 2.2c Master specific knowledge of the neurophysiology of EMG/NCS/SSEP
- 2.3c Show advanced knowledge of the pathophysiology, evaluation, treatment, and rehabilitation management of common and some uncommon problems seen in the outpatient setting to the point where they can teach junior residents in addition to functioning independently.
  - a. Shoulder, elbow, wrist, and hand disorders
  - b. Hip, Knee, ankle, and foot disorders
  - c. Spine disorders
  - d. Chronic pain disorders
  - e. Follow up SCI, TBI, Stroke, Amputee, Total joint replacement
- 2.4c Show mastery of the didactic program such that the resident will be able to



effectively take the board examination and pass.

2.5c Show mastery of all of the objectives listed above for PGY 2 and PGY 3.

**Assessment:**

1. Resident's at all three PGY levels are required to take the standardized in-training examination annually.
2. Results are reviewed in detail at the time of the semi-annual reviews.
3. After a "block" of lectures, an exam will be given.
4. Evaluations of medical knowledge are completed as part of the comprehensive monthly evaluation at the end of each rotation by the attending, physicians.
5. Residents actively participate in case conference in the presence of the chairman, program director, and other key faculty.

**Practice-based learning and improvement:**

Residents must demonstrate competency in the investigation and self-evaluation of patient care, use of technology and appraisal of scientific evidence, apply evidence-based medicine to improve patient care, and other methods of self-improvement in the provision of outstanding patient care. The Basic Objectives are shared among PGY2, 3, and 4 levels but the level of competence expected will be expected to be higher in the more experienced resident.

**Education:**

1. Residents attend a comprehensive didactic course in evidence-based medicine and research methodology.
2. A lecture in library search techniques
3. Journal club, held at least monthly, is presented by two residents and supervised by a faculty member that serves as preceptor. Each study is fully discussed by peer residents and teaching faculty. Discussions of sound medical evidence and application to patient care are emphasized.
4. M & M conferences and performance-improvement conferences stress methods of identifying areas for potential improvement and the open discussion of medical errors.
5. An orientation session on prevention of medical errors is held annually.
6. All deaths, complications, and medical errors are reviewed during M&M report at both JMH and the VAHS.

Areas of Competence (Objectives) that must be achieved:

**PGY-2, 3, 4**

- 3.1.1 Employ principles of quality improvement in practice.
- 3.1.2 Demonstrate awareness of limitation in one's own knowledge base and clinical skills
- 3.1.3 Demonstrate effective methods for lifelong learning
- 3.1.4 Demonstrate the ability to obtain, review, and critically evaluate up-to-date information from scientific and practice literature and other sources (internet

based searches, literature databases such as PubMed, drug information databases) to assist in patient care.

- 3.1.5 Evaluate caseload and practice experience in a systematic manner.
- 3.1.6 Participate in the learning of students and other health care professionals.
- 3.1.7 Employ a strategy to identify medical errors in practice and initiate improvements to eliminate or reduce errors.
- 3.1.8 Attend 75% of all M&M rounds while rotating in participating rotations. Understand the purpose of M&M and how to discuss learning to use unfortunate outcomes to improve your own quality improvements.
- 3.1.9 Work with a mentor to develop and manage an individual learning plan.
- 3.1.10 Create and implement one quality improvement project.
- 3.1.11 Work in a substantial way on an original research project.
- 3.1.12 Submit an abstract to the Academy meeting in order to present at the meeting in their PGY-4 year.
- 3.1.13 Demonstrate respect, compassion, and integrity.
- 3.1.14 Abide by professional attire rules.

**Assessment:**

- 1. Monthly evaluations are completed by the resident's attending, regarding competency in practice-based learning and improvement.
- 2. Case presentations during rounds and at conferences are encouraged to include current literature reviews.
- 3. Problem-based learning objectives are identified and discussed at follow-up conferences.
- 4. 360 degree evaluations to see if residents are keeping up-to-date
- 5. Patient evaluations of professionalism

**Communication and interpersonal skills:**

Residents must demonstrate competency in effective listening and communication skills, and in the ability to develop strong therapeutic relationships with patients, nurses, rehabilitation multidisciplinary team and the families. They must be able to obtain and provide information in clearly understandable ways, and educate and counsel patients effectively. They must demonstrate the ability to work well with others as part of an interdisciplinary health care team.

**Education:**

- 1. Throughout all aspects of residency training, residents are exposed to faculty who are effective and active role models for becoming competent in communication and interpersonal skills. These interactions occur daily in both inpatient and outpatient settings.
- 2. Specifically, in the inpatient setting, residents are exposed to faculty role models and also actively participate in family conferences with patients and families regarding issues of rehabilitation goals, discharge planning, medical and functional prognosis, and psychological issues.
- 3. Specific didactic sessions, including during medical grand rounds, are dedicated to discussion of communication and interpersonal skills.

Areas of Competence (Objectives) that must be achieved:

- 4.2.1 Communicate effectively with consulting physicians and other health professionals, and outline clear and specific recommendations.
- 4.2.2 Maintain up-to-date medical records that respect patient privacy and document essential information.
- 4.2.3 Demonstrate the ability to work effectively as a member of a multidisciplinary treatment team.
- 4.2.4 Demonstrate the ability to effectively leading a multidisciplinary treatment team on the inpatient rehabilitation service and in the outpatient setting.
- 4.2.5 Partner with the patient and his/her family to develop a mutually agreeable healthcare management plan, discuss risks of proposed treatment, and discuss benefits, complications and alternative treatments.
- 4.2.6 Provide preventative education to patients and families.
- 4.2.7 Educate patients and their families about the medical, psychological, and behavioral issues of their disability.
- 4.2.8 Demonstrate the ability to obtain proper informed consent including explanation of risks, benefits, and alternative treatments.
- 4.2.9 Communicate effectively with medical consultants.
- 4.2.10 Communicate the advice of consultants effectively to patients and families.
- 4.2.11 Maintain up-to-date medical records that respect patient privacy and reflect the treatment that is being offered and given. Such records must be understandable to non-rehab physicians, other caregivers, non-physicians, attorneys, and the patient and family.
- 4.2.12 Write legible and accurate prescriptions.
- 4.2.13 Develop a therapeutic relationship with patients by instilling a sense of trust, honesty, openness, rapport, and comfort. Demonstrate the ability to communicate effectively with patients, caregivers, physicians, and other health professionals.
- 4.2.14 Demonstrate the ability to collaborate with patients, caregivers, physicians and other health professionals.

**Assessment:**

1. Peer-to-peer evaluations are completed anonymously in the form of a 360 degree evaluation once per rotation. These are anonymous and immediately available for each resident to review. These are discussed during the semi-annual evaluations with a program director.
2. Monthly evaluations are completed by the resident's attending physician.
3. The Mini-CEX and ROCA exams address a resident's ability to effectively communicate and interact with patients.
4. Patient evaluation of the resident.

**Professionalism:**

Residents must enhance their awareness of one's sensitivity and respect towards patients and co-workers, strengthen their degree of responsibility and accountability, and demonstrate responsiveness to the culture, gender and socioeconomic background of patients. Residents must foster an atmosphere of respect and compassion at all times. Interest and enthusiasm for teaching must be consistently evident in a resident's behaviors.

#### Education:

1. Professionalism is consistently stressed as a critically important part of a resident's life throughout all aspects of the residency program.
2. Faculty role models are expected to exhibit a high level of professionalism at all times.
3. Medical ethics and professionalism are discussed during resident case conferences and during other interactive sessions with residents.
4. Didactics have been presented specifically addressing professionalism.
5. Videos that address this topic are presented and discussed with attending staff.

The Basic Objectives are shared among PGY2, 3, and 4 levels but the level of competence expected will be expected to be higher in the more experienced resident.

- 5.1.1 Demonstrate responsible behavior in the care of patients, including timely response to communications from patients and health professionals and coordination of patient care.
- 5.1.2 Demonstrate confidentiality in the delivery of care.
- 5.1.3 Demonstrate ethical behavior, professionalism, integrity, honesty, and compassion in both spoken and written communications, including matters of informed consent, professional conduct, and conflict of interest.
- 5.1.4 Demonstrate respect for patients, caregivers, and professional colleagues.
- 5.1.5 Communicate verbally and non-verbally
- 5.1.6 Demonstrate respect for all patients, caregivers, and professional colleagues without bias to cultural beliefs, religious beliefs, genders, disabilities, socioeconomic backgrounds, race, political leanings, and sexual orientation.
- 5.1.7 Residents will attend minimum of 75% of all lectures and on time.
- 5.1.8 Demonstrate sensitivity regarding end-of-life care issues.
- 5.1.9 Participate in the review of professional conduct of colleagues with patients, caregivers, and the rehab medical team in an ethical and appropriate manner.
- 5.1.10 Demonstrate comprehensive knowledge of common and uncommon painful disorders with considerations relating to age, gender, race, ethnicity, genetics, and socio-cultural factors.
- 5.1.11 Learn how to obtain consent for research correctly and ethically.
- 5.1.12 Engage in research in an ethical manner.

#### Assessment:

1. Monthly evaluations completed by attendings address this competency, and are reviewed with the resident both immediately after each rotation and during the semi-annual reviews.
2. Peer-to-peer evaluations are completed anonymously in the form of a 360 degree evaluation once per rotation. These are anonymous and immediately available for each resident to review. These are discussed during the semi-annual evaluations with a program director.
3. An award is presented annually to the resident in our program who has best demonstrated the ideals of professionalism.

### **Systems-based practice:**

Residents must demonstrate competency in negotiating the system in which they work to ensure optimal patient care, and to apply knowledge of systems to improve patient care. They must be able to use systematic approaches to reduce errors and improve care, as well as effectively access and utilize outside resources to benefit their patients.

#### Education:

1. Close interaction with social workers, case managers, clinical pharmacists, nursing staff, physical and occupational therapists, nutritionists, and other members of the rehabilitation multidisciplinary team provide residents with opportunities to utilize resources for the benefit of their patients.
2. Social workers and case managers are assigned to specific patient care units and interact daily with residents.
3. Dedicated time with the Geriatric service at the VA is required for all PGY-4 residents. During this rotation, residents are exposed to methods of providing comprehensive care to this population, including the interaction of social workers, geriatric case managers, nurses and physicians to optimize the level of care.
4. Residents will interact with insurance medical directors to obtain increased inpatient rehabilitation days.

The Basic Objectives are shared among PGY2, 3, and 4 levels but the level of competence expected will be expected to be higher in the more experienced resident.

- 6.1.1 Demonstrate the ability to use the diverse systems involved in treating patients, as part of a comprehensive, individualized treatment plan.
- 6.1.2 Utilize community systems of care and assist patients to access appropriate care and other support services.
- 6.1.3 Demonstrate effective utilization of managed health systems
- 6.1.4 Practice cost-effective health care and resource allocation that does not compromise quality of care.
- 6.1.5 Lead the multidisciplinary team in the provision of comprehensive rehabilitation treatment.
- 6.1.6 Demonstrate effective time management skills
- 6.1.7 Utilize systems of care appropriately including rehab placement, nursing home placement, home care, and hospice.
- 6.1.8 Act as an advocate for patients so that they can receive medical care regardless of their sociocultural or financial situation.
- 6.1.9 Behave in a manner that shows awareness of medical-legal and financial aspects of patient care and risk management.
- 6.1.10 Participate effectively in utilization review communications and meetings and advocate for quality of care when appropriate.
- 6.1.11 Practice cost-effective health care that does not compromise patient care.
- 6.1.12 Demonstrate the ability to reference and utilize electronic systems to access relevant medical, scientific and patient information.

#### Assessment:

1. Monthly evaluations completed by attending physicians and reviewed with the resident upon completion of the rotation and at the semi-annual evaluations.
2. Discussion of issues of systems-based practice at rounds regularly.
3. Peer-to-peer evaluations are completed anonymously in the form of a 360 degree evaluation once per rotation. These are anonymous and immediately available for each resident to review. These are discussed during the semi-annual evaluations with a program director.

## **ABREVIATED ROTATION OBJECTIVES AND AFFILIATIONS OVERVIEW**

(Competency based objectives will be presented to each resident and are available on the resident shared drive)

### ***JMH-UM ROTATIONS***

## **ACQUIRED BRAIN INJURY ROTATION OBJECTIVES**

The faculty member(s), will be reporting to the rotation director about the progress and performance of each resident through the course of the rotation. Although the resident will be directly reporting to a faculty member, he/she may also be reporting to the rotation director as needed.

The resident may take care of as many as but usually no more than 14 patients at any given time. On average, a minimum of 8 patients will be on the teaching service. Teaching will occur during bedside rounds to expand the resident's medical knowledge base. In addition, the resident will be exposed to didactic sessions throughout the rotation on topics appropriate to the care of the psychiatric patient. These will be assigned and adjusted according to the clinical load at any given time.

The resident will be expected to:

- Show reliability, punctuality, integrity, and honesty.
- Accept responsibility for any actions and decisions made.
- Demonstrate and exemplify caring and respectful behaviors, present material clearly and accurately, and establish trust and maintain rapport with patients and family members.
- Collaborate and work effectively with other health professionals and maintain appropriate behaviors.
- Effectively communicate verbally and in writing patient needs to all staff involved with the rehabilitation patient.
- Contribute to discussions on the care of the rehabilitation patient with other health care professionals by attending and participating in conferences and rounds in order to facilitate such discussions.
- Complete all chart notes and dictations in a timely and legible manner. This includes daily progress notes on all patients, discharge summaries completed within 24 hours of discharge barring unforeseen circumstances, team rounds summaries, and accurate medication and therapy orders.
- Present 2 conferences for teaching purposes during each 3-month rotation.
- Senior residents will have a topic assigned for teaching purposes weekly.

- Furnish a brief summary or notes taken during the various didactic sessions that are not directly supervised by a faculty member, as evidence of attendance.
- Keep a log of any procedures done during the rotation (i.e. intrathecal drug therapy trials, chemodenervating procedures, pump refills/programming, and the like).

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **COMPREHENSIVE INPATIENT ROTATION**

The resident will be constantly evaluated by the supervising physicians to assure the resident obtains patient care competency as expected for a new practitioner. Specifically the resident will be expected to:

- Demonstrate caring and respectfully behaviors (verbal and non-verbal) with patients.’
- Elicit information using effective questioning and listening skills.
- Diagnose physical, cognitive, and psychosocial impairments in rehabilitation patients with acute and chronic medical problems, musculoskeletal injuries, and disabilities.
- Admit and perform as the primary care provider under attending supervision of all acute and some chronic SCI inpatients. Residents are responsible for all administrative care related to their patient including but not limited to:
  - Daily progress notes, discharge summaries, team rounds summaries, daily patient medication orders, comprehensive therapy orders, family conference summaries
- Perform a full comprehensive neuromuscular examination on selected patients.
- Perform comprehensive internal medical exam on selected patients.
- Perform comprehensive rehabilitation consultations on selected patients.
- Create a differential diagnosis appropriate to the physical findings.
- Recommend appropriate inpatient and outpatient rehabilitation patients based upon their known or suspected 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.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **VAHS PGY2 Combined Inpatient and Consultation**

### **GENERAL REHABILITATION OBJECTIVES FOR THE IN-PATIENT ROTATION**

At the end of the rotation, it is expected that the resident will be able to:

- Cite and apply outcome-based criteria for determination of candidacy for admission to acute inpatient unit
- Apply current knowledge in rehabilitation medicine to the design and implementation of goal-based, therapeutic protocols for inpatients.
- Write detailed, comprehensive prescriptions for durable medical equipment, including ambulatory assistive devices, prosthetics, orthotics, and wheelchairs.
- Cite and apply objective tools of measurement for patients with disability to measure changes in functional status.
- Apply current knowledge in general medicine to the care and improvement of health of rehabilitation inpatients and outpatients with coexisting medical conditions.
- Attain competency and expertise in the management of emergent, complicating conditions affecting inpatients on the rehabilitation unit.
- Cite alternative methods and systems for delivery of rehabilitative services, i.e., sub-acute-short-term, long-term, home care, etc.
- Attain competency and expertise in diagnostic evaluation of patients with neuromuscular, musculoskeletal, cardiopulmonary, rheumatologic, or other disabling conditions.
- Apply appropriate managerial principles toward direction and leadership of the interdisciplinary team.

## **OBJECTIVES OF THE CONSULTATION SERVICE**

At the end of the rotation, it is expected that the resident will demonstrate competency and expertise as a consultant in rehabilitation medicine, including:

- Performance of appropriate history and physical examination focusing on impairment, disability, and other functional aspects of the patient.
- Development of skills required to manage a large consultative service in a tertiary care hospital setting.
- Development and implementation of appropriate therapeutic protocols and plans, including interdisciplinary care, durable medical equipment, and further diagnostic and therapeutic options as indicated.
- Demonstration of ability to present cogent case histories to the attending physician in charge of the consult service
- Application of appropriate selection and screening criteria to determine appropriate level of rehabilitative care and familiarity with all options.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)



## **Individual rotations**

### **PGY-2 NEUROLOGICAL REHABILITATION ROTATION**

**Goal:** To provide a comprehensive Neurological Rehabilitation training for PM&R residents over a 10 weeks period.

**Objectives:** Residents will be required to have knowledge of the following disorders:

1. Multiple Trauma and Traumatic Brain Injury
2. Cerebrovascular Disorders
3. Demyelinating Disorders
4. Degenerative Disorders of the Central and Peripheral Nervous System
5. Primary and Secondary Tumors of the Central and Peripheral Nervous System.
6. Metabolic Disorders affecting the Central and Peripheral Nervous System
7. Transplant
8. Metabolic Disorders causing disabilities.

Residents will be required to achieve the following milestones of learning on the disorders listed above:

1. To be able to perform a comprehensive Neurological Rehabilitation Exam
2. To be understand differential diagnosis and describe the pathophysiology of on Neurological and related disorders in a organized format
3. To be able to do workup and treat the disorders listed above
4. To be able to determine the prognosis of Neurological disorders
5. To be able to develop and recommend rehabilitation programs for patients with Neurological and related disorders
6. To be able to relate structural with functional in the management of the listed disorders
7. To be able to utilize various Neuropharmacologic agents in the management of Neurological disorders and related complications
8. To access safety and risk factors in the Neurological Rehabilitation patients
9. To understand the medical legal aspects of the disabled patient.

#### **Skills to master:**

1. Lumbar Puncture
2. Management of Spasticity disorders with rehabilitation intervention, oral agents, Botox and Baclofen Pumps
3. Conducting team conferences
4. Conducting family conferences
5. Communicating with therapies, consulting physicians, insurance companies, case managers and discharge planners and families
6. Management of patients in the out-patient setting
7. Offering consultative services on patients in the acute care services when transfer is contemplated to rehab or who are involved in discharge planning
8. Write up of consults, admission notes and orders
9. Attend sessions involving medical-legal testimony.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **PGY -2 SCI INPATIENT ROTATION**

Each resident will be under the supervision of Department of Rehabilitation Medicine faculty members specialized in spinal cord medicine throughout this clinical rotation. The faculty members will supervise the resident during examinations on the inpatient rehabilitation unit to assure clinical competency and attainment of objectives including but not limited to those described below. The supervising physicians will constantly evaluate the resident to assure the resident obtains patient care competency as expected for a new practitioner. Additionally, the resident will undergo evaluation by a 360 degree type review of all members of the multidisciplinary rehabilitation team.

Specifically the resident will be expected to:

- Admit and perform as the primary care provider under attending supervision of all acute and some chronic SCI inpatients. Residents are responsible for all administrative care related to their patient including but not limited to:
  - Daily progress notes, discharge summaries, team rounds summaries, daily patient medication orders, comprehensive therapy orders, family conference summaries
  - Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients.
  - Elicit information using effective questioning and listening skills.
  - Diagnose physical, cognitive, and psychosocial impairments in rehabilitation patients with Spinal cord injuries.
  - Perform a full comprehensive neuromuscular examination and ASIA examination on selected patients.
  - Perform comprehensive physiatric examinations on patients admitted to their service.
  - Perform daily examinations on SCI inpatients to prevent medical complications.
  - Create a differential diagnosis appropriate to the physical findings.
  - Recommend appropriate inpatient and outpatient rehabilitation plans based upon the level of spinal cord injury and co-morbid conditions or suspected diagnosis.
  - Learn to order appropriate diagnostics and interpret the findings of the ordered tests.
  - Create organized, coherent, and comprehensive reports that can be easily interpreted by other physicians and allied health personnel.
  - Demonstrate caring with the patients who are going through chronic illness and disability.
  - Lead a multidisciplinary team in the care of SCI patients.
  - Show such leadership in weekly team meetings
  - Show leadership and become proficient at organizing and leading a family meeting.
  - Perform appropriate comprehensive examinations on SCI inpatients daily and on rounds with attending physicians.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **PGY 2 COMPREHENSIVE INPATIENT**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **PGY 2 NEUROREHAB JMH INPATIENT**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **PGY 2 VAHS INPATIENT/CONSULT**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **VA PGY2 Rotation – Outpatient pain management, musculoskeletal, spine, beginning EMG, and general clinic service.**

Each resident will be under the supervision of multiple physiatry faculty members employed by the VAHS and who have voluntary faculty appointments with the University of Miami Department of Rehab Medicine throughout this clinical rotation. The faculty members will supervise the resident during examinations on the inpatient rehabilitation unit to assure clinical competency and attainment of objectives including but not limited to those described below. The resident will be constantly evaluated by the supervising physicians to assure the resident obtains patient care competency as expected for a new practitioner.

Specifically the resident will be expected to:

- Demonstrate caring and respectfully behaviors (verbal and non-verbal) with patients.’
- Elicit information using effective questioning and listening skills.
- Diagnose physical, cognitive, and psychosocial impairments in rehabilitation patients with acute and chronic medical problems, musculoskeletal injuries, and disabilities.
- In the outpatient clinics resident will write comprehensive progress notes and patient medication and therapy orders,
- Perform a full comprehensive neuromuscular examination on selected outpatients.
- Perform comprehensive internal medical exam on selected patients.
- Perform comprehensive rehabilitation consultations on selected patients.
- Create a differential diagnosis appropriate to the physical findings.
- Recommend appropriate inpatient and outpatient rehabilitation patients based upon their known or suspected 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.
- Demonstrate caring with the patients who are going through chronic illness and disability.
- Integrate the findings to recommend rehabilitation treatment based upon the examination findings.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **PGY 3 EMG / NEUROMUSCULAR DISEASE ROTATION**

Each resident will be under the supervision of multiple physiatry and neurology faculty members throughout this clinical rotation. The faculty members will supervise the resident during examinations in the clinics, spine institute, and private outpatient offices to assure clinical competency and attainment of objectives including but not limited to those described below. Additionally, residents will be expected to acquire the psychomotor skills essential to performing electrophysiological examinations. CD ROMS are available for review to assist learning. The resident will be constantly evaluated by the supervising physicians to assure the resident obtains patient care competency as expected for a new practitioner.

Specifically the resident will be expected to:

- Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients.
- Elicit information using effective questioning and listening skills.
- Diagnose physical, cognitive, and psychosocial impairments in patients with neuromuscular injuries and diseases.
- Perform a full comprehensive neuromuscular examination on patients with neuromuscular complaints.
- Create a differential diagnosis appropriate to the physical findings.
- Learn what electrophysiologic tests are appropriate based upon the differential diagnosis.
- Obtain appropriate informed consent for the procedure.
- Respect that the patient is going through an uncomfortable procedure.
- Learn to interpret the findings on electrophysiologic exam.
- Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians.
- Demonstrate caring with the patients who are undergoing a largely unpleasant study.
- Integrate the findings to recommend rehabilitation treatment based upon the electrodiagnostic findings.
- Learn how an intraoperative monitoring procedure is performed.
- Learn how to interpret and somatosensory evoked potential exams.

Residents will be expected to gradually increase their knowledge in electrodiagnostic medicine and neuromuscular disease. They will receive opportunities to learn from their attending via bedside teaching but will also be expected to investigate medical topics via journal articles and specialized textbooks. Each of these will be made available by the supervising attending in the rotation. A didactic course dedicated to both electrophysiologic testing and neuromuscular disease will be taught. Evaluation will occur by direct one-on-one feedback throughout the rotation, through a formal written evaluation at the middle and end of the rotation. The didactic course will offer written exams and an SAE exam will be offered.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

### **PGY-3 MUSCULOSKELETAL/SPINE/SPORTS - UMHC**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

### **PGY-3 COMMUNITY GENERAL REHAB - MOUNT SINAI**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

### **JMH PGY-3 PEDIATRIC REHABILITATION**

- Demonstration of knowledge of normal pediatric development, milestones, and age-appropriate behavior, including learning ability and play skills.
- Demonstration of knowledge of pediatric disorders that creates functional disability, whether congenital or acquired, including presentation, natural history, prognosis, and functional implications.
- Demonstration of ability to perform pediatric development examination.
- Demonstration of ability to devise and implement multidisciplinary plan of rehabilitative care, write appropriate orders, and initiate appropriate modifications in plan as indicated.

Cite and apply tools for screening normal or at-risk populations for developmental disabilities.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

### **PGY-3 VAHS - RESEARCH/Chronic SCI**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

### **PGY-4 ELECTIVE/SELECTIVE ROTATION**

Senior residents have 2 months, at the Program Director discretion, of elective/selective rotation depending on the resident needs and interest. 1 full week of the rotation must include a vacation week. Another week may be taken outside the JMH system with permission and proper filing of paperwork at least 6 weeks in advance of the rotation. The rotations are arranged by the resident unless the resident requests the program director to arrange a selective and may be approved by the Chairperson. The elective/selective rotation will be taken as a PGY-4. Since the

experiences will be so different, depending on the experience, it will be up to the resident to write any rotation objectives if requested. These will be reviewed by the program director and if acceptable then the elective/selective will be approved. Only one week is approved for off-site rotations, all other selective/electives must be through JMH affiliated activities.

## **PGY-4 PAIN MANAGEMENT - Selective**

Senior residents can rotate through the UM-JMH pain management service during their PGY-4 selective JMH rotation. Residents who have an alternate interest may take alternative selective instead with approval of the program director. The resident will be an active participant in the management and follow up of in-patients and out-patients. The resident will also assist in the international procedures performed by the pain service and help the service with consultations. The resident will be trained to do the following:

- Cite methods for evaluation and treatment of patients with chronic pain.
- Cite indications, contraindications, risks and benefits of interventional treatment for the management of chronic pain.
- Develop methods for evaluating patients with chronic pain and selection of patients for invasive procedures.
- Devise a comprehensive multidisciplinary approach to the chronic pain patient.
- Cite indications, uses, and contraindications of noninvasive pharmacological agents for chronic pain.
- Explain the role of behavioral scientists in the evaluation and management of chronic pain patients.

## **JMH PGY-4 Senior Consult Rotation**

- Apply current knowledge in rehabilitation medicine to the design and implementation of goal-based, therapeutic protocols for inpatients.
- Demonstrate proficiency in the evaluation and management of patients with cardiovascular disability.
- Knowledge of application and use of exercise testing, including indications and contraindications.
- Design and implementation of therapeutic exercise programs.
- Impact of cardiovascular morbidity on functional ability.
- Assessment and management of postoperative cardiovascular conditions.
- Discuss pathophysiology of pulmonary disease as it impacts on functional status and rehabilitation potential.
- Demonstrate proficiency in evaluation and management of patients with disability due to primary and secondary pulmonary function impairment.
- Demonstrate proficiency in the management of emergent, complicating conditions affecting inpatients on the rehabilitation unit.
- Effectively teach junior residents.
- Perform accurate senior level consultations on inpatients on the acuter medical surgical services

- Attend and lead multidisciplinary meetings

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

### **JMH PGY-4 Senior INPATIENT Rotation**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

### **VAHS PGY-4 Senior Rotation**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

### **VAHS PGY-4 PAIN/INTERVENTIONAL/MSK Rotation**

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

## **PGY-4 ELECTRODIAGNOSTIC SERVICE/NEUROMUSCULAR DISEASE**

Each resident will be under the supervision of multiple physiatry and neurology faculty members throughout this clinical rotation. The faculty members will supervise the resident during examinations in the clinics, spine institute, and private outpatient offices to assure clinical competency and attainment of objectives including but not limited to those described below. Additionally, residents will be expected to acquire the psychomotor skills essential to performing electrophysiological examinations. CD ROMS are available for review to assist learning. The resident will be constantly evaluated by the supervising physicians to assure the resident obtains patient care competency as expected for a new practitioner.

Specifically the resident will be expected to:

- Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients.
- Elicit information using effective questioning and listening skills.
- Diagnose physical, cognitive, and psychosocial impairments in patients with neuromuscular injuries and diseases.
- Perform a full comprehensive neuromuscular examination on patients with neuromuscular complaints.
- Create a differential diagnosis appropriate to the physical findings.
- Learn what electrophysiologic tests are appropriate based upon the differential diagnosis.
- Obtain appropriate informed consent for the procedure.

- Respect that the patient is going through an uncomfortable procedure.
- Learn to interpret the findings on electrophysiologic exam.
- Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians.
- Demonstrate caring with the patients who are undergoing a largely unpleasant study.
- Integrate the findings to recommend rehabilitation treatment based upon the electrodiagnostic findings.
- Learn how an intraoperative monitoring procedure is performed.
- Learn how to interpret and perform somatosensory evoked potential exams.
- Teach junior residents to perform electrodiagnostic testing.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)



# **GENERAL GUIDELINES**

## ***RESPONSIBILITY, CLINICAL SUPERVISION, AND INSTRUCTIONS***

### **GENERAL GUIDELINES**

### **RESPONSIBILITY, CLINICAL SUPERVISION, AND INSTRUCTIONS**

An important part of residency training is gaining the ability to assume primary responsibility for patient care. However, the desire to create independent practitioners must be balanced with realization that even as a senior resident, an adequate amount of supervision by experienced attending level physician on staff must be available at all times. The amount of responsibility a resident will be given will depend on the knowledge, skill, and judgment they are able to demonstrate. The degree of responsibility will increase as the attending physician feels comfortable with the competence of the resident. The resident must also show a willingness to assume that responsibility.

The resident on the inpatient unit will be supervised only by a licensed attending physician who has been granted clinical hospital rehabilitation privileges through the medical staff process. The attending physician is ultimately legally and ethically responsible for the welfare of the patients assigned to them and the resident. Therefore it is made clear to the residents that regardless of PGY level, they residents are to notify the attending physician with any significant change in medical or mental status, unscheduled admission, death of a patient, new onset medical problem (minor or major), or severe illness requiring evaluation for transfer off the rehabilitation unit. Residents will never be criticized for calling the attending physician, regardless of the hour but are reprimanded if a failure to notify the attending physician results in an unfavorable outcome for the patient..

Clinical experience should allow for progressive responsibility with lesser degrees of supervision as the resident advances and demonstrates additional competency. All clinical activities attended by residents in the first year of training (PGY-2) are supervised by attendings and residents in the second and third year of training. This supervision includes direct clinical observation, teaching, review, and critical appraisal of the resident's work. Residents in the second year of training may be supervised and instructed by attending physicians, SCIM fellows (PGY-5), and senior residents. Residents in the third year of training shall receive supervision and teaching from attending physicians and residents in the final year of training.

## **PGY-II and PGY-III REHABILITATION MEDICINE RESIDENTS**

The role of PGY-II and PGY-III residents involves primarily the care of patients admitted to the Rehabilitation Service or patients evaluated in outpatient rehabilitation clinics. The responsibilities of the inpatient resident include but are not limited to performing admission history and physical, formulating a rehabilitation and medical treatment plan, writing a proper rehabilitation prescription with short and long term goals, providing consultation requests to other services, and leading team conferences with respective attendings. The PGY-II and PGY-III residents also are responsible for management of patients in clinics to which they are assigned.

The PGY-III resident who is assigned to floor duty may fill in for a vacationing resident at JMH or VAHS and may provide leadership and loose supervision of the other PGY-2 resident on the service. In the outpatient clinics, it is expected that all core residents who evaluate a new patient will be able to present this case at an attending level supervising physician. In some of the sports medicine clinics, the chief orthopedic resident often serves as an attending physician like figure and can teach the resident to handle non-operative orthopedic problems independently. The pediatric rotation will present unique challenges to the PGY-4 resident who has taken care of adults only. Therefore there is one area where attending level supervision is critical to providing competent patient care.

Typically, the PGY III electrodiagnostic rotation will be taught one on one by the attending physician but may also involve teaching by a senior resident or a neuromuscular fellow from the department of Neurology.

## **PGY-IV REHABILITATION MEDICINE RESIDENTS**

Residents in their third year of training in rehabilitation medicine (PGY-4) spend the year in rotations through mainly outpatient rotations including an administrative chief/JMH clinic rotation, electrodiagnostic service, and outpatient pain, musculoskeletal, and elective rotations. It is expected that as a PGY4 in this program, the resident will be able to function in a more independent fashion to take good care of patients at this institution. During clinic rotations where junior residents are present, the PGY-4 will be expected to teach the junior residents on the problems the patient presents. Typically patients with non-operative spine, musculoskeletal, and neuromuscular problems are seen most often. Again, in each rotation, the responsible attending physician will need to make a determination as to how much autonomy to grant each individual resident. At the VAHC there are clear teaching responsibilities on the senior rotation in the EMG lab. The JMH senior resident is expected to perform teaching on the unit for PGY-2 level residents.

## **CHIEF RESIDENT**

The faculty and residents together vote and choose two (2) PGY-4 residents to serve as chief residents for the entire academic year. The selection is based on their performance the previous two years and reflects their leadership skills, diligence, scholarship and dependability. The chiefs are the liaison between administration/faculty and the residents and assist the faculty and coordinator to coordinate and enact the program's objectives. The chief residents report directly to the program director and chairman.

The Chief Resident's responsibilities include, but are not limited to:

1. Coordination of resident scheduling for rotation and on-call duties.
2. Direct supervision of junior and senior residents.
3. Direct teaching of junior residents through didactic and clinical methods.
4. Leader of Team Evaluation conferences on the inpatient rehabilitation unit.
5. Screen potential admissions for the inpatient rehabilitation unit.
6. Organize and enact orientation program for new residents.
7. Participate in resident recruitment and interviews.
8. Participate in department Total Quality Management team.
9. Coordinate coverage of resident activities during times of manpower shortage.
10. Attend education committee meetings and retreat.
11. Attend GME committee meetings
12. Keep attendance at lectures including late notices

In addition to the chosen chief residents, all PGY-4 residents will be given the opportunity to rotate as a senior at JMH. This rotation will assign administrative and educational responsibilities to the resident that are both supplemental to, and in addition to, the named chief resident. These responsibilities include:

1. Attend Jackson Rehabilitation Quality meetings
2. Attend GME committee meetings
3. Provide lectures and educational teaching for junior residents that include weekly teaching rounds.
4. Coordinate M&M conferences at JMH

## **CLINICS**

PMR core residents will evaluate patients many different types of clinics. Residents will be supervised at all times regardless of the clinic. At JMH and the Miami VAHS, residents will have more autonomy to make treatment decisions but an attending physician will be on site for assistance at all times. Some clinics will have chief residents or fellows as the most senior member of the physician team on site but an attending physician will always be available by phone for advice and will physically come down to that clinic to examine complex patients.

At Mount Sinai, and University of Miami Health Clinics/Bascolm Palmer Eye Institute, the attending physician will physically see every patient after the resident performs a thorough history and physical examination and formulates a differential diagnosis and treatment plan.

Residents working at UMHC must be trained in the Electronic Chart record UCHART.

## **ACUTE INPATIENT CONSULTATIONS**

Residents will be expected to independently perform a history and physical examination. The attending physician of record will be expected to discuss every consultation with the resident. In most cases, the attending physician will teach at the bedside and re-evaluate each consultation to provide the resident with proper feedback on their treatment decision making skills.

The resident will be responsible for communicating their findings to the rehabilitation office to allow for admission planning, funding approval, and bed placement. Residents may need to intervene with insurance companies and medical directors to gain admission approval. Ultimately the resident will re-screen the patient on the date of transfer in order to make sure that they are medically stable.

## **PROFESSIONAL BEHAVIOR AND DEMEANOR**

Rehabilitation patients are disabled, physically ill, often in pain, and sometimes mentally depressed. The resident is taught by the attending physician that these patients are placing their trust in them. Residents are made to understand that by accepting the career in medicine they are accepting the serious responsibility of acting on their behalf of those who can no longer care for themselves. While at times the responsibility can be overwhelming, the program makes sure that attending physicians are accessible and accountable for providing the proper supervision and professional mentoring to ensure that residents will achieve competence in all of the six competency areas outlined by the ACGME.

## **LETTERS OF REFERENCE**

All residents requesting reference letters from attendings much do so in a timely manner. The policy is as follows: Attendings will write the reference letter and email it to the resident. The resident will have to print the letter, get signature from attending, address and mail their own letters. With this policy of course letters will not be blinded and it may make some attendings uneasy but due to budget restraints and reduced manpower this is the only option in order to get letters completed in a timely manner. Coretha will assist you with this process as much as possible. Envelopes and letterhead are available at the department office.

## ***WORK HOURS AND PUNCTUALITY***

All residents perform the dual roles of physician and student, caring for patients while learning, advancing in experience and knowledge. This double set of constraints on the resident's time demands dedication to a broad range of challenging –and potentially conflicting- academic and clinical responsibilities. Residents are required to attend all didactic sessions and arrive on time. **Only true patient or personal emergencies are considered adequate excuses for a resident's absence or tardiness. Patient emergencies will take precedent over lecture. Absence or late arrival at teaching sessions for any other reason is unacceptable and may result in disciplinary action against the resident. Any resident who anticipates being absent or tardy must inform the program director/residency coordinator in advance and justify good cause. The program director/residency coordinator has the authority to approve or deny the request. Documented unexcused absence to lecture two times per semester will result in a warning. On the third unexcused late or absence, an extra Sunday Call will be granted. Further absences will result in increased call nights accordingly.**

Residents are not allowed to work more than 80 hours per week (including moonlighting). Residents will have at least 10 hours between scheduled shifts. A resident who lives more than 10 miles from the hospital must complete call “in house” in the hospital. When on “in house” call, the resident will

be completed with patient care duties the next day such that they are not on duty more than 24 hours in the hospital. However, in order to care for a very sick patient, the resident may stay up to 4 hours additional (28 total). In such a case the resident will transfer care of the rest of the service to a covering resident. Although we cannot force residents to live within 10 miles of the JMH hospital, we strongly recommend they do to maintain the advantages – both educationally, and personally, of a home call option.

In most instances, a resident who completes home call will work a full day after a call night period. However, residents who spent the majority of their home call in the hospital, may be treated as if they had been "on duty" continuously but are still allowed to perform a limited amount of duties the morning after 24 hours. These Residents will have at least 10 hours between scheduled shifts. In addition residents will have on average one full day out of every seven days off and one full weekend off per month. The resident will not be on-call more than every third night.

Be aware that residents who are post call who have taken call **"in house"** who are ...:

1. On inpatient rotations: Will leave to go home directly after morning rounds and writing progress notes for continuity of care. They will leave absolutely by 10AM even if the notes are not completed. Such residents are exempt from team rounds or family conferences.
2. On outpatient/research/selective rotations: Will go home at 7 AM of the following morning and return the next day – unless managing a sick patient from call that needs to be physically handed off to the day resident and that resident comes in later than 7AM the next morning.
3. No resident who is post "in house" call will be able to attend outpatient clinics for any reason.
4. On Friday morning, residents who are post call will be exempt from lectures and will go home. Those on inpatient rotations will round on their serve as stated above for the benefit of continuity of care. If a resident wishes to monitor the lectures from home they can do so, if they can set up a skype account and if we are able to make a connection. All efforts should be made to not have residents "in house" on call on Thursday nights.
5. No resident is permitted to stay on campus until further notice past 9pm at night. (Since morning work typically does not start before 7AM this ensures compliance with the 10 hour rule). The "on call" resident will be responsible for any care needed after 9PM. If for some reason a resident finds themselves on campus past 9PM, they are to remain home until Noon of the following day.
6. A resident who lives within 10 miles of campus cannot "choose" to perform in house call. If there is a reason the resident cannot perform call from home, they must contact myself or the covering associate program director to explain.
7. Until a final method of alerting attending physicians regarding an on call resident status is created, Program Coordinator Coretha Davis and/or one of the Chief residents will be in charge of sending an email reminder the day of the call to the rehabilitation faculty alerting faculty that a resident is providing "in house" call. Therefore, the faculty instructor can then adjust their schedule and ensure compliance with the ACGME duty hour rules.
8. A resident who lives more than 10 miles away who chooses to spend the night with a resident living less than 10 miles away may take call from home if all the contact information for that resident is available (i.e. if the pager goes out for some reason).

As professionals, residents are expected to be on the hospital grounds, with their beeper on, by 7:00a.m. on most days unless cleared by the supervising attending physician. In ALL inpatient rotations, the resident must round starting at 7AM and attempt to complete rounds prior to the first lecture at 8:10 AM. This time may vary at times based on the individual supervising attending physician's schedule. Typically residents will remain at work until all of the patients are sufficiently cared for. Experience has shown that residents will typically be able to finish their workload between 4:30 p.m. and 6:30 p.m. Even in the absence of scheduled academic or clinical activity,

**residents are to be available in the hospital during his time to tend to clinical and/or administrative duties.**

If free/down time becomes available during the work day, the resident is to spend that time usefully in pursuit of educational advancement: studying in the library, attending optional lectures, in-services or activities within or outside of the department and investigating/exploring research possibilities, preparing presentations, or reading. Except as described above, **under no conditions is the resident to sign out his/her beeper to another fellow or resident and leave the hospital vicinity before 4:30pm without permission from the supervising attending physician.** Similar rules apply to residents on affiliate rotations, however, demands on the resident's time will be dictated by the needs of the affiliate rotation.

Weekend days are completely free from clinical duties when not on call at JMH. Residents rotating while at the VAHS or Mount Sinai may be asked to work a half day every third Saturday with no clinical duties on Sunday. Residents will have then still average of 5 full days off per month, and one free weekend per month at both sites.

### **Educational Days**

All residents are given education days based on PGY year. The days are allotted as follows: PGY 2 – 2 days, PGY 3 – 3 days, and PGY 4 – 10 days to be used as follows (5 days Board Course, 3 days AAPM&R Annual Assembly, and 2 days). These days can be used for conferences or educational activities.

## ***CONFIDENTIALITY OF INFORMATION***

It is imperative to maintain the confidentiality of all patient information. No information of any kind may be released to any person without the written permission of the patient or his/her legal designee/proxy. This includes relatives, friends, other physicians, lawyers and the press. If you have any questions, check with your attending and hospital counsel for guidance. Please familiarize yourself with all HIPPA guidelines. You will receive training in this area during your orientation weeks.

Discussion of patients or their status in public areas, such as elevators is strictly prohibited. This is considered a breach of patient confidentiality.

## ***TELEPHONE ADVICE***

Patients who you speak to on the telephone, with medical questions or problems should be given the most conservative advice possible. It is always better to instruct the patient to go to the nearest emergency room where they can be examined. Whenever possible the reason for the call and advice given should be documented in the patient's chart.

## ***CITI TRAINING***

Since all residents may even accidentally be involved with research subjects, all must be trained and up to date (2) year renewal) in the CITI research certification course. No exceptions.

## ***PRESCRIPTION RENEWAL***

Patients once discharged may not be given prescription for renewal of their medications. Appointments should be made for them to receive these at the appropriate clinics. Please call your supervising attending with any patient prescription requests. If no attending is available, you may call in 72 hours worth of medication to allow the patient to continue their medication until they can find an alternative source for their renewals.

## ***BEEPER***

Each resident is responsible for his/her own beeper. The resident must pay out of his/her pocket for beepers lost or damaged due to negligence, under any condition.

## ***EMERGENCIES ON IN-PATIENT REHAB***

Any emergencies occurring on the in-patient rehab unit should be reported to the admitting attending on call. Emergencies occurring on private patients should be reported to the Rehabilitation Medicine attending on call as quickly as possible. First priority is to stabilize the patient. AT JMH, a medical house officer (MOD) is available 24 hours per day for assistance. Often in acute situations, a nurse not involved in the activity can page the attending of record while the clinical care to stabilize the patient continues.

## **PATIENT CARE**

Patients may be admitted to the Rehabilitation Unit from various sources: other services at Jackson Memorial Hospital, direct admissions arranged by private attendings, from clinics, from the emergency room and other hospitals. All residents who have responsibility of transferring or admitting a patient to the rehabilitation service should be thoroughly familiar with rehabilitation unit admission guidelines. If in question, the program director should be consulted. All private transfers and admissions are cleared by private attendings regarding suitability. If the resident has any question, they should contact the private attending.

If the rehabilitation unit has no available beds, emergency admissions to other units of the hospital may be arranged. Patients 'boarding' on other units are treated exactly as if they were on the rehabilitation unit, including daily rounds and progress notes by the resident, daily delivery of therapeutic services and primary management by the rehabilitation team.

At JMH the assigned resident is responsible for completion of the history and physical examination form and initial rehabilitation orders on all new admissions to their service. Typically admissions will be completed by 5:30 p.m. The resident-on-call may assist with the initial history and physical examination after 5:30 p.m. If the patient is admitted overnight by the on call resident then the primary resident must perform their own history and physical the next morning to familiarize themselves with the patient. However, a full admission note does not have to be re-done and the partial note can serve as the progress note the next day. If the patient cannot give reliable history,

the family or primary caregiver(s) must be interviewed. Information should be sought from prior physicians, other hospitals, friends or neighbors, etc. whenever appropriate

At the VAHS, the history and physical examination form available in the nurses' station is to be completed and placed in the chart within 24 hours of the patient's admission via computer. If the patient cannot give reliable history, the family or primary caregiver(s) must be interviewed. Information should be sought from prior physicians, other hospitals, friends or neighbors, etc. whenever appropriate.

All rehabilitation orders on inpatients must be updated and reviewed *every two weeks* by the resident. The resident is responsible for writing a meaningful, complete, **rehabilitation-oriented** daily progress note on every patient under his/her care. Opioid orders must be renewed every 3 days. The note must reflect a thorough assessment of the day's subjective, objective findings, and summation of the problem list and plan(s) of action. These notes and the total plan of care are to be reviewed with the attending physician. Charts are to be kept on the ward and should be maintained in a complete, up-to-date and legible fashion. Your charts are scientific and legal documents. Your meaningful and legible notes should reflect your thinking and care of the patient.

Bedside teaching rounds occur daily on the inpatient rehabilitation unit and are conducted by the attending physician. A resident may be assigned to patients of more than one attending physician. Each attending will round with the residents on all of his/her patients regularly to assure that the entire team is cohesive and is working toward similar goals for their patients. Consultations from other services may be necessary based on the severity of the patient's condition, and the expertise and comfort level of the attending physiatrist. Do not wait until the problem has reached dangerous proportions before calling a consultation. If in doubt, consult with the attending physiatrist on the case.

Charts should be signed out promptly so that discharge summaries are quickly available for follow-up care. All charts must have a complete diagnosis written on the face sheet before the patient can be discharged.

**All discharge summaries must be dictated the day the patient is discharged (or the day before) and notes in the progress report are to reflect this.** Dictating the summary the night before is acceptable - but keep in mind if the discharge is held, it needs to be completed again in most cases. A sample of the format of a discharge summary may be found in this manual. Please remember that discharge summary should reflect the rehabilitation status of the patient along with the short and long term goals and whether or not these were achieved. For a resident on vacation, covering residents may dictate summaries on those patients being discharged but the ultimate responsibility for those summaries being completed lies with the resident who was the primary caregiver for the patient. Any outstanding discharge summaries will be dictated by the primary resident. A resident failing to assist another resident on vacation with discharge summaries will be considered out of compliance of professional behavior and be subject to disciplinary action.



## ON CALL RESPONSIBILITIES

1. Patients admitted to the rehabilitation medicine service remain under the care of the department of rehabilitation medicine 24 hours per day, seven days per week.
2. All residents will participate in the call schedule except the resident rotating at Mount Sinai Medial Center (he/she will participate in call at that location). The individual dates may vary but on average, an individual resident will be on at home call.
3. Residents doing at home call will be able to leave JMH at 7:00 pm on weeknights only if all patients are clearly stabilized. On weekends you will stay in house until 15 PM on Saturday and 1 PM on Sunday (unless cleared by the attending to leave earlier) and may leave only if all patients are stabilized.
4. If you live more than 10 miles away from the hospital, otherwise, you will have in-house call at Jackson Memorial Hospital one night every two weeks.
5. Residents on in-house call will be able to be free from clinical duties the next day 24 hours after they arrived (8 AM).

Residents who are post call who have taken call “in house” who are ...:

6. On inpatient rotations: Will leave to go home directly after morning rounds and writing progress notes for continuity of care. They will leave absolutely by 10AM even if the notes are not completed. Such residents are exempt from team rounds or family conferences.
7. On outpatient/research/selective rotations: Will go home at 7 AM of the following morning and return the next day – unless managing a sick patient from call that is physically handed off to the day resident.
8. No resident who is post “in house” call will be able to attend outpatient clinics for any reason.
9. On Friday morning, residents who are post call will be exempt from lectures and will go home. Those on inpatient rotations will round on their serve as stated above for the benefit of continuity of care. If a resident wishes to monitor the lectures from home they can do so, if they can set up a skype account and we are able to make a connection. All efforts should be made to not have residents “in house” on call on Thursday nights.
10. No resident is permitted to stay on campus until further notice past 9pm at night. (Since morning typically do not start before 7AM this ensures compliance with the 10 hour rule). The “on call” resident will be responsible for any care needed after 9PM. If for some reason a resident finds themselves on campus past 9PM, they are to remain home until Noon of the following day.
11. A resident who lives within 10 miles of campus cannot “choose” to perform in house call. If there is a reason the resident cannot perform call from home, they must contact myself or the covering associate program director to explain.
12. Until a final method of alerting attending physicians regarding an on call resident status is created, Program Coordinator Coretha Davis and/or one of the Chief residents will be in charge of sending an email reminder the day of the call to the rehabilitation faculty alerting faculty that a resident is providing “in house” call. Therefore, the faculty instructor can then adjust their schedule and ensure compliance with the ACGME duty hour rules.
13. A resident who lives more than 10 miles away who chooses to spend the night with a resident living less than 10 miles away may take call from home if all the contact information for that resident is available (i.e. if the pager goes out for some reason).
14. An attending physician will be on call with each resident from home and available by beeper and cell phone for advice. If needed, the attending physician will come into the hospital to

assist with acute patient emergencies. Certain clinical problems require a resident to contact the attending. The purpose is multi-factorial but ensures proper supervision of residents-in-training. The resident is responsible for all after-hours and weekend/holiday hospital requests for urgent psychiatry consultation, evaluation and patient management, and respond to the needs of all patients admitted to the rehabilitation service.

All residents shall have the opportunity to spend at least one full day, out of every seven, free of inpatient and outpatient care responsibilities. Schedules will be assembled monthly by the chief residents or his/her designee. The resident must remain in/around the hospital grounds and will be provided with access to an on-call room.

15. The residents carry a central on-call beeper to minimize any confusion with communication.
16. Residents will be supervised at all times by a qualified attending physician who will also provide backup coverage and come into the hospital if necessary for difficult management issues.
17. **AT HOME CALL:** On weeknights, the resident on call will stay at JMH until 7:00 PM or until all patients are clearly stabilized. The resident may be asked to do late admissions by the floor resident if the admission is to arrive from out of house after 5:30 pm. The on-call resident will provide this “night float” admission back-up on all occasions.
18. On weekends, the on call resident if they are on call from home must stay in house until a minimum of 1 PM on Saturday and 1 PM on Sunday and may leave the hospital grounds if all patients are stabilized.
19. The resident will be the first physician to be notified for any regular issues during the call period (up to 7 AM of the following day). If there is any urgency or emergency, the nursing staff is to contact **BOTH THE RESIDENT AND THE ATTENDING ON-CALL**, who will provide backup while the resident is en route to the hospital.
20. **IN-HOUSE CALL:** Residents will be supplied with a suitable on-call sleeping quarters. The quarters are supplied by the hospital. If the quarters are not suitable then the resident will notify the program director immediately and the program director will request an intervention from the hospital.  
On weekends, the resident on call will arrive at 7 AM after which the previous resident will give report and then leave the hospital.
21. For any patient that becomes unresponsive (with or without pulse or respirations), the nurse will call a code immediately, followed by calling the resident and attending on-call. This will assure immediate physician response, while our team is en route to assess the patient.
22. In the event the resident or attending physician cannot be reached through their pagers, the nursing staff is to resort to the secondary contact numbers (either cell phones or home phone numbers). A list of these numbers is available to the nurse supervisors on each unit and it is their responsibility to make it available to the nursing staff while maintaining its confidentiality.
23. The following conditions will require personal attendance of the patient by the on-call resident – and thus requires notification of the attending of the event:
  1. Hematemesis
  2. Bright red blood per rectum,
  3. NEW ONSET chest pain or chest pain in a cardiac patient that otherwise had resolved angina
  4. NEW ONSET change in mental status or neurologic deficit
  5. Any changes in clinical status associated with hypotension and/or tachycardia, that might signify evolving shock

6. Acute respiratory distress
7. Seizures
8. Falls that has resulted in trauma and or pain.
9. Any un-witnessed fall.
9. Any other issues arising during the call time will be addressed by the resident to the best of their judgment. Nevertheless, the nursing staff has the responsibility of contacting the on-call attending in cases where that judgment is within question.

## ***MORNING REPORT***

On Saturdays and Sundays, a report is given to the resident coming in. The resident-on-call the previous night may not leave the premises until the resident on call for that day has reported for duty. A similar sign-out session is held at the end of each day to alert the resident-on-call of any developments that may require his/her attention.

## ***CLINICS***

All assigned residents must report to clinics on time. Dress code includes a button down shirt with tie. They may not leave the clinic area without informing the attending physician. If the assigned resident is unable to come to the clinic on time for any reason, the program director must be informed immediately so that a substitute can be assigned to the clinic. See Appendix for Clinic Schedules.

## **CLINIC ATTENDINGS**

1. JMH General Rehabilitation Clinic:
  - ✓ Jose Restrepo, M.D.
  - ✓ Lucinda Arenas, M.D.
2. Prosthetic/Orthotic Clinic:
  - ✓ Tamar Ference, M.D.
3. Wheelchair
  - ✓ Tamar Ference, M.D.
  - ✓ Seema Khurana, D.O.
4. MS, PEDS, Botulinum Toxic Injection:
  - ✓ Seema Khurana, D.O.
5. Traumatic Brain Injury Clinic
  - ✓ Seema Khurana, D.O.
  - ✓ Diana Cardenas, M.D.

6. Spinal Cord Injury
  - ✓ Diana Cardenas, M.D.
  - ✓ Kevin Dalal, MD
6. UMHC Spasticity
  - ✓ Seema Khurana, D.O.
7. UMHC Musculoskeletal/EMG
  - ✓ Andrew Sherman, M.D.
  - ✓ Robert Irwin, M.D.
  - ✓ Tamar Ference, M.D.
  - ✓ Erin Wolff, MD
  - ✓ Jose Mena, MD
  - ✓ Lucinda Arenas, M.D.
8. CRB Wellness Clinic
  - ✓ Andrew Sherman, M.D.
  - ✓ Robert Irwin, M.D.
  - ✓ Erin Wolff, M.D.
  - ✓ Jose Mena, M.D.
  - ✓ Ricardo Vasquez-Duarte, M.D.
9. BPEI
  - ✓ Jose Mena, M.D.
  - ✓ Jose Restrepo, M.D.

## **DEPARTMENTAL CONFERENCES**

### ***TEAM EVALUATION CONFERENCE***

Team evaluation conferences discuss patients on the inpatient rehabilitation service. They are held weekly with the attending physicians at scheduled times. All residents are expected to know their patient's comprehensive medical rehabilitation status. Team conference discussions are recorded by the resident on the team evaluation sheet in the patient's chart. This is a JCAHO and Florida State requirement. Rehabilitation orders are to be updated every 2 weeks on all patients, based on the goals established in the team meeting.

Formal bedside rounds with private attending physicians will occur regularly. The resident will consult with each attending to determine the time rounds will be made.

## ***FAMILY MEETINGS***

Time slots are available for family meetings with the rehabilitation team members. These meetings are to be scheduled as necessary by the rehabilitation attending staff. If for any reason the attending physician is unable to be present, the resident should be prepared to conduct the family/team meeting.

Initially, the attending physician will run the meetings. But as the rotation progresses then the resident is expected to be able to eventually function as the team leader. If they are successful, then the resident will eventually lead the team conference.

## ***PROGRAM DIRECTOR ROUNDS***

The Program Director will meet monthly with the residents to present both didactic and clinical material including, but not limited to, formal lecture, case conference, and associated relevant literature. Topics may include basic or clinical science, modalities, other topics of interest. All residents rotating within JMH-UM must attend. Meetings may separate classes to facilitate a “small group” feeling.

## ***GRAND ROUNDS***

The departmental grand rounds are held once per month, on the fourth Wednesday from 7:30-8:30 AM at Jackson Memorial Hospital Diagnostic Treatment Center (DTC) 2<sup>nd</sup> floor room 270. Prominent guest speakers present state-of-the-art information pertaining to the practice of rehabilitation medicine. Residents may also be scheduled for presentation and are expected to present well-researched rehabilitation related topics. The discussion should be case-oriented, followed by general discussion of the topic, review of the pertinent literature and involve the attendant audience by discussing problem-related issues relevant either to the case presented or the topic in general. The resident should choose a mentor and prepare his presentation under the supervision of an attending. Topics for discussion should include interesting and unusual case reports, research and new developments in rehabilitation medicine. Residents are strongly discouraged from presenting reviewed topics in which no direct clinical case correlation or presentation is made or in which the resident does not have significant, personal clinical or research experience.

## ***JOURNAL CLUB***

Once per month – inter-institutional combined journal club. The date is the second Monday of the month at 5:00 PM-6:00 pm.

An individual attending physician may change the time up or back an hour (Starting between 5:00 and 5:30) depending on their clinical responsibilities with 2 weeks notice. Notify Coretha and she will alter the schedule.

When a Jackson attending is supervising, the site will be at Jackson. When the VA attending supervises, the site is at the VA.

At FORMAL journal club, the resident will be expected to prepare a presentation on their chosen journal article that will include:

A summary of the article – Recommended to be in power point format (20 min maximum).

Maximum of 20 slides allowed

Present the inclusion and exclusion criteria for subject enrollment and analyze the rationale behind these.

Recommended to present a flow diagram or a relevant table illustrating what happens to the enrollees from enrollment to the end of the study.

Recommended to present a handout including the abstract and significant tables and figures (ideally fitting in one page, 2-sided)

The resident or attending will choose an article that is original research, prospective, preferably blinded and placebo controlled and performed within the last 5 years. A “classic article” is one more than 5 years old and considered a “landmark” study. The article will be e-mailed to the residents and attending faculty one full week prior to the journal club.

A list of journals would include:

Journal of Spinal Cord Medicine

American Journal of PM&R (Blue)

Archives of PM&R (White)

Muscle and nerve

American Journal of Sports Med

Journal of head trauma and rehabilitation

Brain injury

American journal of neurology

JAMA

NEJM

PM&R (Purple)

Others can be added if necessary

The attending assigned will do the same for their article.

The entire discussion, presentation of each article is not to exceed 30 minutes.

In addition, each site director is expected to have their own “mini journal club” either every week or every other week on a patient relevant issue.

## **DIDACTIC LECTURE SERIES** (See appendix for schedule)

Each Friday morning the time from 8:10 AM to 12:00 p.m. has been set aside for the didactic teaching program. Lectures will typically occur from 8-11 AM but may stretch to 12. The lectures will cover comprehensively all of the subspecialty and general subjects of the field of Physical Medicine and Rehabilitation. Lectures will be referenced to the textbooks edited by Braddom. The lecture cycle will be 18 months for most lectures in order that each resident will be exposed to the material twice before they graduate. Some lectures such as the general physiatric principle lectures

will be given yearly to the PGY 2 group and taught by the PGY 3 and PGY 4 group. Anatomy also will be presented yearly by the anatomy department to the PGY 2 group with 40% of lectures given and 60% of lectures given by the residents. Pro-sections will be used as well. EMG and neuromuscular medicine is taught to the PGY 3 level yearly. The PMR service also presents a monthly journal club presented by a resident and attending physician who is paired for this purpose.

In addition to the PMR core didactic program, PMR residents can take advantage of didactic programs put on by other departments. Residents are encouraged and often mandated to attend the Orthopedics department or the Neurosurgery departments' weekly Grand Rounds. The Miami Project to Cure Paralysis puts on a weekly morning lecture and monthly grand rounds lecture that the PMR residents are encouraged to attend to gain research experience.

All physicians involved in the residency will participate in the didactic and journal club program.

All lecture evaluations will be done anonymously through New Innovations. You will be notified when you are required to complete the evaluation. Please do so in a timely manner to alleviate disciplinary action as this is a requirement.

### **Lecture Late & Cellphone Use Policy:**

Residents are required to attend all educational activities. If there is an issue on the floor the resident must advise one of the chiefs or Coretha and we will confirm with the respective attending.

The late policy is as follows:

- 1) If the PM&R resident is more than 5 minutes late 3 times to any lecture/mandatory event, he/she will be given an extra Friday call the subsequent month. A second accumulation of 2 or more late arrivals by 5 minutes or more will result in an extra weekend call.
- 2) If PM&R resident misses a lecture/grand rounds/any mandatory event, without acceptable excuse (acceptable by the program director or designee), he/she will be given an extra weekend call the subsequent month.

Some examples of an acceptable excuse are

- 1: Sick patient requiring supervision
- 2: Sick resident requiring a sick leave day – if more than one day requiring a physician note
- 3: On call previous night in-house
- 4: Vacation
- 5: Other patient care or residency related matter that can be brought to the program director or chief's attention that is felt to be an adequate reason.

Although we understand traffic can be an issue, such mishaps are not an acceptable excuse.

Following each infraction, you will receive an email cc'd to the program director listing your late amounts.

If there is an issue on the floor they must advise one of the chiefs and we will confirm with respective attending. We will keep the attendance log, and yes we will mark ourselves late if it happens.

Please be aware that in addition that frequent late appearances to lectures is a reflection on the competency of professionalism which the residency is required to teach to residents. As such, a

resident runs the risk of receiving a letter of notice, being placed on observation, remediation, or probation for continued violations despite adequate warnings.

Please ONLY utilize cell phones to call the floor or an attending physician during lecture times.

## **INTERDEPARTMENTAL CONFERENCES**

- 1. RHEUMATOLOGY/REHABILITATION CONFERENCE**
- 2. COMBINED ORTHOPEDICS/NEUROSUGERY/REHABILITATION SPINE CONFERENCE**
- 3. NEUROLOGY GRAND ROUNDS**
- 4. GERIATRIC GRAND ROUNDS**
- 5. ORTHOPEDIC GRAND ROUNDS**
- 6. MIAMI PROJECT GRAND ROUNDS**
- 7. PAIN FELLOWSHIP ROUNDS**
- 8. UMH SPORTS MEDCINE CONFERENCE**
- 9. ULTRASOUND CONFERENCE**

In addition to the above, other departments have frequent conference announcements and these are posted in the residents' room or on bulletin boards and signs throughout the hospital. All residents are encouraged to attend these conferences as time permits and avail themselves to this tremendous opportunity to learn.

## ***OTHER LEARNING RESOURCES***

### **DEPARTMENTAL LIBRARY**

A departmental library is maintained in the residents' room, the office of the chairman, and the program director's office. New books and journals are added to the library regularly. A list of books available in the department is enclosed. Any resident wishing to borrow a book should sign it out with the program director or residency coordinator.

### **HOSPITAL LIBRARY**

The Medical Library at Jackson Memorial Hospital-Miller School of Medicine University of Miami carries a wide array of textbooks and journals in all the major subspecialties. A list of rehabilitation-



related journal available in the hospital library is enclosed. Any articles or journals not available in the library can be requested through interlibrary loan.

In addition to hard copy material, the library has computer terminals linked through a local area network to the OVID medical literature search program. Each resident will have the opportunity to be trained in the use of the computers. These linked PC's also have word processing capability, and several educational programs. Through a dedicated high-speed line, the hospital library system is linked to the wide-area network at Miller School of Medicine-University of Miami, where medical search and database facilities are available to the resident, as well as connection to selected Internet sites.

## **RESEARCH**

PGY 3 residents will have a research rotation for 1 month. During this time the resident will work intensively on research projects of interest under the supervision of a rotation director. Residents are expected to meet with the director one week minimum prior to the onset of the rotation.

All residents will be required to develop a research interest and project. An original research project must be undertaken. The results of the research will be presented the third Friday of the PGY 4 year during Research Day. Research helps stimulate critical thinking, allows for deep analysis and study of a given field of interest, and gives the individual a chance to contribute meaningfully to the current body of scientific work. One attending physician will be chosen, by each resident, to work as a mentor.

Didactic sessions will be held throughout the year to help residents grasp the fundamentals of research, including critical analysis, statistics, etc. The faculty will keep track of the resident's progress and advise accordingly through regular meetings and academic sessions.

Additionally, an abstract for poster or platform presentation must be submitted to the Annual Scientific Program of the American Academy of Physical Medicine and Rehabilitation for their PGY 4 year. Typically, this means submission of the abstract must occur by March of the PGY 3 year. The two more common formats include: 10-minute oral presentation and poster presentation. This abstract may consist of original research or simple case report. These presentations help the resident develop cogent writing, organization, and presentation skills, as well as allowing for in-depth study in the desired field of physical medicine and rehabilitation. The poster must be completed by Research Day of the PGY 3 year.

## ***TRAVEL POLICY***

The Department of Rehabilitation Medicine will pay for a resident to attend the AAPM&R meeting during the PGY4 year if his/her paper/poster is accepted for presentation. The department will reimburse allowable travel expense with receipts for up to \$960.00 and any costs in excess of the travel allowance will be the personal responsibility of the resident. If the paper/poster was **not** accepted due to content and was submitted in good faith the department will reimburse the allowable travel expense for up to \$560.00 and any costs in excess of the travel allowance will be the personal responsibility of the resident. There will be no travel allowance if the abstract is rejected

due to improper submission format or missed deadline. No reimbursement is allowed for spouse or family member.

The resident/fellow is not allowed to split his/her travel allowance between two conferences. Resident/Fellow should submit the appropriate forms (*scientific/educational leave request and a copy of conference brochure*) at least six to eight weeks prior to the trip for approval by their **rotation attending, residency coordinator and department administrator** before making any travel arrangements for educational purposes. The department will not be responsible for business expenses that have not been approved by the rotation attending and department administration.

Travel request for educational leave not paid by the department also require six to eight weeks approval by rotation attending and submitted to residency coordinator. This process will assist in accessing clinical coverage during resident absence.

**Pre-conference course:** The traveler is responsible for all costs associated with a pre-conference course which includes airfare, registration fee, lodging, meals and incidental expenses. The department will only cover the airfare if the pre-course is associated with the approved meeting and proof of attendance to the pre-course is required.

**Electronic Ticket/Ticketless Airline Travel:** air travel that is reserved with an airline for which no paper ticket is issued. The reservation and seat assignment is secured within the airline's computer reservation system only. The traveler must request a receipt from the airline of the booking or check-in at the airport.

**Domestic travel:** federal regulations define domestic travel as within the United States, its possessions and territories. US possessions and territories include Guam, American Samoa, Puerto Rico, and the Virgin Islands.

### **Documentation Requirements**

Under the IRS Accountable Plan Rules expenses are required to meet these conditions:

- There must be a legitimate business purpose-explanation of the business conducted
- Expenses must be substantiated: original receipt with date, place and amount of the expense
- Receipt must indicate payment; proof of payment must be apparent (cancelled check).
- A conference brochure must be provided for conference/seminar attendance.
- Airfare receipt and itinerary are required for airfare reimbursement.

### **Reimbursable Travel Expenses:**

- Commercial transportation expense, including airline, bus and rail.
- Meals – per diem meal allowance. Domestic travel per diem of \$50 a day (\$25 for departure after 3pm and \$25 for returns before 3pm).
- Lodging – actual cost only and a zero balance receipt is required.
- Incidental expenses – include tolls, parking and taxi. Receipts are required

### **Non-reimbursable Travel Expenses:**

- Conference & convention meals, if already included in registration fees.
- Personal entertainment such as hotel room movies, theater tickets, newspaper, magazines, prescriptions, over the counter drugs, health club facilities, barber/beautician services, etc.
- Personal care items.

- Clothing and clothing rental.
- Hotel “no show” charges, airline, hotel cancellation fees.
- Credit card delinquency assessments due to the action of the traveler.
- Life or travel accident insurance premiums.
- Parking tickets and traffic violations.
- Personal portion of airfare, and hotel.
- First class or business class airfare upgrade vouchers.
- Airline tickets obtained using frequent flyer miles or travel vouchers.
- Expenses submitted more than 12 months after expenses were incurred.
- Other expenses not directly related to the travel assignment.

**An original receipt is lost:** for an incidentally lost receipt, the traveler should write statement to this effect. Submit this along with any additional support such as a fax copy (hotel bill), or credit card statement.

Upon return, the traveler must submit all **original** receipts, airfare receipt/itinerary, zero balance receipt for lodging, etc. to the departmental secretary for reimbursement within 10 days.

### **Professional Reimbursement Allowance**

Jackson Memorial Hospital provides each housestaff officer **\$1,250** per residency academic year an allowance to be used as reimbursement for professional/educational expenses. The allowance should be used for professional/educational expenses including but not limited to educational courses, conferences, workshops, books, tapes, supplies, study-guides, board review courses, licensure expenses, palm pilots and out of country travel and expenses related to such aforementioned activities. Attendance at outside conferences must be approved in advance by the program director.

## **RESIDENT SCHEDULING**

Coretha Davis, Residency Coordinator, will monitor the call schedule and resident duty hours along with the chief residents. New Innovations, an online electronic residency management system, is in place. Into this system, residents must input their work hours and days off to make certain the PMR program adheres to all ACGME work hour laws and guidelines.

### ***HOSPITAL HOLIDAYS***

New Year's Day  
 Martin Luther King, Jr's Birthday  
 President's Day  
 Memorial Day  
 Independence Day

Labor Day  
Thanksgiving Day & Friday after  
Christmas Day

Special consideration will be given to requests for time off Christmas Eve and New Year's Eve. Coverage for these holidays will be divided as fairly as possible among the residents to allow residents time with their families for at least one of the major holidays. Requests to be off on particular holidays will be taken into consideration if requested early enough.

VAHS holidays will allow the resident rotating at the VAHS to be free from clinical duties for that day. However, the resident is still considered working and therefore it is expected that the resident will perform research, attend any lectures or conferences, and perform call if on duty.

## ***SICK DAYS***

Each resident is permitted a total of 14 sick days. If more than 14 sick days are used, the additional days may be added onto the end of the residency in order to fulfill the 36-month requirement of the American Board of Physical Medicine and Rehabilitation. These additional days could alternatively be made up as unspent vacation days. If there is reasonable evidence that sick days, especially on-call days, have been used, that resident may be asked to make up the on-call days. The resident must call the program director/residency coordinator before 8a.m. every day that he/she is out sick, to inform of the absence. The affected resident is expected to be at home to answer any questions about patient care. When taking more than one sick day in succession, it is required to bring a physician's note to document the need to be out for multiple days due to illness.

If the resident is taking prolonged sick leave, the program director has the authority to order a medical or psychiatric evaluation with a physician scheduled and approved by the Public Health Trust. If sick leave is exhausted, the program director may grant unpaid leave based upon the situation and the previous competence and performance of the resident. The decision on whether to grant leave will be based on the physician's competence more so than the illness suffered. To that end, a marginal or incompetent resident still may be dismissed while on sick leave for poor performance.

## ***VACATION DAYS***

Each resident is entitled to 28 paid vacation days (20 week days and the 4 weekend days attached to them). The resident's vacation will typically consist of 5 consecutive work days (Monday through Friday) plus the attached two day weekend. Please be aware that if you take off on a Friday the weekend days will be counted as off as well.

PGY 4 residents are required to schedule 2 (one week) vacations in advance (One of which during selective week) and may split the other two weeks to use for interviews, etc. PGY 2/3 residents are required to schedule 3 (one week) vacations in advance and may use the last week flexibly, using no less than 2 days at a time.

Requests for more than one week vacation are discouraged but with special circumstances can be granted. Requests must be submitted at the beginning of the academic year and permission can **only** be granted by the supervising attending physician – then from the program director. If a signed

document from the supervising attending physician is obtained then the vacation may be granted. There can be no more than two people on vacation at a time. Consideration will be given to residents who may need more than one week at any particular time.

Due to critical manpower needs, vacation time must be approved in advance by the program director, who will make the schedule for the entire academic year. Vacation requests forms for the 3 weeks (PGY 3 & 4) and entire year are to be submitted to the Program Coordinator by **July 30<sup>th</sup>**. However for purposes of "locking in" dates, should be submitted no later than **June 7** each year. Flexible day off requests must be submitted at least 6 weeks in advance for PGY 2/3 and as soon as possible for PGY 4's. Changes in vacation are strongly discouraged and must be approved, in writing, by the program director at least 6 weeks in advance, subject to the needs of the program. Failure to abide by this policy may result in forfeiture of unused vacation time.

Vacation time at the VAHS is limited. Please put in your time requests as soon as possible.

See below a detailed description of vacation days and coverage:

- **Clinic Coverage** -When a resident is on vacation, clinic coverage will be pulled from other services (but not from other facilities) along with the assistance of the Chief Resident.
- **1 Day Vacation** – Will only be allowed for emergencies.
- **2 Week Vacation** – Resident must notify the Dr. Sherman at the beginning of the year and it will be discussed with the staff. The resident may straddle two rotations (take 1 week at the end of one rotation and 1 week at the beginning of the next). This is acceptable with the following exceptions:
  - PGY 2's this is limited to Dr. Need & VA rotations only (not while on SCI, TBI or Comprehensive services).
  - For PGY 3's & 4's only if the VA rotation is the 1<sup>st</sup> week.
- **PGY 2** – Vacation is not allowed during the first week of any rotation. No vacation the last 2 weeks of June or the first 2 weeks of July or during both weeks of the Christmas / New Year's holiday season.
- **PGY 4** – Must notify Dr. Sherman at least 10 weeks prior if you will be leaving before (6/30), end of the year. The covering resident will write notes and discharge summaries should be divided.

## ***HURRICANE COVERAGE***

Unfortunately, the one downside to summer/fall in Miami is the hurricane season (not the football team). Our department has tried to allocate coverage in a fair manner. If you are on call, then you must be in the hospital as the hurricane arrives and plan to stay as long as roads are not passable. The on-call resident will similarly remain in-house during the storm. You must make arrangements for your family during this time or ask a co-worker for assistance if family is an issue. You will stay

in the residents lounge or can sleep in Dr. Sherman's office if necessary. As soon as roads are passable, even if the university is closed, we expect everyone who is available to come in and help out. If the damage is extensive, we can set up a rotation system so each faculty member can also take care of things at home.

## ***SCHEDULE CHANGES***

Changes in schedule arranged between the residents are strongly discouraged. It can only be permitted by completing the change request form and submitting it for approval by the supervising attending physician, Residency Coordinator and then the program director approves. Whenever a change is made it is the responsibility of the resident to notify the residency coordinator, page operator, in-patient nursing stations, and the emergency room at least two week prior to the release of the monthly call schedule.

## ***ROTATION CHANGE POLICY***

Unless circumstances strongly warrant, changes in the rotation schedule are strongly discouraged. *No changes or exchanges are without approval of the Residency Coordinator and Program Director.* The following procedure will be in effect:

1. A resident desiring a change in a scheduled rotation shall, no later than sixty (60) days prior to date of desired change, complete and sign the rotation change request form (residency coordinator will have these) stating desired change and reason.
2. The resident must then secure the approval and signature on the form of all other residents whose schedules are affected by such a change.
3. The form is then submitted to the program for approval and signature. If approved it should then be taken to Coretha Davis, Residency Program Coordinator, for final administrative approval. After which the change becomes official, Ms. Davis will notify all affiliates of the approved scheduled changes.

Requests compliant with the above policy will be processed in a timely manner.

## ***ABSENTEEISM***

Absenteeism without notification of the Department will not be tolerated and is a ground for disciplinary action including dismissal.

## **MISCELLANEA**

### ***RESIDENT STRESS***

(Information also found in the CIR manual)

### **Section 2: Physical and Psychological Impairment**

Residents who feel that they need to speak to someone regarding stress may call the EAP office at 305-381-9998. This office will be able direct you to someone that will help.

A Chief of Service or his/her authorized representative shall have the authority to require employees that have been determined, through reasonable suspicion, to possibly suffer from a physical, psychological, or psychiatric impairment, which may prevent the employee from satisfactorily performing the complete duties and responsibilities of their positions, to submit to a physical, medical, psychological, or psychiatric examination deemed necessary for purposes of determining the employee's fitness to perform the complete duties and responsibilities of their position.

Such examinations will be performed by a physician approved and appointed by the Public Health Trust. The results of such examination(s) shall be promptly furnished to the concerned Chief of Service or their authorized representative.

The result of the applicable information submitted by the examining physician to the Public Health Trust should be limited to information that is pertinent to the issues of the employee's ability to perform the duties and responsibilities of their position.

Based upon the results of such examinations and other relevant information, the Chief of Service may place the employee on either paid or unpaid compulsory leave in accordance with the provisions of the leave manual until such time as the Trust is satisfied that the employee can return to work. The Trust may require the employee or attending physician to furnish additional pertinent medical reports or information deemed necessary while the employee is on compulsory leave.

Should the condition be corrected and so certified by the attending physician or psychologist, the employee may petition the Trust for reinstatement. If the employee's petition for reinstatement is denied by the Chief of Service, disciplinary action must be initiated by the Chief of Service in accordance with the Trust rules. Nothing in the provision of this Article shall prevent the Trust from administering appropriate disciplinary action in accordance with the Trust rules and this collective bargaining agreement.

## ***GRIEVANCES***

(Information also found in the CIR manual) **Article 11**

### **Grievance and Arbitration Procedures**

#### **Section 1:**

In a mutual effort to provide harmonious working relationships between the parties to this Agreement, it is agreed to and understood by both parties that the following shall be the sole procedure for the resolution of grievances arising between the parties as to the interpretation of and application of the provisions of this Agreement.

The parties further agree that other disputes shall be reviewable and appealable as set forth in other parts of this Agreement and that the union-management committee may address concerns not falling under the grievance/arbitration or other appeal procedures.

## **Section 2:**

Except as otherwise provided in this Agreement, the term "grievance" shall mean:

- A. A dispute concerning the application or interpretation of the terms of this collective bargaining agreement;
- B. A claimed violation, misinterpretation, or misapplication of the rules, regulations, authorized existing policy, practice, or orders of the Trust affecting housestaff.

The following shall not be considered grievances: a formal or informal counseling, disputes over progress in the educational program, discharge of clinical responsibilities, the timely decision to renew the appointment of a housestaff officer, advancement decisions, a program termination, and any matters for which other appeal procedures are provided for in this Agreement (or otherwise specifically made available to this bargaining unit).

## **Section 3:**

A class grievance (general grievance) shall be defined as any dispute which concerns two or more employees within the bargaining unit. Class grievances should attempt to name all employees or classifications covered in a grievance; however, the absence of a housestaff officer's name shall not exclude him/her from any final decision or award.

Class grievances, at the option of the union, may be submitted at Step 2.

## **Section 4:**

Each written grievance, when filed, shall contain a brief statement of the facts of the violation claimed (including the date, or approximate date, upon which the violation occurred), together with the article(s) of the contract violated, and the remedy sought.

## **Section 5:**

Grievances shall be processed in accordance with the following procedure:

A grievance may be brought no later than fourteen (14) calendar days after the date on which the grievance arose (or was reasonably likely to have become known) by an individual housestaff officer and CIR, or by CIR alone, and shall be undertaken pursuant to a two (2) step grievance procedure as follows:

**Step 1.** The aggrieved employee, and/or the union, shall discuss the grievance with the concerned Chief of Service or designee. The Chief of Service or designee shall respond to the grievance within (14)\_fourteen calendar days. Grievances of an administrative nature not directly under the control of the Program Director may be filed with the Director of Physician Services.

**Step 2.** If the grievance has not been satisfactorily resolved in Step 1 thereof, the aggrieved employee and/or the union may appeal to the Senior Vice-President for Medical Affairs within (14)\_fourteen calendar days. The Senior Vice-President for



Medical Affairs may conduct a meeting and shall respond to the employee with a copy to the union within (14) fourteen calendar days of the appeal.

#### **Section 6:**

Failure by the employee or the union to observe the time limits for submission of a grievance at any step will automatically result in the grievance being considered abandoned. Failure by the Public Health Trust to respond to a grievance within the prescribed time limits will automatically move the grievance to the next step.

#### **Section 7:**

Each party shall be allowed one (1) extension of time, not to exceed seven (7) calendar days. This extension can be used only once during the grievance. The other party must be notified of the requested extension. Additional extensions may be granted in good faith settlement discussions or by mutual agreement.

#### **Section 8:**

The parties acknowledge that as principle of interpretation, employees are obligated to work as directed while grievances are pending. This does not limit the rights an employee may have under federal, state, or local laws where the employee is faced with an immediate physical danger at work.

#### **Section 9:**

Individual grievants and a representative of the grievant class will be permitted to attend any grievance meeting scheduled by the Trust. Meetings will be scheduled at times mutually convenient to the persons involved.

#### **Section 10: Employer Responses**

All responses required in Step 1 and Step 2 above shall be directed to the aggrieved employee with a copy furnished to the union. In class grievances, copies will be directed to the union only. A rejection of a grievance at any step of the procedure must contain a statement of the reasons for the rejection.

#### **Section 11: Arbitration**

A. If the union is not satisfied with the reply in Step 2 of the grievance procedure, the union shall have thirty (30) days to file a request for arbitration to Federal Mediation and Conciliation Service (FMCS) or American Arbitration Association (AAA) and provide a copy to the Trust.

B. The union shall request a list of seven (7) arbitrators from Federal Mediation and Conciliation Service (FMCS) or American Arbitration Association (AAA). The parties shall each strike from said list, alternately, three (3) names, after determining the first strike by lot, and the remaining name shall be the arbitrator. Nothing herein shall prohibit the parties from agreeing on an impartial arbitrator outside the above procedure.

C. The arbitrator shall promptly conduct the hearing on the grievance at which both parties shall be permitted to present their evidence and arguments pursuant to the Voluntary Labor

Arbitration Rules of the American Arbitration Association. The decision of the arbitrator shall be rendered in writing with copies of the award promptly furnished to both parties, no later than thirty (30) calendar days after the conclusion of the hearing, and such decision shall be final and binding.

D. Each party will pay its own expenses and will share equally in expenses incurred mutually in arbitration. Employees required to testify will be made available without loss of pay; however, whenever possible, they shall be placed on call to minimize time lost from work and, unless directly required to assist the principal union representative in the presentation of the case, they shall return to work upon completion of their testimony. The intent of the parties is to minimize time lost from work and disruption of patient care.

E. The arbitrator shall limit his/her opinion to the interpretation or application of this Agreement and shall have no power to amend, modify, nullify, ignore, or add to the provisions of this Agreement.

Grievances, as defined, may be submitted regarding the matters contained in the Agreement or arising from conditions of employment. Matters excluded from the grievance procedure are not arbitral

## **SEXUAL HARASSMENT**

It is the policy of The Rehabilitation Department at the Miller School of Medicine at the University of Miami and the PMR residency at Jackson Memorial hospital that no male or female member of the University and Hospital community - students, faculty, administrators, or staff - may sexually harass any other member of the community. Sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute harassment when:

- submission to such conduct is made or threatened to be made, either explicitly or implicitly, a term or condition of an individual's employment or education; or
- submission to or rejection of such conduct is used or threatened to be used as the basis for academic or employment decisions affecting that individual; or
- Such conduct has the purpose or effect of substantially interfering with an individual's academic or professional performance or creating what a reasonable person would sense as an intimidating, hostile, or offensive employment, educational, or living environment.

### **Examples of sexual harassment include...**

- Pressure for a dating, romantic, or intimate relationship
- Unwelcome touching, patting, or hugging
- Pressure for or forced sexual activity
- Unnecessary and unwelcome references to various parts of the body
- Belittling remarks about a person's gender or sexual orientation
- Inappropriate sexual innuendoes or humor
- Obscene gestures
- Offensive sexual graffiti, pictures, or posters
- E-mail and Internet use that violates this policy

## **GUIDANCE ON DISCRIMINATION AND HARASSMENT ISSUES**

### **Investigation and Confidentiality**

All reports describing conduct that is inconsistent with these policies will be promptly and thoroughly investigated. Complaints about violations of these policies will be handled confidentially, with facts made available only to those who need to know in order to investigate and resolve the matter.

### **Retaliation**

The Department of Rehabilitation prohibits retaliation against anyone for registering a complaint pursuant to these policies, assisting another in making a complaint, or participating in an investigation under the policies. Anyone experiencing any conduct that he or she believes to be retaliatory should immediately report it to one of the individuals listed under “Where to Get Advice and Help.”

### **Resolution**

If a complaint of discrimination, harassment or sexual harassment is found to be substantiated, appropriate corrective action will follow, up to and including separation of the offending party from the Department, consistent with Department procedure.

### **Academic Freedom**

The Department of Rehabilitation is committed to the principles of free inquiry and free expression -- to providing an environment that encourages the exploration and exchange of ideas. The University's discrimination and harassment policies are not intended to stifle this freedom, nor will they be permitted to do so. Prohibited discrimination and harassment, however, are neither legally protected expression nor the proper exercise of academic freedom; and such conduct is incompatible with the values of Department.

## ***You Have Responsibilities Under This Policy***

All members of the Department and Hospital community are responsible for creating a working, learning and living environment that is free of discrimination and harassment, including sexual harassment. It is important to contact one of the individuals listed under “Where to Get Advice and Help,” if any of the following occurs:

- You believe you have been subjected to conduct or comments that may violate this policy
- You believe you have been retaliated against in violation of this policy
- You hold a supervisory, management or teaching position, and have been told about or witnessed conduct that you think may violate this policy.

### **Vendors, Contractors and Third Parties**

The Department's policies on discrimination and harassment, including sexual harassment, apply to the conduct of vendors, contractors and third parties. If a member of the University or Hospital community believes that he or she has been subjected to conduct that violates this policy by a vendor, contractor or third party, he or she should contact one of the individuals listed under “Where to Get Advice and Help.” The Department will respond as appropriate, given the nature of its relationship to the vendor, contractor or third party.

### **If you are discriminated against or harassed . . .**

- Don't blame yourself.
- Say no.
- Remember that harassment and discrimination, including sexual harassment, are against University policy and may be against the law.
- Know your rights under policy of the Jackson Memorial Hospital and University of Miami.
- Keep a written, dated record of events.
- Tell someone.
- Get help.
- Don't delay.

If the incident is of sufficient magnitude then please report the incident to the program director, or the chairman of the department, the head of the residency GME committee, the DIO, or to the confidential resident psychology or physician hotline.

### **Are you the harasser?**

Accused harassers are often surprised to learn how others view their behavior.

- Review your attitudes and actions toward others. Do you base your behavior on stereotypes? Is your behavior bias free?
- Consider the impact you have on others' attitudes toward their work, education, and self-esteem.
- Examine how others respond to what you say and do.
- Do not assume that colleagues, peers, employees or students enjoy racial or ethnic jokes, sexually oriented comments, remarks about their appearance or religion, or being touched or stared at.
- Do not assume that others will tell you they are offended – or harassed – by what you say and do.

### **If you think you may have offended or harassed someone . . .**

- Apologize as soon as possible.
- Change your behavior.
- Read the policies on discrimination, harassment and sexual harassment
- Get advice from the confidential Resident behavioral medicine department.

## ***MALPRACTICE INSURANCE***

The hospital provides residents with malpractice insurance. This insurance, however, covers you only for duties ascribed directly to the training program.

## ***SOCIETY MEMBERSHIP***

All residents must apply to the American Academy of Physical Medicine and Rehabilitation for junior membership. This membership includes the subscription to the journal ARCHIVES. Also the Southern Medical Association offers complementary membership for residents & fellows. The Florida Academy of Pain Medicine accepts resident members for free as does the FSPMR.

### ***RESIDENT SELECTION:***

Currently the goal is to matriculate six new PGY 2 residents per year. All positions are placed in the match. All applicants are expected to utilize the ERAS system to submit their applications for evaluation. Residents who are on target to complete medical school in an accredited Osteopathic or Allopathic medical school will be given preference for interview slots. Students who are completing medical school at a Foreign Medical School will be given consideration if they demonstrate a consistently excellent performance as demonstrated by measures of performance as listed below. Between 50 and 60 medical students will be interviewed per year.

Residents are selected on the basis of their ability to demonstrate competence in all aspects of their medical school experience. This experience includes but is not limited to:

- 1) Basic science grades
- 2) Clinical rotation grades
- 3) Successfully pass USMLE or COMLEX Board exams
- 4) Letters of Recommendation that demonstrate the resident's ability to perform in a competence and professional manner
- 5) Research exposure or experience
- 6) Intangible abilities that can be mentioned in a Dean letter.

Residents who are felt to meet the criteria for admission are granted an interview for admission. An admissions committee of four members with one alternate is in place. All applicants interview with all four members of the committee but the alternate will be used if necessary. Permanent members of this committee are Program Director, Dr. Andrew Sherman and Associate Program Director, Dr. Andres Restrepo.

A comprehensive evaluation form, that includes ten measures of competence, is given to the interviewers for scoring that will allow for the most objective evaluation of the interview candidates. Residents are ordered according to average score and ordered in that manner. However, in addition to the objective score, a subjective component is allowed to exist that may boost or reduce a candidate's score. Ultimately, a final score is given after subjective and objective considerations are taken into account. Residents will then be ranked in the NRMP match according to this list.

If a spot goes unmatched, candidates will be evaluated for these positions on an individual case by case basis.

## ***NON-DISCRIMINATION POLICY***

The department of rehabilitation medicine follows and adheres in every way to the non-discriminatory policy of Jackson Memorial Medical Center-University of Miami. The hospital maintains full compliance with the Americans with Disability Act.

## ***POST-RESIDENCY PLACEMENT***

The department will make every effort to assist residents in finding placement at the completion of their training. Announcement of job openings are regularly posted in the rehabilitation residents room. Members of the faculty will be glad to advise the senior residents in this all-important step.

## ***RESIDENT CONTRACTS***

Contracts are issued for period of one year and are not automatically renewable. A new appointment form and approval by the program director is required for each successive year.

## ***RESIDENT PERFORMANCE***

Resident promotion decisions will occur typically at the end of the third rotation – 6 months into the year.

### **The factors taken into account:**

- 1) Rotation evaluations
- 2) Lecture performance
- 3) Attendance to work, professionalism, attitudes.

### **The promotions committee consists of permanent members and rotating members:**

#### **Permanent Members:**

- 1- Program Director - Andrew Sherman, MD
- 2- Associate Program Director - Andres Restrepo, MD
- 4- Associate Program Director - Tamar Ference, MD
- 5- Committee Chair - Associate Program Director

#### **Current rotating Members:**

1. Jasmine Martinez, DO
2. L. Adriana Arenas, MD
3. Robert Irwin, MD.

**The Promotions and Rules committee will meet regularly to set rules and also if called upon by one of two issues:**

- 1- Resident non-performance
- 2- Attending non-performance.

If one of the attending MD's on the list of committee members is being discussed, they will not attend the initial meeting and will be replaced by an alternate.

**Rotation evaluations:**

- Residents are evaluated on 6 competencies.
- They will be evaluated every month by the site director and attending MD's who have close contact with the resident (Midpoint and Final).

**Scores will be on a 1-9 level. Anything under 4 (1-3) is a failing grade.**

If the first evaluation has any 3's or less or averages less than 5, the resident will be placed upon unofficial watch. Both the site director and the resident will check in WEEKLY with the Program director who will monitor progress. The goal will be to identify the limiting performance factors, enhance performance, and turn around unsatisfactory behaviors.

A follow up evaluation will be presented after 2-3 weeks.

If one rotation is failed with an average of 2-3. Then the resident will not be given credit for the rotation. The board will meet with the resident and the site director individually. The resident may be placed upon official probation. The site director will present a plan to the resident on what work will need to be accomplished to earn a passing grade. In some cases, passing the rest of the year may suffice to improve to a passing score. Other suggestions will include remedial testing, written project, or extra time added onto the end of the residency (pending approval from the hospital to fund the salary line).

If the resident fails one rotation, and then receives a failing grade in the next or subsequent rotation, they will not be renewed for the following year.

In certain cases, when it is unclear that the resident is entirely at fault, expectations are unclear, structure is necessary, the resident may be switched to a different rotation.

***PROMOTION:***

Residents will meet twice per year with the residency program director. At that meeting, the resident performance to date will be discussed. A promotions committee will meet each December to consider resident promotion. Based upon resident performance a vote will be taken. A resident who passes all of their rotations, exhibits good professionalism, and who has a satisfactory attendance record will automatically be promoted to the next PGY year. This promotion however must be confirmed by the Promotion Committee. If a resident has clearly marginal academic performance on tests, has failed a rotation or nearly failed multiple rotations, and/or is on probation then the committee must meet sooner to discuss and vote on the case. A majority vote must be

given to promote a resident to the next level. If the resident does not receive those votes, then disciplinary action will be taken in accordance with the procedures outlined in the resident CIR.

Residents must make at least one attempt at USMLE III during their internship year. Residents are expected to pass the exam prior to moving onto their PGY3 year. Any resident not complying with this requirement risk not being promoted to the PGY 3 level; unless specific circumstances arise and this must be discussed and approved by the Program Director. The department reserves the right to hold back a resident who does not achieve a passing score vs. placing the resident on academic remediation/probation. A resident who has continued to fail to achieve a passing score on the USMLE III by November 30 of their PGY 3 year will be subject to any of a number of consequences. The possibilities include but are not limited to dismissal, academic probation, extension of the residency program, hold back, or dismissal. The ultimate decision on how to proceed will be decided by the Promotions and Rules Committee and will be based upon the resident's overall performance outside of the testing environment.

## ***DISMISSAL***

Resident discipline policy is shared with the policies and procedures outlined in the resident handbook. Resident dismissal is taken very seriously by this department. It is understood that physicians-in-training are inexperienced, learning, and can make mistakes. However, there are times when dismissal is necessary. The residents are given a handbook at the beginning of their residency that discusses the basic expectations that are necessary for completion of the residency. The book also discusses some of the behaviors that a young physician-in-training should exemplify if they want to graduate from this program and represent this department.

Because the department recognizes the impact that resident dismissal can have on that physician's individual career, the other residents in the program who may have more work to cover, and the department as a whole, residents who fail to perform properly are given multiple opportunities to be warned and improve their performance before ultimately being fired.

As such, dismissal cannot be discussed out of context of the entire resident disciplinary process. Therefore the process will be repeated here:

## ***CORRECTIVE ACTION, DISCIPLINE, AND APPEAL PROCEDURES***

(Information also found in the CIR manual) Article 13

### **Section 1:**

The Chief of Service (hereafter "Chief" or "Chief of Service") or his/her designee shall periodically consult with the housestaff officer about his/her progress in the residency program and discharge of clinical responsibilities. The Chief of Service shall give notice of any deficiencies, improvement required, and plan to accomplish such, and time within which the improvement must be made.

Continued deficiencies in performance after counseling may result in non-renewal or non-advancement/non-certification, reprimands, or disciplinary action, as below.



The housestaff officer shall regularly be given photocopies of his/her evaluations. The fact and date of counseling shall be documented.

Discipline by the employer or Chief of Service may include relief of the housestaff officer from clinical duties and/or reassignment to other duties, suspension with or without pay, termination for unsatisfactory performance and/or conduct in discharging clinical responsibilities, for conduct unbecoming an employee, or for excessive tardiness or absenteeism.

## **Section 2:**

Any housestaff officer covered by this collective bargaining agreement shall not be discharged or disciplined without just cause. The employer or Chief will follow progressive disciplinary procedures, whenever appropriate, and in all instances will have the burden of proving just cause for disciplinary action.

Whenever it is alleged that a housestaff officer's discharge of clinical responsibilities is unsatisfactory or that he/she has violated any law, rule, regulation, or policy, that housestaff officer shall be so notified and informed of the areas deemed unsatisfactory, or law, rule, regulation, or policy allegedly violated.

The employer or Chief shall initiate an investigation prior to notification to the housestaff officer of a pending disciplinary action. The employer or chief shall conduct the necessary investigation to include full consideration of any documentation submitted by the housestaff officer prior to making a final decision.

The employer or Chief agrees to inform the housestaff officer and union of their right to representation in the disciplinary process. The employer or Chief will give the housestaff officer 48-hours written notice providing date, time, and place that a disciplinary/counseling session is scheduled. This notice will include the law, rules, regulation, or policy allegedly violated and the nature of the alleged violation.

Disciplinary action determinations will not be rendered until the completion of the presentation and rebuttal meetings where the employer or Chief of Service and the housestaff officer, together with his/her representative, through use of documents and witnesses, have opportunity to present their respective cases. Rebuttal meetings should be scheduled within fourteen (14) calendar days, unless time is extended by mutual agreement. The Chief of Service or the employer shall render a written decision within seven (7) calendar days after the rebuttal meeting. The Union and the housestaff officer shall receive a copy of the rebuttal decision.

The housestaff officer may request, within fourteen (14) calendar days, that the Senior Vice-President for Medical Affairs or his designee meet to review or rescind the proposed discipline. The disciplinary action will take effect unless the housestaff officer makes a timely request for review. Unless the Senior Vice-President rescinds the proposed action, it will become effective following his/her review and decision. The Union and the housestaff officer shall receive a copy of the Senior Vice-President's decision within (7) seven calendar days.

## **Section 3: Emergency Situations**

Where the Chief of Service, Senior Vice-President for Medical Affairs, or their designee makes a tentative determination that a housestaff officer's discharge of his/her clinical

responsibilities is so unsatisfactory that to allow him/her to continue in his/her assignment would expose patients to unnecessary medical risks and the hospital to unnecessary liability, he/she may, prior to a hearing, temporarily reassign the housestaff officer to duties other than his/her clinical responsibilities.

#### **Section 4:**

In the case of a suspension without pay or termination, the President of the Public Health Trust may withhold the housestaff officer's compensation when the action becomes effective, as in Section 2 above, while further appeal process and any subsequent grievance or arbitration is being pursued.

#### **Section 5:**

A disciplinary action of a suspension without pay or dismissal may be appealed by the housestaff officer disciplined or the union by petitioning the President of the Public Health Trust for an appeal hearing within fourteen (14) calendar days of receiving notice of the Senior Vice-President's decision. Any such disciplinary action that is not timely appealed shall be considered final as of the date of receipt of the decision.

Upon receipt of a petition, the President shall direct the Senior Vice President for Medical Affairs to appoint a Peer Review Committee, which shall consist of two housestaff officers and two members of the medical staff. The two medical staff members shall be selected by the Senior Vice-President and the two housestaff officers by the union. The appointment of the committee shall be within seven (7) calendar days of the receipt of the petition. The committee shall meet within five (5) calendar days of their appointment to agree upon a fifth committee member as chairperson (an attending physician other than a housestaff officer) to conduct a hearing regarding discipline. The panel shall conduct a hearing within ten (10) calendar days after the selection of the fifth committee member. The housestaff officer may bring and be assisted by a union representative or counsel of his/her choosing, may present evidence, and may otherwise fully participate in the proceedings.

After a hearing or hearings, the chairperson shall promptly submit a report regarding the Committee's findings and recommendations within fourteen (14) calendar days to the President of the Trust and the union for a final determination regarding the disposition of the disciplinary action under appeal. The President shall issue a written decision to the housestaff officer and the union within thirty (30) calendar days of receipt of the committee's report.

#### **Section 6:**

housestaff officer shall also terminate any reappointment of the housestaff officer to any subsequent year of training that may have occurred by the terms of this Agreement or otherwise.

#### **Section 7:**

If the determination of the President is adverse to the housestaff officer, the Union may request arbitration in accordance with Article 11 (B).

#### **Section 8:**

Arbitration hereunder shall determine whether just cause or basis exist for the disciplinary action. The arbitrator shall be authorized to accept, reject, or modify the charge or disciplinary

action. The arbitrator shall not have the authority to substitute his or her judgment for clinical or academic evaluations, but may issue decisions and create remedies that include impartial evaluation procedures.

#### **Section 9:**

Representation and Information: Housestaff officers shall have the right of representation by the union in investigatory meetings and/or hearings. The housestaff officer and his/her representative shall have the right, prior to all hearings, to receive and review all statements and other documents on which the proposed charges are based, along with other appropriate materials.

At formal hearings (the Peer Review Committee hearing or in arbitration), the housestaff officer shall have the right to confront and question all witnesses, under oath where appropriate, and shall have the full and unimpaired right to present such evidence as the housestaff officer and union may deem necessary.

#### **Section 10:**

All written notices required to be sent to the housestaff officer and union pursuant to this article shall be by certified mail or personal delivery by the Chief of Service, Senior Vice-President, or designees. The date of receipt shall be documented.

#### **Section 11: Reprimands**

Reprimands may be appealed by the employee through the grievance procedure up to and including Step 2, but shall not be further appealable to either an arbitrator or to the Peer Review Committee. Within thirty (30) calendar days of the receipt of the Trust's reply to such a grievance at any step of the grievance procedure, the housestaff officer and/or the union shall have the right to file a written response to the written reprimand and have said response inserted in the housestaff officer's personnel folder.

#### **Section 12:**

Written reprimands and records of counseling, together with any reference to such reprimands and records of counseling, excluding performance evaluations, shall cease to be of any force or effect for employment purposes after a two-year period from receipt of the record of counseling or written reprimand in which the housestaff officer has received no further disciplinary action or records of counseling.

#### **Section 13: Rescinded Disciplinary Actions**

Documents reflecting disciplines that have subsequently been rescinded shall be appropriately noted as either "no longer in effect" or "rescinded," in accordance with the requirements of the Florida Public Records A

## ***MOONLIGHTING***

A. A housestaff officer wishing to engage in limited employment in addition to his/her regularly assigned duties must first file request with the Chief of the appropriate service and obtain in writing the Graduate Medical Office approval. Such approval will not be unreasonably denied. The Chief of Service may request a reduction in hours or total abolishment of such additional employment, when, in the Chief's judgment, the educational progress or clinical service requirements of said housestaff officer is being compromised.

B. All moonlighting hours WILL count toward the 80 hour work week limitation.

C. A housestaff officer may engage in limited employment during his/her vacation period(s) with prior written notice and the approval of the Chief of Service. Such approval will not be unreasonably denied.

It is department policy that PGY 2 residents are not permitted to moonlight without special permission from the program director.

Further details are in the attached JMH moonlight policy and procedure.

## ***MEDICAL RECORDS***

Residents are expected to visit the medical records department **AT LEAST ONCE A WEEK** to complete the charts. Substantial numbers of uncompleted charts or excessive delays in completing charts may result in disciplinary action.

## **SITE AFFILIATIONS**

### **MOUNT SINAI MEDICAL CENTER**

- A. Attain competency and expertise in the evaluation and management of ambulatory patients with neuromusculoskeletal impairments and their attendant disabilities.
- B. Attain proficiency in the planning and technical execution of electrodiagnostic evaluation of patients with neuromuscular disorders.
- C. Attain proficiency in designing and prescribing prosthetics and orthotics.
- D. Establish competency in designing goal-based therapeutic programs and in accurately prescribing them.
- E. Cite and apply techniques of treatment of wounds and chronic ulcers.

### **MIAMI VA HEALTHCARE SYSTEM**

The Miami VA Healthcare System includes a tertiary medical center comprising a 223-bed teaching hospital with an on-site 120-bed nursing home care unit and a 58-bed Psychosocial Residential Rehabilitation Treatment Program. The Miami VA Healthcare System is one of the elite 30 level-1a facilities that is considered highly complex with the largest number and dimension of physician specialists and healthcare professionals. It is one of the largest VA facilities with regards to volume, teaching, and research. In Fiscal year 2006 the Miami VAHS

served over 52,960 veterans with 6,026 acute care discharges and 570,854 outpatient visits. The Miami VAHS is the recipient of many awards including the 2005 ER department recipient of a Chest Pain Center of Excellence, the Carey Award for 2006 and 2007 as the Best in VA Health Care. Finally, in 2007 the Miami VA was the proud recipient of the Governor's Sterling Award for the quality health care. The community outreach extends from Key West to Deerfield Beach with its outpatient clinics. Through its affiliation with the University of Miami Miller School of Medicine and Jackson Memorial Hospital it supports over 600 residents rotating annually through its 152 positions.

The PM&R department at the Miami VA is comprehensive in its approach including 5 full-time physiatrists and one part-time physiatrist with skills ranging from electrodiagnosis, pain medicine, amputation, and spinal cord injury. There is also a full-time chiropractor who specializes in the treatment of the spine and incorporation of acupuncture into the program. This department completes all of the EMG's in the hospital system and is equally incorporated into the Pain Center with Anesthesia. Further, the PM&R department runs the newly created Polytrauma System of care designed to treat the returning OIF/OEF veterans. It also is the first point of contact for the veterans screening positive for traumatic brain injury. The department has become one of the busiest services and is expanding to six full-time residents this year. In addition, the rotations are dynamic and include the full spectrum from inpatient to outpatient and interventional pain. In addition, residents will have the opportunity to manage acute and chronic spinal cord injury. We have a newly established general rehab clinic which is designed to enhance resident education and allow the resident to evaluate patient and present their diagnosis and plan of care for the patient and then complete any follow-up interventions such as peripheral injections. Last year, the PM&R department initiated the first Cardiac Rehab program in the entire university system and has the unique teaching abilities which includes a cardiologist dedicated to the sessions along with a cardiology fellow and rehab resident. There is a separate reading list geared to each resident year within the VA system designed to enhance the residents' experiences. In summary, PM&R is quickly becoming one of the most prolific departments within the Miami VA Healthcare System and provides some of the most unique and educational aspects of the residency.

## DISCHARGE SUMMARY

The discharge summary should reflect the following:

- ✓ Discharge Diagnosis
- ✓ Present Illness
- ✓ Past Medical History
- ✓ Previous Operations
- ✓ Review of Systems
- ✓ Social and Living Arrangements
- ✓ Physical Examination
- ✓ Laboratory Data, EKG, X-rays
- ✓ Hospital Course: Medical
- ✓ Rehabilitation –P.T., O.T., Speech, ADL
- ✓ Family Meetings
- ✓ Social Service Intervention
- ✓ Psychology
- ✓ Goals-Established at time of admission to Rehab, and whether these were achieved. If not, why?
- ✓ Re-establishment of Goals.
- ✓ Discharge Diet
- ✓ Discharge Level of Activity
- ✓ Follow-up:     Medical  
                              Rehab -M.D.  
                              Therapy
- ✓ Medications
- ✓ Condition on Discharge

# **SAMPLE DISCHARGE SUMMARY**

JACKSON MEMORIAL MEDICAL CENTER - UNIVERSITY OF MIAMI

Name: SAMPLe  
Adm.  
Disch.  
Chart#

This was the second inpatient admission of this 42 year old white male with the admitting diagnosis of juvenile rheumatoid arthritis; quadriparesis secondary to arthritis in the cervical spine; status post recent cervical laminectomy; status post insertion of bilateral total hip prostheses; old history of pancreatitis; mature cataract left eye.

PRESENT ILLNESS: A review of the patient's first admission reveals that at age 4 he was diagnosed as having juvenile rheumatoid arthritis. In 1959 he had a left prosthetic hip inserted and this was replaced in 1965. He states that he was able to walk until 1968 when he underwent a total replacement of the right hip in Boston. At that time, he was told that the left hip prosthesis would eventually need replacement and was advised to walk on crutches to extend the period of time until such replacement would be necessary. In 1978 he had a total replacement of the left hip in Boston. He states that following this surgery he became a "total wreck" with psychological and multiple physical problems. In January 1979 he was discharged to his home and received physical therapy at home. Beginning in March 1979 he began to develop numbness in both lower extremities and also noted increasing numbness in both hands. X-rays were taken of the cervical spine and thoracic spine and myelogram was advised which the patient refused. In August 1979, however, because of progressive symptoms, he returned to Boston and a myelogram was done which was negative. The diagnosis was made there of paraparesis secondary to vasculitis but this was not confirmed by biopsy.

The patient was seen for an initial evaluation at \_\_\_\_\_ on 4/21/79 by Dr. \_\_\_\_\_ and admission was recommended.

The patient was first admitted to \_\_\_\_\_ on 5/14/80. A modest improvement in independence had occurred by the time of his discharge on 7/10/80. The patient felt that he had improved considerably. By August 1980 the patient noted decreasing function and in November 1980 he was hospitalized at \_\_\_\_\_ Hospital in \_\_\_\_\_. Workup there revealed increasing symptoms attributable to the disease of the cervical spine and recommendation was made for laminectomy. The patient decided to return to \_\_\_\_\_ Hospital in Boston where, on December 7, 1980, he underwent cervical laminectomy. Halo was applied and removed on March 5, 1981. He was discharged on March 16, 1981 to his home while awaiting admission here. According to the patient, improvement has been noted, particularly in the right arm, post operatively compared to his stated in November 1980. There were no complications of his stay in Boston.

The patient was admitted to \_\_\_\_\_ for a period of evaluation and therapy.

PAST MEDICAL HISTORY: There are no known allergies. The patient had a severe attack of pancreatitis 18 years ago.

PREVIOUS OPERATIONS: See above.

REVIEW OF SYSTEMS: Head: Negative. EENT: Patient has been told he has a cataract in the left eye.

Cardiopulmonary: Negative.

Gastrointestinal: Negative.

Genitourinary: Negative.

MARITAL: Patient has been married for 25 years. Patient's wife and two children are living and well.

PHYSICAL EXAMINATION: The patient is well developed, thin, white male who is alert, oriented and cooperative. Blood Pressure: 110/64. Pulse: 102. Head: Negative. Eyes: No change is noted since the patient's last examination. Neck: The neck is encased in a soft collar. There is a well-healed laminectomy incision over the posterior part of the neck. Heart: No abnormalities. Lungs: Clear. Abdomen: The bladder is palpable four fingerbreadths above the symphysis pubis. No other organs are palpable. Extremities and neurological: Elbow flexion on the right is good plus, on the left is good. Wrist flexion/extension is present through a limited range. Active motion is noted in the fingers of the right hand. Left hand, some active motion is seen in the thumb and index finger. There are multiple contractures noted secondary to the rheumatoid arthritis in the wrist and fingers. Lower extremities: There are well healed surgical incisions over both hips. Sever equines deformity is noted, particularly noticeable on the left. The right lower extremity is stronger than the left. Hip strength is poor to poor plus, knees trace poor. Ankles: The right ankle shows fair dorsiflexion and plantar flexion. The left ankle shows fair minus plantar flexion, zero dorsiflexion.

LABORATORY: Admission urinalysis showed numerous red cells and 2+ occult blood with sterile culture X2. CBC, differential, creatinine and BUN were normal. Fasting blood sugar was 51.

X-RAY: Chest x-ray showed unchanged cardiomegaly, flattening of the diaphragm with hyperlucent lungs, fibrosis, suggestive of chronic obstructive pulmonary disease, and an old healed fracture deformity of the right humeral neck. Cervical spine x-rays showed fusion of C2, 3, 4, and C7, T-1 with upper wire posterior stabilization and pantopaque droplets. Later flexion/extension views were done which showed no instability. There were rheumatoid arthritic changes with erosion of C-1. KUB showed no calculi. Cystogram showed small bladder with trabeculation.

ELECTROCARDIOGRAM: EKG showed incomplete right bundle branch block.

HOSPITAL COURSE: In Physical Therapy patient needed assistance with the parts of his power driven wheelchair or manual wheelchair in preparation for transfer. He was able to push a manual wheelchair for short distance. He learned to do a sliding board transfer with non-contact guarding and occasional minimal assistance. Mat mobility required maximum assistance. He had several times with moderate to maximum assistance, and minimal assistance to maintain with his crutches. There were the stable limitations in passive range of motion of all four extremities. Trunk strength was fair, shoulders fair to fair plus, elbows fair plus good minus, wrist good. Hip was poor plus, fair minus, knees fair minus to fair plus, which an improvement on the right, ankles fair was minus and some increased spasticity was seen.



Occupational therapy found minimal improvements in the hand strength overall –but he did improve in dexterity and manipulation. He became involved in the Yard School of Art and had some equipment at home to pursue this for vocational purposes.

Activities of Daily Living found the patient also could propel the wheelchair manually for a short distance. He needed moderate assistance in use of the side rails to roll in bed, maximum assistance to sit in the soft bed, but had functional short sitting balance. Grooming was independent, except for combing hair, but he did have a combing aid at home. He needed moderate assistance to dress the upper body very slowly, and maximum assistance for the lower body. He was provided previously a shower bench, stair glide, ramping and ADL equipment. New parts for his manual wheelchair were requested and delivered. The bathroom is to be used at home with help from the family.

Social Service did interview the wife, who was in for a session of ADL, and also the daughter. The wife continued to refuse to be involved in meetings with the physician or other team members.

Psychology found him to be passive dependent with poor self-esteem, but he was starting to take some initiative in changing his long-standing rigid behavioral habits in the face of his disability.

Medically there were no complications of stay. He was weaned off the collar. Initially there was poor voiding of the bladder but this improved, documented by residual urine determination. Patient refused IVP and cystogram studies.

DISCHARGE DIAGNOSES:

1. Juvenile rheumatoid arthritis.
2. Quadriparesis secondary to cervical spine arthritis.
3. Status post cervical laminectomy.
4. Remote bilateral total hip replacements.
5. Old history of pancreatitis.
6. Mature cataract left eye.

DISCHARGE MEDICATIONS:

1. Colace 100mg t.i.d.
2. Dulcolax suppository T1W
3. Ascriptin 10gr b.i.d.
4. Prednisone 15mg o.d.

DISCHARGE RECOMMENDATIONS:

1. Home health aid
2. Home Physical Therapy
3. To be seen by Dr. \_\_\_\_\_ in six weeks.

CONDITION ON DISCHARGE: Improved.

## INCOMPLETE MEDICAL RECORDS

TO: Residents

FROM: Diana D. Cardenas, M.D., M.H.A.  
Chair  
Fellowship Program Director  
Department of Rehabilitation Medicine  
Jackson Memorial Hospital  
Miller School of Medicine University of Miami

Andrew L. Sherman, M.D.  
Residency Program Director  
Department of Rehabilitation Medicine  
Jackson Memorial Hospital  
Miller School of Medicine University of Miami

RE: Medical Records

Incomplete medical records are a serious accreditation deficiency that has important financial ramifications. Medical record completion by house staff as well as attendings is required before billing can be submitted. Charts are not to be compiled. Patients' charts are to be reviewed on a weekly basis.

Severe action will be taken for any resident whose medical records charts are incomplete. Please remember that keeping good medical notes is just as important as seeing the patient.

Thank you for your cooperation.

# **JOURNALS AND PERIODICALS FOR USE AT JOURNAL CLUB**

(Available through our Central Library)

## **CARDIOVASCULAR**

Circulation

Stroke

## **GENERAL MEDICINE**

Journal of the American Medical Association

Lancet

Mayo Clinic Proceeding

New England Journal of Medicine

New York State Journal of Medicine

British Medical Journal

## **NEUROLOGY**

Annals of Neurology

Archives of Neurology

Journal of Neurology, Neurosurgery and Psychiatry

Journal of Neurosurgery

Muscle and Nerve

Neurology Clinics

Neurology

Paraplegia

Surgical Neurology

Yearbook of Neurology and Neurosurgery

## **NURSING**

Rehabilitation Nursing

Rehabilitation Psychology

## **ORTHOPEDICS**

Acta Orthopaedic Scandinavica

Clinical Orthopedics and Related Research

Hand Clinics of North America

Journal of Bone and Joint Surgery (American Volume)

Journal of Bone and Joint Surgery (British Volume)

Journal of Hand Surgery –American

Journal of Hand Surgery – British

Orthopedic Clinics of North America

Spine

## **PEDIATRICS**

Pediatric Clinics of North America

Clinical Pediatrics

## PSYCHIATRY, PSYCHOLOGY, MENTAL HEALTH

Child's Nervous System

Journal of Neurology, Neurosurgery and Psychiatry

Rehabilitation Psychology

## REHABILITATION

American Journal of Occupational Therapy

American Journal of Physical Medicine

Archives of Physical Medicine and Rehabilitation

Clinics in Sports Medicine

Journal of Burn Care and Rehabilitation

Journal of Head Trauma Rehabilitation

Journal of Speech and Hearing Disorders

Paraplegia

Physical Medicine and Rehabilitation Clinics of North America

Physical Therapy

Rehabilitation Literature

Rehabilitation Nursing

Rehabilitation Psychology

Scandinavia Journal of Rehabilitation Medicine

State-of-the-Art Reviews in Physical Medicine and Rehabilitation

## RHEUMATOLOGY

American Journal of Rheumatology

Arthritis and Rheumatism

British Journal of Rheumatology

## SURGERY

Journal of hand Surgery (American)

Journal of hand Surgery (British)

## UROLOGY

Urological Clinics of North America

## DEPARTMENTAL TELEPHONE NUMBERS

|                     | NAME                           | PHONE        | PAGER        |
|---------------------|--------------------------------|--------------|--------------|
| CHAIRPERSON         | Diana D. Cardenas, M.D., M.H.A | 305-243-9516 | 305-276-5882 |
| FACULTY ATTENDINGS: | Lucinda Arenas, M.D.           | 305-243-4588 | 305-750-2193 |
|                     | Larry Brooks, PhD              | 305-243-3671 |              |
|                     | Kevin Dalal, M.D.              | 305-585-1326 | 305-208-0510 |
|                     | Elizabeth Felix, Ph.D.         | 305-243-4497 |              |
|                     | Tamar Ference, M.D.            | 305-243-8146 | 305-287-6689 |
|                     | Robert Irwin, M.D.             | 305-585-1323 | 305-291-0883 |
|                     | Douglas Johnson-Greene, M.D.   | 305-243-8472 | 305-276-6863 |
|                     | Seema Khurana, D.O.            | 305-243-4518 | 305-750-1982 |
|                     | David Kushner, M.D.            | 305-259-6418 | 305-874-8135 |
|                     | Alberto Martinez-Arizala, M.D. | 305-575-3174 |              |
|                     | Jose Mena, M.D.                | 305-243-6537 | 305-277-2640 |
|                     | German Ojeda Correal, M.D.     | 305-243-4588 | 305-277-4929 |
|                     | Jose Andres Restrepo, M.D.     | 305-585-1413 | 305-750-1745 |
|                     | Andrew Sherman, M.D.           | 305-243-3289 | 305-287-8701 |
|                     | Ricardo Vasquez-Duarte, M.D.   | 305-243-4588 | 305-2771898  |
|                     | Erin Wolff, M.D.               | 305-243-8305 | 305-750-0189 |

### VOLUNTARY ATTENDINGS

|  |                                 |                       |
|--|---------------------------------|-----------------------|
|  | David Lipkin, M.D.              | 305-604-3261          |
|  | Jasmine Martinez-Barrizonte, MD | 305-575-3217          |
|  | Kester Nedd, D.O.               | 305-585-1258          |
|  | James Salerno, M.D.             | 305-672-1256          |
|  | Heather Sered, M.D.             | 305-575-3217          |
|  | Miguel Tabaro, M.D.             | 305-324-4455 ext4453  |
|  | Steven Taub, M.D.               | 305-575-3217          |
|  | Jose Toledo, M.D.               | 305-604-3261          |
|  | Kenneth Ward, M.D.              | 305-324-4455 ext 6258 |

RESIDENTS: 305-585-2255 hospital pager number

|  |                             |      |
|--|-----------------------------|------|
|  | <b>PGY 2</b>                |      |
|  | Anthony Esposito, D.O.      | 1648 |
|  | Deep Garg, M.D.             | 1937 |
|  | Lina Hurtado, M.D.          | 2310 |
|  | Peter Michael               | 1443 |
|  | Peter Navarro               | 0957 |
|  | Oghenevwogaga Ophori (Gaga) | 0703 |

|  |                     |      |
|--|---------------------|------|
|  | <b>PGY 3</b>        |      |
|  | Usman Amhad, D.O.   | 2858 |
|  | Jamil Bashir, M.D.  | 0356 |
|  | Luis Batlle, M.D.   | 2045 |
|  | Jackson Cohen, M.D. | 2424 |
|  | Jeremy Jacobs, D.O. | 1984 |
|  | Nitin Putcha, D.O.  | 2692 |

**PGY 4**

|                            |      |
|----------------------------|------|
| Gizelda Casella, M.D.      | 2585 |
| Myrlynn Delille, M.D.      | 2221 |
| Michelle Francavilla, D.O. | 9312 |
| Henry Lee, D.O.            | 2644 |
| Alberto Panero, D.O.       | 0278 |
| Daniel Rivera, M.D.        | 2579 |

***Fellows:***

|                         |      |
|-------------------------|------|
| Eduardo Ballestas, M.D. | 2420 |
| Sharmatie Lal, M.D.     | 0592 |

***EMERGENCY NUMBERS***

FIRE & ALL EMERGENCIES \_\_\_\_\_ 305-585-6123

EMERGENCY, SECURITY \_\_\_\_\_ 305-585-6111

***DEPARTMENT ADMINISTRATION***

EDUCATION COORDINATOR \_\_\_\_\_ Coretha Davis 305-585-1431

ADMINISTRATOR \_\_\_\_\_ Nadine Knight 305-243-4593

SECRETARY \_\_\_\_\_ Jesus Sanchez-Reyes 305-243-9516

***REHABILITATION MEDICINE THERAPY DEPARTMENTS***Occupational Therapy

|            |        |
|------------|--------|
| Outpatient | 5-7224 |
| Hand       | 5-7224 |
| Neuro      | 5-8362 |
| Spine      | 5-6985 |

Physical Therapy

|            |        |
|------------|--------|
| Outpatient | 5-6842 |
| Spine      | 5-5382 |
| Neuro      | 3-1923 |

Speech 3-1260

Pediatric Unit 5-6040

## ***JMH NURSING STATIONS***

|                         |        |
|-------------------------|--------|
| Rehab 2 Annex           | 5-5495 |
| Neuro Rehab             | 3-1257 |
| Pedi Rehab              | 5-6040 |
| Rehab Outpatient Clinic | 5-6262 |

## **LIST OF PROCEDURES TO BE OBSERVED WHILE IN PM&R RESIDENCY**

### **REHABILITATION PROCEDURES**

- ✓ Modified Barium Swallow
- ✓ Placement of Passy- Muier Valve
- ✓ Audiogram
- ✓ Visit to Gait Analysis Lab
- ✓ Visit to Vocational Rehab
- ✓ Pressure garment use
- ✓ Acupuncture
- ✓ Modalities: heat, ice, TENS, US, E-stim
- ✓ Splint Fabrication
- ✓ Hubbard Tank
- ✓ Whirlpool
- ✓ Crutch walking
- ✓ Bladder Sono
- ✓ Cystometrics

### **ORTHOPEDIC PROCEDURES**

- ✓ Carpal Tunnel Release
- ✓ Total Knee arthroplasty
- ✓ Total Hip arthroplasty
- ✓ ORIF fractures
- ✓ Shoulder Arthroplasty
- ✓ Arthroscopy
- ✓ Rotator Cuff Repair
- ✓ Scoliosis Surgery
- ✓ BKA/AKA

### **NEUROSURGERY PROCEDURES**

- ✓ Muscle/Nerve biopsy
- ✓ Laminectomy/Discectomy
- ✓ Brachial Plexus Surgery
- ✓ Intraop. SSEP
- ✓ Kyphoplasty

## **CARDIAC PROCEDURES**

- ✓ Stress test

## **EMG**

- ✓ SSEP
- ✓ Facial EMG

## **PEDIATRIC SURGERY**

- ✓ Baclofen Pump Placement
- ✓ Botox Injection
- ✓ Tendon Release/Transfer Surgery

## **JOINT/SOFT TISSUE INJECTIONS**

Bursae injections  
Intra-articular – Knee/Shoulder/Hip?Elbow  
Para-tendon – Elbow, Shoulder, Trochanter, Knee  
Myofascial trigger point  
Ultrasound guided

## **PAIN MANAGEMENT**

- ✓ Discogram
- ✓ IDET
- ✓ Radio Frequency Facet
- ✓ Lumbar Epidural Steroid Injection
- ✓ Cervical ESI
- ✓ Spinal Cord Stimulator Placement
- ✓ Sacro-iliac injection
- ✓ Facet steroid injection
- ✓ Medial Branch Block procedure

## **BOOKS** **MANDATORY**

EMG books May be purchased after the PGY 2 year.

Physical Medicine and Rehabilitation (Braddom, Physical Medicine & Rehabilitation) by Randall L. **Braddom** MD – Department will buy

Physical Medicine and Rehabilitation Board Review by Sara J. **Cuccurullo**

Physical Medicine and Rehabilitation Pocketpedia by Howard **Choi**



**Hollinshead's** Functional Anatomy of the Limbs and Back by David B. Jenkins

**MacLean** textbook for EMG

A Manual of **Nerve Conduction Studies**, Second Edition (Plastic Comb) Ralph M. Buschbacher OR  
DELISA

EMG atlas – Gerenger

PM&R Secrets.

Essentials of Physical Medicine and Rehabilitation: **Review and Self-Assessment** [Illustrated]  
(Paperback)

~ Walter R. **Frontera** MD PhD (Author), Julie K. Silver MD (Author)

AAPMR membership to obtain online educational materials

Electromyography and Neuromuscular Disorders: Clinical-Electrophysiologic Correlations,  
Textbook – Preston & Shapiro

**These below are recommended but *NOT* mandatory.**

Essentials of Physical Medicine and Rehabilitation (Frontera, Essentials of Physical Medicine and  
Rehabilitation) (Hardcover)

~ Walter R. Frontera MD PhD (Author), Julie K. Silver MD (Au

Image-Guided Spine Intervention by Douglas S. **Fenton**

Sports medicine Secrets

EMG secrets

E-Medicine – PMR textbook – likely need a subscription

AAP Membership

Hoppenfeld book of physical exam

## Residents' Library List

American Journal of Physical Medicine & Rehabilitation (Starting Volume 84 No. 7 July 2005)

Atlas of Amputations and Limb Deficiencies

Surgical, Prosthetic, and Rehabilitation Principles.....Doutlas G. Smith, M.D.  
John W. Michael, Med, CPO & John H. Bowker, M.D.

Atlas of Image-Guided Spinal Procedures.....Michael B. Furman, Thomas S. Lee,  
Leland Berkwits

Brian Injury Medicine .....Nathan D. Zasler, Douglas I. Katz, Ross D. Zafonte

Electrodiagnosis and Clinical Neurophysiology:

A High Intensity Review (DVD Set).....Wesley M. & Suzanne S.  
Dixon Education & Training Center

Electromyography and Neuromuscular Disorders.....David C. Preston, Barbara E. Shapiro

ENDNOTE Advance your Research and Publish Instantly (CD)

Essentials of Musculoskeletal Care (with CD-ROM).....Walter B. Greene, M.D.

Essentials of Musculoskeletal Imaging (with CD-ROM).....Thomas R. Johnson, M.D.  
Lynne S. Steinbach, M.D.

Executive Skills for Medical Faculty.....Neal Whitman,  
Elaine Weiss & F. Marian Bishop

Healthy Body Healthy Mind (DVD - The TV Series)

Hollinshead's Functional Anatomy of the Limbs and Back, 8<sup>th</sup> Ed.....David B. Jenkins

Independent Medical Evaluations (2 Copies) .....Thomas G. Grace, M.D.

International Standards for Neurological

Classification of Spinal Cord Injury (19 copies).....ASIA Reprinted 2002

Manual of NERVE CONDUCTION VELOCITY and CLINICAL NEUROPHYSIOLOGY 3<sup>rd</sup>  
Edition.....Joel A. Delisa, Hang J. Lee  
Ernest M. Baran, Ka-Siu Lai, and Neil Spielholz

Musculoskeletal Ultrasound.....John O'Neill, M.D.

Orthopaedic knowledge Update – Sports Medicine3.....James G. Garrick, M.D.

|  |   |
|--|---|
| Practical Electromyography – fourth edition.....   | Willaim S. Pease<br>Henry L. Lew<br>Ernest W. Johnson                     |
| Physical Examination of the Knee (DVD Video).....  | J. Scott Delaney, M.D.<br>John Antoniou, MD, PhD                          |
| Physical Examination of the Shoulder (DVD Video).....  | John Antoniou, MD, PhD<br>J. Scott Delaney, M.D.                          |
| Physical Medicine and Rehabilitation First Edition.....  | Randall L. Braddom, MD, MS  |
| Physical Medicine and Rehabilitation Third Edition/Mulitmedia...                                       | Randall L. Braddom, MD, MS  |
| Physical Medicine and Rehabilitation Board Review.....   | Sara J. Cuccurullo, M.D.  |
| Physical Medicine & Rehabilitation Poketpedia.....   | Howard Choi, Ross Sugar, David E. Fish,<br>Matthew Shatzer & Brian Krabak |
| Practical Electromyography fourth edition/ DVD ROM.....  | William Pease, MD,<br>Henry Lew, MD, PhD,<br>Ernest W. Johnson, MD        |
| Preceptors as Teachers: A Guide to Clinical Teaching.....  | Neal Whitman, Ed.D &<br>Thomas L. Schwenk, M.D.                           |
| Residents as Teachers:<br>A Guide to Educational Practice –Second Edition (2 Copies).....              | Thomas L. Schwenk, M.D.<br>Neal Whitman, Ed.D.                            |
| Spinal Cord Medicine Principles and Practice Second Edition.....                                       | Vernon W. Lin   |
| State of the Art Reviews: Spinal Rehabilitation.....   | Mark Allen Young, M.E<br>Robert A. Lavin, M.D.                            |
| The Clinical Measurement of Joint Motion.....  | Walter B. Greene, M.D.<br>James Heckman, M.D.                             |
| The Choice is Yours -Medical Professionalism:<br>Using Film to Promote Self-Reflection (with DVD)..... | Ruth Yorkin Drazen  |
| Thieme Atlas of Anatomy – General Anatomy and Musculoskeletal System...                                | Michael Schuenke<br>Erik Schulte & Udo Schumacher                         |

MRI of the Brain, Head and Neck, and Spine

Musculoskeletal MRI