Table of Contents

Forward .................................................................................................................................................. 4
A History of Physiatry: An Overview ................................................................................................. 5
Description of Physical Medicine and Rehabilitation Program ......................................................... 6
Faculty Roster 2018-2019 ..................................................................................................................... 8
Department Chairman Kevin M. Means, MD .................................................................................... 10
Resident Roster 2018-2019 .................................................................................................................. 11
Signs of Resident Fatigue ..................................................................................................................... 12
Introduction for Educational Program ............................................................................................... 14
Residency Training Overall Goals and Objectives .............................................................................. 15
PGY1 Rotation Introduction .................................................................................................................. 20
PGY1 Rotations .................................................................................................................................. 22
Sample Residency Rotation Schedules ............................................................................................... 49
Introduction for Rotation Objectives .................................................................................................. 50
PGY2-PGY4 Resident Rotations .......................................................................................................... 51
Scheduled Didactic Activities for Residents 2018-2019 ................................................................. 73
Resident Grand Rounds ...................................................................................................................... 74
Resident Seminars ............................................................................................................................... 75
Resident Journal Club ........................................................................................................................... 77
Resident Scholarly Activity Program ................................................................................................... 79
Objective Structured Clinical Examination (OSCE) ......................................................................... 80
Program Policies & Procedures ........................................................................................................... 81

Resident Selection Criteria and Recruitment Process ...................................................................... 81
Resident Evaluations ........................................................................................................................... 85
Faculty Evaluations by Residents ....................................................................................................... 86
Resident Leave .................................................................................................................................. 87
Vacation Request Form for Upcoming Academic Year .................................................................... 90
Resident Request Form for Leave with Pay ...................................................................................... 91
Educational & Administrative Leave .................................................................................................. 92
Procedure for Leave Request ............................................................................................................ 94
Moonlighting ....................................................................................................................................... 96
Duty Hours and Work Environment .................................................................................................. 98
Night Call .......................................................................................................................................... 100
BHRI Housestaff Policies .................................................................................................................. 101
BHRI Hand Off and Transfer of Care Policy ...................................................................................... 103
Meals for BHRI On-Call Residents .................................................................................................... 106
Resident Pagers .................................................................................................................................. 107
Photocopying for Residents and Medical Students ......................................................................... 108
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Book Funding</td>
<td>107</td>
</tr>
<tr>
<td>Travel</td>
<td>110</td>
</tr>
<tr>
<td>Chief Residents</td>
<td>111</td>
</tr>
<tr>
<td>Guidelines for Resident to Resident Supervision</td>
<td>113</td>
</tr>
<tr>
<td><strong>Criteria and Processes for Academic Actions of Reappointment, Evaluation, Promotion, and Other Disciplinary Actions</strong></td>
<td>114</td>
</tr>
<tr>
<td>UAMS/PM&amp;R Library Rules</td>
<td>117</td>
</tr>
<tr>
<td>PM&amp;R Housestaff Fringe Benefits</td>
<td>118</td>
</tr>
<tr>
<td>Self-Assessment Examination (SAE)</td>
<td>122</td>
</tr>
<tr>
<td>Addressing Resident Concerns</td>
<td>123</td>
</tr>
<tr>
<td>Supervision</td>
<td>125</td>
</tr>
<tr>
<td>American Board of Physical Medicine &amp; Rehabilitation – Registration of New Residents</td>
<td>126</td>
</tr>
<tr>
<td>Appendix</td>
<td>127</td>
</tr>
<tr>
<td>Resident Check Out Form</td>
<td>128</td>
</tr>
<tr>
<td>Request to Participate in Moonlighting Activities</td>
<td>129</td>
</tr>
<tr>
<td>Resident Counseling Form</td>
<td>130</td>
</tr>
<tr>
<td>UAMS Office of Graduate Medical Education Transfer of Care Policy</td>
<td>132</td>
</tr>
</tbody>
</table>
Foreword

“We are a young specialty in an organized sense. Under the leadership of Dr. Frank Krusen, we were recognized as the “American Board of Physical Medicine” in 1947 by the Accreditation Council on Graduate Medical Education (ACGME). Two years later, the word “Rehabilitation” was added at the urging of Dr. Howard Rusk.

However, using physical agents, i.e., exercise and heat, may have been the earliest method of medical rehabilitation by our physician forebears.

Many American physicians and philanthropists contributed to the development of the specialty “Physical Medicine and Rehabilitation.”

An account of the maturation of our specialty reflects somewhat the biases of the persons assembling the history, but clearly this narrative presents an objective view of our beginnings and subsequent growth during the past 75 years.

Others may add to or subtract from the story, but this will serve as the consensus for our own album.

Much appreciation to Bradley R. Johns for his thorough investigation and presentation.”

Ernest W. Johnson, MD Professor of PM&R
Ohio State University
September 14, 1994
The History of Physiatry: An Overview

Physical means of healing have been practiced since prehistoric times, but Physiatry did not become recognized as a separate medical specialty until 1947. Most widely known as the field of Physical Medicine and Rehabilitation, the medical specialty of modern-day Physiatry comprises the related disciplines of Physical Medicine, Rehabilitation Medicine and Electromyography.

The term Physiatry derives from the Greek word physikos (physical) and iatreia (art of healing). A Physiatrist is a physician who creatively employs physical agents as well as other medical therapeutics to help in the healing and rehabilitation of a patient. Treatment involves the whole person and addresses the physical, emotional and social needs that must be satisfied to successfully restore the patient’s quality of life to its maximum potential.

Since the beginning of time, people have used physical means for treatment of illness and injury. Such physical agents for healing have included water, heat, cold, massage, light, exercise and electricity. Throughout history, water has functioned as a primary means of physical healing. Written accounts of physical techniques for healing can be traced as far back as the writing of Hippocrates in 400 B.C.

Rehabilitation involves the restoration of a diseased or disabled person to optimal physical, psychological and social functioning.

The History of Physiatry
Presented by the Association of Academic Physiatrists Historical Committee

Link to http://www.physiatry.org/?page=History_PMR
Description of Physical Medicine and Rehabilitation Program

Physical Medicine and Rehabilitation (PM&R) program encourages residents to become competent Physiatrists by having experience in clinical, didactics, and by participating in research curriculum. This program has qualified faculty to implement the program and residents are expected to fulfill the components of this program.

The University of Arkansas for Medical Sciences (UAMS) is the sponsoring institution and several sites participate in this program. The PM&R program is a multi-clinical site utilizing Arkansas Children’s Hospital (ACH), Baptist Health Rehabilitation Institute (BHRI), Central Arkansas Veterans Hospitals in Little Rock (CAVH-LR) and North Little Rock (CAVH-NLR), and the University of Arkansas for Medical Sciences (UAMS). These facilities allow students to have the opportunity to work in a rehab facility and private practice. Arkansas Children’s Hospital (ACH) is the seventh largest pediatric hospital in the country, and the only pediatric medical center in the state.

ACH has a strong pediatric rehab program with a large number of patients and a 20-bed inpatient rehabilitation pediatric unit. In addition to inpatient care, there are regular clinics for myelomeningocele, muscular dystrophy, and cerebral palsy. Burn and hemophilia clinics are optional.

BHRI is a free standing institute that allows residents to obtain good clinical training in PM&R. In addition to inpatient care, there are extensive on-site outpatient facilities, as well as multiple satellite therapy centers.

UAMS is an acute care teaching hospital. PM&R residents interact with medical students of different specialties, residents, and faculty from other services such as Neurosurgery, Neurology, Trauma Surgery, Medicine, Geriatrics, Oncology, Rheumatology, Family Practice, and Orthopedics.

CAVH-LR is an acute care hospital with a spacious section devoted to Rehabilitation Medicine Services. It is a tertiary facility that admits complex medical problems from the surrounding district plus the usual mix of patients from the local metropolitan area. The hospital is adjacent to and closely affiliated with University Hospital and the faculty of most services have joint appointments in the hospitals. There is a PM&R consultation service at this hospital. CAVH-NLR is a long-term hospital for patients with psychiatric and chronic medical problems. A 20-bed rehabilitation unit and a 38-bed geriatric unit provide a solid environment for learning and training. There is an extensive consultation service, including diagnostic EMG’s and numerous outpatient clinics (i.e., brace, seating, spinal cord, general rehabilitation, back, amputee clinics, and falls clinics.)

PM&R is a four-year graduate medical education program that requires four years of graduate medical education to complete training for a physician seeking specialization in this field, three years of which must be physical medicine and rehabilitation training. Of these three years, no more than six months can be elective. Three years are spent in the Department of Physical Medicine and Rehabilitation with three month rotations, which provide a wide variety of clinical experience in both neuromuscular and musculoskeletal diagnosis. This includes comprehensive rehabilitation of severe physical disabilities such as spinal cord injury, head injury, stroke, amputation, electrodiagnosis, management of acute and chronic musculoskeletal problems, and management of chronic pain syndromes. No more than one month of this elective time may be taken in a non-ACGME–accredited program, unless prior approval is given by the Residency Review Committee (RRC).

The remaining months of this year may include any combination of accredited specialties or subspecialties. Most or best areas excelled in: Spinal Cord, Geriatrics, and VA (Spinal Cord expanded with VA). Students are going to get a variety of experiences in patient populations at VA-Geriatrics,
BHRI-Private Rehab, UAMS and ACH-Pediatrics, which will give students diversity. One year of the four years of training is to develop fundamental clinical skills. This year of training in fundamental clinical skills must consist of an accredited transitional year or include six months or more responsibility in accredited training with inpatient responsibility in family practice, internal medicine, obstetrics-gynecology, pediatrics, or surgery, or any combination of these patient care experiences.

Accredited training in any of these specialties or subspecialties selected must be for a period of at least four weeks. PGY1 would do six months of inpatient ward medicine at the VA and six months of the following specialty areas: Neurology, Emergency Medicine, Ambulatory Medicine (VA), Radiology/Rheumatology, Orthopedics and PM&R. No more than eight weeks may be in non-direct patient care experiences. Training in fundamental clinical skills must be completed within the first two years of the four-year training program.

This training program may choose either to provide three years of physical medicine and rehabilitation training and appoint residents at the PGY2 level contingent on satisfactory completion of first year’s accredited training in fundamental clinical skills or to provide four years of training to include twelve months of these fundamental clinical skills in areas other than physical medicine and rehabilitation. It is the responsibility of this program for the quality of the integrated educational experience for the entire training program, including twelve months of training in fundamental clinical skills in areas other than physical medicine and rehabilitation.
UAMS Department of Physical Medicine and Rehabilitation
Faculty Roster 2018-2019

http://pmr.uams.edu/faculty/

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Kevin M. Means, MD, is the Associate Residency Program Director and the Department Chairman in the UAMS Department of Physical Medicine and Rehabilitation. He holds the rank of Professor. Dr. Means received his MD degree from Howard University School of Medicine in Washington, D.C. He completed a residency in Physical Medicine and Rehabilitation at the Rehabilitation Institute of Chicago, located in Chicago, Illinois. Dr. Means became certified by the American Board of Physical Medicine and Rehabilitation in 1986.

After residency, he came to Arkansas as one of six founding faculty members of the newly created UAMS Department of Physical Medicine and Rehabilitation. Dr. Means was instrumental in developing the UAMS PM&R residency program that was started in 1987. Since that time, Dr. Means has been involved in virtually every aspect of the department and residency program at one time or another. He has served as Chief of the PM&R Service at Central Arkansas Veteran’s Healthcare and Medical Director at BHRI. In 1997, Dr. Means became the second Chairman and the third Residency Program Director in the history of the UAMS Department of PM&R. He has served on the department’s Curriculum, Research, and Resident Selection Committees and has chaired or served on every PM&R clinical and administrative committee. Dr. Means founded the PM&R Department’s research program and developed a research experience for the PM&R residents that became mandatory starting in 1997.

Clinically, Dr. Means holds PM&R leadership positions on the medical staff and actively practices in two of the four UAMS PM&R affiliated hospitals. His area of clinical expertise is in geriatric rehabilitation. He is nationally and internationally recognized for his work in prevention of falls and rehabilitation of balance disorders. Dr. Means was awarded the PM&R Department’s “Outstanding Clinical Educator” award in 1996 and has received other honors for his work as a researcher, a clinician and an educator. Dr. Means is an active member of several professional organizations and has held several leadership positions within these organizations, including National Chairman of the PM&R Section of the National Medical Association and chairman of several committees and task forces. Dr. Means has authored and edited several publications and he has extensive experience mentoring scholarly projects of residents, students, and professional staff. He is a regular guest examiner for the American Board of Physical Medicine and Rehabilitation.
UAMS Department of Physical Medicine and Rehabilitation
Resident Roster 2018-2019

http://www.uams.edu/pmr/residents/

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Residency Program Coordinator: 501-526-7732

Chief Residents

Noël Pristas, MD, PGY4
Annie Sevy, DO, PGY4

Residents (PGY effective 7/1/18)

<table>
<thead>
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<tr>
<td>Ahren Geilenfeldt, DO</td>
<td>PGY4</td>
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<td>Brett Lile, DO</td>
<td>PGY4</td>
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<tr>
<td>Noel Pristas, MD</td>
<td>PGY4</td>
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<td>Annie Sevy, DO</td>
<td>PGY4</td>
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<td>Tory Hunton, MD</td>
<td>PGY3</td>
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<td>Yen Nguyen, MD</td>
<td>PGY3</td>
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<td>Lauren Poindexter, MD</td>
<td>PGY3</td>
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<tr>
<td>Namath Ali, DO</td>
<td>PGY2</td>
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<td>Lucas Bider, MD</td>
<td>PGY2</td>
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<td>Jason Kaushik, MD</td>
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<td>Namratha Ramavaram, DO</td>
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<td>Drake Hardy, MD</td>
<td>PGY1</td>
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<td>Marie Hewett, DO</td>
<td>PGY1</td>
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<td>Barbara Lacy, MD</td>
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<td>Mitchell Pham, MD</td>
<td>PGY1</td>
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We are acutely aware of the impact of resident fatigue on our residents’ personal and professional lives. We continually look for symptoms of resident fatigue and offer guidance, assistance and support for residents in need.

**Definition:** Fatigue is defined as a weariness, tiredness, or lack of energy and motivation. Fatigue can be a normal and important response to physical exertion, or emotional stress and fatigue can occur with long working hours and sleep deprivation.

**Physical Signs and Symptoms** of fatigue may include:
- exhaustion
- lethargy
- drowsiness
- somnolence

**Psychological and Behavioral Signs and Symptoms** of fatigue may include:
- inappropriate affect
- feelings of apathy, depression, anger, hostility, anxiety, tension, confusion, or irritability

**Performance Signs and Symptoms** of fatigue may include:
- memory deficits
- difficulty thinking clearly
- inattention or lack of concentration
- difficulty performing manual tasks

*If you observe any of these signs or you suspect fatigue in a resident:*

1. Monitor the resident closely, if possible.
2. Question the resident about his/her physical, mental, and emotional state and their ability to perform their job.
3. If necessary, relieve the resident (or ask the appropriate clinical supervisor to have the resident relieved) of any direct patient care responsibilities until further evaluation.
4. Report all incidents to the program director immediately.
Further Readings on Resident Fatigue


7/18/03
UAMS Department of Physical Medicine and Rehabilitation
Introduction for Educational Program

Points:
1) Curriculum guides educational offerings.
2) Rotations have general objectives that cover general PM&R skills and specific objectives that cover content pertinent to PM&R.
3) Emphasizing general competencies including: interaction with other members of health care teams and working with patient and family to master the system.
4) Relationship between faculty and resident
5) Resident expectations in general – active participation in education, responsible for requirements in syllabus for each rotation and for the general curricular including lectures and journal club.
6) Evaluate faculty
7) Evaluate program
8) Evaluation for competencies
9) Semi-annual meeting with the Residency Program Director

Patient Care:
Evaluated by faculty at the end of each rotation, oral examination, ROCA’s.

Medical Knowledge:
Evaluated annually in in-training examination and in the annual PM&R OSCE (Objective Structured Clinical Examination), oral examination, ROCA.

Professionalism:
360 evaluation, faculty end of rotation evaluation.

Systems Based Practice:
Progress note reports, 360 evaluations, portfolio.

Communications and Interpersonal Skills:
360 evaluation, faculty end of rotation evaluation, systems base practice portfolio, communicate with other professionals, communicate with families and caregivers.

Practice Based Learning:
- Journal Club
- Research Scholarly Activity
- Conference Presentations
- Seminars
- Grand Rounds
It is the intent of the Physical Medicine and Rehabilitation (PM&R) program to develop physicians well trained and able to practice in a competent and independent manner as Physiatrists. This training will be achieved through a) supervised clinical work with increasing responsibility for outpatients and inpatients and b) a foundation of organized instruction in the basic neurosciences. Physicians completing the program will be eligible for certification by the American Board of Physical Medicine and Rehabilitation with an ultimate goal of an eventual 100% pass rate on both the oral and written examinations. This program has training level specific educational goals that must be met to ensure residents are aware of the level of education in this program. They are:

**Mastery Level**: Competent in all essential knowledge areas; technically proficient in skill areas; minimal input by attending faculty required for subtle or fine points only; capable of unsupervised independent PM&R practice.

**Advanced Level**: Competent in most essential knowledge areas; basic knowledge areas have been mastered, but some advanced areas may need further improvement; technically proficient in many, but not all skills areas; requires some supervisory input by attending faculty, but less than basic level resident.

**Basic Level**: Familiar with basic PM&R knowledge areas; competence still improving; familiar with some PM&R technical skills; requires moderate supervisory input by attending faculty, especially for advanced areas.

Residents are also required to develop competencies in the six areas below to the level expected of a new practitioner. Toward this end, the resident is provided through the training program with the appropriate experience to develop and demonstrate the following specific knowledge, skills, and attitudes:

a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

b. **Medical Knowledge** about established and evolving biomedical, clinical and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

c. **Practice-based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvement in patient care.

d. **Interpersonal and Communication Skills** that result in effective information exchange and learning with patients, their families, and other health professionals.

e. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

f. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care that is of optimal value.

Physical Medicine and Rehabilitation residency program must document that it provides an educational experience of such quality and excellence as to offer its graduates the
opportunity for attainment of those competencies necessary for entry level independent practice of this specialty. This must include knowledge about the diagnosis, pathogenesis, treatment, prevention and rehabilitation of those neuromusculoskeletal, neurobehavioral, cardiovascular, pulmonary, and other system disorders common to this specialty in patients of both sexes and all ages. This program will provide the opportunity for the graduate to develop the attitudes and psychomotor skills required to:

a. Modify history-taking technique to include data critical to the recognition of functional abilities and physical and psychosocial impairments that may cause functional disabilities;
b. Perform the general and specific physiatric examinations, including electromyography, nerve conduction studies, and other procedures common to the practice of physical medicine and rehabilitation;
c. Make sound clinical judgments; and
d. Design and monitor rehabilitation treatment programs to minimize and prevent impairment and maximize functional abilities.

In addition, this program must provide the opportunity for the graduate to be able to coordinate effectively and efficiently an interdisciplinary team of allied rehabilitation professionals for the maximum benefit of the patient by:

a. An understanding of each allied health professional’s role,
b. The ability to write adequately detailed prescriptions based on functional goals for physiatric management, and
c. The development of management and leadership skills.

Additionally, this training program will stress the importance of self-evaluation, continuing medical education and continued professional development after graduation. The training program must provide the opportunity for the resident to develop the necessary written and verbal communication skills essential to the efficient practice of physiatry. The organization and philosophy of the residency program must provide the opportunity for development of the clinical competence of the resident. The curiosity and creativity of all residents must be stimulated and must be involved in the critical appraisal of current literature. All provisions of the Institutional Requirements must also be met for accreditation.

Clinical competence requires:

a. A solid fund of basic and clinical knowledge,
b. The ability to perform an adequate history and physical exam,
c. The ability to order and interpret appropriate diagnostic tests,
d. Adequate technical skills to carry out selected diagnostic procedures,
e. Clinical judgment to critically apply the above data to individual patients,
f. Attitudes conducive to the practice of Physiatry, including appropriate interpersonal interactions with patients, professional colleagues, supervisory faculty, and all paramedical personnel,
g. Personal integrity,
h. Regular, timely attendance at departmental and divisional educational activities,
i. Timely dictations and signature of inpatient discharge summaries and outpatient notes, as well as completion of appropriate letters or phone calls to referring physicians,
j. Recognition of personal limits. Controversial issues require direct and immediate participation of the responsible attending,
k. Ongoing dedication to critical evaluation of one’s own skills and knowledge and to continuing education through literature review, communication with colleagues, and attendance at society meetings and other educational forums, and

l. Interaction with other facets of the health care delivery system at large in a comprehensive yet cost-effective manner.

Within the PM&R program, there are educational goals for specific PGY level residents. These goals ensure residents have mastered skills at a certain level before progressing to a higher level. The educational goals for PGY 1-4 are as follows:

**Educational Goals - PGY1 Resident**

*Upon completion of the first postgraduate year, a PM&R resident should:*

1. Recognize typical clinical problems among patients with physical medicine and rehabilitation problems in various clinical settings and their management.  
   (Patient Care, Systems-Based Practice, Medical Knowledge)
2. Discuss the management of typical clinical problems among patients with physical medicine and rehabilitation problems in various clinical settings.  
   (Systems-Based Practice, Medical Knowledge, Practice-Based Learning)
3. Demonstrate proper history and examination techniques.  
   (Patient Care, Communication, Professionalism)
4. Identify various diseases and conditions that are amenable to rehabilitation efforts.  
   (Medical Knowledge)
5. Describe allied health professionals involved in the rehabilitation team.  
   (Systems-Based Practice, Practice Based Learning)

**Educational Goals - PGY2 Resident**

*Upon completion of the second postgraduate year, a PM&R resident should:*

1. Demonstrate proficiency in physiatric assessment, diagnosis and prescription for functional impairments, arising from acute and chronic neurological, musculoskeletal, cardiovascular and pulmonary conditions.  
   (Patient Care, Medical Knowledge)
2. Perform basic physiatric interventional procedures like trigger point and intra-articular injections, nerve and phenol blocks, botox injections and diagnostic examination, including nerve conduction and electromyographic studies.  
   (Patient Care, Medical Knowledge)
3. Develop leadership skills to promote the team approach and responsible utilization of consulting services to maximize rehabilitation outcomes.  
   (Systems-Based Practice, Interpersonal and Communication Skills, Professionalism)
4. Demonstrate a basic level competence in performing the comprehensive and physiatric physical examination and in the analysis of data from pertinent diagnostic tests to achieve the appropriate diagnosis.  
   (Patient Care, Medical Knowledge)
5. Demonstrate a basic ability to formulate, implement and monitor appropriate PM&R treatment plans to archive maximum physical, psychological, social, vocational, avocational and educational outcomes for patients in the acute hospital setting, the acute rehabilitation unit or hospital, the sub-acute or long-term care environment and the outpatient setting.  
   (Patient Care, Medical Knowledge)
6. Demonstrate a basic understanding of the roles of interdisciplinary rehabilitation team members and a basic ability to lead and coordinate their efforts.  
   (Patient Care, Medical Knowledge, Systems-Based Practice)
7. Demonstrate basic communication skills in communicating with patients, families, medical staff, team members, and other personnel.  
   (Communication)
8. Demonstrate a basic level of competency relative to decision-making in the physical medicine and rehabilitation management of adults and children with most of the following conditions: traumatic brain injury, stroke, spinal cord injury, amputations, hereditary, developmental and acquired neuromuscular and musculoskeletal conditions, acute and chronic pain syndromes, cardiovascular and pulmonary disorders, soft-tissue disorders including burns and ulcers.  
   (Patient Care, Medical Knowledge)
9. Demonstrate basic familiarity with journals that constitute the medical literature relevant to PM&R and in the basic components of research papers.  
   (Practice Based Learning)
10. Demonstrate basic familiarity with common cost containment issues in physical medicine and rehabilitation practice,  
    (Systems-Based Practice)

Educational Goals - PGY3 Resident

Upon completion of the third postgraduate year, a PM&R resident should:

1. Demonstrate an advanced level competence in performing the comprehensive and physiatric physical examination and in the analysis of data from pertinent diagnostic tests to achieve an appropriate diagnosis.  
   (Patient Care, Medical Knowledge)
2. Demonstrate an advanced ability to formulate, implement and monitor appropriate PM&R treatment plans to achieve maximum physical, psychological, social, vocational, avocational, and educational outcomes for patients in the acute hospital setting, the acute rehabilitation unit or hospital, the sub-acute or long term care environment and the outpatient setting.  
   (Patient Care, Medical Knowledge, Systems-Based Practice, Communication)
3. Demonstrate advanced ability to lead and coordinate the efforts of an interdisciplinary rehabilitation team.  
   (Systems-Based Practice, Professionalism, Communication)
4. Demonstrate advanced communication skills to be an effective communicator with patients, families, medical staff, team members, and other personnel.  
   (Interpersonal and Communication Skills)
5. Demonstrate an advanced level of competency relative to decision-making in the physical medicine and rehabilitation management of adults and children with most of the following conditions: traumatic brain injury, stroke, spinal cord injury, amputations, hereditary, developmental and acquired neuromuscular and musculoskeletal conditions, acute and chronic pain syndromes, cardiovascular and pulmonary disorders, soft-tissue disorders including burns and ulcers.  
   (Patient Care, Medical Knowledge)
6. Demonstrate advanced technical skill in the performance of common PM&R procedures (and in the prevention and management of associated complications) including: Electrodiagnosis (electromyography and nerve conduction studies), joint and soft tissue injections. (Patient Care, Medical Knowledge)

7. Demonstrate advanced knowledge of the biomedical research process and demonstrate advanced knowledge of the components of research papers and what journals constitute the medical literature relevant to PM&R. (Practice-Based Learning)

8. Take an active role in common cost containment issues in physical medicine and rehabilitation practice when making choices in types of procedures and management. (Systems-Based Practice)

Educational Goals - PGY4 Resident

Upon completion of the fourth postgraduate year, a PM&R resident should:

1. Recognize Physical Medicine and Rehabilitation conditions, address the natural history, and anticipate nature of conditions when providing care. (Patient Care, Medical Knowledge)

2. Demonstrate competence in performing comprehensive physical examination and analysis of pertinent data from diagnostic tests to achieve an appropriate diagnosis. (Patient Care, Medical Knowledge) (OSCE)

3. Continue to demonstrate the ability to formulate, implement and monitor appropriate PM&R treatment plans to achieve maximum physical, psychological, social, vocational, avocational and educational outcomes for patients in the acute hospital setting, the acute rehabilitation unit or hospital, the sub-acute or long term care environment and the outpatient setting. (Patient Care, Medical Knowledge)

4. Demonstrate ability to lead and coordinate the efforts of an interdisciplinary rehabilitation team with minimal supervision. (Systems-Based Practice, Communication)

5. Demonstrate excellent communication skills to be an effective communicator with patients, families, medical staff, team members, and other personnel. (Communication)

6. Continue to demonstrate a level of competency to be able to independently make decisions regarding appropriate physical medicine and rehabilitation management of adults and children with all of the following conditions: traumatic brain injury, stroke, spinal cord injury, amputations, hereditary, developmental and acquired neuromuscular and musculoskeletal conditions, acute and chronic pain syndromes, cardiovascular and pulmonary disorders, soft tissue disorders including burns and ulcers. (Patient Care, Medical Knowledge, Systems-Based Practice)

7. Continue to demonstrate technical skill in the performance of common PM&R procedures and in the prevention and management of associated complications including: Electrodiagnosis (electromyography and nerve conduction studies), joint and soft tissue injections. (Patient Care, Medical Knowledge)

8. Completion of research project. (Practice Based Learning)

9. Demonstrate the ability to supervise and guide junior residents in PM&R activities. (Practice Based Learning)
The first year, the internship, was designed to provide a foundation for subsequent training in Physical Medicine and Rehabilitation. The clinical rotations and didactic curriculum are integrated to prepare resident to competently manage a wide variety of skills that are required by a modern-day physiatrist.

Residents in this program will spend one month in Emergency Medicine, three months in Medicine Wards, one month in Rheumatology, one month in Radiology, two months in Geriatric Wards, one month in Pediatric Wards, one month in Orthopedic clinics, one month in PM&R and one month in Neurology.

On the Emergency Medicine rotation, residents will learn this discipline through Baptist Health Medical Center (BMHC) where 35,000 Emergency Department patients are treated, which makes this a very active rotation and one that is rich in clinical experience. At this facility, residents will learn to approach and treat patients in emergency settings, develop skills in the performance of appropriate diagnostic testing in the emergency department testing, and develop skills in adult and pediatric resuscitation. The Medicine Ward rotation will be held at the Central Arkansas Veterans Hospital in Little Rock. At this facility, residents are offered a variety of experiences such as learning to analyze patient medical problems through history and physical examination, obtain skills in intervention procedures drawing blood cultures, and analyzing cardiopulmonary resuscitation codes.

In addition to the Medicine Ward rotation, residents will also experience Geriatric Wards at the North Little Rock Veterans Hospital. On this rotation residents are offered a variety of learning experiences which include performing history and physical examinations on the geriatric patient.

The Radiology rotation will be held at BMHC or the University of Arkansas for Medical Sciences (UAMS). Residents will obtain experience in special procedures when cases occur, gain some familiarity with the limitations of common imaging modalities, and observe as many imaging studies as possible during the rotation.

The PM&R rotation takes place at BHRI. The purpose of this rotation is to expose the resident to the practice of physical medicine and rehabilitation in various clinical settings including acute care, subacute/recuperative care, acute rehabilitation, and outpatient. The resident will receive instruction and experience in clinical history and examination, identifying and managing clinical problems typical among patients with rehabilitation needs. The resident also will be shown state of the art diagnosis and treatment techniques employed in the diagnosis and management of patients in the outpatient physical medicine and rehabilitation setting. The resident will make daily attending and consultation rounds, will maintain contact (as appropriate) with select patients in physical and occupational therapy, and will see patients in the outpatient setting.

The Orthopedic rotation takes place in conjunction with the UAMS Orthopedics rotation. The purpose of this rotation is to develop the knowledge, attitudes, and skills needed to provide effective, acute, preventive, and continuity medical care for the patient with musculoskeletal pathology. This will include developing clinical and procedural skills in musculoskeletal and sports medicine and learning to work with an interdisciplinary team to
deliver comprehensive patient care. Your time will be spent in various outpatient ortho clinics in Little Rock.

The Neurology rotation takes place on at UAMS. On this rotation the resident is expected to demonstrate the ability to provide patient care, to localize the neurological lesions, to communicate effectively, to counsel and educate patients and families about the neurological illness and the prevention of common neurological disorders and to gain knowledge of the basic neurosciences and the pathophysiology of major psychiatric and neurological disorders. The formal didactic curriculum during PGY1 focuses on fundamental knowledge based upon which subsequent training and education will build on. The curriculum includes lectures, seminars, case conference, grand rounds and workshops. These programs are directed and taught by faculty, many of whom are renowned experts in their areas.
UAMS Department of Physical Medicine and Rehabilitation
PGY1 Rotations

PM&R Fundamental Clinical Skills Rotation – BHRI

Contacts: Mickey Burroughs, BHMC, 501-202-2673, Fax 501-202-1159
Preceptors: Thomas Kiser, MD
Rotation Length: One Month

Clinical Settings: This rotation includes primarily inpatient experience, but when available, consultations and outpatient clinic will be included. A cardiac rehabilitation experience is mandatory during this rotation.
Performance Expectations: Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. PM&R Department leave/vacation policy will apply.

General:
The general goal of this rotation is to expose the resident to the practice of physical medicine and rehabilitation in various clinical settings including acute care, sub-acute/recuperative care, acute rehabilitation, and outpatient. The resident will receive instruction and experience in clinical history and examination, identifying and managing clinical problems typical among patients with rehabilitation needs. The resident also will be shown state-of-the-art diagnosis and treatment techniques employed in the diagnosis and management of patients in the outpatient physical medicine and rehabilitation setting. The resident will make daily attending and consultation rounds, will maintain contact (as appropriate) with select patients in physical and occupational therapy, and will see patients in the outpatient setting. Attendance of weekly didactics while on PM&R rotation is expected.

Educational Objectives:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>PHYSICAL MEDICINE AND REHABILITATION FUNDAMENTAL CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goals and Objectives</td>
</tr>
</tbody>
</table>

Competency

Definition
To provide compassionate, appropriate, and effective treatment for all patients.
Demonstrate ability to obtain and record an accurate and A, B, A,
### MEDICAL KNOWLEDGE

**Definition**
To understand biomedical, clinical, and socio-behavioral knowledge about patient care.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Task Description</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>A, B, D, E</td>
<td>Recognize typical clinical problems among patients with physical medicine and rehabilitation patients in various clinical settings and their management.</td>
<td>A, D</td>
</tr>
<tr>
<td>A, B, D, E</td>
<td>Discuss the management of typical clinical problems among patients with physical medicine and rehabilitation problems.</td>
<td>A, D</td>
</tr>
<tr>
<td>A, B, D, E</td>
<td>Identify several diseases and conditions that are amenable to rehabilitation efforts.</td>
<td>A, D</td>
</tr>
</tbody>
</table>

### PRACTICE-BASED LEARNING AND IMPROVEMENT

**Definition**
Practice-Based Learning and Improvement: Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Task Description</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>A, B, D, E</td>
<td>Identify and discuss opportunities for improvement in the clinical management of patients encountered while on call in the acute care setting.</td>
<td>A, D</td>
</tr>
<tr>
<td>A, B, D, E</td>
<td>Identify opportunities for improvement of fundamental clinical skills.</td>
<td>A, D</td>
</tr>
<tr>
<td>A, B, D, E</td>
<td>Discuss at least one method of quality improvement used in healthcare</td>
<td>A, D</td>
</tr>
<tr>
<td>B, D, E</td>
<td>Demonstrate appropriate use of technology to aid practice.</td>
<td>A, D</td>
</tr>
<tr>
<td>B, D, E</td>
<td>Eagerly seeks and accepts feedback</td>
<td>A, D</td>
</tr>
</tbody>
</table>

### INTERPERSONAL AND COMMUNICATION SKILLS

**Definition**
To communicate with patients, families, and other health care professionals.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Task Description</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>A, B, D, E</td>
<td>Demonstrate the ability to use effective listening, verbal, and nonverbal skills to communicate with patients and families.</td>
<td>A, D</td>
</tr>
<tr>
<td>A, B, D, E</td>
<td>Demonstrate the ability to document timely and clear history and physical examinations, medical notes, and physician orders in the medical chart.</td>
<td>A, D</td>
</tr>
<tr>
<td>A, B, D, E</td>
<td>Demonstrate the ability to effectively communicate with other members of the healthcare team.</td>
<td>A, D</td>
</tr>
</tbody>
</table>

### PROFESSIONALISM

**Definition**
To carry out responsibilities in a professional manner.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Task Description</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>B, D, E</td>
<td>Demonstrate the ability to interact with peers and other healthcare team members in a professional manner.</td>
<td>A, D</td>
</tr>
<tr>
<td>B, D</td>
<td>Demonstrate respect, compassion, and integrity in relationships</td>
<td>A, D</td>
</tr>
<tr>
<td>Competency</td>
<td>Definition</td>
<td>Teaching Methods</td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>SYSTEMS-BASED PRACTICE</td>
<td></td>
<td>A. Reading</td>
</tr>
<tr>
<td>Definition</td>
<td>Understand and access relevant healthcare systems in order to provide optimal care.</td>
<td>B. Rounds</td>
</tr>
<tr>
<td></td>
<td>Identify and understand the appropriate roles of all the members of the multi-disciplinary health care team.</td>
<td>C. Educational Lectures</td>
</tr>
<tr>
<td></td>
<td>Residents will demonstrate accuracy and thoroughness in patient sign outs/hand offs.</td>
<td>D. Direct Patient Care</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to make appropriate discharge and post-discharge arrangements for patients.</td>
<td>E. Resident/Attending Mentoring</td>
</tr>
</tbody>
</table>

Last Review/Revision: 11/17/15
Emergency Medicine – BHMC

Contacts: Mickey Burroughs, BHMC, 501-202-2673, Fax 501-202-1159
Preceptors: Clinton Evans, MD
Rotation Length: One Month

Clinical Settings: This rotation includes acute medical management in a large teaching hospital emergency department during various shifts. During this rotation, PGY1 residents take in-house call in the hospital for emergencies.

Performance Expectations: Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. PM&R and Emergency Department leave/vacation policies will apply.

Emergency Medicine is the 23rd recognized medical specialty by the American Board of Medical Specialties. The practice of Emergency Medicine involves the diagnosis and initial treatment interventions of acute medical and surgical conditions in virtually all specialties and subspecialties of medicine.

BHMC in Little Rock is a 787-bed tertiary care hospital, is the largest medical center in our state, which operates the only hospital-based EMS helicopter system in central Arkansas. Approximately 35,000 Emergency Department patients are treated at BHMC annually, making this a very active rotation and one that is rich in clinical experience. We enjoy a diverse patient mix of acute cardiac, traumatic, medical, surgical, obstetric, neurologic, pediatric, orthopedic, ophthalmic, and psychiatric emergencies.

The educational experience of this Emergency Medicine rotation is enhanced by bedside teaching, didactic conferences, and “hands on” training in the technical emergency medical skills such as suture technique, endotracheal intubation, EKG interpretation, static and dynamic arrhythmia recognition, and x-ray interpretation. Emphasis will be placed on Emergency Department malpractice prevention and recent advances in the specialty of Emergency Medicine and the EMS system. Supervised clinical decision making is a very positive experience gained on this rotation. The Emergency Medicine staff at BHMC is composed of all board certified specialists who are interested in teaching. Housestaff officers are strongly encouraged to complete the American Heart Association’s Advanced Cardiac Life Support course prior to this rotation.
## Educational Objectives:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>EMERGENCY MEDICINE FUNDAMENTAL CLINICAL SKILLS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Goals and Objectives</td>
</tr>
<tr>
<td></td>
<td>Teaching Methods</td>
</tr>
<tr>
<td></td>
<td>Assessment Methods</td>
</tr>
</tbody>
</table>

### Competency: PATIENT CARE

**Definition**
To provide compassionate, appropriate, and effective treatment for all patients.

- Demonstrate ability to obtain and record an accurate and comprehensive general medical history.
- Demonstrate proper physical examination techniques.

### Competency: MEDICAL KNOWLEDGE

**Definition**
To understand biomedical, clinical, and socio-behavioral knowledge about patient care.

- Recognize typical clinical problems seen in the emergency department setting and their management.
- Discuss the management of typical urgent and emergent medical problems among patients seen in the emergency department setting.
- Identify several diseases and conditions that are seen in the emergency department setting.

### Competency: PRACTICE-BASED LEARNING AND IMPROVEMENT

**Definition**
Practice-Based Learning and Improvement: Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.

- Identify and discuss opportunities for improvement in the clinical management of patients encountered while on call in the acute care setting.
- Identify opportunities for improvement of fundamental clinical skills.
- Eagerly seeks and accepts feedback.

### Competency: INTERPERSONAL AND COMMUNICATION SKILLS

**Definition**
To communicate with patients, families, and other health care professionals.

- Demonstrate the ability to use effective listening, verbal, and nonverbal skills to communicate with patients and families.
<table>
<thead>
<tr>
<th>Competency</th>
<th>PROFESSIONALISM</th>
<th>B, D, E</th>
<th>A, D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>To carry out responsibilities in a professional manner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate the ability to interact with peers and other healthcare team members in a professional manner.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td>Demonstrate respect, compassion, and integrity in relationships with patients and families.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td>Demonstrate sensitivity and responsiveness to patients and colleagues in consideration of sex, age, culture, religion, sexual preference, etc.</td>
<td>B, D, E</td>
<td>A, D</td>
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<thead>
<tr>
<th>Competency</th>
<th>SYSTEMS-BASED PRACTICE</th>
<th>B, D, E</th>
<th>A, D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Understand and access relevant healthcare systems in order to provide optimal care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify and understand the appropriate roles of all the members of the multi-disciplinary health care team.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td>Residents will demonstrate accuracy and thoroughness in patient sign outs/hand offs.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td>Demonstrate the ability to make appropriate discharge and post-discharge arrangements for patients.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
</tbody>
</table>

**Teaching Methods**
A. Reading  
B. Rounds  
C. Educational Lectures  
D. Direct Patient Care  
E. Resident/Attending Mentoring

**Assessment Methods**
A. Direct and Indirect Observation by Srn Residents/Attendings  
B. In-Service Training Exam  
C. OSCE  
D. Rotation Evaluation

Last Review/Revision: 11/06/2015
Medicine Wards – CAVHS

Contacts: Cyndi Shaw, Program Analyst, Medicine Service  
501-257-5972, Cynthia.Shaw@va.gov

Preceptors: Various, as assigned

Rotation Length: Three (3) One-Month Rotations during the PGY1 year

Clinical Settings: This rotation includes primarily inpatient care of acute medicine patients. Residents also attend outpatient PM&R continuity clinic experiences on a weekly basis during this rotation.

Performance Expectations: Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. PM&R Department and VA leave/vacation policies will apply.

Educational Objectives:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>MEDICINE WARDS - FUNDAMENTAL CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goals and Objectives</td>
</tr>
</tbody>
</table>

Competency PATIENT CARE

<table>
<thead>
<tr>
<th>Definition</th>
<th>To provide compassionate, appropriate, and effective treatment for all patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyze patient’s medical problems both new and existing through history and physical examination, and monitoring of daily progress of the patient.</td>
<td>A, B, D, E</td>
</tr>
<tr>
<td>Determine a diagnostic work up plan and treatment of patients.</td>
<td>A, B, D, E</td>
</tr>
<tr>
<td>Evaluate a variety of medical emergencies and determine how to stabilize patient, prior to transfer to the intensive care units.</td>
<td>A, B, D, E</td>
</tr>
<tr>
<td>Demonstrate basic skill in medicine procedures, including drawing of blood cultures, bladder catheterizations, lumbar punctures, insertion of naso-gastric tubes, abdominal paracenthesis, thoracenthesis, and insertion of central venous lines.</td>
<td>A, B, D, E</td>
</tr>
<tr>
<td>Participate in and appropriately conduct cardiopulmonary resuscitation codes.</td>
<td>A, B, D, E</td>
</tr>
</tbody>
</table>

Competency MEDICAL KNOWLEDGE

| Definition | To understand biomedical, clinical, and socio-behavioral knowledge about patient care. |

<table>
<thead>
<tr>
<th>Teaching Methods</th>
<th>Assessment Methods</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Competency</td>
<td>PRACTICE-BASED LEARNING AND IMPROVEMENT</td>
</tr>
<tr>
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</tr>
<tr>
<td>Definition</td>
<td>Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
</tr>
<tr>
<td></td>
<td>Identify and discuss opportunities for improvement in the clinical management of patients encountered in the acute care setting.</td>
</tr>
<tr>
<td></td>
<td>Identify opportunities for improvement of one’s fundamental clinical skills.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate appropriate use of technology to aid practice.</td>
</tr>
<tr>
<td></td>
<td>Eagerly seeks and accepts feedback</td>
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</table>

<table>
<thead>
<tr>
<th>Competency</th>
<th>INTERPERSONAL AND COMMUNICATION SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>To communicate with patients, families, and other health care professionals.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to clearly and concisely summarize the clinical history and examination findings, pertinent laboratory and imaging data, presumptive diagnosis and initial management plan to senior residents and attending physicians on the medicine team.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to use effective listening, verbal, and nonverbal skills to communicate with patients and families.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to document timely and clear history and physical examinations, medical notes, and physician orders in the medical chart.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to effectively communicate with other members of the healthcare team.</td>
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</table>

<table>
<thead>
<tr>
<th>Competency</th>
<th>PROFESSIONALISM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>To carry out responsibilities in a professional manner.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to interact with peers and other</td>
</tr>
<tr>
<td>Competency</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>healthcare team members in a professional manner.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate respect, compassion, and integrity in relationships with patients and families.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate sensitivity and responsiveness to patients and colleagues in consideration of sex, age, culture, religion, sexual preference, etc.</td>
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<tr>
<td></td>
<td><strong>SYSTEMS-BASED PRACTICE</strong></td>
</tr>
<tr>
<td>Definition</td>
<td>Understand and access relevant healthcare systems in order to provide optimal care.</td>
</tr>
<tr>
<td></td>
<td>Identify and understand the appropriate roles of all the members of the multi-disciplinary health care team.</td>
</tr>
<tr>
<td></td>
<td>Residents will demonstrate accuracy and thoroughness in patient sign outs/hand offs.</td>
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<tr>
<td></td>
<td>Demonstrate the ability to make appropriate discharge and post-discharge arrangements for patients.</td>
</tr>
<tr>
<td></td>
<td>Discuss the role of at least three sub-specialty branches of internal medicine and obtain appropriate consultations.</td>
</tr>
</tbody>
</table>

**Teaching Methods**

A. Reading  
B. Rounds  
C. Educational Lectures  
D. Direct Patient Care  
E. Resident/Attending Mentoring

**Assessment Methods**

A. Direct and Indirect Observation by Srn Residents/Attendings  
B. In-Service Training Exam  
C. OSCE  
D. Rotation Evaluation

Last Review/Revision: 11/17/15
Radiology – BHMC

Contacts: Mickey Burroughs, BHMC, 501-202-2673, Fax 501-202-1159
Preceptors: Cary Guidry, MD
Rotation Length: One Month

Clinical Settings:

Performance Expectations: Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. PM&R Department leave/vacation policy will apply.

Objectives & Goals: To learn fundamentals of radiographic interpretation, indications for special procedures and evaluation of patients for radiation therapy under the supervision of a practicing Radiologist in a community hospital setting.

Rotation Schedule:
Reading Room at Baptist, Magnetic Resonance imaging section, Nuclear medicine/Ultrasound, Fluoroscopy, and “special procedures”.

Requirements: Approximately one week prior to the start of the rotation the resident should contact Dr. Cary Guidry.

Educational Objectives:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>RADIOLOGY: FUNDAMENTAL CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goals and Objectives</td>
</tr>
</tbody>
</table>

Competency PATIENT CARE

Definition To provide compassionate, appropriate, and effective treatment for all patients.

| Demonstrate the ability to decide which imaging modality is appropriate and when is it appropriate to request. | A, E, F | A, D |
| Demonstrate basic familiarity with the limitations of common imaging modalities | A, E, F | A, D |
| Demonstrate the ability to appropriately request various types of radiology imaging studies | A, E, F | A, D |

Competency MEDICAL KNOWLEDGE

Definition To understand biomedical, clinical, and socio-behavioral knowledge about patient care.

| Describe the scope of radiology practice and what the radiologist can do to aid clinical diagnosis. | A, E, F | A, D |
After review of as many imaging studies as possible during the rotation, identify the imaging modality when shown the study images.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Practice-Based Learning and Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Practice-Based Learning and Improvement: Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
</tr>
<tr>
<td>Identify and discuss opportunities for practice improvement in the radiology setting.</td>
<td>B, D, E</td>
</tr>
<tr>
<td>Identify opportunities for improvement of fundamental clinical skills.</td>
<td>B, D, E</td>
</tr>
<tr>
<td>Demonstrate appropriate access of clinical radiology imaging technology.</td>
<td>B, D, E</td>
</tr>
<tr>
<td>Eagerly seeks and accepts feedback</td>
<td>B, D, E</td>
</tr>
</tbody>
</table>

Discuss the limitations of common imaging modalities.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Interpersonal and Communication Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>To communicate with patients, families, and other healthcare professionals.</td>
</tr>
<tr>
<td>Demonstrate the ability to clearly and concisely summarize the pertinent clinical findings and basic imaging findings to the attending radiologist.</td>
<td>B, D, E</td>
</tr>
<tr>
<td>Demonstrate the ability to effectively communicate with other members of the healthcare team.</td>
<td>B, D, E</td>
</tr>
</tbody>
</table>

Discuss the approach to basic plain film interpretation without necessarily being able to render a detailed reading or diagnosis.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Professionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>To carry out responsibilities in a professional manner.</td>
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<tr>
<td>Demonstrate the ability to interact with peers and other healthcare team members in a professional manner.</td>
<td>B, D, E</td>
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<tr>
<td>Demonstrate sensitivity and responsiveness to patients and colleagues in consideration of sex, age, culture, religion, sexual preference, etc.</td>
<td>B, D, E</td>
</tr>
<tr>
<td>Demonstrate the ability to be punctual with respect to attending to clinics and required conferences.</td>
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</tr>
</tbody>
</table>

Demonstrate the ability to make appropriate imaging requests from various sub-departments within the Radiology department.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Systems-Based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Understand and access relevant healthcare systems in order to provide optimal care.</td>
</tr>
<tr>
<td>Identify and understand the appropriate roles of all the members of the radiology team.</td>
<td>B, D, E</td>
</tr>
<tr>
<td>Demonstrate the ability to make appropriate imaging requests from various sub-departments within the Radiology department.</td>
<td>B, D, E</td>
</tr>
</tbody>
</table>
Teaching Methods
A. Reading
B. Rounds
C. Educational Lectures
D. Direct Patient Care
E. Resident/Attending Mentoring

Assessment Methods
A. Direct and Indirect Observation by Snr Residents/Attendings
B. In-Service Training Exam
C. OSCE
D. Rotation Evaluation

Last Review/Revision: 8/26/2016
Neurology – UAMS

Contacts: UAMS – Angela Bauer, Residency Program Coordinator, 501-296-1165, Fax 501-686-8689

Preceptors: Varies

Rotation Length: One Month

Clinical Settings:

Performance Expectations: Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. Department leave/vacation policy will apply.

Educational Objectives:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>NEUROLOGY: FUNDAMENTAL CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goals and Objectives</td>
</tr>
<tr>
<td>Competency</td>
<td>PATIENT CARE</td>
</tr>
<tr>
<td>Definition</td>
<td>To provide compassionate, appropriate, and effective treatment for all patients.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health</td>
</tr>
<tr>
<td></td>
<td>Gather and document an accurate comprehensive history and to perform a complete examination</td>
</tr>
<tr>
<td></td>
<td>Localize the neurological lesion and to generate differential diagnoses</td>
</tr>
<tr>
<td></td>
<td>Evaluate, recommend and carry out a cost-effective diagnostic and therapeutic management plan</td>
</tr>
<tr>
<td></td>
<td>Develop technical skills: lumbar puncture, caloric testing, apnea testing, nerve conduction/electromyographic testing</td>
</tr>
</tbody>
</table>

Competency MEDICAL KNOWLEDGE

Definition: To understand biomedical, clinical, and socio-behavioral knowledge about patient care.

Recognize the basic mechanism of operation, the indications, contra-indications, and the limitation of investigative procedures and their interpretation in the diagnosis of neurologic diseases.
<table>
<thead>
<tr>
<th>Competency</th>
<th>Practice-Based Learning and Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Practice-Based Learning and Improvement: Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
</tr>
<tr>
<td>Identify and discuss opportunities for practice improvement in the neurology setting.</td>
<td>B, D, E, A, D</td>
</tr>
<tr>
<td>Identify opportunities for improvement of fundamental clinical skills.</td>
<td>B, D, E, A, D</td>
</tr>
<tr>
<td>Eagerly seeks and accepts feedback</td>
<td>B, D, E, A, D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency</th>
<th>Interpersonal and Communication Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>To communicate with patients, families, and other health care professionals.</td>
</tr>
<tr>
<td>Demonstrate the ability to clearly and concisely summarize the pertinent clinical findings and basic imaging findings to the attending neurologist.</td>
<td>B, D, E, A, D</td>
</tr>
<tr>
<td>Demonstrate the ability to effectively communicate with other members of the healthcare team.</td>
<td>B, D, E, A, D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency</th>
<th>Professionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>To carry out responsibilities in a professional manner.</td>
</tr>
<tr>
<td>Demonstrate the ability to interact with peers and other healthcare team members in a professional manner.</td>
<td>B, D, E, A, D</td>
</tr>
<tr>
<td>Demonstrate sensitivity and responsiveness to patients and colleagues in consideration of sex, age, culture, religion, sexual preference, etc.</td>
<td>B, D, E, A, D</td>
</tr>
<tr>
<td>Demonstrate the ability to be punctual with respect to attending to clinics and required conferences.</td>
<td>B, D, E, A, D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency</th>
<th>Systems-Based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Understand and access relevant healthcare systems in order to provide optimal care.</td>
</tr>
<tr>
<td>Identify and understand the appropriate roles of all the members of the neurology team.</td>
<td>B, D, E, A, D</td>
</tr>
</tbody>
</table>
Teaching Methods
A. Reading  
B. Rounds  
C. Educational Lectures  
D. Direct Patient Care  
E. Resident/Attending Mentoring

Assessment Methods
A. Direct and Indirect Observation by Srn Residents/Attendings  
B. In-Service Training Exam  
C. OSCE  
D. Rotation Evaluation

Last Review/Revision: 11/06/2015
Pediatric Wards – ACH

**Contacts:** Lori Miloni, Residency Coordinator, 501-364-1874

**Preceptors:** ACH Pediatrics Chief Residents

**Rotation Length:** One Month

**Clinical Settings:**

**Performance Expectations:** Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. Department leave/vacation policy will apply.

**Educational Objectives:**

<table>
<thead>
<tr>
<th>Rotation</th>
<th>PEDIATRIC INPATIENT: FUNDAMENTAL CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goals and Objectives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency</th>
<th>PATIENT CARE</th>
<th>Definition</th>
<th>Teaching Methods</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>To provide compassionate, appropriate, and effective treatment for all patients.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demonstrate ability to analyze the major problems of pediatric patients through history and physical examination, and monitoring of daily progress.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Determine a diagnostic work up plan and treatment of pediatric patients.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evaluate common pediatric emergencies and determine how to stabilize patient, prior to transfer to the intensive care units.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demonstrate basic skill in the performance of common pediatric procedures; venous cannulations, lumbar puncture, subdural tap, bone marrow, aspiration, etc.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participate in and appropriately conduct cardiopulmonary resuscitation codes.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency</th>
<th>MEDICAL KNOWLEDGE</th>
<th>Definition</th>
<th>Teaching Methods</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>To understand biomedical, clinical, and socio-behavioral knowledge about patient care.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demonstrate knowledge of advanced cardiopulmonary life support protocols and related techniques.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recognize typical clinical problems among hospitalized pediatric patients in various acute pediatric settings and their</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>Competency</td>
<td>Definition</td>
<td>A, B, D, E</td>
<td>A, D</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Management</td>
<td>Analyze and discuss the status patients’ medical problems through history and physical examination, and monitoring of daily progress of the patient.</td>
<td>A, B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss an appropriate differential diagnosis for patients seen.</td>
<td>A, B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss the selection and interpretation of appropriate laboratory tests, radiological and imaging studies, and cardiovascular diagnostic studies.</td>
<td>A, B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td>Competency</td>
<td><strong>PRACTICE-BASED LEARNING AND IMPROVEMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definition</td>
<td>Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify and discuss opportunities for improvement in the clinical management of patients encountered in the pediatric acute care setting.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify opportunities for improvement of one’s fundamental clinical skills.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate appropriate use of technology to aid practice.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eagerly seeks and accepts feedback</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td>Competency</td>
<td><strong>INTERPERSONAL AND COMMUNICATION SKILLS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definition</td>
<td>To communicate with patients, families, and other health care professionals.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to clearly and concisely summarize the clinical history and examination findings, pertinent laboratory and imaging data, presumptive diagnosis and initial management plan to senior residents and attending physicians on the pediatric inpatient team.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to use effective listening, verbal, and nonverbal skills to communicate with patients and families.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to document timely and clear history and physical examinations, medical notes, and physician orders in the medical chart.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to effectively communicate with other members of the healthcare team.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td>Competency</td>
<td><strong>PROFESSIONALISM</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definition</td>
<td>To carry out responsibilities in a professional manner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to interact with peers and other healthcare team members in a professional manner.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate respect, compassion, and integrity in relationships with patients and families.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate sensitivity and responsiveness to patients and family.</td>
<td>B, D, E</td>
<td>A, D</td>
<td></td>
</tr>
<tr>
<td>Competency</td>
<td>SYSTEMS-BASED PRACTICE</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definition</td>
<td>Understand and access relevant healthcare systems in order to provide optimal care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify and understand the appropriate roles of all the members of the multi-disciplinary health care team.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Residents will demonstrate accuracy and thoroughness in patient sign outs/hand offs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to make appropriate discharge and post-discharge arrangements for pediatric patients and families.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Discuss the role of at least three sub-specialty branches of pediatrics and obtain appropriate consultations.</td>
<td></td>
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</tr>
</tbody>
</table>

### Teaching Methods
- A. Reading
- B. Rounds
- C. Educational Lectures
- D. Direct Patient Care
- E. Resident/Attending Mentoring

### Assessment Methods
- A. Direct and Indirect Observation by Snr Residents/Attendings
- B. In-Service Training Exam
- C. OSCE
- D. Rotation Evaluation

Last Review/Revision: 7/8/2010
Geriatric Wards – NLR VA

**Contacts:** Scott Cheek, APN, 257-2002, Jeffrey.cheek@med.va.gov

**Preceptors:** Meshach Samuel, MD

**Rotation Length:** Two (2) 1 month rotations

**Clinical Settings:**

**Performance Expectations:** Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. Department leave/vacation policy will apply.

**Educational Objectives:**

<table>
<thead>
<tr>
<th>Rotation</th>
<th>MEDICINE WARDS - FUNDAMENTAL CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Goals and Objectives</strong></td>
</tr>
<tr>
<td>Competency</td>
<td><strong>PATIENT CARE</strong></td>
</tr>
<tr>
<td>Definition</td>
<td>To provide compassionate, appropriate, and effective treatment for all patients.</td>
</tr>
<tr>
<td></td>
<td>Analyze geriatric patients’ medical problems both new and existing through history and physical examination, and monitoring of daily progress of the patient.</td>
</tr>
<tr>
<td></td>
<td>Determine a diagnostic work up plan and treatment of geriatric medicine patients.</td>
</tr>
<tr>
<td></td>
<td>Evaluate a variety of medical emergencies and determine how to stabilize patient, prior to transfer to the intensive care units.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate basic skill in medicine procedures, including drawing of blood cultures, bladder catheterizations, lumbar punctures, insertion of naso-gastric tubes, abdominal paracenthesis, thoracenthesis, and insertion of central venous lines.</td>
</tr>
<tr>
<td></td>
<td>Participate in and appropriately conduct cardiopulmonary resuscitation codes.</td>
</tr>
<tr>
<td>Competency</td>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
</tr>
<tr>
<td>Definition</td>
<td>To understand biomedical, clinical, and socio-behavioral knowledge about patient care.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate knowledge of advanced cardiopulmonary life support protocols and related techniques.</td>
</tr>
<tr>
<td></td>
<td>Recognize typical clinical problems among hospitalized patients</td>
</tr>
</tbody>
</table>
in various acute internal medicine settings and their management. | D, E
---|---
Analyze and discuss the status patients’ medical problems (both new and existing) through history and physical examination, and monitoring of daily progress of the patient. | A, B, D, E | A, D
Discuss an appropriate differential diagnosis for patients seen. | A, B, D, E | A, D
Discuss the selection and interpretation of appropriate laboratory tests, radiological and imaging studies, and cardiovascular diagnostic studies. | A, B, D, E | A, D

<table>
<thead>
<tr>
<th><strong>Competency</strong></th>
<th><strong>PRACTICE-BASED LEARNING AND IMPROVEMENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
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<tr>
<td></td>
<td>Identify and discuss opportunities for improvement in the clinical management of patients encountered in the acute care setting.</td>
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<tr>
<td></td>
<td>Identify opportunities for improvement of one’s fundamental clinical skills.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate appropriate use of technology to aid practice.</td>
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<tr>
<td></td>
<td>Eagerly seeks and accepts feedback</td>
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</table>

<table>
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<tr>
<th><strong>Competency</strong></th>
<th><strong>INTERPERSONAL AND COMMUNICATION SKILLS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>To communicate with patients, families, and other health care professionals.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to clearly and concisely summarize the clinical history and examination findings, pertinent laboratory and imaging data, presumptive diagnosis and initial management plan to senior residents and attending physicians on the geriatric medicine team.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to use effective listening, verbal, and nonverbal skills to communicate with patients and families.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to document timely and clear history and physical examinations, medical notes, and physician orders in the medical chart.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to effectively communicate with other members of the healthcare team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Competency</strong></th>
<th><strong>PROFESSIONALISM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>To carry out responsibilities in a professional manner.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to interact with peers and other healthcare team members in a professional manner.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate respect, compassion, and integrity in relationships with patients and families.</td>
</tr>
<tr>
<td>Competency</td>
<td>SYSTEMS-BASED PRACTICE</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Definition</td>
<td>Understand and access relevant healthcare systems in order to provide optimal care.</td>
</tr>
<tr>
<td></td>
<td>Identify and understand the appropriate roles of all the members of the geriatrics multi-disciplinary health care team.</td>
</tr>
<tr>
<td></td>
<td>Residents will demonstrate accuracy and thoroughness in patient sign outs/hand offs.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to make appropriate discharge and post-discharge arrangements for patients.</td>
</tr>
<tr>
<td></td>
<td>Discuss the role geriatric medicine as it relates to PM&amp;R.</td>
</tr>
</tbody>
</table>

### Teaching Methods

- A. Reading
- B. Rounds
- C. Educational Lectures
- D. Direct Patient Care
- E. Resident/Attending Mentoring

### Assessment Methods

- A. Direct and Indirect Observation by Srn Residents/Attendings
- B. In-Service Training Exam
- C. OSCE
- D. Rotation Evaluation

Last Review/Revision: 11/06/2015
Rheumatology – BHMC

Contacts: Mickey Burroughs, BHMC, 501-202-2673, Fax 501-202-1159
Preceptors: Jasen Chi, MD, BHMC
Rotation Length: One Month

Clinical Settings: Primarily outpatient clinic experience but when available inpatient rheumatology consultations will be included.

Performance Expectations: Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. Department leave/vacation policy will apply.

Core Topics: (to be covered by patient care, didactic lectures, or independent reading) include the evaluation, diagnosis and treatment of:
- Rheumatoid arthritis
- Systemic lupus erythematosis
- Mixed connective tissue disease
- Scleroderma
- Seronegative Spondyloarthropathies
- Osteoarthritis
- Crystalline arthropathies
- Infectious arthritis
- Systemic vasculitides
- Fibromyalgia
- Poly/Dermatomyositis
- Osteoporosis, bursitis, joint pain, back pain

Procedures: arthrocentesis, trigger point injections

Educational Objectives:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>RHEUMATOLOGY FUNDAMENTAL CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goals and Objectives</td>
</tr>
<tr>
<td>Competency</td>
<td>PATIENT CARE</td>
</tr>
<tr>
<td>Definition</td>
<td>To provide compassionate, appropriate, and effective treatment for all patients.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate ability to obtain and record an accurate and comprehensive general medical history.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate proper physical examination techniques.</td>
</tr>
<tr>
<td>Competency</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MEDICAL KNOWLEDGE</td>
<td>To understand biomedical, clinical, and socio-behavioral knowledge about patient care.</td>
</tr>
<tr>
<td></td>
<td>Discuss core rheumatology topics (see above) including relevant anatomy and pathophysiology of rheumatologic disorders and the indications, contraindications, and benefits of arthrocentesis.</td>
</tr>
<tr>
<td></td>
<td>Recognize typical clinical problems among patients with rheumatologic disorders and their management.</td>
</tr>
<tr>
<td>PRACTICE-BASED LEARNING AND IMPROVEMENT</td>
<td>Practice-Based Learning and Improvement: Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
</tr>
<tr>
<td></td>
<td>Identify and discuss opportunities for improvement in the clinical management of patients encountered while on call in the acute care setting.</td>
</tr>
<tr>
<td></td>
<td>Identify and discuss rheumatology knowledge and skill deficiencies and identify opportunities for increasing knowledge and skill.</td>
</tr>
<tr>
<td></td>
<td>Use information technology, imaging and appropriate laboratory studies to answer clinical questions</td>
</tr>
<tr>
<td></td>
<td>Eagerly seeks and accepts feedback</td>
</tr>
<tr>
<td>INTERPERSONAL AND COMMUNICATION SKILLS</td>
<td>To communicate with patients, families, and other health care professionals.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to use effective listening, verbal, and nonverbal skills to communicate with patients and families.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to document timely and clear history and physical examinations, medical notes, and physician orders in the medical chart.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to effectively communicate with other members of the healthcare team.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate ability to present patients and rheumatology topics informally and formally to another physician or group.</td>
</tr>
<tr>
<td>PROFESSIONALISM</td>
<td>To carry out responsibilities in a professional manner.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate the ability to interact with peers and other healthcare team members in a professional manner.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate respect, compassion, and integrity in relationships</td>
</tr>
<tr>
<td>Competency</td>
<td>SYSTEMS-BASED PRACTICE</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Definition</td>
<td>Understand and access relevant healthcare systems in order to provide optimal care.</td>
</tr>
<tr>
<td></td>
<td>Identify and understand the appropriate roles of all the members of the multi-disciplinary health care team.</td>
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<tr>
<td></td>
<td>Demonstrate accuracy and thoroughness in patient sign outs/hand offs.</td>
</tr>
<tr>
<td></td>
<td>Discuss systems unique to the subspecialty of rheumatology and the role of rheumatology relative to PM&amp;R.</td>
</tr>
</tbody>
</table>

**Teaching Methods**
- A. Reading
- B. Rounds
- C. Educational Lectures
- D. Direct Patient Care
- E. Resident/Attending Mentoring

**Assessment Methods**
- A. Direct and Indirect Observation by Snr Residents/Attendings
- B. In-Service Training Exam
- C. OSCE
- D. Rotation Evaluation

Last Review/Revision: 11/06/2015
Orthopedics – UAMS

Contacts: Darlene Clinton, Residency Coordinator, ClintonDarleneM@uams.edu, 686-5259

Preceptors: Varies

Rotation Length: One month

Clinical Settings: Various UAMS Orthopedic clinics in Little Rock: Shackleford, Autumn Road and Colonel Glenn

Performance expectations: Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. PM&R Department leave/vacation policy will apply.

Core Topics:
Functional restoration after musculoskeletal injury.
Functional restoration after sports injury.
Functional restoration after musculoskeletal surgery.
Preserving function in musculoskeletal disease.

Procedures: Orthopaedic examination of the spine and extremities, special tests, interpretation of orthopaedic imaging, prescription of prosthetics and orthotics.

Educational Objectives:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>ORTHOPEDICS FUNDAMENTAL CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goals and Objectives</td>
</tr>
</tbody>
</table>

Competency PATIENT CARE

<table>
<thead>
<tr>
<th>Definition</th>
<th>Teaching Methods</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide compassionate, appropriate, and effective treatment for all patients.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>Demonstrate ability to obtain and record an accurate and comprehensive general medical history.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>Demonstrate proper physical examination techniques.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>Demonstrate ability to respond to consultation requests.</td>
<td>A, B, D, E</td>
<td>A, D</td>
</tr>
</tbody>
</table>

Competency MEDICAL KNOWLEDGE

<table>
<thead>
<tr>
<th>Definition</th>
<th>Teaching Methods</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>To understand biomedical, clinical, and socio-behavioral knowledge about patient care.</td>
<td>A, B,</td>
<td>A, D</td>
</tr>
<tr>
<td>Discuss core orthopedic topics (see above) including relevant</td>
<td>A, B,</td>
<td>A, D</td>
</tr>
<tr>
<td>Competency</td>
<td>Definition</td>
<td>A, B, D, E</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Anatomy and pathophysiology of orthopedic disorders and the indications, contraindications.</td>
<td>D, E</td>
<td></td>
</tr>
<tr>
<td>Recognize typical clinical problems among patients with orthopedic disorders and their management.</td>
<td>A, B, D, E A, D</td>
<td></td>
</tr>
</tbody>
</table>

### Competency: PRACTICE-BASED LEARNING AND IMPROVEMENT

**Definition**

Practice-Based Learning and Improvement: Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.

<table>
<thead>
<tr>
<th></th>
<th>A, B, D, E A, D</th>
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</thead>
<tbody>
<tr>
<td>Identify and discuss opportunities for improvement in the clinical management of patients encountered while on call in the acute care setting.</td>
<td></td>
</tr>
<tr>
<td>Identify and discuss orthopedic knowledge and skill deficiencies and identify opportunities for increasing knowledge and skill.</td>
<td>A, B, D, E A, D</td>
</tr>
<tr>
<td>Use information technology, imaging and appropriate laboratory studies to answer clinical questions</td>
<td>B, D, E A, D</td>
</tr>
<tr>
<td>Eagerly seeks and accepts feedback</td>
<td>B, D, E A, D</td>
</tr>
</tbody>
</table>

### Competency: INTERPERSONAL AND COMMUNICATION SKILLS

**Definition**

To communicate with patients, families, and other health care professionals.

<table>
<thead>
<tr>
<th></th>
<th>A, B, D, E A, D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate the ability to use effective listening, verbal, and nonverbal skills to communicate with patients and families.</td>
<td></td>
</tr>
<tr>
<td>Demonstrate the ability to document timely and clear history and physical examinations, medical notes, and physician orders in the medical chart.</td>
<td>A, B, D, E A, D</td>
</tr>
<tr>
<td>Demonstrate the ability to effectively communicate with other members of the healthcare team.</td>
<td>B, D, E A, D</td>
</tr>
<tr>
<td>Demonstrate ability to present patients and orthopedic topics informally and formally to another physician or group.</td>
<td>B, D, E A, D</td>
</tr>
</tbody>
</table>

### Competency: PROFESSIONALISM

**Definition**

To carry out responsibilities in a professional manner.

<table>
<thead>
<tr>
<th></th>
<th>B, D, E A, D</th>
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</thead>
<tbody>
<tr>
<td>Demonstrate the ability to interact with peers and other healthcare team members in a professional manner.</td>
<td></td>
</tr>
<tr>
<td>Demonstrate respect, compassion, and integrity in relationships with patients and families.</td>
<td>B, D, E A, D</td>
</tr>
<tr>
<td>Demonstrate sensitivity and responsiveness to patients and colleagues in consideration of sex, age, culture, religion, sexual preference, etc.</td>
<td>B, D, E A, D</td>
</tr>
</tbody>
</table>

### Competency: SYSTEMS-BASED PRACTICE

**Definition**

Understand and access relevant healthcare systems in order to provide optimal care.

<table>
<thead>
<tr>
<th></th>
<th>B, D, E A, D</th>
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</thead>
<tbody>
<tr>
<td>Identify and understand the appropriate roles of all the members of the multi-disciplinary health care team.</td>
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<tr>
<td>Demonstrate accuracy and thoroughness in patient sign</td>
<td>B, D, E A, D</td>
</tr>
<tr>
<td>Teaching Methods</td>
<td>Assessment Methods</td>
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<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>A. Reading</td>
<td>A. Direct and Indirect Observation by Snr</td>
</tr>
<tr>
<td>B. Rounds</td>
<td>Residents/Attendings</td>
</tr>
<tr>
<td>C. Educational Lectures</td>
<td>B. In-Service Training Exam</td>
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<tr>
<td>D. Direct Patient Care</td>
<td>C. OSCE</td>
</tr>
<tr>
<td>E. Resident/Attending Mentoring</td>
<td>D. Rotation Evaluation</td>
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</tbody>
</table>

Discuss systems unique to the subspecialty of orthopedics and the role of orthopedics relative to PM&R.

outs/hand offs.

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<tbody>
<tr>
<td>E</td>
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<tr>
<td>B, D, E</td>
</tr>
<tr>
<td>A, D</td>
</tr>
</tbody>
</table>
UAMS Department of Physical Medicine and Rehabilitation
Sample Residency Rotation Schedules

<table>
<thead>
<tr>
<th>PGY-1</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Assignment</td>
<td>PM&amp;R</td>
<td>Neuro</td>
<td>Geriatric Wards</td>
<td>Med Wards</td>
<td>Peds Wards</td>
<td>Geriatric Wards</td>
<td>Rheum Clinic</td>
<td>Radiology</td>
<td>Med Wards</td>
<td>Emer Med</td>
<td>Med Wards</td>
<td>Ortho</td>
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<td>Institution*</td>
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<td>1/3</td>
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<td>2</td>
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<td>2</td>
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<td>2</td>
<td>1/3</td>
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<table>
<thead>
<tr>
<th>PGY2</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
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</thead>
<tbody>
<tr>
<td>Sample Assignment</td>
<td>Inpatient PM&amp;R</td>
<td>Inpatient PM&amp;R</td>
<td>PM&amp;R Outpatient</td>
<td>Inpatient PM&amp;R</td>
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<tr>
<td>Institution*</td>
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<td>1/2/4</td>
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<table>
<thead>
<tr>
<th>PGY-3</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
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</thead>
<tbody>
<tr>
<td>Sample Assignment</td>
<td>Inpatient PM&amp;R</td>
<td>EMG</td>
<td>Inpatient PM&amp;R</td>
<td>PM&amp;R Outpatient/VA Outpatient</td>
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<tr>
<th>PGY4</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Assignment</td>
<td>PM&amp;R Outpatient</td>
<td>PM&amp;R Outpatient</td>
<td>Inpatient PM&amp;R</td>
<td>PM&amp;R Outpatient</td>
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<td>Institution*</td>
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* Institution Key:

1. University Hospital
2. VA
3. BHRI
4. Arkansas Children’s Hospital
5. Private Practice
The overall goal of the PM&R residency training program is to develop physiatrists who are ethical, competent, caring, knowledgeable and skilled in the diagnosis, management, prevention, and rehabilitation for conditions resulting or potentially resulting in impairment and disability. To achieve this goal, educational objectives have been established for each level of training in the program. These objectives comprise both cognitive and psychomotor elements (i.e., physical examination skills, procedural skills, etc.). The objectives direct the faculty teaching and the resident learning experiences during each rotation.
# UAMS Department of Physical Medicine and Rehabilitation

### PGY2-PGY4 Resident Rotations

## Inpatient Goals & Objectives (includes ACH/BHRI Inpatient Rotations)

### Patient Care - Inpatient Rotations

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Teaching Methods</th>
<th>Assessments</th>
<th>Objectives</th>
<th>Teaching Methods</th>
<th>Assessments</th>
<th>Objectives</th>
<th>Teaching Methods</th>
<th>Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Residents will obtain and record accurate and comprehensive medical history.</td>
<td>D, E</td>
<td>A, D</td>
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<td>D, E</td>
<td>A, D</td>
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<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>b. Residents will perform and record complete general physical and physiatric examinations.</td>
<td>D, E</td>
<td>A, C, D</td>
<td>b. Residents will demonstrate competence in performing and recording complete general physical and physiatric examinations.</td>
<td>D, E</td>
<td>A, C, D</td>
<td>b. Residents will demonstrate proficiency performing and recording complete general physical and physiatric examinations.</td>
<td>D, E</td>
<td>A, C, D</td>
</tr>
<tr>
<td>d. Residents will prescribe a basic rehabilitation program including all appropriate rehabilitation therapies and precautions for patients with common rehabilitation diagnoses.</td>
<td>A, B, C, D, E</td>
<td>A, B, C, D</td>
<td>d. Residents will demonstrate competence in prescribing a rehabilitation program including all appropriate rehabilitation therapies and precautions for patients with common rehabilitation diagnoses.</td>
<td>A, B, C, D, E</td>
<td>A, B, C, D</td>
<td>d. Residents will demonstrate proficiency in prescribing a rehabilitation program including all appropriate rehabilitation therapies and precautions for patients with complex or atypical rehabilitation problems or diagnoses.</td>
<td>A, B, C, D, E</td>
<td>A, B, C, D</td>
</tr>
<tr>
<td>e. Residents will evaluate the need for and when appropriate, prescribe self-help aids, wheelchairs patient's home modifications, orthotic and prosthetic devices, and durable medical equipment.</td>
<td>A, C, D, E</td>
<td>A, C, D</td>
<td>e. Residents will demonstrate competence in evaluating the need for and when appropriate, prescribing self-help aids, wheelchairs patient's home modifications, orthotic and prosthetic devices, and durable medical equipment.</td>
<td>A, C, D, E</td>
<td>A, C, D</td>
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<td>A, C, D, E</td>
<td>A, C, D</td>
</tr>
</tbody>
</table>

### Teaching Methods
- A. Reading
- B. Rounds
- C. Educational Lectures
- D. Direct Patient Care
- E. Resident/Attending Mentoring
- F. Educational Modules

### Assessment Methods
- A. Direct and Indirect Observation by Snr Residents/Attendings
- B. In-Service Training Exam
- C. OSCE
- D. Rotation Evaluation
- E. 360 Multi-Rater Evaluation
- F. Patient Survey
### MEDICAL KNOWLEDGE- INPATIENT

<table>
<thead>
<tr>
<th>PGY 2 Medical Knowledge: To understand biomedical, clinical, and socio-behavioral knowledge about patient care in a hospital setting.</th>
<th>PGY 3 Medical Knowledge: To understand biomedical, clinical, and socio-behavioral knowledge about patient care in a hospital setting.</th>
<th>PGY 4 Medical Knowledge: To understand biomedical, clinical, and socio-behavioral knowledge about patient care in a hospital setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td><strong>Teaching Methods</strong></td>
<td><strong>Assessments</strong></td>
</tr>
<tr>
<td>a. Residents will demonstrate the ability to conduct online searches of primary medical literature relevant to PM&amp;R inpatient topics.</td>
<td>A, C, E</td>
<td>A, Crisk handling and trauma care.</td>
</tr>
</tbody>
</table>
| b. Residents will develop knowledge of basic & clinical science that relates to inpatient Physical Medicine and Rehabilitation. | A, B, C, D | A, E
| c. Residents will apply this knowledge (as above) in developing critical thinking, clinical problem solving and clinical problem solving skills. | A, A, B, C, D, E | A, B, C, D, E |
| d. Residents will demonstrate basic skills in applying scientific principles in clinical decision-making. | A, B, C, D | A, B, C, D |
| e. Residents will demonstrate familiarity with the definition, concepts and methods of Evidence-Based Medicine. | A, C, E | A, B, C, D |
| f. Residents will demonstrate the ability to find practice-relevant information from appropriate resources on the Internet. | A, B, C, E | A, B, C, D |
| g. Residents will participate in the active review and dissemination of current developments in medical knowledge. | A, B, C, E | A, B, C, D |
| **Objectives** | **Teaching Methods** | **Assessments** |
| a. Residents will demonstrate the ability to appraise the scientific merit and generalizability of primary medical literature to their daily clinical inpatient practice. | A, B, C, D | A, B, C, D |
| b. Residents will develop in-depth and detailed knowledge of basic and clinical science that makes up Physical Medicine & Rehabilitation. | A, B, C, D | A, B, C, D |
| c. Residents will demonstrate proficiency in the application of this knowledge (as above) in developing critical thinking and clinical problem solving skills. | A, B, C, D, E | A, B, C, D, E |
| d. Residents will demonstrate proficiency in applying scientific principles in clinical-decision making. | A, B, C, D | A, B, C, D |
| e. Residents will demonstrate the ability to interpret Evidence-Based Medicine from the PM&R literature and apply this to aid patient care. | A, B, C, D | A, B, C, D |
| f. Residents will demonstrate an advanced knowledge of research design and methods. | A, B, C, D | A, B, C, D |
| g. Residents will formulate a diagnosis and provide a list of differential diagnoses | A, B, C, D | A, B, C, D |

### Teaching Methods
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### Assessment Methods
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### Teaching Methods

**A. Reading**

**B. Rounds**

**C. Educational Lectures**

**D. Direct Patient Care**

**E. Resident/Attending Mentoring**

**F. Educational Modules**

### Assessment Methods

**A. Direct and Indirect Observation by Srn Residents/Attendings**

**B. In-Service Training Exam**

**C. OSCE**

**D. Rotation Evaluation**

**E. 360 Multi-Rater Evaluation**

**F. Patient Survey**
<table>
<thead>
<tr>
<th>PGY 2 Systems-Based Practice: Understand and access the healthcare systems at participating institutions in order to provide optimal inpatient care.</th>
<th>PGY 3 Systems-Based Practice: Understand and access the healthcare systems at participating institutions in order to provide optimal inpatient care.</th>
<th>PGY 4 Systems-Based Practice: Understand and access the healthcare systems at participating institutions in order to provide optimal inpatient care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td><strong>Teaching Methods</strong></td>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td>a. Residents will demonstrate an understanding of the contexts and systems in which health care is provided, and demonstrate the ability to apply this knowledge to improve and optimize health care.</td>
<td>D, E</td>
<td>a. Residents will demonstrate skill in advocating and facilitating patients’ engagement with the health care system in all of its dimensions.</td>
</tr>
<tr>
<td>b. Residents will understand the process for requesting and providing appropriate inpatient consultations for their patients.</td>
<td>D, E</td>
<td>b. Residents will demonstrate skill in selecting appropriate ancillary services for specific clinical problems.</td>
</tr>
<tr>
<td>c. Residents will demonstrate the ability to apply strategies for diagnosis, disease management, and prevention of secondary complications.</td>
<td>A, C, D</td>
<td>c. Residents will demonstrate skill in utilizing health care resources efficiently and prudently.</td>
</tr>
<tr>
<td>d. Residents will understand the appropriate roles of the members of the inpatient rehabilitation team.</td>
<td>A, D</td>
<td>d. Residents will demonstrate skill in coordinating the functions of the inpatient rehabilitation team.</td>
</tr>
<tr>
<td>e. Residents will demonstrate skill in performing daily discharge and predischarge duties.</td>
<td>D, E</td>
<td>e. Residents will demonstrate skill in facilitating and coordinating complex discharge functions.</td>
</tr>
<tr>
<td>f. Residents will demonstrate ability to maintain timely and accurate medical records.</td>
<td>D, E</td>
<td>f. Residents will demonstrate skill in modeling and teaching the appropriate maintenance of medical records.</td>
</tr>
<tr>
<td>g. Residents will demonstrate accuracy and thoroughness in patient sign outs/hand offs.</td>
<td>E</td>
<td>g. Residents will demonstrate skill in teaching and modeling appropriate sign out/hand off techniques.</td>
</tr>
<tr>
<td>h. Resident will explain the importance of the role of each rehabilitation team member to the patient and family members.</td>
<td>A, D</td>
<td>h. Residents will demonstrate knowledge of the sources of financing for patients as appropriate to the medical context.</td>
</tr>
<tr>
<td>i. Residents will formulate precautions for the inpatient rehabilitation team, as necessary.</td>
<td>A, D</td>
<td>i. Residents will formulate precautions for the inpatient rehabilitation team, as necessary.</td>
</tr>
<tr>
<td>j. Residents will identify and interact with a team of rehabilitation professionals essential to optimal management of an inpatient’s rehabilitation problem(s).</td>
<td>D, E</td>
<td>A</td>
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</tr>
<tr>
<td>k. Residents will understand the basic elements required for prescribing a rehabilitation program for a patient.</td>
<td>D, E</td>
<td>A</td>
</tr>
</tbody>
</table>

**Teaching Methods**

A. Reading

B. Rounds

C. Educational Lectures

D. Direct Patient Care

E. Resident/Attending Mentoring

F. Educational Modules

**Assessment Methods**

A. Direct and Indirect Observation by Snr Residents/Attendings

B. In-Service Training Exam

C. OSCE

D. Rotation Evaluation

E. 360 Multi-Rater Evaluation

F. Patient Survey
## INTERPERSONAL AND COMMUNICATION SKILLS - INPATIENT

<table>
<thead>
<tr>
<th>PGY 2 Interpersonal and Communication Skills: To have communication with patients, families, and other health care professionals in the inpatient rehabilitation setting.</th>
<th>PGY 3 Interpersonal and Communication Skills: To have communication with patients, families, and other health care professionals in the inpatient rehabilitation setting.</th>
<th>PGY 4 Interpersonal and Communication Skills: To have communication with patients, families, and other health care professionals in the inpatient rehabilitation setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td><strong>Teaching Methods</strong></td>
<td><strong>Assessments</strong></td>
</tr>
<tr>
<td>a. Residents will develop effective and professional relationships with patients, families, and colleagues.</td>
<td>D, E</td>
<td>A, D, E</td>
</tr>
<tr>
<td>b. Residents will demonstrate the ability to use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families.</td>
<td>D, E</td>
<td>A, D, F</td>
</tr>
<tr>
<td>c. Residents will demonstrate the ability to provide their patients and families with clear information about their treatment programs and accepted alternatives.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>d. Residents will demonstrate the ability to convey bad news while supporting the emotional needs of the recipients and their families.</td>
<td>C, D, E</td>
<td>A, D, E</td>
</tr>
<tr>
<td>e. Residents will demonstrate the ability to write clear medical notes, orders in the medical chart, and requests for consultation.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>f. Residents will demonstrate the ability to obtain and record an appropriately detailed and pertinent clinical history including the chief complaint, history of present illness, past medical history and comorbid conditions, family and social history, and functional history.</td>
<td>A, D, E</td>
<td>A, C, D</td>
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</tbody>
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<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>a. Residents will sustain effective and professional relationships with patients, families, and colleagues, including listening skills.</td>
<td>D, E</td>
<td>A, D, E</td>
</tr>
<tr>
<td>b. Residents will demonstrate competency in the use of effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>c. Residents will demonstrate competence in providing their health care team, patients and families with clear information about their treatment programs and accepted alternatives.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>d. Residents will demonstrate the ability to teach members of their team to convey bad news while supporting the emotional needs of the recipients and their families.</td>
<td>C, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>e. Residents will demonstrate competence in teaching their team members to write clear medical notes, orders in the medical chart, and requests for consultation.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>f. Residents will demonstrate proficiency in the ability to obtain and record an appropriately detailed and pertinent clinical history.</td>
<td>A, D, E</td>
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<tr>
<td>a. Residents will demonstrate proficiency in effective and professional communication for all members of the house staff team, including listening skills.</td>
<td>D, E</td>
<td>A, D, E</td>
</tr>
<tr>
<td>b. Residents will teach and model effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>c. Residents will demonstrate proficiency in providing their health care team, patients and families with clear information about their treatment programs and accepted alternatives in guiding patients and families in making difficult decisions.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>d. Residents will demonstrate proficiency in teaching members of their team to convey bad news while supporting the emotional needs of the recipients and their families.</td>
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</table>

**Teaching Methods**

A. Reading

B. Rounds

C. Educational Lectures

D. Direct Patient Care

E. Resident/Attending Mentoring

F. Educational Modules

**Assessment Methods**

A. Direct and Indirect Observation by Snr Residents/Attendings

B. In-Service Training Exam

C. OSCE

D. Rotation Evaluation

E. 360 Multi-Rater Evaluation

F. Patient Survey
### PROFESSIONALISM - INPATIENT

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<thead>
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<th>PGY 2 Professionalism: To project a professional attitude and carry out responsibilities in a professional manner.</th>
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<td></td>
<td><strong>C. Educational Lectures</strong></td>
<td><strong>F. Educational Modules</strong></td>
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<td></td>
<td><strong>D. Direct Patient Care</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Outpatient Goals & Objectives

<table>
<thead>
<tr>
<th>PATIENT CARE - OUTPATIENT</th>
<th>PGY 2 Patient Care: To provide compassionate, appropriate, and effective diagnosis and treatment for all assigned patients seen in the outpatient setting.</th>
<th>PGY 3 Patient Care: To provide compassionate, appropriate, and effective diagnosis and treatment for all assigned patients seen in the outpatient setting.</th>
<th>PGY 4 Patient Care: To provide compassionate, appropriate, and effective diagnosis and treatment for all assigned patients seen in the outpatient setting.</th>
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<td><strong>Teaching Methods</strong> / <strong>Assessments</strong></td>
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<td><strong>Teaching Methods</strong> / <strong>Assessments</strong></td>
</tr>
<tr>
<td>a. Residents will obtain concise and pertinent medical history of the chief complaint(s).</td>
<td>D, E A, D</td>
<td>a. Residents will obtain concise and pertinent medical history of the chief complaint(s).</td>
<td>D, E A, D</td>
</tr>
<tr>
<td>b. Residents will obtain accurate and pertinent co-morbid medical history</td>
<td>D, E A</td>
<td>b. Residents will obtain accurate and pertinent co-morbid medical history</td>
<td>D, E A</td>
</tr>
<tr>
<td>c. Residents will conduct a concise, competent, and pertinent physical exam relevant to the chief complaint(s).</td>
<td>D, E A, C, D</td>
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<td>D, E A, C, D</td>
</tr>
<tr>
<td>d. Residents will select and interpret appropriate radiological imaging studies &amp; reports and other diagnostic tests &amp; results and utilize the information to determine, monitor or adjust the rehabilitation diagnosis and plan.</td>
<td>A, C, D</td>
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<td>A, C, D</td>
</tr>
<tr>
<td>e. Residents will determine and analyze the rehabilitation goals and develop a rehabilitation program including appropriate monitoring and follow up for the patient</td>
<td>D, E A</td>
<td>e. Residents will determine and analyze the rehabilitation goals and develop a rehabilitation program including appropriate monitoring and follow up for the patient</td>
<td>D, E A</td>
</tr>
<tr>
<td>f. Residents will establish a diagnosis and formulate a list of differential diagnoses</td>
<td>A, C, D</td>
<td>f. Residents will establish a diagnosis and formulate a list of differential diagnoses</td>
<td>A, C, D</td>
</tr>
<tr>
<td>g. Residents will evaluate the need for and when appropriate, prescribe self-help aids, orthotic and prosthetic devices, medical equipment, therapeutic exercise, and modalities and physical agents.</td>
<td>A, C, D</td>
<td>g. Residents will demonstrate competence in evaluating the need for and when appropriate, prescribing self-help aids, orthotic and prosthetic devices, medical equipment, therapeutic exercise, and modalities and physical agents.</td>
<td>A, C, D</td>
</tr>
</tbody>
</table>

### Teaching Methods

A: Attending; C: Case Presentation; D: Didactic; E: Electronic Case Presentation; F: Field Experience; P: Patient Care
h. Residents will demonstrate knowledge of the indications, contraindications and appropriate techniques for common physiatric diagnostic and therapeutic injection procedures and basic skill in the performance of these procedures.

<table>
<thead>
<tr>
<th>Teaching Methods</th>
<th>Assessment Methods</th>
</tr>
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<tbody>
<tr>
<td>A. Reading</td>
<td>A. Direct and Indirect Observation by Sr Residents/Attendings</td>
</tr>
<tr>
<td>B. Rounds</td>
<td>B. In-Service Training Exam</td>
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<td>C. OSCE</td>
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<td>D. Direct Patient Care</td>
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<tr>
<td>E. Resident/Attending Mentoring</td>
<td>E. 360 Multi-Rater Evaluation</td>
</tr>
<tr>
<td>F. Educational Modules</td>
<td>F. Patient Survey</td>
</tr>
</tbody>
</table>
### MEDICAL KNOWLEDGE - OUTPATIENT

<table>
<thead>
<tr>
<th>PGY 2 Medical Knowledge: To understand biomedical, clinical, and socio-behavioral knowledge about patient care in an outpatient setting.</th>
<th>PGY 3 Medical Knowledge: To understand biomedical, clinical, and socio-behavioral knowledge about patient care in an outpatient setting.</th>
<th>PGY 4 Medical Knowledge: To understand biomedical, clinical, and socio-behavioral knowledge about patient care in an outpatient setting.</th>
</tr>
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<tbody>
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<tr>
<td><strong>Teaching Methods</strong></td>
<td><strong>Assessments</strong></td>
<td><strong>Teaching Methods</strong></td>
</tr>
<tr>
<td>a. Residents will develop knowledge of basic &amp; clinical science that relates to Physical Medicine and Rehabilitation.</td>
<td>A, C</td>
<td>B, C, D</td>
</tr>
<tr>
<td>b. Residents will utilize knowledge (as above) in developing critical thinking, clinical problem solving, and decision making skills.</td>
<td>C, D</td>
<td>A, B, D</td>
</tr>
<tr>
<td>c. Residents will demonstrate familiarity with the definition, concepts and methods of Evidence-Based Medicine.</td>
<td>C, D, E</td>
<td>A, B, D</td>
</tr>
<tr>
<td>d. Residents will demonstrate the ability to conduct appropriate searches of the scientific literature.</td>
<td>C, D</td>
<td>A, D</td>
</tr>
<tr>
<td>e. Residents will demonstrate the ability to find PM&amp;R practice-relevant information on the Internet.</td>
<td>C, E</td>
<td>A, E</td>
</tr>
<tr>
<td>f. Residents will demonstrate basic competence in applying scientific principles in clinical decision-making.</td>
<td>C, E</td>
<td>A, D</td>
</tr>
<tr>
<td>g. Residents will participate in the active review and dissemination of current developments in medical knowledge.</td>
<td>A, C, D</td>
<td>A, C, D</td>
</tr>
</tbody>
</table>

### Teaching Methods

A. Reading  
B. Rounds  
C. Educational Lectures  
D. Direct Patient Care  
E. Resident/Attending Mentoring  
F. Educational Modules

### Assessment Methods

A. Direct and Indirect Observation by Snr Residents/Attendings  
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C. OSCE  
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F. Patient Survey
### PRACTICE-BASED LEARNING AND IMPROVEMENT (PBLI) - OUTPATIENT

<table>
<thead>
<tr>
<th>PGY 2 Practice-Based Learning and Improvement</th>
<th>PGY 3 Practice-Based Learning and Improvement</th>
<th>PGY 4 Practice-Based Learning and Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematically analyze resident outpatient practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
<td>Systematically analyze resident outpatient practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
<td>Systematically analyze resident outpatient practice using quality improvement methods, and implement changes with the goal of practice improvement.</td>
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</tbody>
</table>

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<tr>
<th>Objectives</th>
<th>Teaching Methods</th>
<th>Assessments</th>
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<th>Assessments</th>
<th>Objectives</th>
<th>Teaching Methods</th>
<th>Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Residents will demonstrate an understanding of the tools and methodology for assessing outpatient practices.</td>
<td>D, E</td>
<td>A, D</td>
<td>a. Residents will demonstrate the ability to apply PBLI tools and methods to their own practice.</td>
<td>D, E</td>
<td>A, D</td>
<td>a. Residents will demonstrate skill in incorporating novel PBLI tools and methodology in their own practice.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>b. Residents will demonstrate skill in the utilization of the results of practice analysis in improving one aspect of the quality of their outpatient care.</td>
<td>D, E</td>
<td>A, D</td>
<td>b. Residents will demonstrate ongoing application of PBLI in order to achieve continuous quality improvement in their outpatient practice.</td>
<td>D, E</td>
<td>A, D</td>
<td>b. Residents will demonstrate proficiency in monitoring and improving the performance measures of the outpatient team.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>c. Residents will demonstrate basic skill in utilizing data from electronic and/or non-electronic medical record system(s) available at their assigned institution for outpatient practice analysis.</td>
<td>D, E</td>
<td>A, D</td>
<td>c. Residents will demonstrate competence in utilizing data from electronic and/or non-electronic medical record system(s) available at their assigned institution for outpatient practice analysis.</td>
<td>D, E</td>
<td>A, D</td>
<td>c. Residents will demonstrate proficiency in utilizing data from electronic and/or non-electronic medical record system(s) available at their assigned institution for practice analysis and for monitoring the performance measures of the outpatient rehabilitation team.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>d. Residents will identify at least three performance measures as they pertain to quality improvement in their assigned outpatient clinic.</td>
<td>E</td>
<td>A</td>
<td>d. Residents will demonstrate understanding of how improvement in performance measures are related to the outpatient practice of their assigned clinic.</td>
<td>E</td>
<td>A</td>
<td>d. Residents will demonstrate an understanding of using outcomes research in formulating new outpatient performance measures.</td>
<td>E</td>
<td>A</td>
</tr>
</tbody>
</table>

### Teaching Methods

A. Reading
B. Rounds
C. Educational Lectures
D. Direct Patient Care
E. Resident/Attending Mentoring
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### Assessment Methods

A. Direct and Indirect Observation by Snr Residents/Attendings
B. In-Service Training Exam
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D. Rotation Evaluation
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F. Patient Survey
### SYSTEMS BASED PRACTICE - OUTPATIENT

<table>
<thead>
<tr>
<th>PGY 2 Systems-Based Practice: Understand and access the healthcare systems at participating institutions in order to provide optimal care.</th>
<th>PGY 3 Systems-Based Practice: Understand and access the healthcare systems at participating institutions in order to provide optimal care.</th>
<th>PGY 4 Systems-Based Practice: Understand and access the healthcare systems at participating institutions in order to provide optimal care.</th>
</tr>
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<tr>
<td><strong>Objectives</strong></td>
<td><strong>Teaching Methods</strong></td>
<td><strong>Assessments</strong></td>
</tr>
<tr>
<td>a. Residents will demonstrate an understanding of the contexts and systems in which health care is provided, and demonstrate the ability to apply this knowledge to improve and optimize health care.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>b. Residents will understand the process for requesting and providing appropriate outpatient consultations for their patients.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>c. Residents will demonstrate the ability to apply strategies for prevention, diagnosis, and disease management.</td>
<td>A, C, B, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>d. Residents will understand the appropriate roles of the members of the outpatient rehabilitation team.</td>
<td>A, D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>e. Residents will demonstrate skill in arranging, monitoring, and evaluating outcomes of post-discharge and pre-discharge, and outpatient rehabilitation interventions.</td>
<td>D, E</td>
<td>A</td>
</tr>
<tr>
<td>f. Residents will demonstrate ability to maintain timely and accurate medical records.</td>
<td>D, E</td>
<td>A, D</td>
</tr>
<tr>
<td>g. Residents will respond to consultations and make recommendations based on the musculoskeletal diagnosis(es), and co-morbidities within the context of optimizing benefit from the prescribed rehabilitation program.</td>
<td>A, D, E</td>
<td>A</td>
</tr>
<tr>
<td>h. Residents will formulate precautions for the outpatient rehabilitation team, as necessary.</td>
<td>A, D, E</td>
<td>A, D</td>
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</table>
i. Residents will educate the patient on complementary community-based exercise programs to optimize and maintain goals from the prescribed rehabilitation program.

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<td>A, C, D, E</td>
<td>A, D</td>
<td>A, C, D, E</td>
<td>A, D</td>
<td>A, C, D, E</td>
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j. Residents will organize a team of rehabilitation professionals essential to optimal management of an ambulatory patient's rehabilitation problem(s).

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k. Residents will understand the basic elements required for prescribing a rehabilitation program for a patient.

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**Teaching Methods**

A. Reading

B. Rounds

C. Educational Lectures

D. Direct Patient Care

E. Resident/Attending Mentoring

F. Educational Modules

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**Assessment Methods**

A. Direct and Indirect Observation by Snr Residents/Attendings

B. In-Service Training Exam

C. OSCE

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F. Patient Survey
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<th>PGY 2 Interpersonal and Communication Skills: To have communication with patients, families, and other health care professionals in the ambulatory setting.</th>
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<td>f. Residents will demonstrate the ability to obtain and record a concise and pertinent history of the present illness and the chief complaint(s).</td>
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<td>A, D, C, D</td>
</tr>
<tr>
<td>g. Residents will demonstrate the ability to determine and analyze the rehabilitation goals of a patient.</td>
<td>D, E</td>
<td>A, D</td>
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</tbody>
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**Teaching Methods**
- A: Active Learning
- B: Block Teaching
- C: Case Based Learning
- D: Didactic
- E: Experiential Learning
- F: Expert Demonstration
- G: Group Discussion
- H: Journal Club
- I: Lecture
- J: Family Teaching Day
- K: Observation
- L: Role Play
- M: Simulation
- N: Small Group Teaching
- O: Teaching Rounds
- P: Tutorials
- Q: Workshops

**Assessments**
- A: Admission Evaluation
- B: Progress Notes
- C: Problem List
- D: Physical Examination
- E: Process Notes
- F: Teaching Plan
- G: Teaching Report
- H: Teaching Summary
- I: Teaching Test
- J: Teaching Evaluation
- K: Teaching Conference
- L: Teaching Portfolio
- M: Teaching Observation
- N: Teaching Observation Report
- O: Teaching Observation Conference
- P: Teaching Observation Summary

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65
### PROFESSIONALISM - OUTPATIENT

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**Objectives**

| a. Residents will demonstrate respect, compassion, and integrity and will demonstrate the ability to interact with other health care team members and peers in a professional manner. | a. Residents will achieve proficiency in the ability to demonstrate respect, compassion, and integrity and in the ability to interact with other health care team members and peers in a professional manner. | a. Residents will demonstrate proficiency in and the ability to teach and model attitudes of respect, compassion, and integrity in relationships and interaction with other health care team members and staff. |

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<tr>
<td>C. Educational Lectures</td>
<td>D, E, F</td>
</tr>
<tr>
<td>D. Direct Patient Care</td>
<td>A, C, D, E</td>
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<tr>
<td>E. Resident/Attending Mentoring</td>
<td>A, D, E, F</td>
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<tr>
<td>F. Educational Modules</td>
<td>A, D, E, F</td>
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</tbody>
</table>

**Teaching Methods**

- A. Reading
- B. Rounds
- C. Educational Lectures
- D. Direct Patient Care
- E. Resident/Attending Mentoring
- F. Educational Modules

**Assessment Methods**

- A. Direct and Indirect Observation by Snr Residents/Attendings
- B. In-Service Training Exam
- C. OSCE
- D. Rotation Evaluation
- E. 360 Multi-Rater Evaluation
- F. Patient Survey
Electrodiagnostic Medicine

Contacts: Kim McGaughey, PMRS Program Manager
kimberly.mcgaughey@va.gov (501) 257-6397
Preceptors: John Tait, MD
Rotation Length: Three months

Clinical Settings:
Performance expectations:
Core Topics:
Procedures:

Educational Objectives:

<table>
<thead>
<tr>
<th>Patient Care</th>
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<tbody>
<tr>
<td>Perform a comprehensive history and physical evaluation of each patient and</td>
<td>to provide a concise differential diagnosis and EDX evaluation</td>
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<tr>
<td>provide a concise differential diagnosis and EDX evaluation plan</td>
<td>plan</td>
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<tr>
<td>Describe the variety of conditions frequently encountered in electrodiagnostic</td>
<td>medicine</td>
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<td>medicine</td>
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<tr>
<td>Determine a logical approach of testing for each individual condition</td>
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<tr>
<td>Discuss the electrophysiology of common normal and abnormal findings</td>
<td>encountered in Electromyography and Nerve conduction studies</td>
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<tr>
<td>encountered in Electromyography and Nerve conduction studies (EMG/NCS)</td>
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<tr>
<td>Familiarize oneself with the EMG/NCS machine and be able to troubleshoot</td>
<td>common errors and problems encountered in EMG/NCS testing</td>
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<td>common errors and problems encountered in EMG/NCS testing</td>
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<tr>
<td>Identify patient and family concerns associated with the testing process</td>
<td>as well as the results</td>
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<td>as well as the results</td>
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<tr>
<td>Define the patient safety issues with EMG/NCS including proper maintenance,</td>
<td>machine with implanted cardiac devices (e.g. pacemaker), risk of</td>
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<tr>
<td>machine with implanted cardiac devices (e.g. pacemaker), risk of blood born</td>
<td>blood borne pathogen exposure, and safety in patients</td>
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<td>pathogen exposure, and safety in patients</td>
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<tr>
<td>Obtain appropriate informed consent for the procedure</td>
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<tr>
<td>Respect that the patient is experiencing an uncomfortable procedure</td>
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<tr>
<td>Medical Knowledge</td>
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<tr>
<td>Instrumentation</td>
<td></td>
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<tr>
<td>Describe the purpose of the EMG/NCV recording device</td>
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<tr>
<td>Identify the relative contraindications to electrodiagnosis</td>
<td></td>
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<tr>
<td>Identify the complications of electrodiagnosis</td>
<td></td>
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<tr>
<td>List the components of the EMG machine and their purpose</td>
<td></td>
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<tr>
<td>Discuss the concept of differential amplification and the purpose of G1 and G2 electrodes</td>
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<tr>
<td>Define sensitivity and gain</td>
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<tr>
<td>Describe the differences between monopolar and concentric needles in terms of recording area, noise and wave form characteristics</td>
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<tr>
<td>List at least three ways to reduce stimulus artifact</td>
<td></td>
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<tr>
<td>Give examples of high and low frequency responses commonly seen during Electrodiagnostic studies</td>
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<tr>
<td>Discuss the effects of inadequate or excessive stimulus intensity</td>
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<tr>
<td>List five causes of electrical interference and how to minimize them</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Knowledge, Cont’d</th>
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</thead>
<tbody>
<tr>
<td>Nerve conduction Studies (NCS)</td>
</tr>
<tr>
<td>Describe the proper placement of recording, reference and ground electrodes for common NCS; recognize proper stimulation sites; measure the latencies and calculate conduction velocities</td>
</tr>
<tr>
<td>State the various physiological factors, which can influence the electrodiagnostic results, e.g., age, body temperature, volume conduction, electrical interferences, and measurement error</td>
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<tr>
<td>Memorize normal values for distal latencies amplitudes and conduction velocities of commonly performed motor and sensory NCS</td>
</tr>
<tr>
<td>Measure sensory latencies and amplitudes of median, ulnar, radial, superficial peroneal, dorsal ulnar cutaneous nerve, and medial/lateral antebrachial cutaneous nerves</td>
</tr>
<tr>
<td>Measure motor latencies, amplitude and conduction velocities of median, ulnar, radial, peroneal, and tibial nerves</td>
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<tr>
<td>Distinguish between the late responses (H, F, A) waves, their etiology and clinical significance</td>
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<tr>
<td>Demonstrate the ability to perform H reflex and F wave studies and interpret the results</td>
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<tr>
<td>Differentiate between axon loss and conduction block</td>
</tr>
<tr>
<td>Demonstrate the ability to perform and diagnose upper and lower extremity nerve entrapments and radiculopathies</td>
</tr>
<tr>
<td>Differentiate axonal versus demyelinating type of peripheral neuropathies</td>
</tr>
<tr>
<td>Demonstrate the ability to diagnose neuropraxia versus axonotmetic and neurotmetic nerve lesion in mononeuropathies</td>
</tr>
</tbody>
</table>
### Practice-Based Learning and Improvement
- Review the literature for electrodiagnostic medicine “Best Practices” for neuromuscular disorders
- Disseminate these “Best Practices” to patients, consultants, and staff

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

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

### System-Based Practice
- Appreciate when electrodiagnostic medicine procedures are most appropriately rendered to maximize information gain and patient outcome
- Appreciate when electrodiagnostic medicine procedures are/are not cost-effective for the patient and health care system
- Understand where electrodiagnostic medicine testing “fits” in the continuum-of-care for persons with neurologic disorders
Arkansas Children’s Hospital Burn Clinic

Contacts: Tiffany Teague, Nurse Practitioner
TGETeague@uams.edu

Preceptors: Esther Teo, MD

Rotation Length: Last Thursday, monthly – upper level resident on UAMS Outpatient Rotation

Clinical Settings: ACH Burn Clinic

Performance expectations: Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. PM&R Department leave/vacation policy will apply.

Educational Objectives:

- Understand, discuss, and manage the secondary complications from burns/wounds
- Contracture management
- Compression garment management, selection of appropriate garments
- Edema management
- Wound care, including but not limited to medications to promote wound healing and infection prevention
- Working with an interdisciplinary burn and wound care team
Prolo Little Rock - Interventional

**Contacts:** Brent Sprinkle, DO  [brent@prololittle.com](mailto:brent@prololittle.com)

**Preceptors:** Dr. Brent Sprinkle

**Rotation Length:** Varies - upper level resident on UAMS Outpatient Rotation

**Clinical Settings:** Prolo Little Rock, 6020 Ranch Dr., Suite C-5

**Performance expectations:** Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. PM&R Department leave/vacation policy will apply.

**Educational Objectives:**
OrthoArkansas - Interventional

**Contacts:**  Stephen Paulus, MD  spaulus@orthoarkansas.com

**Preceptors:**  Dr. Stephen Paulus

**Rotation Length:**  Varies - upper level resident on UAMS Outpatient Rotation

**Clinical Settings:**  OrthoArkansas, 10301 Kanis Road

**Performance expectations:**  Residents are expected to arrive to their clinical assignments promptly and to notify their attending faculty preceptor in advance of any schedule changes. PM&R Department leave/vacation policy will apply.

**Educational Objectives:**
UAMS Department of Physical Medicine and Rehabilitation
Scheduled Didactic Activities for Residents 2018-2019

Below is a general schedule, however, events are changed & updated on the PM&R website.

<table>
<thead>
<tr>
<th>Week</th>
<th>Tuesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>First</td>
<td>7:00-8:00 am Resident-Led Board/Chapter Review&lt;br&gt;8:00-9:00 am Faculty Lecture</td>
<td>7:00-8:00 am Mentor Group Work&lt;br&gt;8:00-9:00 am PM&amp;R Clinical Case Reviews</td>
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<tr>
<td>Second</td>
<td>7:00-8:00 am Resident-Led Board/Chapter Review&lt;br&gt;8:00-9:00 am Faculty Lecture</td>
<td>7:00-8:00 am Resident-Led Board/Chapter Review&lt;br&gt;8:00-9:00 am Resident Seminar (topic follows lecture series)</td>
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<tr>
<td>Third</td>
<td>7:00-8:00 am Resident-Led Board/Chapter Review&lt;br&gt;8:00-9:00 am Faculty Lecture</td>
<td>7:00-8:00 am Resident-Led Board/Chapter Review&lt;br&gt;8:00-9:00 am PM&amp;R Clinical Case Reviews OR 8:00-9:00 am Journal Club (every other month, 6 sessions)</td>
<td>12:00 pm Invitational Lecture/Wellness Lecture OR</td>
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<tr>
<td>Fourth</td>
<td>7:00-8:00 am Resident-Led Board/Chapter Review&lt;br&gt;8:00-9:00 am Faculty Lecture</td>
<td>7:00-8:00 am Faculty-Supervised Board Review&lt;br&gt;8:00-9:00 am Grand Rounds OR M&amp;M Conference (quarterly)</td>
<td>12:00 pm Invitational Lecture/Wellness Lecture</td>
</tr>
<tr>
<td>Fifth</td>
<td>7:00-8:00 am Resident-Led Board/Chapter Review&lt;br&gt;8:00-9:00 am Faculty Lecture</td>
<td>7:00-8:00 am Resident-Led Board/Chapter Review&lt;br&gt;8:00-9:00 am Resident Seminar (topic follows lecture series)</td>
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UAMS Department of Physical Medicine and Rehabilitation
Resident Grand Rounds

FREQUENCY: Monthly (4th Thursday) from 8:00 – 9:00 am

LOCATION: PM&R Spine, 7th Floor Conference Room

OBJECTIVES:
1. To address current concepts in PM&R.
2. To teach PM&R issues to residents, faculty, and community physicians.
3. Illustrate areas needing further study that physicians should be aware of.

FORMAT: The resident (in consultation with the attending physician) will select an appropriate patient to present. Preferably one with positive physical findings that can be demonstrated to the audience. Cases may be chosen for several reasons.

1. An unusual or complex problem.
2. A typical example of a common condition to review current management strategy.
3. An interesting or novel approach in management.
4. An aspect of care not covered through other didactic means.

The preparation for Grand Rounds should include a pertinent literature review, but not in the depth required for seminar presentation. Physical Medicine and Rehabilitation faculty or others who have expertise in the subject to be presented can be asked to prepare comments about the subject. It is best to speak to these discussants sufficiently in advance so they may prepare their remarks.

The sequence of presentation should be:

1. Brief outline of the pertinent history and physical – handouts are helpful
2. Presentation of the patient with demonstration of physical findings.
3. Review of the topic by the resident
4. Group discussion.
5. Evaluation form.

Pertinent handouts should be prepared to include a bibliography (2-3 references), which residents may keep on file for future reference. Label handouts:

Grand Rounds
Resident name
Date

Reviewed/Revised: 11/10/2015
UAMS Department of Physical Medicine and Rehabilitation  
Resident Seminars

TIME: 8:00 - 9:00 am

DAY: Monthly following the Anatomy Series; 2nd and 5th Thursdays

LOCATION: PM&R Spine, 7th Floor Conference Room

OBJECTIVES:
1. Analyze in-depth specific topics in PM&R.
2. Demonstrate effective teaching and presentation skills.

WHO SHOULD ATTEND: All Residents and Faculty

FORMAT: Each resident will be expected to present two formal seminars per year. The seminar should be an in-depth report on a subject pertinent to Physical medicine and Rehabilitation. There will be a general theme for each quarter (which may be basic science or clinical oriented) and the subject selected must relate to this theme. Seminars are not intended to be a broad review of a subject.

Unacceptable examples:
- Stroke rehabilitation
- Rheumatoid arthritis
- Orthotics for the lower extremities

Acceptable examples:
- Heat regulation and the effects of ultra-sound vs. superficial heat
- Cerebral blood flow
- Pathophysiology of the myoneural junction
- Cerebral lateralization
- Pathophysiology and management of decubitus ulcers
- Neurologic outcomes in low birth weight and very low birth weight infants
- C1-C2 dislocation in rheumatoid arthritis
- Steroid myopathy*

* A specific entity (diagnosis) may be used as a subject when it is narrow by itself and can be covered in-depth by virtue of its limited focus and scarcity of literature.

In general, a relatively narrow focus will yield an in-depth study of a subject. As a guideline the content of a seminar should be at a quality suitable for publication in a refereed journal.
Residents should review their subject with a faculty member, program director or department head for advice about seminar preparation and approval of the selected topic.

Residents should provide handouts at the time of the seminar to include:

1. An outline of the presentation (with title, date, and name of the presenter at the top of the page).
2. A bibliography with at least 10 references used as part of the presentation.
3. Any pertinent supplements which will help the audience to understand, such as graphs, tables, etc.

Residents will send a copy of PPP to the Program Coordinator to display on Sharepoint.

All seminar attendees will complete an evaluation of the presentation.

Results of the seminar evaluation will be made available to the presenter from the Residency Program Coordinator.

Reviewed/Revised: 11/10/2015
UAMS Department of Physical Medicine and Rehabilitation
Resident Journal Club

**TIME:** Third Thursday from 8:00 – 9:00 am (Aug, Oct, Dec, Feb, April, June)

**LOCATION:** PM&R Conference Room

**OBJECTIVES:**
1. Demonstrate skills in clinically appraising the PM&R literature.
2. Apply findings to current patient care.
3. Illustrate areas needing further study that physicians should be aware of.
4. Demonstrate effective teaching and presentation skills.

**FORMAT:**

First Journal Club of the academic year will be Session 1 and the following scheduled Journal Clubs will alternate between Sessions 2 and 3. The final Journal Club of the academic year will be Session 4.

**Session 1 - How to Critically Assess/Approach a Journal Article**
Presented by UAMS Research Librarians

**Session 2 - Classic PM&R Article Journal Club**
Attending assigns up to two articles for residents to review two weeks in advance of Journal Club. Residents are guided by attending through discussion on why the articles are relevant and how to select appropriate journal articles for future Journal Clubs meetings.

**Session 3 - Clinical Question Journal Club**
A clinical question is assigned by attending a month before the meeting and two Mentor Groups tasked with selecting an article per group for the residents to review. The articles are sent to residents two weeks in advance for review. During the meeting, the group discusses each article and decides if the article is valid and appropriate.

**Session 4 - Study Design Journal Club**
Mentor Groups are to design a study based on proposed question. Questions is provided by attending with enough time for Mentor Groups to hold one monthly session to discuss study design.

Reviewed/Revised: 03/08/2018
UAMS Department of Physical Medicine and Rehabilitation
Resident Scholarly Activity Program

A) Goals: To develop an educated consumer of research and the scientific literature, through scholarship; and to promote the involvement of the Department of PM&R in scholarly activities.

B) Participation: Mandatory for all residents entering their PGY2 year.

C) Outcome:
   1) A professional presentation acceptable for presentation at a specific meeting.
   2) A paper which is appropriate for submission to a scientific journal.
      Scientific research projects are strongly encouraged; review papers and case reports are acceptable.

D) General Timetable:
   1) Early During the PGY2 year (by September 30th), residents will:
      a. Consult informally with PM&R faculty to develop ideas;
      b. Identify a prospective faculty member for this project. If necessary, research mentors may be selected from outside the Department of PM&R, but this should be discussed with the Research Committee first;
      c. Consult with the mentor and decide on a topic for the scholarly project.

   2) By midway through the PGY2 year (by December 31st), residents will:
      a. Submit the name of the mentor;
      b. Submit the topic of their scholarly project to the Residency Program office.
         This information will be distributed to and reviewed within 2 weeks by the Research Committee. Appropriate feedback will be provided to the resident.
      c. Complete required WebCT course(s).

   3) By the end of the PGY2 year (by June 30th), the resident will submit 150-300 word proposal in IRB format to the Residency Program office. This proposal will contain information about:
      a. A final decision on a mentor;
      b. A definitive topic;
      c. Objectives (specific purpose or questions to be answered) by doing the project;
      d. Methods to be used (hypothesis, subjects, procedures, analysis, etc.);
      e. Timetable;
      f. Budget, if applicable.
         Prior examples are available to assist as a guide in preparing this proposal. Mentors should play a major role in helping the resident to develop the proposal.
      g. PowerPoint presentation is required at Annual PM&R Research Forum.

4) The PM&R Residency Coordinator will distribute the proposals to all members of the Research Committee. The Research Committee chair will assign two members as
primary reviewers for each proposal. Primary reviewers will provide written comments. All committee members read each proposal and vote to approve as is, approve contingent upon specific changes, or to recommend revision. 

*Research Committee feedback will be provided to the resident and mentor within 2 weeks.* 

5) **Within 30 days of receiving Research Committee feedback,** residents should meet with the mentor, review the proposal feedback, make necessary revisions and if necessary, submit a revised proposal to the Research Committee through the Residency Program office. The above review process is repeated, as necessary. 

6) **During the PGY3 year,** the resident should proceed with a scholarly project, according to the established timetable. Frequent communication with the mentor during this time period is strongly advised. The project should be started and completed in enough time to allow for analysis of the data (if necessary) and preparation of the final report. The resident and mentor should plan well in advance, what meeting the work will be presented at and/or what journal it will be submitted to. 

7) **By the end of the PGY3 year (June 30th),** the resident should submit a manuscript or poster, an abstract and a written report to the PM&R Residency Coordinator who will distribute this material to all members of the Research Committee. 

   **Within 30 days (July 30th),** the Research Committee will review the reports and vote to approve or not approve. This information is provided to the PM&R Residency Program Director for inclusion in the resident’s education records. Reports not approved will need immediate corrective action taken with resubmission of a revised report to the Research Committee as soon as possible. This must be completed by December 31st – graduation may be delayed if not fulfilled. 

8) As soon as possible after completing the project and writing up the results, the resident should submit their work to a scientific meeting committee (in abstract form for presentation), or to a journal (in manuscript form for publication). *Note: Abstract submission deadlines may occur and should be met, before the final report will be due in the Residency Program office.* 
   a. The resident should be listed as first author if they completed at least the initial draft of the manuscript, although this should be discussed with the mentor. Authorship guidelines are available from several sources including the Journal of the American Medical Association (See JAMA Attachment on Sharepoint) 

Revised 4/23/2009
UAMS Department of Physical Medicine and Rehabilitation
Objective Structured Clinical Examination (OSCE)

I. History of the OSCE
   Developed about 21 years ago (around 1994).
   Was given every other year.
   Now given yearly in association with the Functional Anatomy and Physical Diagnosis course blocks.

II. Reasons for Development of the OSCE
   A) Skills assessment of musculoskeletal and peripheral nerve exam – we desire that our residents be the best in these areas because these exam skills form the basis for the treatment plan for patients.
   B) Functional assessment and musculoskeletal exam, in general, are not well taught in medical schools.
   C) Assessment using the OSCE has evolved to be coordinated and given at the end of the Functional Anatomy and Physical Diagnosis course blocks. These blocks are given yearly to strengthen our residents’ ability to be highly proficient in the musculoskeletal and peripheral nerve examination.
   D) Motivation for the residents to study these important parts of our specialty.
   E) Be able to evaluate the need for remediation.

III. Nuts and Bolts of the OSCE
   There are 5-6 patient assessment stations which include faculty with or without simulated patients. The residents are given a brief history. They are then to do a focused physical examination (either just watched/observed or told what to assess) or evaluated a videotape of a patient.

   They have 6 minutes at each station (but this time may be increased to 10 minutes).

   Prior to the OSCE, the faculty decide what parts of the physical exam the resident should complete at each station. The OSCE is scored as follows:
   A) Not done
   B) Done but incorrectly
   C) Done correctly

   At the end, the faculty give feedback to the residents as to what was expected at each station.

Revised 11/20/2015
In accordance with the UAMS COM GME Committee Policy on Recruitment and Appointment the following describes the eligibility requirements, the selection criteria and the procedure for appointment to the PM&R program.

The PM&R Residency program uses both objective and subjective criteria to select applicants. The Program Director and Departmental Chairperson are responsible for selection and appointment of residents to the program. The application process meets all requirements of the Equal Employment Opportunity and the Americans with Disability Acts and does not discriminate with regard to sex, race, age, religion, color, national origin, disability or veteran’s status. The criteria and processes for resident selection follow:

**Application Process**
1. Applicants should visit our website at [http://pmr.uams.edu/](http://pmr.uams.edu/) - click the Application Requirements link.
2. The program only accepts applications via Electronic Residency Application Service (ERAS) from applicants who are participating in the National Resident Matching Program (NRMP).
3. Only applications submitted through ERAS, which submits application materials from applicants and medical schools to the program director using the Internet, will be considered.

**PGY2 Process**
1. Applicants should visit our website at [http://pmr.uams.edu/](http://pmr.uams.edu/) - click the “Applying for Residency?” link.
2. We accept applications via ERAS from applicants who are participating in the NRMP.
3. Resident Selection and Evaluation Committee reviews all information and decides which applicant(s) are qualified for the position.
4. Committee determines priority order for offers.

**Eligibility**
All applicants must meet the following eligibility requirements:
1. Ability to carry out the duties as required of the PM&R program.
2. Proficient in the English language to include reading printed and cursive English, writing (printing or typing) English text, understanding spoken English on conversational and
medical topics, speaking English on conversational and medical topics as determined by the program director and/or selection committee.

3. Meet one of the following qualifications:
   a. Graduate of a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME).
   b. Graduate of a college of osteopathic medicine in the United States or Canada accredited by the American Osteopathic Association (AOA).
   c. Graduate of medical school outside the United States who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
   d. Graduate who holds a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction
   e. Graduate of a medical school outside the United States or Canada with the following qualifications:
      A currently valid certificate from the Education Committee for Foreign Medical Graduates (ECFMG), or
      A full and unrestricted license to practice medicine in a U.S. licensing jurisdiction

4. The ability to reside continuously in the U.S. for the length of training.

5. Must be physically capable (with reasonable accommodations) of performing a physical examination and other essential physical functions required of practicing medicine.

Selection

1. Applications are downloaded from ERAS and reviewed for eligibility and completion by the program coordinator. The following information must be received before the application will be considered and before an applicant is invited for an interview: medical school transcript, personal statement, curriculum vitae, citizenship status, USMLE Step 1 test score and/or COMLEX 1 test score, and three letters of recommendation.

2. Once an applicant has been found to meet minimal selection criteria, the program coordinator distributes applicant information to selection committee members for review.

3. The selection committee selects applicants to interview.

3. An applicant invited for an interview should review and be familiar with the terms, conditions and benefits of appointment (and employment) including financial support, vacation, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the resident and their family, and conditions under which living quarters, meals and laundry or the equivalents are provided. This information will be provided to all interviewed candidates on the date of interview. Applicants can also access much of this information through the UAMS Resident Handbook.

4. The interview consists of at least a half day with a minimum of two one-on-one interviews with faculty members, tours of UAMS and/or other facilities where residents will rotate, and at least two resident representatives meet with the applicant during dinner the evening before or during tours of the facilities.

5. Residents and faculty who interact with the applicant are encouraged to complete a written evaluation form to assess communication skills, clinical performance (if applicable), and personal qualities.

6. Criteria for selection include:
   Confirmation of eligibility requirements
Performance on standardized medical tests (COMLEX< USMLE)
Overall academic performance in medical school (or in former/current residency for PGY2 and above)
Recent clinical training or experience
Demonstrated ability to choose goals and complete the tasks necessary to achieve those goals
Maturity and emotional stability
Honesty, integrity and reliability
Lack of history of drug or alcohol abuse
Demonstrated interest and motivation to pursue a career in the specialty of PM&R
Prior research and publication experience
Verbal and written communication skills

To determine whether and to what degree applicants meet the above selection criteria, several sources of information are reviewed and considered including:

A. Letters of recommendation from faculty or former/current Program Director for PGY2 and above
B. Dean’s letter
C. Medical school transcript
D. Personal statement
E. Communications with the residency program coordinator, program director, and faculty interviews
F. The ability to reside continuously in the US for the length of the training

7. Following the interview, the Program Selection Committee (Program Director, Program Coordinator, at least 2 members of the Faculty, and Chief Resident(s)) reviews the applicant’s file and written interview evaluations and ranks the applicant based on the criteria above.
8. Following completion of discussion by the Program Selection Committee, the Program Director compiles a final rank list in priority order for submission to the NRMP.

Upon verification by the Program Director that the applicant has met eligibility requirements, completed the application process, and been selected according to established criteria, the applicant will begin the process of appointment and registration with the College of Medicine. An applicant is considered fully appointed and registered only after all of the following documents have been completed and returned to the Director of Housestaff Records. Once the Director of Housestaff Records has received all the documents, the applicant is registered in the payroll system to receive a stipend and may begin the residency program.
1. Documentation of a negative drug test
2. Verification of successful graduation if previously anticipated (e.g., final transcript, letter from registrar, copy of diploma, currently valid ECFMG certificate, if applicable)
3. All of the following with valid signature:
   a. Resident Agreement of Appointment (contract)
   b. Medical Records Agreement
   c. Attestation acknowledging receipt of GME Committee policies and procedures
   d. Confidential Practitioner Health Questionnaire
e. Employee Drug Free Awareness Statement
f. Housestaff Medical Screening Form
g. Post-Doctoral Medical Education Biographical Form

Accepted/Appointed residents should report to UAMS by the start of the new resident orientation. Residents that cannot report to start their residency by July 1 of the academic year will forfeit their appointment.
Quarterly: At the end of each rotation, the supervising faculty members are encouraged to complete an evaluation and review it with the resident before submitting it to the Residency Program Director.

In order to provide feedback to residents on their performance and to identify opportunities for improvement, faculty are encouraged (although not required) to provide a formal or informal evaluation of the resident halfway (mid-rotation) through the rotation so that strengths and weaknesses can be pointed out before the official evaluation at the completion of the rotation.

Criticisms should be made in a constructive manner whenever possible so the resident will know exactly what needs to be done to meet acceptable standards.

The resident should request the mid-rotation review if not initiated by the attending physician. Constructive criticism is difficult for most people to do and there is a tendency to avoid it whenever possible.

Semi-Annual: Each resident will meet with the residency program director twice a year (generally during December and May of each year of training) to discuss the resident’s progress, identify any problems and set goals/plans for the resident's training program. This meeting will also be an opportunity to discuss any problem areas within the Department's educational programs.

Annual: The American Board of PM&R requires that an annual evaluation form be completed on each resident in the program. The information provided will be a summary of the monthly (PGY1) and quarterly reports (PGY24) submitted at the end of each rotation by the supervising faculty member.
Evaluations of faculty by residents are carried out twice a year and are coordinated by the Program Coordinator using confidential evaluations in New Innovations. Faculty are rated in a number of areas (copy of the evaluation is located in the Appendix). In addition to the specific ratings there is also the opportunity for comments. Compilations of these individual evaluations are reviewed by the Program Director and forwarded to the Chairman of the department who in turns discusses results with the individual faculty members at their annual appreciative inquiry meeting. To preserve resident confidentiality, resident evaluations of faculty are only revealed and discussed with the individual faculty members on a six-month delayed basis and resident responses are made anonymously.
UAMS Department of Physical Medicine and Rehabilitation  
Residency Program Policy - Resident Leave  

Number: P.3  
Date Developed: 6/27/00  
Last Review/Revision: (8/17/2018)  

Vacation  

1. Residents receive 21 days (15 work days plus 6 weekend days) of paid vacation during each year of training. In addition, PGY4 residents receive an extra five days of vacation for the purpose of fellowship interviews or job interviews.  

2. Vacation cannot be "carried over" from one year to the next.  

3. Residents may take no more than 1 week (7 days) of vacation during each rotation. Also, residents may not take vacation on more than one of each particular day during a rotation. For example, one Monday, one Tuesday, etc. Exceptions will be considered for PGY4 residents going on interviews.  

4. Vacation will be requested in writing by June 1 prior to the beginning of the upcoming academic year or at least 45 days in advance of the vacation request (paperwork must be filled out and signed off of by the program director prior to 45 days). The form to request leave is included in this policy. Leave requests less than 45 days may only be approved by faculty, then by the Program Director; they are generally discouraged.  

5. No more than **ONE** PGY2-PGY4 resident may be on leave at any time. (The Program Director will consider exceptions for seniors attending a Board review course, AAPM&R Annual Meeting, AAP Annual Meeting, interviews, or other extenuating circumstances.)  

6. Residents graduating from the program may request vacation during the last week of June. These requests will be considered IF the resident has obtained approval IN ADVANCE from their attending faculty. The program director has final say on vacation requests. Otherwise, no vacation requests allowed the last week of June or the first two weeks of July.  

7. Vacation days taken the day before or day after a weekend/holiday will require that the weekend days also be charged to vacation, when the resident is not available for urgent/emergent call requests from the PM&R Chief(s) on those days. For example, if a resident will be out of town on a weekend and is using vacation the day before or day after the weekend – the entire weekend will be charged against vacation.  

8. No vacation will be granted during the first 2 weeks of July, week of Christmas, New Year’s Day or Thanksgiving week or during the week of the annual board review.
In general, when conflicts occur vacation requests will be given priority based on seniority, then by the date received. The final decision or exceptions to the above statements will be made by the Program Director.

**Holidays**

Resident physicians are not given holidays or compensatory time off for holidays worked. However, if a holiday occurs during a rotation, it will be at the discretion of the attending physician as to whether the resident will or will not report for duty on this day for their regular rotation assignment. However, residents who are excused from their regular rotation assignment by the rotation attending should report to the Program Director for an alternative assignment.

**Leave Without Pay**

The American Board of PM&R Booklet of Information states "a resident should not be absent from the residency training for more than six weeks yearly". This includes sick leave, vacation, maternity leave, military leave, leave for locum tenens, clinical trips, or work in another institution that is not an ACGME accredited residency." Regardless of institutional policies regarding absences, any leave time beyond six weeks would need to be made up by arrangement with the Program Director.

Under exceptional circumstances, leave without pay can be granted at the discretion of the Department Chairman. However, in order to be Board eligible at the end of training, it will be necessary to make up any absence exceeding six weeks per year. This is not easy to do because of funding restrictions, therefore this practice is to be discouraged unless absolutely necessary.

**Sick Leave**

1. Residents are provided up to 12 days of sick leave (including weekend days) for medical reasons during each year of training. Appropriate uses of sick leave are: doctor or dentist appointments, time off for medical reasons.

2. Sick leave cannot be "carried over" from one year to the next.

3. Sick leave in excess of 12 days requires special review by the Department Chairman/Program Director.

4. Sick leave requested for medical appointments MUST be requested in advance using the online Sick Leave Request Form. Unless sick leave is requested for urgent or emergency purposes ADVANCE NOTICE is required, if approval is not obtained in advance, vacation will be charged.

5. If sick leave is requested for medical reasons that do not allow advance notice the Resident must:
   a. Contact the Chief Resident by phone or pager—Chief Resident will assign coverage, if necessary,
b. Contact the assigned PM&R attending faculty member by phone or pager (i.e., ACH, BHRI, UAMS, VA),

c. Notify the Residency Program Director (via phone and email), and;

d. Notify the Residency Coordinator (via phone and email).

e. Complete the online Sick Leave Request Form as soon as possible.

**Educational Leave** – addressed in Educational & Administrative Leave, Number: P4
UAMS Department of Physical Medicine and Rehabilitation
Vacation Request Form for Upcoming Academic Year

(Please print)

Name_________________________________________

I am requesting consideration for 3 weeks of vacation from the following 5 weeks listed in order of preference:

1. Week starting Monday___________ and ending Sunday_______________    Approved___
2. Week starting Monday___________ and ending Sunday_______________    Approved___
3. Week starting Monday___________ and ending Sunday_______________    Approved___
4. Week starting Monday___________ and ending Sunday_______________    Approved___
5. Week starting Monday___________ and ending Sunday_______________    Approved___

Signature_________________________ Date_________________________

I understand that the Program Director will give consideration based on seniority and residency program coverage obligations.

Once I receive approval for the requested vacation weeks above, I will immediately begin the Procedure for Leave Request on pg. 93
UAMS Department of Physical Medicine and Rehabilitation
Resident Request for Leave with Pay

(Vacation, Sick Leave, Educational Leave, Administrative Leave and Military Leave)

This form MUST be approved 45 days BEFORE taking vacation, educational, administrative, military, or sick leave for medical appointments. If sick leave is taken for medical reasons (other than appointments) submit the form upon returning to work. *Use the online Leave Forms unless they are not available*

Name____________________________________________  Date____________________

I hereby request ____ day(s) of leave with pay during absence from duty beginning _______, 20__, and ending ____________, 20__.

This is to be charged to:
_____Vacation
_____Sick Leave (if unable to provide advance notice, please turn in form the day you return – fax to 225-0627)
_____Educational Leave to attend __________________________________________
_____Administrative Leave to attend __________________________________________
_____Military Leave

FOR OFFICE USE ONLY
Revised 10/22/2010

Approved by: (in the following order)

This request is not in violation of the Leave Request Policy. I also confirm that the resident requesting the leave has leave to take.

Residency Coordinator____________________________  Date: ________________

Coverage Resident_______________________________  Date: ________________

Chief Resident_______________________________  Date: ________________

Attending Faculty_______________________________  Date: ________________

Other Resident at same Institution: _________________  Date: ________________

Program Director_______________________________  Date: ________________

Department Chair_______________________________  Date: ________________
UAMS Department of Physical Medicine and Rehabilitation
Residency Program Policy - Educational & Administrative Leave

Number: P.4
Date Developed: 6/28/00

Last Review/Revision: 5/01/2015

Educational Leave:

1. **Educational Course** - Each PM&R resident is allowed one 4-day period of leave to attend an educational course at department expense provided they are presenting at the meeting. This must be taken during the PGY3 year or PGY4 year of training. Courses chosen must be approved IN ADVANCE by the Program Director and Department Chairman. The Department will provide up to $1,500.00 of funding to meet tuition costs, hotel/travel expenses, etc, per trip. Appropriate travel authorization forms must be completed and approved prior to the travel. This will be charged as Educational Leave and will not affect vacation. The resident will be expected to provide verification of their attendance and costs upon returning. Any costs in excess of the $1,500.00 will be the responsibility of the resident. All requirements pertaining to leave requests - i.e., scheduling 45 days in advance, arranging coverage, etc., will apply to the educational leave.

2. **Chief Resident** - Each chief resident will be permitted to attend one additional professional meeting of choice (usually AAPM&R/AAP Annual Meeting), including an additional $1,500 for travel expenses, etc. The above rules and benefits for an Educational Course apply.

3. **Paper Presentation** - Requests for educational leave for residents to present papers at professional meetings will be reviewed on an individual merit basis. The resident will be required to submit a paper for publication in order to receive additional educational leave and up to $1,500.00 of funding. Department funding for such leave would be based on both merit and the availability of funding. If approved, the above rules and benefits for an Educational Course apply.

**NO Educational Leave will be permitted for:**

**Professional Meetings** which a resident chooses to attend other than the above. These are to be charged to vacation and will be at the resident’s own expense.

Administrative Leave:

**Board Review Course Attendance** – Each year, the Department Chairman, with faculty input may elect to allow administrative leave for PGY4 residents to attend a board review course. Funding for this travel will not be provided. Requests for administrative leave for residents to
attend a board review course will be reviewed on an individual merit basis. **If approved**, this period of leave will be charged to Administrative Leave and will not affect vacation time.

In an effort to facilitate good performance on the ABPM&R Oral Boards, the Department Chairman, with faculty input may elect to provide funding, based on availability, of up to $1,000 for residents who have graduated from the PM&R Residency Program to attend a board review course prior to taking the Oral Boards for the first time.

**Professional Meetings/Courses sponsored outside the Department of PM&R** – Each year, the Department Chairman, with faculty input **may** elect to allow administrative leave for PGY-2, PGY3 or PGY4 residents to attend professional meetings and/or conferences that are sponsored by funding from outside the Department of PM&R. Requests for administrative leave for residents to attend these professional meetings and/or conferences will be reviewed on an individual merit basis. Funding for this travel will not be provided.

**Traveling for Interviews** – Time required for interviews will be used as vacation days. Funding for this travel will not be provided.
UAMS Department of Physical Medicine and Rehabilitation
Residency Program Policy - Procedure for Leave Request

Number: P.6
Date Developed: 6/20/00
Last Review/Revision: 8/17/2018

Vacation:
1. At or near the beginning of the academic year, residents will be required to submit a leave request form to the Residency Program Coordinator. Use the Vacation Request for Upcoming Academic Year form (found on pg. 89).
2. For leave that was not requested at the beginning of the academic year, the resident must first consult the Program Coordinator to ensure leave is available, within policy scopes, etc. The Coordinator will let the resident know if they can proceed with the leave request.
3. During the academic year leave must be requested 45 days in advance. Leave requested less than 45 days may only be approved by faculty, then by the Program Director; they are generally discouraged. Online forms cannot be used for personal/educational/administrative leave less than 45 days in advance.
4. The resident will then obtain approval from the Resident providing the coverage, Chief Resident(s), Attending Faculty, and other resident assigned to the same service, preferably via email.
5. Upon receiving approvals, the resident will complete the online Leave Request Form which is emailed to the Program Director and Coordinator. The Coordinator will contact all involved parties and post the leave on Outlook to parties whom are involved.

All of the above steps including return of the form to the residency office must be completed 45 days prior to beginning your leave.

Sick Leave

1. Sick leave requested for medical appointments MUST be requested in advance using the Leave Request Form. Unless sick leave is requested for urgent or emergency purposes ADVANCE NOTICE is required, if approval is not obtained in advance, vacation will be charged.
2. If sick leave is requested for medical reasons that do not allow advance notice the Resident must:
   a. Contact the Chief Resident by phone or pager—Chief Resident will assign coverage, if necessary,
   b. Contact the assigned PM&R attending faculty member by phone or pager (i.e., ACH, BHRI, UAMS, VA),
   c. Notify the Residency Program Director (via phone), and;
   d. Notify the Residency Coordinator (via phone and email).
   e. Complete the Leave Request Form upon return to work.

Important!
If for any reason the days are not taken, please notify the Residency Program Coordinator immediately, otherwise you will be charged for these days.
Moonlighting is defined as any professional activity arranged by an individual resident, which is outside the course and scope of the approved residency (includes fellowships) program, whether or not the resident receives additional compensation. For purposes of accreditation, ‘moonlighting’ covered by this policy is ‘external moonlighting’, which is outside the University of Arkansas for Medical Sciences (UAMS) system. (UAMS system includes the participating teaching hospitals.)

In order to be eligible for moonlighting activities, the resident must follow the procedure as outlined in the UAMS College of Medicine GME Committee policy, Moonlighting and Malpractice Insurance Coverage while Moonlighting. The resident must submit a written request to the training Program Director and obtain his/her written approval. This information is contained in the resident’s file. Professional liability coverage (malpractice insurance) provided through UAMS does not cover moonlighting activities. Malpractice insurance for such activities is the sole responsibility of the resident. It is the responsibility of the clinical faculty hiring the resident to determine whether the appropriate credentials, adequate liability coverage and appropriate skill levels are in place.

The Department of Physical Medicine and Rehabilitation permits Moonlighting only if it does not interfere with training activities in any way. A resident’s total clinical time commitment may not exceed 80 hours a week - this includes residency activities, night-call requirements and moonlighting. As an example; if a resident is spending 50 hours carrying out his/her routine residency duties during a given week and is also scheduled for one night call at BHRI (15 hours of duty) only 15 hours of moonlighting is permissible that week. If a weekend call day (24 hours of duty) were scheduled, rather than an evening call, only 6 hours of moonlighting would be allowed. In all cases, official residency duties must take priority. Residents are required to submit an annual request indicating any plans for Moonlighting. If there are significant changes in frequency or intensity of Moonlighting during the year, a revised form is to be submitted at the beginning of each clinical rotation. Resident must discuss any planned moonlighting with their attending physician to be sure that they will not interfere with any residency rotation activities. Residents must provide the Program Director/Coordinator with a monthly report of their Moonlighting duties.

*Note - Residents are not required to moonlight.

Moonlighting privileges will be withdrawn if the resident is no longer performing satisfactorily in the program. In the event permission to moonlight is withdrawn by the program director, the obligation to notify an outside employer is the responsibility of the resident who established that employment and not the responsibility of the program director or UAMS.
Residents will be subject to dismissal from the program for the following:
1. Moonlighting without approval of the program director.
2. Continuing to moonlight after permission to do so is withdrawn.
3. Using the University Hospital’s or Arkansas Children’s Hospital DEA number while moonlighting.
UAMS Department of Physical Medicine and Rehabilitation
Residency Program Policy - Duty Hours and Work Environment

Number P.11
Date Developed: 3/28/00
Last Review/Revision: 5/01/2015

In compliance with the UAMS COM GME Committee policies on duty hours/work environment and moonlighting and considering that the care of the patient and educational clinical duties are of the highest priority, the following guidelines apply:

**Duty Hours**
1. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
2. Residents are provided one day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
3. In order to ensure adequate time for rest and personal activities, a 10-hour time period is provided between daily duty periods and after in-house call.

**On-Call Activities**
The goal of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period.
1. **In-house call:**
   a. Occurs no more frequently than every third night, averaged over a four-week period.
   b. Does not exceed 24 consecutive hours of continuous on-site duty. However, residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity care.
   c. No new patients, (defined as any patient that the resident has not seen previously), may be accepted after 24 hours of continuous duty.

The resident is expected to be on duty during normal working hours, 7:30 AM-5:00 PM, Monday through Friday. Additional duty hours include on-call duties. Night, weekend and holiday call schedules are formulated by the faculty or chief resident and depend on the specific educational rotation. Residents must be available by telephone or pager while on duty, including while on-call. Specific call schedules and responsibilities are delineated in the written goals/objectives of each rotation, which are reviewed with the resident at the beginning of the rotation.

**Work Environment**
1. **Meals:** food is available for those residents/fellows who provide 12 consecutive hours of in-house call.
2. **Call rooms:** call rooms are provided for all residents who take in-house call.
3. **Ancillary support:** adequate ancillary support for patient care is provided. Except in unusual circumstances, providing ancillary support is not the resident responsibility except for
specific educational objectives or as necessary for patient care. This is defined as, but not limited to, the following: drawing blood, obtaining EKGs, transporting patients, securing medical records, securing test results, completing forms to order tests and studies, monitoring patients after procedures.

4. **Other work environment benefits (department funded benefits include):**
   - book allowance
   - educational allowance
   - elective rotation
   - meal tickets
   - travel to professional meetings
PM&R residents are responsible for providing IN-HOUSE emergency coverage for all inpatients at BHRI on nights, weekends, and holidays (not just UAMS patients).

1. **Scheduling** - Coordinating the call schedule will be the responsibility of the chief resident(s).

2. **Frequency** - Call will be rotated between the residents who are on the Call Roster. The number of residents taking call may vary from year to year. The exact frequency and schedule will be determined by the chief resident(s) and approved by the program director.

3. **Substitution** - the resident whose name is on the official schedule is responsible for seeing that arrangements are made for substitute coverage anytime he/she is not able to report for duty due to illness, vacation, or any other reason.

   All pertinent individuals are to be notified of any changes in the posted schedule. This is the responsibility of the person whose name is on the schedule. Residents who provide substitute call coverage for others, must be familiar with the ACGME Work Hours Policy and must not make any coverage substitution that would violate any requirement of the ACGME Work Hours Policy. Any change that would result in a violation is prohibited.

   A signed attestation form acknowledging that the coverage substitution will not violate the Work Hours Policy is required prior to making any call substitution. If a resident who is assigned to call coverage cannot find a qualified substitute (an eligible PM&R resident, who, by providing substitute call coverage will not be violating the ACGME Work Hours Policy) the responsibility for the call remains with the resident who was originally scheduled for that date.

4. **Call Location** - The resident on call must remain within the confines of Baptist Health Medical Center or BHRI when on call. A call room is provided.

5. **Other rotations:**
   a. **Transitional Year** - All night call will be dependent on the specific rotation and the requirements of that service.
BHRI Housestaff Policies

PURPOSE: To delineate responsibilities and expectations of the Physician Housestaff. The Physician Housestaff of BHRI are present during evenings, nights, weekends and holidays to provide for immediate medical care needs. The Physician Housestaff are not utilized for routine medical needs (e.g. medication renewal, patient passes, routine patient/family response, review of routine lab work, orders for laxatives and/or stool softeners); these types of concerns are addressed to the attending physician or his/her designee.

GENERAL STATEMENT: As stipulated in the BHRI, UAMS College of Medicine and UAMS Department of Physical Medicine and Rehabilitation Interinstitutional Agreements, PM&R Physician Housestaff are to provide care to patients and receive concurrent training from UAMS/PM&R faculty attending physician at BHRI. Physician Housestaff are under supervision of the BHRI Nursing House Supervisor as well as the attending BHRI/UAMS faculty physician member as evidenced by the BHRI Housestaff application(s) on file at BHRI. The Housestaff are to provide immediate attention to BHRI patients for life threatening situations, acute and/or subacute medical concerns and Occurrence Reporting of medical needs.

DELINEATIONS:
1. PM&R physician Housestaff are present in BHRI Monday through Thursday, 5 PM to 7:30 AM; Friday, 5 PM to Saturday, 7:30 A.M, Saturday 7:30 AM to Sunday 7:30 AM, and Sunday 7:30 AM to Monday 7:30 AM. and holidays to respond to immediate medical needs.
2. Physician Housestaff responsibilities include life threatening situations (e.g., cardiac arrest, respiratory distress, seizures, acute psychotic events, drug reactions); acute and/or subacute medical concerns (e.g., fevers, hypertensive episodes, chest/abdominal pain, bleeding, mental status changes, swollen extremities) and Occurrence Reporting response (patient injuries/trauma, inappropriate/skipped medications).
3. Physician Housestaff are not responsible for:
   b. Refill of routine medication.
   c. Evening or weekend passes.
   d. Rash of more than eight hours duration.
   e. Change in attending physician’s management of patient.
   f. Routine discussions with family regarding patient care. These concerns are to be communicated directly to the attending physician and his/her designated coverage.
   g. Ordering laxatives and/or stool softeners.
4. The nursing supervisor is utilized for requests for BHRI Physician Housestaff response. Exceptions are life threatening situations and Occurrence Reporting responses.
5. BHRI Physician Housestaff will respond to all cases requested by the nursing house supervisor. Should a Housestaff member disagree with a nursing house supervisor request they will respond and then refer the question of appropriateness to the BHRI Medical Director for resolution.
6. The Director of Nursing will report any adverse event involving the Housestaff, including failure to show for a call assignment, to the Chief Resident and to the Program Director, who will, in turn, assess each situation for appropriateness. When warranted, the Administrator or Medical Director will report the situation and any Administrative recommendations to the UAMS PM&R assigned faculty physician, Residency Program Director and Chief Resident.

7. BHRI Physician Housestaff may have visitors in the Call Room while on duty with discretion (e.g. no loud noise to disturb unit) and must at all times be able to respond immediately to a call. BHRI Physician Housestaff who are parents may have their children present in the Call Room, but must have another adult responsible for the children while they are on call.
Purpose: To establish standards and protocols within the Department of Physical Medicine Rehabilitation to ensure the quality and safety of patient care during transfers of responsibility occurring during duty hour shift changes, location of service transfers, or other scheduled or unscheduled circumstances.

Definitions: Hand-off. The communication of information to support the transfer of care and responsibility for a patient or a group of patients from one provider to another. Transitions of care. A daily event in the clinical setting including change in level of patient care, admission from the ED and making Saturday rounds at BHRI.

Procedure: In addition to complying with the UAMS GME Transitions of Care policy (Appendix), the Physical Medicine and Rehabilitation program will utilize the following policy and procedures tailored for the program’s needs. The program regulates the number of transitions in patient care for our UAMS Consults and BHRI services utilizing multiple formats developed by resident physicians approved by faculty and the program director.

The residents rotating on the BHRI inpatient services cover their own patients each weekday from 7:00 am to 5:00 pm. In-house call is on weekdays from 5:00 pm to 7:30 am and weekends from 8:00 am to 8:00 am (7:30am Mondays). The on-call residents are responsible for urgent and emergent patient issues during call hours and Saturday morning patient rounds, and are responsible for updating the call log which lists overnight patient care updates. The on-call resident is required to physically round at BHRI on designated weekend days and designated holidays. The on-call attending physicians provide supervision of care provided by the on-call residents.

The SBARQ mnemonic (UAMS GME Policy 3.800) will be used for face-to-face and over the phone hand-offs:

Situation – Patient clearly identified, disease and situation clearly described
Background – Relay recent procedures, current medications, vitals, tests and results
Assessment – Relay recent diagnosis, patient status, and level of acuity
Recommendation – Relay detail about potential treatment plans, tests and vitals needed
Quiet Place – Environment is quiet and next doctor understands the SBAR
Transfer of Care is performed by the following methods:

1. Inpatient resident reviews call log daily.
2. EPIC sign-out report
   a. Filled out on each new patient
   b. Updated as needed
   c. Serves as the template for interactive communication during hand-off process.
   d. Epic sign-out report must contain at the minimum:
      i. Patient name and age
      ii. Code status
      iii. Principle problem
      iv. Consult/Admitting physician
      v. Abnormal labs or images within the past 24 hours
      vi. Special issues.
3. Inpatient resident performs face-to-face hand-off with on-call resident at beginning and end of call shift and rotation using the SBARQ format.
4. Consult resident is responsible for face-to-face and written hand-offs with covering residents when they are post-call, on personal leave and end of rotation using the SBARQ format.

**Scenarios requiring hand-off**
The below listed scenarios require adherence to the hand-off policy for transition of care:

1. Weekday call. During the weekday, in the evening, when a resident is assigned to be on call during the weekday, the BHRI resident will initiate sign-out with the on-coming on-call overnight resident.
2. Weekday call. During the weekday, in the morning, when a resident has completed their on-call responsibilities, the on-call resident will sign-out significant events overnight to the BHRI resident assigned to service.
3. Saturday call. On Friday, the BHRI resident will sign-out to the resident on-call on Saturday morning.
4. Saturday call. On Friday, the BHRI resident will sign-out to the BHRI resident tasked with rounding on BHRI patients Saturday morning.
5. Saturday call. If the BHRI resident rounding on Saturday is not on-call, said resident is responsible for initiating sign-out to the resident assigned to be on call on Saturday.
6. Acute care transfer. When the patient requires an acute level of care exceeding BHRI capabilities, the resident may facilitate transfer of patient to higher level of care and contact the attending physician as needed to advise or take over transfer to acute care.
7. Change of service. At the end of the resident’s rotation, the off-going resident must hand-off patient care to the on-coming resident.
8. Vacation. When a BHRI resident goes on vacation, the resident must hand-off care to the covering BHRI resident.
9. Holidays. The BHRI resident granted the holiday must hand off patient care to the on-call resident assigned to assume patient care before the holiday morning shift begins.

Transfer of Care is evaluated by the following methods:

1. Resident Observation and Competency Assessment (ROCA) completed annually by attending physician, scoring the resident’s proficiency at transfer of care.
2. BHRI call log is reviewed at the monthly chart review meetings by a senior inpatient resident to ensure compliance. A compliance report is provided to the program coordinator for review.

Any transfer of care compliance issues are reviewed by the program director and at CCC meetings, quarterly resident meetings, and resident appreciative inquiries as necessary.
The resident on call at BHRI will be issued a packet of meal tickets on a monthly basis to be used towards the purchase of their evening meal at the BMHC cafeteria. In addition, the resident taking call on Saturday, Sunday, or any designated holiday requiring 24 hour coverage will receive an additional $6.50 meal ticket to be used for lunch at the BMHC cafeteria. The procedure for using the meal tickets is as follows:

1. Wear UAMS and Baptist Medical Center Housestaff ID badge.

2. Select your food items and take to the cashier.

3. Notify the cashier that you are the resident on call at BHRI and present the meal ticket. You are responsible for any amount over the $6.50, and if you are wearing your UAMS and Baptist Medical Center Housestaff ID badge you will receive a 20% discount on the difference.

4. The cashier will keep an itemized list of charges and send to BHRI Administration on a monthly basis for payment processing.

The same procedure will follow for obtaining lunch on the weekend and designated holidays requiring 24 hour coverage. If you choose to eat breakfast, you are responsible for the cost, and be sure to wear your ID badge to get a 20% discount.

Cafeteria Hours

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<thead>
<tr>
<th></th>
<th>Time</th>
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<tbody>
<tr>
<td>Breakfast</td>
<td>7:00 am - 10:30 am</td>
</tr>
<tr>
<td>Lunch</td>
<td>11:00 am - 2:00 pm</td>
</tr>
<tr>
<td>Dinner</td>
<td>4:45 pm - 8:00 pm</td>
</tr>
<tr>
<td>Midnight breakfast</td>
<td>10:30 pm - 12:00 midnight</td>
</tr>
</tbody>
</table>

In addition, cold cuts and sandwiches are available from:

- 2:00 pm - 4:00 pm
- 8:00 pm - 10:30 pm
Pager policies

Pagers are issued to each Resident by the Residency Program Coordinator.

For any problems or questions regarding pagers (e.g., need for new batteries, pager stops working, etc.) contact the Residency Program Coordinator at 526-7732.
UAMS Department of Physical Medicine and Rehabilitation
Residency Program Policy - Photocopying for Residents and Medical Students

Number: P.16
Date Developed: 6/15/99
Last Review/Revision: 11/17/15

The Department would like to be as generous as possible in assisting residents with the cost of photocopying, but everyone must realize that this is very expensive to provide and must be used sparingly or the privileges might be revoked. Please remember - the photocopying privilege is for residency training activities only and is not to be used for personal copying. The policy will vary depending on the specific institution as follows:

ACH
Check with the Pediatric Rehabilitation Medicine Secretary (364-4374). Department copier can be used.

BHRI
Use the copy machine in the BMHC Medical Library. Wear your UAMS and Baptist Medical Center Housestaff ID badge and identify yourself as a PM&R Resident to the librarian when checking out the key.

There will be no charge to the resident, but a monthly fee for this service is paid by BHRI. This service is restricted to work related copying. Personal copying should be paid for.

Medical students at BHRI should have the resident on their service check out the key to the copier.

LRVA
See the VA PM&R Secretary and follow department procedure.

NLRVA
The PM&R Residents are permitted to use the copy machine in the PM&R office for duplicating small quantities (3 or less copies) or any document less than 10 pages.

UAMS
The copier in the PM&R Office can be used for educational purposes.

Appropriate Copying:
Handouts for seminars, grand rounds, journal club, etc.

Inappropriate Copying:
Personal items and Books
UAMS Department of Physical Medicine and Rehabilitation
Residency Program Policy - Book Funding

Number: P.17
Date Developed: 6/15/00
Last Review/Revision: 11/17/15

All residents are provided, by the department, with the following textbook in their PGY1 year:

Braddom RL. *Physical Medicine and Rehabilitation. 5th ed. Elsevier, 2015*

Additionally, all residents will be allotted $500.00 for the purchase of books necessary for their education/training starting at the beginning of their PGY2 year. To purchase a book, each resident must present to the residency program coordinator an exact reference of the book and a printed description of the book from an online vendor. All funds must be spent prior to completing residency.
Residents are allowed one education trip during their 4 year tenure with the department. This trip must be taken in the PGY3 or PGY4 year and the resident must show that they are presenting at the meeting. If the trip is not taken in the PGY3 or PGY4 year, the educational allowance will be forfeited. Chief Residents are allowed an additional educational trip (American Academy of PM&R).

1. Residents must first obtain approval from the Residency Program Coordinator for travel. They must present conference/meeting brochures with date, time and location in advance.
2. Residents should begin the travel request process at least two to three months prior to the travel to ensure approval and to complete the required procedures.
3. Residents should not incur travel expenses until they receive approval from the Resident Coordinator. This process may take several weeks.
4. Residents are limited to $1,500.00 per trip. (This also includes the Chief Resident educational trip.)
5. After traveling, residents should turn in all detailed/itemized receipts to the Administrative Coordinator. (To guarantee reimbursement, this form should be submitted to the Residency Program Coordinator within 30 days of completing the trip.)
6. Residents must provide explanations for any changes which may have occurred between the Travel Advance Request and Travel Expense Reimbursement form, i.e., sharing hotel rooms, etc.

Note: Please refer to the UAMS Administrative Guide to obtain detailed travel policy and procedures. Specifically refer to sections 8.4.01 Employee Travel Regulations; 8.4.03 Travel Advance Requests; 8.4.04 Authority to Travel; 8.4.05 Travel Expense Reimbursement.
UAMS Department of Physical Medicine and Rehabilitation
Residency Program Policy - Chief Residents

Number: P.19
Date Developed: 6/28/1999
Last Review/Revision: 3/11/15

Appointment and Term of Service:
At the discretion of the Department Chair, either one or two resident(s) will be selected to serve as Chief Resident during an academic year. If one Chief Resident is selected, the period of service will be for twelve months. If two residents are selected for service as Chief Residents, each resident may serve for a six month term or both residents may serve concurrently for twelve months. The term(s) of service will be determined by the Residency Program Director after discussing options with the resident or residents selected. Term(s) of service for the Chief Resident(s) will start April 1 through March 30 for one Chief or two Chiefs serving concurrently or from April 1 through September and October through March 31 for two Chiefs serving consecutive six month terms. The Department Chair will request recommendations of candidates for Chief Resident from the PM&R faculty, the Residency Coordinator, the immediate past Chief Resident(s), and the current residents. The Department Chair will make the official appointment(s) after discussions with the leading candidate(s) and the Program Director.

Qualifications:
The ideal individual selected for Chief Resident should have demonstrated exceptional maturity and responsibility; must possess excellent leadership and communication skills, at least above average academic performance, and a history of exemplary professionalism. Not all residents will have an opportunity to serve as Chief Resident. It is considered a special honor to be selected and is based on performance and leadership skills demonstrated during the first three years of residency training. Professional recognition of selection and service as Chief Resident is appropriate to be included in one’s curriculum vitae.

Performance Expectations:
The Chief Resident serves as a liaison between the PM&R residents and faculty. Additionally, the Chief Resident is expected to serve as an effective representative and leader of the PM&R residents. The Chief Resident duties will be performed in addition to regular resident clinical assignments. As an added performance incentive, a small salary bonus will be given as extra compensation. An evaluation of the Chief Resident will be conducted by the Program Director during the term of service, based on these expectations. This evaluation will become part of the resident’s training file. Unsatisfactory performance could result in termination of this appointment prior to its scheduled completion.

Delegation of Authority:
The Residency Program Director is the immediate supervisor of the Chief resident and delegates certain responsibilities and authority to the Chief Resident, such as making resident call and coverage assignments, and conducting resident meetings.
Responsibilities of Chief Resident:

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Frequency</th>
<th>Required Tasks</th>
<th>Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Arrange Invitation Lecture Series</td>
<td>Monthly</td>
<td>Plan, contact speakers, arrange &amp; host lectures</td>
<td>100% (6 lectures per term)</td>
</tr>
<tr>
<td>2. Coordinate resident evaluations of faculty</td>
<td>Twice yearly</td>
<td>Distribute, collect, &amp; turn in evaluations from all residents</td>
<td>100% (1 evaluation per term; December &amp; June)</td>
</tr>
<tr>
<td>3. Coordinate Board Review sessions</td>
<td>At least Monthly</td>
<td>Distribute questions, remind residents</td>
<td>100% (6 meetings per term)</td>
</tr>
<tr>
<td>4. Curriculum Committee meetings</td>
<td>Quarterly</td>
<td>Attend/participate</td>
<td>100% attendance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(2 meetings per term)</td>
</tr>
<tr>
<td>5. Faculty Meeting</td>
<td>Monthly</td>
<td>Attend/participate</td>
<td>100% (6 meetings per term)</td>
</tr>
<tr>
<td>6. Department Exec. Committee Meeting</td>
<td>Quarterly as needed</td>
<td>Attend/participate</td>
<td>100% attendance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(2 meetings per term)</td>
</tr>
<tr>
<td>7. Research Committee Meeting</td>
<td>Quarterly</td>
<td>Attend/participate</td>
<td>100% attendance</td>
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<td></td>
<td></td>
<td></td>
<td>(2 meetings per term)</td>
</tr>
<tr>
<td>8. Resident Meetings with Program Director</td>
<td>Quarterly</td>
<td>Survey residents in advance to assess problems; make an agenda; distribute follow-up information</td>
<td>100% (2 meetings per term)</td>
</tr>
<tr>
<td>9. Coordinate the Resident Call &amp; Post-Call Schedule</td>
<td>Quarterly</td>
<td>Make &amp; distribute schedules; contact resident or serve as back-up if a call is missed</td>
<td>100% on-time completion</td>
</tr>
<tr>
<td>10. Serve as an effective liaison between residents and faculty</td>
<td>As needed</td>
<td>Maintain communication lines</td>
<td>At least 4 on 1-5 scale of effectiveness</td>
</tr>
<tr>
<td>11. Coordinate the Visiting Professor Lectures</td>
<td>2 to 4 times a year</td>
<td>Survey resident needs; suggest topics; contact speakers; serve on planning committee; make arrangements as assigned</td>
<td>100% (1-2 lectures per term)</td>
</tr>
<tr>
<td>12. Coordinate the Annual Resident Picnic</td>
<td>Annually</td>
<td>Assist the Program Coordinator with planning</td>
<td>100% completion</td>
</tr>
<tr>
<td>13. Resident Orientation</td>
<td>Annually</td>
<td>Present information at PGY1 and PGY2 orientations</td>
<td>100% (conduct 2 orientations in July)</td>
</tr>
<tr>
<td>14. Selection Committee Meeting</td>
<td>Quarterly</td>
<td>Attend and participate</td>
<td>100% attendance</td>
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<td></td>
<td></td>
<td></td>
<td>(2 meetings per term)</td>
</tr>
<tr>
<td>15. Coordinate Resident Retreat</td>
<td>Annually</td>
<td>Assist the Program Director and Coordinator in planning</td>
<td>100% completion</td>
</tr>
<tr>
<td>16. Coordinate the Winter Holiday Party (and other social events)</td>
<td>Annually</td>
<td>Make all arrangements in coordination with Program Coordinator</td>
<td>100% completion</td>
</tr>
<tr>
<td>17. Lecture and Conference Evaluation</td>
<td>Weekly</td>
<td>Facilitate completion of evaluations from resident attendees at all Lectures, conferences and Seminars</td>
<td>100% (at least 8 event evaluations per month; at least 46 events per term)</td>
</tr>
<tr>
<td>18. Other Responsibilities</td>
<td>Variable</td>
<td>As assigned</td>
<td>100%</td>
</tr>
</tbody>
</table>
An intentional feature of the PM&R training program is a provision of opportunities for residents to gain experience in supervisory roles. Generally, senior residents are more advanced in clinical experience and in physiatric knowledge. Accordingly, more junior residents should take advantage of this knowledge resource by seeking the advice of senior residents, as a supplement to the advice of attending faculty. This is especially true for routine operational matters on most clinical rotations.

The following describes the supervisory opportunities within the program:

- **Chief Residents to Other Residents**
  Chief Residents are usually senior level residents selected for their advanced clinical skills and leadership potential. Chief residents provide general supervision (as a supplement to the Program Director and other faculty) to other residents in many administrative and clinical activities (scheduling, managing communications, general direction, leadership by example, etc).

- **Senior Resident to Junior Resident**
  Two clinical rotations are designed as supervisory opportunities for senior residents. 1) The VA Inpatient Ward Rotation may have assignments for a senior resident and junior resident. When this occurs, the senior resident is assigned fewer patients and admissions. This smaller patient load is to ensure that the senior resident will have time available to function as a clinical supervisor for the junior resident. This supervisory role includes assisting the faculty attending with clinical teaching of the junior resident, managing the census and patient flow on the ward, and assisting the junior resident with the management of clinical problems on a daily basis. 2) The VA outpatient rotation may also have both a junior and senior resident assigned. The senior resident similarly takes on a supervisory role, assisting the attending faculty with clinical teaching and assisting the junior resident in managing clinical problems.

- **Other Rotations**
  At times on other rotations may have more than one resident assigned to the same clinical institution (BHRI Inpatient Ward, ACH). When this occurs, a senior resident may end up paired with more junior residents. The senior resident is encouraged by faculty attendings to adopt a supervisory role providing supplementary teaching and clinical back-up assistance.
In compliance with the UAMS COM GME Committee policy on Evaluation and Promotion, the following guidelines apply:

**Reappointment**

Educational appointments to the PM&R residency program are for a term not exceeding one year. The resident agreement of appointment, which outlines the general responsibilities for the College of Medicine and for the resident, is signed at the beginning of each term of appointment. Renewal of the resident agreement of appointment for an additional term of education is the decision of the Program Director and the Department Chair. Promotion to the next level of training is dependent upon the resident performing at an acceptable level and meeting the requirements for clinical competence for that PGY year.

It is the intent of the PM&R program to develop physicians clinically competent in the field of PM&R. Physicians completing the program will be eligible for certification by the American Board of PM&R with an ultimate goal of a 100% pass rate on both the oral and written parts of this examination.

**Clinical competence requires:**

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
Evaluation and Promotion

During the residency/fellowship period, the above elements of clinical competence will be assessed in writing (at least quarterly), by direct faculty supervisors with subsequent review by the Program Director. Evaluations by peer resident physicians, patients, nursing staff and other paramedical personnel may be included at less frequent intervals. A resident will meet with the Program Director (and other designee such as the assigned faculty mentor), at least twice a year to review results of evaluations, SAE examinations, clinical exercises, scholarly project, procedure logs, EMG logs, 360 evaluations, ROCA’s and OSCE examination. A summary of the evaluations will be reviewed and signed by the resident. The evaluations will be maintained in confidential files and only available to authorized personnel. Upon request, the resident may review his/her evaluation file at any time during the year.

Reappointment and promotion to a subsequent year of training require satisfactory ratings on these evaluations and:

- satisfactory performance or observation of electrodiagnostic studies at training level-specific targets established by the faculty
- passing USMLE Step 3 by the end of the PGY1 year beginning 7/1/14
- a favorable recommendation by the Resident Evaluation Committee, if the resident has had academic problems and is being monitored by that Committee.

A resident receiving one or more unsatisfactory ratings on a quarterly evaluation during the year or scores less than the 30th percentile on the SAE Exam during any year will be reviewed by the Program Director and Resident Evaluation Committee and written recommendations made to him/her may include:

1. specific corrective actions and/or remediation
2. repeating a rotation
3. psychological counseling
4. academic warning status or probation
5. suspension or dismissal, if prior corrective action has been unsuccessful or academic performance and behavior remains unsatisfactory after academic warning and/or probation has been unsuccessful.

The Resident Evaluation Committee consists of the Program Director (Chair), at least two faculty representatives, two resident representatives (non-voting), and the Program Coordinator (non-voting).

The resident may appeal an unsatisfactory evaluation by submitting a written request to appear before the department’s Resident Evaluation Committee in a meeting called by the Program Director. The Committee reviews a summary of the deficiencies of the resident, and the resident has the opportunity to explain or refute the unsatisfactory evaluation. After review, the decision of this Committee is final.

At the completion of the residency program the Program Director prepares a final evaluation of the clinical competence of the resident. This evaluation stipulates the degree to which the resident has mastered each component of clinical competence – patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. In this evaluation the Program Director verifies that the resident “has demonstrated sufficient professional ability in PM&R to practice competently and independently”. This evaluation remains in the program’s
files to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in the actions of other bodies.

**Academic and Other Disciplinary Actions (in accordance with UAMS COM GME Policy on Disciplinary Actions)**

**Academic Warning Criteria:**
- First non-compliance with policies and procedures of the Department.
- Unsatisfactory attendance, performance of participation in conferences, rounds, clinic or ward rotations.
- First occurrence of failure to report to work without appropriate notifications.
- Suspicion of substance abuse.
- First documented failure to complete medical records in a timely and appropriate manner.

**Probation/Suspension/Dismissal Criteria:**

Actions of Probation/Suspension/Dismissal will follow the guidelines in the GME Committee Policy on Academic and Other Disciplinary Actions policy. In addition, specific PM&R program criteria follow:

1. Recurrent failure to attend, participate or perform satisfactorily at conferences, rounds, clinic and ward rotations
2. Receiving more than one unsatisfactory performance or overall unsatisfactory on the resident end-of rotation evaluation.
3. Failure to comply with the policies and procedures of the department, the program, the GME Committee, UAMS Medical Center or the participating institutions
4. Recurrent misconduct that infringes on the principles and guidelines set forth by this training program
5. Documented recurrent failure to complete medical records in a timely and appropriate manner defined as signed verbal orders within 24 hours, discharge summaries dictated within 24 hours of discharge.
6. When reasonably documented professional misconduct or ethical charges are brought against the resident, which bear on his/her fitness to participate in the program.

A resident involved in the disciplinary actions of probation, suspension and dismissal has the right to appeal according to the GME Committee policy Adjudication of Resident Grievances.
PM&R Library Housed at Stephens Spine Institute, 7th Floor:

1. Nothing is to be removed from the library unless proper check-out procedures are followed (Make a copy of the front of the book, list your name & date and give to Residency Coordinator to record.) If you check something out, you are responsible for returning it.

2. An item may be checked out for two weeks. At the end of this time, it may be renewed for another two weeks and only if no one else has requested the item. NO item may be kept for longer than four weeks without authorization from the Department Chairman via the Medical Staff Liaison.

3. A list will be maintained of all overdue or missing items, and notification will be made to those responsible for their return.

4. Anyone who keeps an item more than one week overdue will not be permitted to check out any additional items until the overdue item is returned.

5. No materials may be transferred to another resident or faculty member. Exceptions to this must be authorized by the Department Chairman through the Medical Staff Liaison.

6. Anyone with a total of four overdue notifications or with repeated unauthorized transfers of materials will be restricted to interoffice viewing only of any library materials.

7. Lost materials must be replaced within one month of notification to replace, or a monetary reimbursement must be made according to the cost of the item.
Vacation – Three weeks per year. This cannot be carried over from one year to the next. The PM&R Department will set specific limitations on when the leave can be taken and how far ahead it must be taken.

Sick Leave – Twelve days per year. This cannot be carried over from one year to the next.

Holidays –

(Official UAMS Holidays are):
New Year’s Day
Memorial Day
Independence Day
Labor Day
President’s Day
Veteran’s Day
Thanksgiving Day
Christmas Eve
Christmas Day
Martin Luther King Day

(Official VA Holidays are):
New Year’s Day
Martin Luther King Day
President’s Day
Memorial Day
Independence Day
Labor Day
Columbus Day
Veteran’s Day
Thanksgiving Day
Christmas Day

Depending on the rotation the resident is assigned to, holidays will not automatically be a day off. The attending physician at each rotation site will make the decision as to whether the resident will or will not work on the holiday. Resident physicians are not given compensatory time off for holidays worked.

Contractual Agreement – House Staff appointments are for a period not exceeding one year except in the case of the PGY1 resident which allows for two extra weeks pay for attendance of orientation. A House Staff agreement outlining the general mutual responsibility of the College of Medicine and House Staff member is signed at the beginning of the term of service and is in effect for the full term of service. Renewal of an agreement for an additional term of service is at the discretion of the Chief of Service.

Pay Schedules – Residents whose paychecks come from UAMS (all non-VA salaries) are required to have the checks deposited to their bank. Checks are deposited monthly on the last working day of the month.

House Staff who are paid by the VA are paid bi-weekly. The checks are sent by mail or direct deposit to the bank.
Parking – Dependent on institution.

BHRI: Resident may park in the BHRI Visitors Parking Deck. (A BHRI card key may be required). Card keys may be obtained from the UAMS Medical Towers Office at BHRI.

UAMS: All members of the House Staff are granted parking privileges on Deck 2 any level but A and the top of B where the faculty park. A UAMS decal and a card key to operate the parking gate can be obtained from the Public Safety Office. A fee of $5.00 will be charged and refunded to you at the end of your residency training.

LRVA: Residents are issued an ID badge and this badge allows resident access to the VA staff Parking area.

NLRVA: No special arrangements. Park in General Parking area.

ACH: Residents park in the Doctors’ Parking Lot. The PM&R Secretary will obtain parking Stickers and parking cards for you to use.

Name Tag – One name tag and ID Badge will be provided by the House Staff Office at orientation.

Uniforms – Three lab coats are provided for each resident. No replacements are provided during training.

Laundry – None provided.

Insurance

A. Hospitalization – Health services and hospitalization is provided to all members of the staff. Coverage for spouses and children may be purchased by the individual Housestaff member.

No salary deductions are made for time lost due to illness. However, an excessive amount of time lost in this manner must be made up before the College of Medicine can issue a certificate indicating satisfactory completion of internship or residency requirement.

When a Housestaff member cannot assume his responsibilities because of personal illness, he shall inform the Attending Physician on the service to which he is assigned.

B. Life Insurance – Is provided to the Housestaff physician and is equal to resident’s salary up to $50,000.00.

C. Dental Coverage – Provided to the resident for a monthly fee.

D. Professional Liability – Each Housestaff physician is provided professional liability insurance when on official duty. Forms for the insurance are available in the Housestaff Office. Additional coverage may be obtained from the insurance carrier. It is the responsibility of the
Housestaff member to pay the difference in the amount of premium if the additional insurance coverage is purchased.

E. Moonlighting by House Officers

It is the position of the College of Medicine that excessive or inappropriate moonlighting by residents not be allowed. Accordingly, the following policy is in effect:

1. Housestaff physicians will not be permitted to moonlight in any official clinical programs operated by UAMS without written consent from the Office of the Dean, College of Medicine; Executive Director of Clinical Programs and the Department Chairman.

2. Although moonlighting by Housestaff physicians in clinical programs outside UAMS is discouraged, it is not appropriate for the institution to curtail such activities. Moonlighting by PGY1 level trainees, in particular, is discouraged.

3. All moonlighting activities must be approved in advance by the responsible Chief of Service to ensure they will not interfere with the individual’s training program and activities at UAMS and that the anticipated moonlighting responsibilities are consistent with the resident’s competence and level of training.

4. Professional Liability Insurance is provided for House Staff only when on official duty. It is the resident’s responsibility to obtain additional insurance coverage for professional liability if he/she engages in moonlighting activities.

F. National Guard Duty – UAMS does not have an official policy. The Department of Physical Medicine and Rehabilitation will permit two weeks off as “Leave with Pay”. It will not be charged to vacation time and will not be deducted from required training time. (However, total absence from training for all reasons may not exceed 6 weeks/year).

G. Educational Materials – Residents will be provided the following by the Department of Physical Medicine and Rehabilitation:

1. AAPM&R Self-Assessment Exam (SAE) - (PGY2 – PGY4)
2. Study Guide – (PGY2 resident)
3. AAPM&R Membership Dues – (PGY2 – PGY4). Includes subscription to Archives of PM&R.
5. Educational Course –Includes 4 day period of leave of resident’s choice of PMR related educational course at Department’s expense ($1,500.00 maximum funding).
6. Fringe benefits (PGY- 4)

H. Licenses and Certificates – Arkansas does not require residents to have a state license while in training, but it is strongly encouraged for PGY2 level and above.

I. ACLS – A current ACLS certification is required for night call at BHRI as well as for the VA.
J. **BLS** - A current BLS certification is required by the VA.

K. **Function of Housestaff Office** – The House Staff Office provides administrative assistance to the clinical departments, interns, residents and fellows for issues or problems pertaining to Housestaff affairs. Examples of situations in which the Housestaff Office may be involved include the following:

1. Professional liability insurance
2. Health insurance
3. Medical licensure
4. Payroll
5. Ordering of uniforms
6. Letters of recommendation
7. Narcotic exemption forms

The Housestaff Office is located in Room M1/1021B on the first floor of University Hospital.
Each year in January the AAPM&R provides an online Self-Assessment Examination for residents. All residents in PM&R throughout the U.S. take the exam on the same day. All scoring is done using a code number and no record is kept by the Academy of how any individual performed.

The examination is divided into the same 10 categories as the Study Guide, and scores are calculated separately for each individual section.

All participants in the examination are compared according to the year in training (i.e., 1st year residents are compared to other 1st year residents) as well as to all participants.

ALL UAMS PM&R RESIDENTS PGY2-4 WILL BE REQUIRED TO TAKE THIS ANNUAL EXAMINATION, AND WILL BE REQUIRED TO GIVE PERMISSION FOR THE RESULTS TO BE SENT TO THE PROGRAM DIRECTOR.

OBJECTIVES:

1. To familiarize residents with the type of questions which will be used on Part I of the Board examination.
2. For each resident to see how well he/she compares to residents in the same year of training in other programs.
3. For the Program Director to evaluate strengths and weaknesses of the training program so appropriate modifications can be made.
4. So residents can evaluate their study methods and modify as needed.
5. For residents to see how well they are improving from one year to the next.
6. For the Program Director to recognize early the residents who are not doing well so that appropriate assistance can be given.
7. The results of the examination will be made available to all Faculty as part of the training program evaluation.
Background
In order to establish a forum and procedure by which an individual resident or group of residents can address concerns in a confidential and protected manner.

Definitions
Chief Resident: the resident or residents appointed by the Program Director to serve as a liaison between all UAMS PM&R residents and the UAMS PM&R faculty.
Resident Council: the oversight body of the University of Arkansas for Medical Sciences College of Medicine (COM) Resident Organization. The Resident Council is a standing subcommittee of the Graduate Medical Education Committee and has equal authority with the other subcommittees. The Resident Council is composed of peer-elected residents, appointed chief residents and other residents who represent special groups (e.g. AAMC Organization of Resident Representatives, AMA Resident Section).

Policy
When a concern exists, residents are encouraged to take advantage of intra-departmental mechanisms to resolve the concern prior to going outside the Department, unless an intra-departmental resolution will compromise confidentiality of the individual(s) raising the concern.

Procedure
1. Primary Intra-departmental Contacts: Concerns may be raised with the PM&R Chief Resident(s), the Program Director or Associate Program Director, the resident’s assigned faculty mentor, or the Department Chairperson.
   A. The primary intra-departmental contact will assist the resident in resolving the concern or for seeking resolution in the appropriate forum. If further discussion is necessary, the concern will be raised by the primary intra-departmental contact without disclosing the confidential source of the concern.
   B. The procedure for resolution will vary depending on the type of issue.
      • For issues related to work environment, interaction with other residents, faculty, or staff, the primary intra-departmental contact may discuss this with the Program Director or Department Chairperson while protecting the resident’s anonymity. The Program Director or Department Chairperson may resolve this issue his/herself or discuss the issue further with the entire faculty or an appropriate Department committee.
      • For issues related to evaluation, the matter will be addressed according to the UAMS PM&R Policy on Resident Evaluation.
• For issues related to disciplinary action, the matter will be addressed according to the PM&R Policy on Disciplinary Action including Probation, Suspension and Dismissal.

2. Secondary Extra-departmental Contacts: If the issue is of such a nature that it cannot be discussed at the program/departmental level or the resident desires additional discussion, the resident should notify one of the following:
   A. The resident contacts either the Associate Dean for GME or a member of the Resident Council.
   B. The procedure for resolution will vary depending on the type of issue.
      • For issues related to general work environment, the Associate Dean for GME or Resident Council may discuss the issue and make recommendations for resolution through the GME.
      • For issues related to disciplinary action, the matter will be addressed according to the procedure outlined in the GMEC policy on Disciplinary Action including Probation, Suspension and Dismissal.
      • Should a resident believe that a rule, procedure, or policy has been applied to him or her in an unfair or inequitable manner or that he or she has been the subject of unfair or improper treatment, the resident should refer to the GMEC policy on Adjudication of Resident Complaints and Grievances.

Discussions and recommendations by the Resident Council and/or the GMEC will be confidential to the extent authorized by law and handled in a manner to protect the resident.
In compliance with the UAMS COM GME Committee policy on Resident Supervision, the following guidelines are followed for supervision of the care of patients and backup support:

1. Qualified faculty physicians supervise all patient care and their schedules are structured so that adequate supervision is available at all times.
2. Attending faculty physician supervision is provided appropriate to the skill level of the residents on the service/rotations.
3. Specific responsibilities for patient care are included in the written description of each service/rotation; this information is reviewed with the resident at the beginning of the service/rotation. In general, on certain rotations, the more senior level resident oversees the lower level resident and intern. The faculty physician oversees the entire team and is available at all times in person, by telephone or beeper.
4. Rapid, reliable systems for communication with supervisory physicians are available.
5. On-call responsibilities and supervision is documented by the call schedules and is reviewed with the resident at the beginning of each service/rotation or if/when there is a change in the schedule.
6. The following procedure is followed to address fatigue of the resident/fellow:
   a. The attending faculty is notified of or observes signs of resident fatigue.
   b. The chief resident is contacted and arranges for the backup person to relieve the resident/fellow.
   c. The attending faculty determines when the resident should return to the education program.
   d. The attending faculty notifies the Program Director about these arrangements.
American Board of Physical Medicine & Rehabilitation –
Registration of New Residents

Registration for Residents is completed annually with the American Board of Physical Medicine & Rehabilitation using the form located at the following link:

https://online.abpmr.org/users/director/phyRegister_step1.html
From: Kevin Means, MD, UAMS PM&R Department Chairman and Rani L. Lindberg, MD, Residency Program Director

Prior to leaving the Program, in addition to the UAMS Housestaff Checkout form, it is necessary for you to obtain signatures from each of the following individuals to indicate that you have completed all of your work, turned in institution property, paid outstanding debts, returned all library books, etc.

I. Attending Physician: ____________________________________________________________
   Printed Name Here

   All outstanding paperwork and clinical obligations have been completed.

   __________________________________________  __________________________
   Signature                  Date

II. VA – Kim McGaughey __________________________________________________________

III. BHRI – Christi Strayhorn ____________________________________________________
    (On-Call room key, ID Badge, Parking Card, Medical Records Clearance)

IV. PM&R – Leigh Austin _________________________________________________________
    (PM&R library books, Beeper, Complete ALL Evaluations in New Innovations)

V. Residency Program Director __________________________________________________

Please return this completed form to the Residency Program Coordinator prior to your departure.
Moonlighting is defined as any professional activity arranged by an individual resident/fellow, which is outside the course and scope of the approved residency/fellowship program, whether or not the resident/fellow receives additional compensation. For purposes of this request, ‘moonlighting’ is ‘external moonlighting’ which is outside the University of Arkansas for Medical Sciences (UAMS) system. UAMS system includes the participating teaching hospitals.

In order to be eligible for moonlighting activities, the resident must follow the procedure as outlined in the UAMS COM GME Committee Policy, Moonlighting and Malpractice Insurance Coverage while Moonlighting. Residents are not required to moonlight. Moonlighting is allowed only with the written permission of the program director upon the resident’s written request to moonlight. This information is contained in the resident’s file. Professional liability coverage (malpractice insurance) provided through UAMS is provided only when on official duty (activities within the residency program) and does not cover moonlighting activities. Malpractice insurance for such activities is the sole responsibility of the resident. It is the responsibility of the clinical facility hiring the resident to determine whether the appropriate credentials, adequate liability coverage and appropriate skill levels are in place. Proof of a current medical license is required.

Moonlighting privileges will be withdrawn if the resident is no longer performing satisfactorily in the program. In the event permission to moonlight is withdrawn by the program director, the obligation to notify an outside employer is the responsibility of the resident who established that employment and not the responsibility of the program director or UAMS. Privileges will be withdrawn if the resident fails to report monthly their moonlighting hours worked to the Program Director and Coordinator.

Resident will be subject to dismissal from the program for the following:

- Moonlighting without written approval of the program director,
- Continuing to moonlight after permission to do so is withdrawn,
- Using the University Hospital’s or Arkansas Children’s Hospital DEA number while moonlighting.

As a resident in the Physical Medicine and Rehabilitation training program, I understand and will abide by the above requirements for moonlighting activities. I understand that the performance of these activities will not interfere with my ability to achieve the goals and objectives of my residency program. I agree to show the Program Director proof of licensure, name of outside employer and hours to be worked. I agree to report monthly to the Program Director and Coordinator my moonlighting hours worked. I request permission to engage in moonlighting activities.

List Moonlighting Activities:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Signature of Resident Date

Signature Program Director Date

Revised 6/12/2014
UAMS Department of PM&R Residency Program
Resident Counseling Form

This form is initiated when an Academic Warning is issued by the Program Director, or when a resident is placed on Probation status. The faculty member may complete section B of this form or provide the Program Director with the relevant details in writing. A personal meeting with the resident and Program Director is required.

Date: ______________________  Faculty Name: ____________________________
Resident Name: ____________________________  PGY level: __________

A. Behavioral Standards (Performance Expectation) cite policy or manual page if possible:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

B. Infraction(s) (include dates)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

C. Remediation Plan (Steps to Take to Improve Behavior/Performance)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

D. Timeframe
Beginning of Remediation: __________  Ending of Remediation: __________

E. How and by whom will the Resident be Re-Evaluated:
______________________________________________________________________________
______________________________________________________________________________
F. Expected Outcomes:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
G. Consequences of the Resident’s Failure to Meet Expectations:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
_____________________________________________________

Signatures

Resident (Print) __________________________________________________
(Sign)  __________________________________________________
(The resident signature confirms being informed – not necessarily agreement)

Faculty (Print) __________________________________________________
(Sign)  __________________________________________________

Resident Evaluation Committee Review Date: ______________________

Outcome Date ___________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Signatures

Resident ______________________ Date ___________________

Faculty ______________________ Date ___________________
UAMS Office of Graduate Medical Education Transfer of Care Policy

Purpose and Scope:
To support the continuity and safety of patients by providing a standard framework for care transitions occurring during duty hour shift changes, location or service transfers, or other scheduled or unscheduled circumstances when the patient moves from one stage of care to another stage with new care personnel. This policy applies to all Residents and Fellows practicing medicine within the University of Arkansas for Medical Sciences Graduate Medical Education programs.

Policy:
Residency and fellowship programs ("programs") must:
- Work with clinical sites to optimize hand-offs while being mindful of the site's handoff policies.2,3
- Design clinical assignments with clinical sites to optimize hand-offs overall.2,3
- Maintain a schedule of attending physicians and residents responsible for care.2,3
- Ensure hand-offs meet the essence of SBARQ (See below)
- Teach and assess housestaff on safe hand-off practices.1
- Document the evaluation of handoff procedures in the Annual Program Evaluation.1,2,3
- Ensure continuity of care in case a resident becomes fatigued or ill.2,3

The institution offers professional development on these standards as part of Institution for Healthcare Improvement mandatory training modules, PS104, Lesson 3.1,2,3

Procedure:
At each transition or handoff, a resident or fellow should seek to meet the essence of SBARC as follows:

Policy 3.800
Graduate Medical Education Committee

Section
Educational Administration

Subject
Transitions of Care and Handoffs

Policy Requirements:
ACGME Institutional III.B.31;
ACGME Common Program Requirements VI.E; VI.E.3. (a- e)2
CLER Care Transitions Pathways 1 through 63

Version History:
Date Developed: 1/14/2013
Last Review/Revision: 5/2014, 5/2017
Legal Review: June 13, 2017
<table>
<thead>
<tr>
<th>SITUATION</th>
<th>BACKGROUND</th>
<th>ASSESSMENT</th>
<th>RECOMMENDATION</th>
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<td>Recent procedures</td>
<td>Diagnosis</td>
<td>Next Actions</td>
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<td>Medical record number</td>
<td>Changes in condition</td>
<td>Status</td>
<td>Anticipated procedures</td>
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<tr>
<td>Admitting physician</td>
<td>Changes in treatment</td>
<td>Level of acuity</td>
<td>Outstanding tasks</td>
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<td>Overall situation</td>
<td>Current medication</td>
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<td>Current Status</td>
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<td>Current Vitals</td>
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<td>Allergies</td>
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<td></td>
<td>Recent lab tests</td>
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**QUIET PLACE**

Receiver asks questions, repeats handoff information
Face-to-Face in a Quiet Place (PREFERRED). No texting.

**Definitions:**

Clinical Sites: CAVHS, UAMS Medical Center, Children’s Hospital, Baptist Hospital

Clinical Learning Environment (CLE): The intersection of organized patient care and organized medical education together with their respective shared functions, goals and strategies. Typically the CLE is where residents learn to be independent physicians and/or surgeons with real patients in a real clinical setting.

**Handoff** - the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another.

SBAR – Situation Background Assessment Recommendation is the handoff framework adopted by GME to standardize handoff and improve transitions in the CLE.

**Transitions of care** - A daily event in the clinical setting including change in level of patient care, admission from the ED, outpatient clinic, or outpatient procedure area, discharge to home or another facility, and at housestaff rotation or shift changes.
## HOW TO USE THIS FORM

### a. THIS FORM IS A GUIDELINE:
The form does not necessarily have to be completed as a record in a file. It can be used for oral or written evaluations, formal or informal training sessions, or any mode that fits your program’s format. It will help you report a method of Care Transitions on your APE.

### b. TRAINING MATERIALS:
The GME Office created this form for programs, attending physicians, instructors or evaluators to both teach and evaluate the quality of transitions/handoffs performed by trainees at UAMS. Use GME policy 3.800 and this form while conducting an actual patient handoff or in a didactic setting. Ideally, live transitions and handoffs will be assessed.

### c. RATING SCALE:
It is possible to rate INDEPENDENT on some areas and COMPETENT or NOVICE on others. *If you rate a trainee as COMPETENT or NOVICE*, however, we recommend completing the LEARNING GOALS field to help the learner understand how to improve their skills.

### d. TRAINING GOAL:
The overall goal is for trainees to achieve a score of INDEPENDENT in all SBARQ categories by the completion of training.

### e. PROMPTS FOR TEACHING and LEARNING:
- How have you conducted handoffs in the past?
- How are you currently conducting handoffs?
- What did you learn today that helps your handoff quality?
- Use SBARQ as the mnemonic device for memory.

### SITUATION
Works with the system to ensure the patient is clearly identified; disease and situation are clearly described.

### BACKGROUND
Proactively relays recent procedures, current meds, vitals, tests and results for the future caregiver and team.

### ASSESSMENT
Proactively relays recent diagnosis, patient status, and level of acuity for the future caregiver and team.

### RECOMMENDATION
Proactively relays details about past and potential treatment plans, tests and vitals for the future caregiver and team.

### QUIET/FOLLOW UP
Maintains privacy, environment is quiet, Communicates with past and future caregivers and team to ensure continuity of care.

### INDEPENDENT
Understands the importance of patient identification, but with some lapses in pertinent or timely information. Still needs some supervision.

### INDEPENDENT
Understands the need to communicate diagnosis, patient status, level of acuity, but lacks detail for the future caregiver. Still needs some supervision.

### INDEPENDENT
Understands the need to relay potential treatment plans, tests and vitals. Still requires some supervision.

### INDEPENDENT
Understands the need to maintain privacy and confidentiality and the need to ensure clear communication with past and future caregivers for continuity of care. Still requires some supervision.

### COMPETENT
Is learning the importance of patient identification, disease and situation, and requires closer supervision.

### COMPETENT
Is learning to relay recent procedures, current medications, vitals, tests and results, and requires closer supervision.

### COMPETENT
Is learning the need to relay recent diagnosis, patient status, level of acuity, and requires closer supervision.

### COMPETENT
Is learning the need to relay information about potential treatment plans, tests and vitals needed, but still requires closer supervision.

### COMPETENT
Is learning the need to maintain a quiet or private environment and learning the need to communicate with caregivers. Still requires closer supervision.

### NOVICE
Learning Goals

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UAMS GME SBARQ Experiential Training and Evaluation Form / GME Policy 3.800: Transitions of Care and Handoffs