PM&R RESIDENCY HANDBOOK

2017-2018

Department of Physical Medicine and Rehabilitation

Michigan State University

College of Osteopathic Medicine

PM&R Mission Statement

The Department of Physical Medicine and Rehabilitation strives to enhance the quality of life and functional independence of persons with injuries and disabling illness through excellence in rehabilitative care and management, the training and education of persons in the discipline of rehabilitation medicine and through the advancement of knowledge through research.

PM&R

CORE PROGRAM GOALS & OBJECTIVES

Competency Based and by PGY Level

MEDICAL KNOWLEDGE

Goal: Residents should demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and socio-behavioral sciences, as well as the application of this knowledge to patient care. Residents are expected to:

PGY-2 Objectives:

1. Discuss 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
2. Describe basic sciences relevant to physical medicine and rehabilitation such as anatomy, physiology, pathology and pathophysiology of the neuromusculoskeletal, cardiovascular and pulmonary systems, kinesiology and biomechanics, functional anatomy, Electrodiagnostic medicine, fundamental research design and methodologies, and instrumentation related to the field
3. Demonstrate skills in reviewing pertinent laboratory and imaging materials for the patient, including the proper use and function of equipment and tests
4. Demonstrate basic skills in nerve conduction studies.

5. Describe the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care
6. Describe the principles of pharmacology as they relate to the indications for and complications of drugs utilized in physical medicine and rehabilitation

PGY-3 Objectives:

1. Review procedures commonly employed in physiatry
2. Examine the decision-making process involving ethical issues that arise in the diagnosis and management of patients
3. Demonstrate basic needle EMG skills Discuss the principles of bioethics as applied to medical care
4. Demonstrate skills in orthotics and prosthetics, including fitting and Physical Medicine and Rehabilitation manufacturing, through instruction and arrangements made with appropriate orthotic-prosthetic facilities
5. Demonstrate ability to perform critical appraisal of current medical literature

PGY-4 Objectives:

1. Participate in decision-making process involving ethical issues that arise in the diagnosis and management of patients
2. Demonstrate ability to produce a peer-reviewed publication or engage in an in-depth scholarly activity
3. Demonstrate skills proficiency in the procedures commonly employed by physiatry
4. Discuss comprehensively physiologic responses to the various physical modalities and therapeutic exercises

PATIENT CARE

Goa*l:* Residents should be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

PGY-2 Objectives:

1. Demonstrate skills proficiency in writing patient history and perform physical examination
2. Present patient's illness, background, management strategies, and to be able to perform a lucid presentation of the case summary
3. Demonstrate proficiency in diagnosing, assessing, and managing the conditions commonly encountered by the physiatrist in the rehabilitative management of patients of all ages in the following areas:
    a. acute and chronic musculoskeletal syndromes, including sports and occupational injuries
    b. rehabilitative care of spinal cord trauma and diseases, including management of bladder and bowel dysfunction and pressure ulcer prevention and treatment;
    c. neurorehabilitative care of traumatic brain injury, cerebrovascular accident and other brain disorders
4. Develop competence in the following areas:
    a. history and physical examination pertinent to physical medicine and rehabilitation
    b. assessment of neurological, musculoskeletal and cardiovascular-pulmonary systems;
    c. assessment of disability and impairment and familiarity with the ratings of disability and impairment
    d. data gathering and interpreting of psychosocial and vocational factors

e. written prescriptions with specific details appropriate to the patient for therapeutic modalities, therapeutic exercises and testing performed by physical therapists, occupational therapists, speech/language pathologists
f. familiarity with the safety, maintenance, as well as the actual use, of medical equipment common to the various therapy areas and laboratories
g. Development of a differential diagnosis and initial plan for nerve conduction studies in a patient sent for EMG evaluation.
h. performance of EMG 40 consultations per resident under appropriate supervision

PGY-3 Objectives:

1. Demonstrate proficiency in diagnosing, assessing, and managing the conditions commonly encountered by the physiatrist in the rehabilitative management of patients of all ages in the following areas:
    a. congenital or acquired myopathies, peripheral neuropathies, motor neuron and motor system diseases and other neuromuscular diseases
    b. hereditary, developmental and acquired central nervous system disorders, including cerebral palsy, stroke, myelomeningocele, and multiple sclerosis
    c. sexual dysfunction common to the physically impaired
    d. post-fracture care and rehabilitation of postoperative joint arthroplasty
2. Develop competence in the following areas:
    a. diseases, impairments and functional limitations seen in the geriatric population
    b. medical conditioning, reconditioning and fitness
    c. soft tissue disorders and conditions including burns, ulcers and wound care
    d. prescriptions for orthotics, prosthetics, wheelchairs and ambulatory devices, special beds and other assistive devices
    e. understanding and coordination of psychologic and vocational interventions and tests
    f. inpatient and outpatient pediatric rehabilitation
    g. inpatient and outpatient geriatric rehabilitation
    h. Development of complete differential diagnosis and test design for needle EMG and NCS.
    i. performance of EMG 100 consultations per resident under appropriate supervision

PGY-4 Objectives:

1. 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 which 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
    d. design and monitor rehabilitation treatment programs to minimize and prevent impairment and maximize functional abilities
    e. prevent injury, illness and disability
2. Develop competence in the following areas:
    a. experience in evaluation and application of cardiac and pulmonary rehabilitation as related to physiatric responsibilities
    b. pulmonary, cardiac, oncologic, infectious, immunosuppressive and other common medical conditions seen in patients with physical disabilities;
    c. rheumatologic disorders treated by the physiatrist

d. performance of EMG 200 consultations per resident under appropriate supervision
e. therapeutic and diagnostic injection techniques
f. Sports medicine rehabilitation

3. Demonstrate proficiency in diagnosing, assessing, and managing the conditions commonly encountered by the physiatrist in the rehabilitative management of patients of all ages in the following areas:
    a. acute and chronic pain management; Physical Medicine and Rehabilitation
    b. rehabilitative care of amputations for both congenital and acquired conditions;
    c. chronic pain

PRACTICE-BASED LEARNING & IMPROVEMENT

Goal*:* Residents should demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following objectives:

PGY-2 Objectives:

1. Identify strengths, deficiencies, and limits in one's knowledge and expertise
2. Set learning and improvement goals for one-self
3. Identify and perform appropriate learning activities

PGY-3 Objectives:

1. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
2. Incorporate formative evaluation feedback into daily practice
3. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems

PGY-4 Objectives:

1. Demonstrate the application of information technology to optimize patient care and learning
2. Demonstrate skills in educating patients, families, students, residents and other health professionals
3. Exemplify the importance of self-evaluation, continuing medical education, and continued professional development after graduation
4. Identify an area of improvement and complete a process improvement project

INTERPERSONAL & COMMUNICATION SKILLS

Goal

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

PGY-2 Objectives:

1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
2. Communicate effectively with physicians, other health professionals, and health related agencies

3. Provide comprehensive, timely, and legible discharge summary dictations and notes, and any other medical records

PGY-3 Objectives:

1. Act in a consultative role to other physicians and health professionals
2. Maintain comprehensive, timely, and legible medical records
3. Work effectively as a member or leader of a health care team or other professional group

PGY-4 Objectives:

1. Develop the necessary written and verbal communication skills essential to the efficient practice of physiatry
2. Counsel patients and family members, including end of life care issues
3. Discuss the medical administration and teaching methodologies

PROFESSIONALISM

Goal*:* Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to:

PGY-2 Objectives:

1. Demonstrate compassion, integrity, and respect for others
2. Model responsiveness to patient needs that supersedes self-interest
3. Respect patients' privacy and autonomy

PGY-3 Objectives:

1. Recognize the importance of personal, social and cultural factors in the disease process and clinical management
2. Exemplify sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
3. Demonstrate a spirit of collegiality and a high standard of moral behavior within the clinical setting in the care of patients, in the education of residents, and in conducting research

PGY-4 Objectives:

1. Be accountable to patients, society and the profession
2. Participate in community service, professional organizations, or institutional committee activities
3. Demonstrate humanistic qualities that foster the formation of appropriate patient/physician relationships. These qualities include integrity, respect, compassion, professional responsibility, courtesy, sensitivity to patient needs for comfort and encouragement, and an appropriate professional attitude and behavior toward colleagues.

SYSTEM-BASED PRACTICE

Goal*:* Residents should demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

PGY-2 Objectives:

1. Coordinate patient care within the health care system relevant to their clinical specialty
2. Work in inter-professional teams to enhance patient safety and improve patient care quality

3. Demonstrate proper skills in the continuing care of patients with long-term disabilities through appropriate follow-up care

PGY-3 Objectives:

1. Participate in identifying system errors and implementing potential systems solutions.
2. Discuss the principles, objectives and process of performance improvement and program evaluation, risk management and cost effectiveness in medicine
3. Examine the types of patients served, referral patterns and services available in the continuum of rehabilitation care in community rehabilitation facilities. These might include subacute units and skilled nursing facilities, sheltered workshops and other vocational facilities, schools for persons with multiple handicaps, including deafness and blindness, independent living facilities for individuals with severe physical impairments, day hospitals, and home health care services, and community based rehabilitation. Introduction to these options for care may be made by on-site visits to some of these facilities as well as didactic lectures. Residents should be encouraged to interact with health care consumer groups and organizations in supervised working environments
4. Coordinate effectively the inpatient rehabilitation service.

PGY-4 Objectives:

1. Demonstrate effective collaboration in various health care delivery settings and systems relevant to their clinical specialty
2. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate
3. Advocate for quality patient care and optimal patient care systems
4. Coordinate effectively and efficiently an interdisciplinary team of allied rehabilitation professionals for the maximum benefit of the patient through:
    a. understanding of each allied health professional's role
    b. ability to write adequately detailed prescriptions based on functional goals for physiatric management
    c. development of management and leadership skills.

OSTEOPATHIC PRACTICE, PRINCIPLES AND MANUAL MEDICINE

Goal*:* Residents should demonstrate an awareness of and responsiveness to the larger context and system of osteopathic medical practices including the integration of osteopathic principles and effective practice of manual medicine.

PGY-2 Objectives:

1. Coordinate osteopathic patient care for all patients as relevant to the practice of PM&R
2. Work with appropriate supervision to enhance patient safety and improve patient care quality
3. Demonstrate basic osteopathic manual medicine skills as applied to the care of patients with long-term disabilities

PGY-3 Objectives:

4. Participate in identifying osteopathic “lesions” and in implementing an appropriate treatment plan
5. Discuss the osteopathic principles, practices and techniques appropriate to specific patient presentations.
6. Examine the types of patients served, common compensatory patterns and techniques available for use in community rehabilitation facilities including subacute units, skilled nursing facilities, sheltered workshops and other vocational facilities, schools for persons with multiple handicaps and independent living facilities

for individuals with severe physical impairments. Introduction to these options for care may be made by on-site visits to some of these facilities as well as didactic lectures. Residents should be encouraged to interact with health care consumer groups and organizations in supervised working environments

7. Coordinate effective osteopathic treatment on the inpatient rehabilitation service.

PGY-4 Objectives:

8. Demonstrate effective collaboration in various health care delivery settings and systems relevant to the osteopathic practice in PM&R
9. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate
10. Advocate for osteopathic patient care and optimal patient care systems
11. Develop an understanding of the role of osteopathic manipulation in both inpatient and outpatient settings and be able to write appropriate osteopathic treatment prescriptions.

Resident Rotations

Inpatient Rehab/Ward:	EWSH/MFB, Lansing, MI. McLaren Hospital, Flint, MI.
Electrodiagnostic Medicine:	McLaren Lansing-Neurodiagnostic Lab, EWSH, and SPB, Musculoskeletal Rehabilitation McLaren Lansing, Lansing, MI; MFB, Grand Rapids, MI; McLaren Hospital Flint, Eyde Bldg., East Lansing
Physiatric Consultation:	McLaren Lansing; EWSH; MFB; McLaren Hospital Flint, Eyde Bldg.
Elective	Varies
Research	Lansing
Neurology	MSU Neurology EWSH, Lansing, and East Lansing, MI Ambulatory
Orthopaedics	Varies, Lansing
Rheumatology	Varies, Lansing
Sports Medicine	MSU Sports Medicine, East Lansing
Osteopathic Manipulative Medicine	MSU OMM, East Lansing
Spinal Cord Injury	MFB
Traumatic Brain Injury	MFB,SPB, Origami Mason, MI; EWSH,
Pediatric Rehabilitation	MFB, EWSH
Occupational Medicine	Sparrow Occ Health Medical Arts Building
Pain Medicine	Lansing, East Lansing, Flint

Outpatient PM&R	McLaren Lansing, SPB, Eyde, McLaren Flint, MFB
Prosthetics & Orthotics	Lansing/Northwestern University/McLaren/MFB
Residency Continuity Clinic	SPB Lansing
Sparrow Hospital	General inpatient/outpatient PM&R, EMG's

Some rotations feature combined experiences (i.e. EMG/Consults, EMG/SPB, Ortho/P&O etc.)

Resident Meetings:

Monday mornings, 7:00 a.m. (preceding the scheduled didactic lecture). Business issues will be addressed and/or Board and Self-Assessment Exam (SAE) review will take place. You will be notified by the Chief Residents of Board and SAE review sessions.

Didactic Program

Residency Didactics

The PM&R Didactic Program at Michigan State University College of Osteopathic Medicine, Department of Physical Medicine and Rehabilitation is outlined below. Unless otherwise specified, all residents are expected to attend and actively participate in all didactic sessions.

Regularly Scheduled PM&R didactic lectures

Monday mornings (except as announced in advance), usually 8:00 a.m. – 11:30 a.m. in the Sparrow Professional Building (SBP) with specific room assignments announced in advance by the Chief Residents. The PM&R didactic program follows a pre-determined three year rotating cycle designed to meet residents' general education needs. Presenters include staff, guest faculty, medical students, interns and residents. Lectures include resident case presentations, Grand Rounds and EMG practice sessions as scheduled by the Chief Residents (with input from the Inpatient Service residents).

EMG lectures and case presentations

Monday mornings (except as announced in advance): Generally include one or more case studies followed by "hands on" sessions regarding a specific EMG technique. Presenters include PM&R Faculty, guest lecturers, Residents and Fellows.

PM&R Grand Rounds

Designated Monday mornings, 7:30-8:30 am on the 6th floor Rehabilitation Unit in Sparrow Hospital. A schedule of topics and locations will be provided by the Chief Residents. Patient cases will be presented in an interdisciplinary manner to include therapies and psychosocial issues. Patient examinations will be conducted

bedside or in the therapy gym to demonstrate pertinent physical exam findings or to evaluate therapeutic interventions. Residents learn how to improve patient care by reviewing difficult cases with the Faculty.

PM&R Board Review

Resident-directed, Faculty-assisted board review scheduled on designated Monday mornings, 7:00 a.m. to 8:00 a.m. Chief Residents will assign content areas for review; location and time will be announced in advance.

Neuro-Rehabilitation Conference

Multi-disciplinary conference at Sparrow Hospital Cardiac Conference Room, 4th Floor, Friday mornings, September through May, 8:00 a.m. - 9:00 a.m. Attendees include neurologists, neurosurgeons, physiatrists, neuropathologists, neuroradiologists, neuropsychologists and psychiatrists from the Lansing/East Lansing area. Lectures are assigned on a rotation basis and include sponsored speakers with nationally recognized expertise. Presentation style varies and can include PowerPoint presentations, case presentations, literature reviews or neuroimaging/neuropathology presentations. This conference offers the rare opportunity for inter-specialty collaboration on a variety of topics and rehabilitation related issues.

***Muscle Conference**: Monthly joint presentation in conjunction with Neuro-Rehabilitation Conference. Consists of complex cases presented by Neurology, PM&R residents and Dr. Howard Chang, neuropathologist

OMM Conference

Primarily "hands-on" didactic is generally conducted by the OMM Faculty in the OMM Lab at West Fee Hall or at Sparrow Hospital on the MSU Campus on designated Monday mornings.

Grand Rounds at Mary Free Bed Hospital

Weekly lectures are attended by PM&R Residents assigned to the Spinal Cord Service at Mary Free Bed Hospital in Grand Rapids, MI. Lectures are scheduled on a rotating basis and include presentations by the PM&R Residents. Past topics have included pediatric rehabilitation, traumatic brain injury rehabilitation, and spinal cord injury rehabilitation.

Functional Neuroanatomy Course

Senior residents, with faculty participation, will conduct a neuro-musculoskeletal anatomy review, including cadaver pro-sections, on Tuesday and Thursday mornings throughout July and August. A schedule will be distributed.

Course Goals:

1. To gain a working knowledge of functional neuro-musculoskeletal anatomy.

2 To functionally correlate basic principles of muscle and joint function.

3. To improve the residents' neuro-musculoskeletal system physical exam

Course Participants:

All PGY2 PM&R residents at MSU College of Osteopathic Medicine

Course Description:

A lecture-discussion-demonstration format will include the following:

a. A detailed examination of the functional anatomy of muscles and joints of the human body with emphasis upon upper extremity and brachial plexus, lower extremity and lumbosacral plexus, the neck, trunk, and cranial nerves

b. Acquisition of the skill and knowledge necessary to accomplish efficient, accurate manual muscle testing of the non-impaired as well as disabled infant, child and adult via increased awareness of muscle topography.

c. Assessment of muscle strength and function as components integral to movement, based on joint motion caused by primary and secondary movers, including pertinent interactions.

d. A detailed examination of the key muscles by body region, including nerve and vascular supply, nerve root level, origins, insertions, and actions.

e. Exposure to the fundamentals of kinesiology and function of normal muscle with electromyographic correlations.

f. Application of anatomy and muscle function to clinical experience, including correlation of structure and function with clinical pathology.

g. Review of common peripheral nerve entrapment.

h. Cadaver anatomy lab sessions to reinforce concepts and information discussed in class.

Course Coordinators:

Chief Residents; Department of Physical medicine and Rehabilitation (with assistance from Residency Program Directors and other Faculty).

Resource Persons:

1. Physical Medicine and Rehabilitation attending physicians

2. Sports Medicine Fellow – Department of Physical Medicine & Rehabilitation

3. Other Michigan State University, College of Osteopathic Medicine faculty from the Division of Anatomy, Department of Neurology and the Department of Osteopathic Manipulative Medicine

Course Schedule:

The course will meet 1-2 hours per week, for 6-8 weeks, with outside preparation and study by the participant. The exact schedule of the course will be determined by the Residency Program Directors and the Course Coordinators in conjunction with residents' clinical rotation schedule.

Course Completion and Participant Evaluation:

Successful completion of the course by the participant will require the following:

1. Prompt attendance and active participation at all course meetings unless excused.
2. Performance of an accurate manual muscle testing examination with functional correlation.
3. Evidence of appropriate pre-class preparation.
4. Completion of written examinations, with a minimum score of 70% (re-testing will be at the discretion of the Residency Program Directors).

Note: All residents must pass all elements of this course; failure to meet minimum requirements for course completion will initiate a Residency Committee meeting to discuss remediation strategies.

PM&R Textbooks

Six textbooks are provided for each new resident by the Department. Attending physicians and residency program directors expect you to proactively use these resources on an ongoing basis. Reading these textbooks in preparation for clinical examinations, patient care rounds, inpatient and outpatient contact, formal and informal presentations and other settings is expected:

1. Hollingshead's Functional Anatomy of the Limbs and Back (9th Ed.). Jenkins DB. Philadelphia: WB Saunders Co., 2009
2. Electromyography and Neuromuscular Disorders Clinical-Electrophysiologic Correlations (3rd Ed). David C. Preston Barbara E. Shapiro, ELESVIER Saunders Co., 2013
3. Physical Medicine and Rehabilitation: Expert Consult-Online and Print, (5th Ed). Braddom RL., David Cifu, ELSESVIER Saunders Co., 2015
4. Manual of Nerve Conduction Study and Surface Anatomy for Needle Electromyography, (4th Ed.). Hang J. Lee, Joel A. DeLisa Lippincott Williams, and Wilkins, 2005
5. Easy EMG, Lyn Weiss, J. Silver, J. Weiss, Butterworth Heinemann, 2004
6. PM&R Pocketpedia, Howard Choi, R. Sugar, D. Fish, M. Shatzer, B. Krabak (2nd Ed.). Philadelphia, Lippincott, Williams, and Wilkins, 2013
7. Physical Medicine and Rehabilitation Principles and Practice; Walter ar. Frontera, Joel DeLisa (5th Ed.)

8. Orthopedic Physical Assessment (Musculoskeletal Rehabilitation Series) (6th Ed.) David J. Magee BPT, PhD, CM

Suggested Textbooks:

1. **Muscle Testing: Techniques of Manual Examination and Performance Testing**, (9th Ed), Daniels and Worthingham
2. Medical school level gross anatomy text.
3. Medical school level anatomy atlas.
4. Krusen's Handbook of Physical Medicine and Rehabilitation (4th Ed.). Kotte FJ, Lehmann J. Krusen's, WB Saunders Co.
5. Kinesiology: Applications to Pathological Motion. Soderberg & Soderberg GL. Baltimore: Williams & Wilkins, 1996.
6. Clinically Oriented Anatomy. Moore KL., Arthur F. Dalley, Anne MR Agur, (8th Ed.)

RESIDENT RESEARCH PROGRAM

PURPOSE: In order to ensure adequate knowledge of the methodology and practice of clinical research upon graduation from the MSU COM SCS PM&R Residency Program, and to implement AOA and ACGME requirements to demonstrate competency in research as part of the core competencies of Professionalism and Practice-Based Learning and Improvement, this Resident Research Program has been established.

GOALS:

1) Immediate goal: Provide MSU PM&R residents with a basic foundation in clinical research methods and skills, as well as an initial experience in designing, implementing and completing a research project.

2) Long-term goal: Increase the quantity and improve the quality of research within the specialty of Physical Medicine and Rehabilitation.

OBJECTIVES: By the conclusion of their residency training, MSU PM&R physician residents will:

1) Complete a research literature review and develop an acceptable research question and research hypotheses.

2) Develop a research design and statistical analysis plan appropriate to the research hypotheses.

a) Implement and complete a data collection process (or a simulated data collection process, as outlined in the Appendix) that addresses

b) Presentation of poster or oral presentation at a regional or national professional meeting.

c) Publication of an abstract or full article in a professional journal.

d) Written paper presented to the MSU PM&R Research Advisory Committee within the first six months of the third year of residency (PGY4) (simulated data collection option only).

RESOURCES:

1) The MSU COM SCS web-based series on Research Methodology, at http://scs.msu.edu/mm/rtc

2) The MSU IRB researcher certification program

3) The MSU COM SCS Medical Ethics training module

4) Mentoring opportunities from various PM&R research and clinical faculty

PERFORMANCE EXPECTATIONS:

(Unless specified otherwise, all written submissions are to the Residency Director.)

PGY 2:

July - June:

Complete the MSU COM SCS Research Methods series

September 30:

1. Submit the following in writing:

a. Identify area of research interest

b. Identify Mentors for area of interest

- You are advised to have at least one mentor with a Ph.D. background and expertise in research, and
- another who is a physician who can give you direction regarding the clinical aspects of research

2. Begin Literature Review of topic of interest

October/ November:

1. Attend the MSU PM&R Resident Research Day

March 15:

1. Complete MSU IRB researcher certification

2. Submit certificate of completion to Residency Director

April 15:

1. Submit written progress report; include:

a. Formulation of research question

b. Hypothesis/es

c. Names of Mentors and their roles

2. Complete Literature Review (written form not needed yet)

3. Begin Methods and Design planning (Written form not needed yet)

4. Written evaluation by mentors

May:

Attend the UM James Rae Scientific Day

May 31:

Review IRB process and requirements

June 15:

As a preliminary exercise in grant writing, submit to the chair of the MSU COM PM&R Research Advisory Committee the following (in writing): A completed informal resident research application, including a brief literature review

PGY 3:

August 15: Submit IRB application

September 15:

1. Following feedback from the MSU COM PM&R Research Advisory Committee, submit written progress report including:

a. Completed Literature Review

b. Final version of Methods and Design

c. Date of IRB documents submission with assigned IRB number

2. Prepare for MSU PM&R Resident Research Day presentation

a. Review draft abstract with mentor

b. Submit final abstract (initialed by mentor) by four weeks prior to MSU PM&R Resident Research Day

c. Assemble PowerPoint or similar presentation

d. Presentation should include:

1. Names of mentors

2. Title

3. Research Question

4. Research Hypothesis(es)

5. Literature Review

6. Proposed Methods and Design

October/ November:

1. Present at MSU PM&R Resident Research Day

a. Power Point or similar format

2. Presentation MUST include:

a. Names of mentors

b. Title

c. Research Question

d. Research Hypothesis(es)

e. Literature Review

f. Proposed Methods and Design

3. IRB approval attained

4. Begin implementation

January 15:

1. First written progress report with:

a. Status of project implementation

b. Status of data collection

2. Evaluation from Mentors

May 1:

1. Evaluation of project progress by mentor

2. Second written progress report with:

a. Implementation status

b. Summary of data collected thus far

May: Attend the UM James Rae Scientific Day

PGY 4:

July-October:

Practice 20-minute presentation and critique of project and results at a MSU COM PM&R Research Advisory Committee meeting

October/ November:

1. Review results and draft of research abstract with mentor

2. Submit final research abstract (initialed by mentor) by four weeks prior to MSU PM&R Resident Research Day

3. MSU PM&R Resident Research Day presentation

a. Literature review

b. Hypothesis(es)

c. Implementation status

d. Preliminary results

December:

PUBLICATION/POSTER OPTIONS

James Rae Day poster	**Present at National Meeting**	**Journal Publication**
March 15: Submit written draft of poster for GMEI Research Day or James Rae Scientific Day	December: Submit abstract for poster or oral presentation to AAPM&R, AAP, AAEM or other	Submit draft manuscript written for submission to publications (check instructions to authors

May: Present Poster of for the journal you select)

project at GMEI Research

Day or James Rae Scientific Day

For the simulated data collection option:

Present a written paper to the MSU PM&R

Research Advisory Committee within first

six months of the third (PGY4) year of the

residency

June 10:

1. Submit final project report to Residency Director, Mentor(s) and MSU COM PM&R Research Advisory Committee
2. Written evaluation by mentors submitted to Residency Director

REVIEWED: February 20, 2015,

RESEARCH REQUIREMENTSF FOR PM&R RESIDENTS-SIMULATED RESEARCH OPTION

The simulated research project would include all steps in the process of doing a research study, but without actually collecting real data for the study.

This option is to be used only in cases involving major time constraints for completion of the resident research requirement, and only with permission from the Program Director and/or Research Mentor.

The simulated data collection would include at a minimum:

- Development of a valid research question and associated hypotheses
- Selection of primary and secondary outcome measures
- Filling out simulated data for a small number of outcome measures
- Working with a statistician to put together a spreadsheet for simulated data collection; i.e. if 1000 patients are being used for the study, 1000 data points would be put into the data base (even though none had actually been collected)
- Analysis of this data with the statistician, and even “manipulation” of the data to decide the best way to analyze and report it

- Actual writing of a paper and discussion of the simulated data analysis, which would be consistent with any other paper written for an actual research project

QUALITY IMPROVEMENT PROJECT REQUIREMENT

Each resident is required to complete a quality improvement project and complete the IHI online curriculum on Quality Improvement, Patient Safety and Leadership prior to graduation for the program. The resident can collaborate with other residents on the completion of the project.

Journal Club

A Journal Club is a mandatory monthly experience which includes presentation of critical reading skills and evidence-based medicine, as well as resident presentation of articles demonstrating the application of those principles to current medical literature. Articles contributing to recent advancements in physiatric knowledge are stressed. The sessions are led by attending physicians and Ph.D. basic scientists.

Journal Club Improvement Modules provided by the College of Osteopathic Medicine State Wide Campus office can be found at: http://scs.msu.edu/media/jcs/, to assist you in enhancing your journal club experience.

Article assignments will be made by the Chief Residents with the approval of the Program Directors. Each presentation will be evaluated as follows:

Each resident is required to complete a quality improvement project and complete the IHI online curriculum on Quality Improvement, Patient Safety and Leadership prior to graduation from the program. The resident can collaborate with other residents on the completion of the project

JOURNAL CLUB CHECKLIST

Did the presenter:

State the problem(s) being addressed in the study? Y N

State the research question(s) or hypotheses? Y N

Describe the primary variables being measured? Y N

Present information on the subjects used in the study and assess their appropriateness? Y N

Describe the research design and assess its appropriateness? Y N

Evaluate the appropriateness of the data analyses? Y N

Evaluate the appropriateness of the conclusions presented in the paper and their general applications? (Were they supported by the data presented?) Y N

Article assignments will be made by the Chief Residents with the approval of the Program Directors.

Revised: 4/14/ 10, 5/24/13, 2/20/15, 4/13/17, 6/15/17

ASIA Learning Module

The ASIA InStep Learning is a six-module on line course. Completion is a Residency Requirement. The course prepares clinicians to properly conduct and score the exam for the International Standards for the Classification of Spinal Cord Injury.

WeeSTep is a complement to InSTep that supports clinicians who will be performing the International Standards exam for pediatric patients.

ASTeP describes the changes in autonomic functions following SCI, as well as how to document and classify remaining autonomic neurologic function

The course is free, but a certificate of completion is 25.00 dollars and is recommended you get the certificate for your portfolio. Submit your receipt with a GMEI request for reimbursement form, and a copy of the certificate to the residency coordinator and the request will be submitted to GMEI on your behalf. If you prefer the fee can be paid by the residency coordinator on the department credit card.

To register for the course, go to: http://www.asia-spinalinjury.org/elearning/elearning.php

Then click on the VisitAsiaLearningCenter.org link to register at the NEW USER tab at the top right hand side of the page.

The Program Directors will follow residents progress on-line

(Should probably add a time line for when in the first year this should be started and completed)

PORTFOLIOS

PORTFOLIOS: Residents are expected to keep portfolios of their activities as part of their professional development.

Purpose: To provide an informative evaluation and progression of your "best work" over time. Portfolios are designed to assist professionalism, personal growth and scholarly achievement. Portfolios are a collection of documents taken from residents' actual didactic and clinical experiences, chosen by the resident (with advice from attending physicians and other faculty) to demonstrate competency and to document leaning and achievement related to an established learning plan (guided by the 6 core competencies, which should be put to memory). It is expected that the portfolio will be characterized by self-assessment, reflection on what has been learned in a self-directed manner that will be initiated and developed in a longitudinal manner to allow the tracking of progress. Portfolios will include, but not limited to, the following content:

Current Curriculum Vitae

Current License(s) BLS, ACLS

Journal Club attended (at least on article /year presented at Journal Club)

Research on line (certificate of completion of on-line modules)

Research conducted, participation in research project (tracking of increased knowledge of research methods)

Summary of literature reviews used to make treatment decisions (1 article/quarter: copy first page of the article and make a quick notation about how you apply this to a patient's care)

Patient or family counseling (this can by date/time of inpatient family conferences)

Community/volunteer activity

Publications

Examples of H&P's discharge summaries, and other medical records (not required)

Presentations developed/given

Lists of procedures complete (ACGME logs)

ROCAs (13/year need for promotion/graduation)

Ask Senior residents if you can see their portfolios, some in paper an others computerized for ideas.

Don't fall behind on your portfolio

Revised: 7/1/11, 5/24/13, 2/20/15, 4/13/17, 6/26/17

DIDACTIC PRESENTATION GUIDELINES

Grand Rounds

1. Grand Rounds allow attending physicians, residents, fellows, students on rotation, and rehabilitation staff the opportunity to hear case presentations, examine patients, and discuss diagnostic and/or management concerns as a group. Grand Rounds are generally the presentation of a difficult diagnostic/treatment case to discuss further options emphasize key rehab concepts or to review common clinical diagnoses.

2. Chief Residents will arrange the Grand Rounds schedules and should be notified of the proposed presentation title one week in advance. A brief, one-page summary of the case for distribution is desirable. Residents will be required to do Grand Rounds presentations periodically throughout each academic year.

3. Suggested format – (55-60 minutes):

a. Presentation of case (5-10 minutes). This should include a comprehensive presentation of all pertinent aspects of the patient's history, physical exam, laboratory data and hospital reports. Questions may be asked by or of the audience to enhance understanding of a given topic.

b. Image presentation as appropriate (5 minutes). Pertinent radiographs should be presented with findings described as they pertain to the case.

c. Patient presentation (5-15 minutes). When possible and appropriate, physical examination of the patient is encouraged. When this is not feasible, slides, videotapes or other media may be used. Significant physical exam findings should be demonstrated in addition to standard reflex and manual muscle testing.

d. Discussion of patient management issues (10-20 minutes). Some areas of the presentation may be explored in-depth. Background information and pertinent literature may be discussed. Discussion is "free form" can be directed by the resident, attending staff physicians, or other attendees.

4. Residents are encouraged to involve attending physicians or other resource persons in advance of their presentation. This will allow the resident to present a much higher quality Grand Rounds, and to avoid common pitfalls. Presenters will receive feedback after their presentations, from attending staff and/or the residents.

Formal Academic Presentations

1. Formal academic presentations allow the resident to gain experience in presenting a focused topic pertinent to physical medicine and rehabilitation and suitable for presentation in a formal academic environment. Topics include exploration of areas discussed during patient rounds, grand rounds or other settings. An in-depth knowledge of applicable literature is required.

2. The Chief Residents should be notified of a proposed presentation title one month in advance. A brief summary of the topic to be discussed including a bibliography is standard and will be placed in each resident's permanent file for reference. A formal academic presentation is required of each resident annually. The Chief Residents will schedule these presentations with input from the residency program directors.

3. Formal presentations should be 40-50-minute-long with time allowed for discussion and questions. A copy of each PowerPoint presentation will be filed in the resident's permanent file.

4. Residents are strongly encouraged to meet with staff physicians or other resource persons at least 4-5 weeks in advance of a formal academic presentation. Their input will improve presentation quality and provide additional feedback and references. Resident presentations will evaluated by the attending staff and residents with a goal of preparing the resident for academic presentations in his/her post-residency academic career.

5. At least ONE formal academic presentation is required of each first year resident. At least TWO formal academic presentations are required of 2nd and 3rd year residents.

Reviewed 2/20/2015, 4/13/17, 6/23/17

Electrodiagnostic (EDX) Medicine Program Outline and Competency Testing

This program's EDX medicine experience is spread over all 3 years and EMG is integrated into most rotations.

There are 3 specific one-month rotations and another 3 months with incorporated EDX including Sparrow SPB, Sparrow Inpatient, MGL Flint Outpatient, Consults, P&O.

Year in training: PG 2, 3 and 4

Level of supervision by attending physician: Direct supervision

Supervision of junior residents: Indirect supervision of junior residents.

Location of rotation: McLaren Ortho Campus, SPB, Sparrow Inpatient, MGL Inpatient.

Responsible Faculty: Drs. Andary, Sylvain, Schlinger, Storm, Prokop, O'Connor, MSU PM&R Faculty, On-call faculty.

Goals of rotation: This is a primarily out-patient based experience (and occasional hospital EMGs) with a graduated approach from basic to advanced concepts in neuroanatomy, neurophysiology, and electrodiagnostic medicine with a correspondingly increased complexity of skill performance.

1. **Patient Care**

Post Graduate Year **Competency Based Objectives**

Year 2

- Perform a complete, pertinent, and efficient clinical evaluation of a patient (by history and directed physical examination) and develop differential diagnoses pertaining to electrodiagnostic evaluation.
- Develop and implement a basic plan for nerve conduction studies.
- Successfully complete a practical exam covering nerve conduction studies including wave form recognition and analysis, latency and amplitude determination and calculation of conduction velocities, with emphasis on the median, ulnar, sural, radial, tibial, and peroneal nerves.

Year 3

Successfully complete a practical electrodiagnostic medicine skills-proficiency examination concerning pertinent EMG-related anatomy, needle placement, muscle recruitment, and proper equipment usage.

- Adequately perform nerve conduction studies required for common focal/peripheral neuropathies (e.g., median, ulnar, radial, peroneal, tibial, sural nerves, H reflex, F wave) and recognize abnormal values and common sources of operator error.
- Adequately perform needle electromyography and identify normal and abnormal findings and their significance
- Analyze data from EMG and NCS to formulate an EDX diagnosis
- Develop comprehensive differential diagnoses based on history and exam to guide the EDX study
- Demonstrate the following in regard to needle electromyography: patient preparation, choice of electrode, insertional and spontaneous activity analysis and motor unit analysis

Year 4

- Use electrodiagnostic data to modify the study as it is being performed
- Prepare a complete electrodiagnostic report with appropriate recommendations
- Recognize and reconcile results that are not consistent with the history and physical exam
- Quickly and efficiently prioritize the electrodiagnostic study based on presenting symptomatology Demonstrate performance of advanced electrodiagnostic procedures and complete an appropriate and concise EDX report

2. **Medical Knowledge**

Post Graduate Year **Competency Based Objectives**

Year 2

- In regard to nerve conduction studies:
- Explain methods of measuring compound and sensory nerve action potentials
- List and explain at least three types of late responses
- Describe the rationale, indications, and general procedures for conducting repetitive stimulation studies.
- Describe basic anatomy of peripheral nerves and skeletal muscle
- Demonstrate basic familiarity and proficiency with electrodiagnostic evaluation of the following disease states/diagnoses (including history, pertinent physical examination, planning and

executing a complete electrodiagnostic study and generating a succinct and complete report according to AANEM standards):

- carpal tunnel syndrome
- radiculopathy
- plexopathy
- peripheral neuropathy
- myopathy disease
- nerve entrapment/compression
- Neuromuscular diseases: Amyotrophic Lateral Sclerosis, Myasthenia Gravis, Myasthenic Syndrome,
- Inflammatory Diseases: Polymyositis, Dermatomyositis, Inclusion Body Myositis, Acute Inflammatory Demyelinating Polyneuropathy (Guillain-Barré Syndrome) and cranial-facial disorders.

Year 3 and 4

- Demonstrate basic familiarity and proficiency with electrodiagnostic evaluation of the following disease states/diagnoses (including history, pertinent physical examination, planning and executing a complete electrodiagnostic study and generating a succinct and complete report according to AANEM standards):
  - carpal tunnel syndrome
  - radiculopathy
  - plexopathy
  - peripheral neuropathy
  - myopathic disease
  - nerve entrapment/compression
  - Neuromuscular diseases: Amyotrophic Lateral Sclerosis, Myasthenia Gravis, Myasthenic Syndrome,
  - Inflammatory Diseases: Polymyositis, Dermatomyositis, Inclusion Body Myositis, Acute Inflammatory Demyelinating Polyneuropathy (Guillain-Barré Syndrome) and cranial-facial disorders.
- Identify EMG needle insertion sites in commonly studied muscles

- Explain the basic concepts of electrodiagnostic instrumentation
- Explain the basic concepts of clinical electrophysiology pertaining to electrodiagnostic medicine including (but not limited to):
- Action potential initiation and propagation
- Generation of wave form morphology
- Characteristics of nerve, muscle, and end-plate potentials
- Motor unit analysis
- Characteristics and analysis of abnormal spontaneous potentials
- Classification of peripheral nerve injuries.
- Given data obtained in a real or simulated electrodiagnostic evaluation, demonstrate the ability to localize peripheral nerve lesions and to estimate a prognosis.

3. Practice-Based Learning and Improvement

Post Graduate Year Competency Based Objectives

Year 2 and 3

- Review current literature regarding medical information for diagnoses seen in EDX clinic

Year 3 and 4

Effectively solicit and utilize constructive feedback from all team members, including attending physicians, patients and their families

- Integrate newly acquired knowledge into the assessment of rehabilitation treatment and outcomes
- Properly alter the EDX interpretation and treatment recommendations based on response to treatment
- Self-analyze practice experiences and perform practice-based improvement activities using a systematic methodology

Basic Skills Checklist for Electrodiagnostic Medicine

This review process is implemented to ensure that residents demonstrate the following basic knowledge and skills prior to being scheduled independently with patients. These will be reviewed with the EMG attending physician.

Electromyography (EMG)

The resident will be able to: a) Identify the location of b) nerve and root innervations of c) methods to activate each of the following muscles:

Cervical paraspinals	_____	Lumbar paraspinals	_____
Deltoid	_____	Vastus medialis	_____
Biceps	_____	Anterior tibialis	_____
Extensor Digitorum	_____	Tensor Fascia Lata	_____
Pronator teres	_____	Short Head of Biceps Femoris	_____
Flexor Carpi Ulnaris	_____	Medial gastrocnemius	_____
Triceps	_____	Rectus femoris	_____
Flexor carpi-radialis	_____	Adductor longus	_____
First dorsal interosseous	_____	Lateral Gastrocnemius	_____
Abductor pollicus brevis	_____		

Nerve Conduction Studies (NCS)

Resident will turn in waveform tracings for the following NCS:

_____ 1. Median sensory – antidromic from wrist and mid palm to index finger.

_____ 2. Ulnar – antidromic between wrist and little finger

_____ 3. Median – sensory to the thumb

_____ 4. Radial – sensory to the thumb

_____ 5. Median – motor to APB at elbow and wrist with nerve conduction velocity. Ulnar to Thenar

_____ 6. Ulnar – motor at elbow, below elbow, above elbow and axilla to the ADM and FDIM

_____ 7. Peroneal motor to EDB at ankle, below fibular head and above fibular head

_____ 8. Tibial motor to abductor hallucis at ankle and knee

_____ 9. Sural sensory antidromic from calf to ankle

_____ 10. Tibial H reflexes and Tibial F-waves.

Techniques can be found in the DeLisa Handbook of Manual Nerve Conductions or in AAEM Handout Sensitive Techniques for the Diagnosis of Carpal Tunnel Syndrome.

Reviewed by: MTA, Director, Electrodiagnostic Laboratory

Revision date: 06-28-2010, 6/13

Reviewed 2/20/2015, 7/2/2017

ELECTRODIAGNOSTIC QUALITY ASSURANCE SHEET

Patient: _____

Electromyographer(s): _____

Date of Test: _____

1. Is there a history and physical? Y _____ N _____ N/A_____

a. Does the history and physical support the testing done?

2. Are the nerve conductions, distal latencies and distal latencies recorded?

Y _____ N _____ N/A _____

3. Is the temperature recorded? Y _____ N _____ N/A _____

4. Are the EMG findings recorded?Y _____ N _____ N/A _____

a. Should there be more tests? (Explain Yes Answer)

_____

_____

b. Should there be fewer tests? (Explain No Answer)

_____

_____

Impressions

a. Is it clearly stated where this test is normal, borderline or abnormal?

Y _____ N _____ N/A_____

b. Does the impression list the major finding?

Y _____ N _____ N/A _____

C. Does the impression list any major rule outs (if any)?

Y _____ N _____ N/A _____

D. Does the Impression give a clinical correlation?

Y _____ N _____ N/A _____

e. Any other suggestions to improve the quality of this test?

Y ___ N ___ N/A ¬____

_____

_____

Explain any NO answers: _____

_____

(Revised: 6/2013. Reviewed 2/2/2015, 7/2/17)

Pediatric Service

Inpatient pediatric rehabilitation will be done primarily at Mary Free Bed Hospital (MFB) under the supervision of Andrea Kuldanek, MD and A.J Rush, MD, and Lisa Voss, DO. These three physicians are Board Certified in pediatrics and physiatry and have extensive experience in training pediatric residents, interns, and rotating physiatry residents. MFB has approximately 108 pediatric inpatient admissions per year and extensive outpatient clinics. Residents will be following between 5-10 inpatients at a time during their month of pediatric rehabilitation.

There is exposure to a wide variety of diagnoses: spinal cord injury, traumatic brain injury, congenital developmental delay, inborn errors of metabolism, myelomenigocoele, etc. MFB is the primary pediatric rehabilitation referral center for northern and western Michigan.

Inpatient pediatric rehabilitation experience is also available on an intermittent basis on consults at EWSH. During clinic rotations, residents will be exposed to outpatient pediatric rehabilitation including treatment spasticity with oral and injectable medications.

Self-Assessment Examinations (SAEs)

The Department of Physical Medicine and Rehabilitation will pay the fee for each resident to participate in two annual Self-Directed Medical Knowledge Program SAEs: PM&R (AAPMR sponsored) and EMG/NCV (AANEM sponsored).

Residents are required to participate in the PM&R SAE (scheduled on a Saturday in January each year) and in the EMG/NCV SAE (scheduled on a Saturday in June each year). Residents are expected to adjust their schedules to allow time to take these exams at the appointed times. Residents will be notified well in advance of each of these examinations.

SAE results allow individual residents to assess their relative areas of strength and weakness and to guide further study and reading. The Department of PM&R uses these results to evaluate the effectiveness of our training program's educational objectives. Your performance on these examinations will not affect your good standing in the residency program.

SAE results are shared only with the resident and attending physicians. Questions regarding SAEs and how the results are disseminated should be referred to residency program directors.

Department Library:

Resource materials, books, CDs and journals are available for you to check out from the informal libraries in the residency room in 401 West Fee, the PM&R residency room in on 6 Foster and SPB in Suite 520.

Educational License

The Sparrow GME Department will pay for a Limited Educational License and a Limited Educational Controlled Substance License for each resident each year. These licenses are issued by the State of Michigan, Department of Licensing and Regulatory Affairs. The scope of Limited Educational License is restricted to those duties and responsibilities directly associated with the residency training program or as otherwise approved by the residency program directors. Residents are responsible to complete appropriate applications promptly.

Residents may obtain a full license to practice medicine from the State of Michigan, Department of Licensing and Regulatory Affairs at their own expense. The GME office will reimburse each resident each year for the cost of renewing educational licenses. Any "moonlighting" requires an unrestricted Medical License as well as a

Controlled Substance License from the State of Michigan, Department of Licensing and Regulatory Affairs. Most moonlighting facilities also require Federal Narcotics Registration with the Drug Enforcement Administration. The Department of Physical Medicine and Rehabilitation will not pay for any portion of a full Medical License, Controlled Substance License, or a Federal Narcotics Registration/DEA number. Sparrow Hospital Policy requires that if you obtain your full license that you must also get a permanent State of Michigan pharmacy license.

Verification of Employment

The Human Resource Department of Sparrow Hospital will verify employment. Other details will not be released without the resident's expressed, written permission.

Medical Records Completion

Residents are expected to promptly and accurately complete all medical records throughout their residency program. Questions concerning the completion of medical records should be directed to the appropriate attending physician or to a residency program director.

Please Note: To successfully complete any rotation, medical records must be fully and accurately completed prior to the end of the rotation

Organizational Membership and Dues

The Department of Physical Medicine and Rehabilitation will pay membership dues for each resident in the following organizations:

1) American Academy of Physical Medicine and Rehabilitation (AAPMR)

2) American Osteopathic College of Physical Medicine & Rehabilitation (AOCPMR, for Osteopathic Residents)

3) American Osteopathic Association (AOA, for Osteopathic Residents)

Secretarial Support

Secretarial support is available to residents on a limited basis at the Physical Medicine & Rehabilitation Department Academic Office (West Fee Hall). Support is available for completion of forms and preparation of PowerPoint presentations, etc. For the secretarial/support staff to more efficiently meet your needs, you will be requested to a) fill out a Work Assignment Sheet describing what you want done; b) place the Work Assignment Sheet in the appropriate work box; c) give the secretary as much advance notice as possible. Short term, "emergency" requests for secretarial support will be honored on an "as able" basis. Please do not leave work or other requests on the secretary's desk – put it in the work box.

Questions concerning secretarial support should be directed to the Department Secretary, or to the Residency Coordinator.

Resident Leave Time

Vacation

1. 15 paid days per academic year for PGY 1

2. 20 paid days per academic year for PGY 2

3.. These are requested on the rotation and vacation request forms found on the web site under the resident tab. http://pmr.msu.edu/index.php/residents

4. Unused days at the end of a year will not be carried over into the next year and will not be paid out.

Other Leave

1. All requests for leave time other than scheduled vacations MUST be made in writing at least 30 days in advance. There are exceptions for extenuating circumstances, but all requests must still be in writing.

2. Any requests are subject to approval and are not guaranteed. All attempts will be made to grant requests and leave will not be unreasonably denied.

3. Requests are subject to an approval process, so that scheduled leave time does not interfere with the day-to-day functioning of the institution. This will be granted on a first-come, first-serve basis, except in regard to conference time.

4. Conference time will be judged on the basis of seniority and preference will be given to senior residents.

5. Preference will also be extended to any residents involved in presenting research topics or case presentations.

8. Any sick time for longer than 3 consecutive days may require a doctor's note, will require that the Family Medical Leave Act paperwork through Sparrow's GME department be started. It may be necessary to repeat the rotation if more than five days a missed form any one give rotation.

9. Military Service leave is allowed without pay consistent with the Sparrow Human Resources Policy. Arrangements for a military service leave is to be made through the Program Director with the approval by the Vice President of Medical Education (VPME)

9. Resident requesting leave MUST secure coverage from his/her fellow residents in order for leave to be approved. Any difficulties in securing this coverage should be brought to the attention of the Chief Resident first and subsequently the Residency Program Director, who will assist in obtaining that coverage.

Family and Medical Leave Policy

Family Medical Leave Act

Sparrow GME has a policy in place for the Family Medical Leave Act. Please contact the Sparrow GME department to help you select the form that best applies to your situation.

The federal Family and Medical Leave Act (FMLA) permits certain employees who qualify to take unpaid leave for their own serious health conditions, to care for a spouse, child or parent with a serious health condition, to care for a newborn child, a newly adopted child, or a new foster child.

Qualifications: You may qualify for a family and medical leave of absence if:

- you have received paychecks or stipends from Sparrow for at least 12 months, and
- you have worked at least 1,250 hours during the 52-week period preceding the start of your leave of absence

Circumstances for Eligibility: Sparrow Medical Education trainees who qualify may take up to 12 weeks of unpaid leave, in a 12 month rolling period, in the following situations:

1. The after of your child if the leave is completed within twelve (12) months of the date of birth of the child
2. The placement for adoption or foster care of a child with you if the leave is completed within 12 months of the date of placement of the child
3. To care for an Eligible Family Member if that individual has a Serious Health Condition
4. For you own Serious Health Condition that renders you unable to perform the essential functions of your job
5. Qualifying Exigency Leave - this leave is taken because of a Qualifying Exigency arising out of the fact that a Military Member in your family is on Covered Active Duty Status (or has been notified of an impending call or order to such covered Active Duty) in the Armed Forces; or
6. Military Caregiver Leave – this leave is taken because a Covered Service member in your family has a Serious Illness or Injury and needs your care.

The 12-month rolling period is the 12-month period immediately prior to the request. If you and your spouse both are eligible an employed by Sparrow, you are jointly entitled to a combined total of 12 weeks of leave for the birth of your child or for placement for adoption or foster care of a child with you or for the care of a parent with a Serious Health Condition. Likewise, spouses who are both employed by Sparrow are jointly entitled to a combined total of 26 weeks of Military Caregiver Leave to care for ta Covered Service member.

A “serious health condition” is defined by federal regulation as an illness, injury, impairment or physical or mental condition that requires in-patient care in a hospital, hospice or residential medical care facility or that requires continuing treatment by a health care provider.

When possible, you must provide reasonable notice a 30 days in advance of the need for leave under this policy. Notice should be provided to the Sparrow Hospital Medical Education Director of Operations. You will be required to support your claim for leave by providing a copy of a certification from a health care provider. You may also be required to provide medical recertification, second and third opinions, and fitness for duty reports.

When taking leave under this policy, you will not lose any employment benefits you have accrued prior to taking leave. Benefits will not accrue during an unpaid leave, however. Also, during the period of your leave under this policy, Sparrow will maintain your coverage in its group health plan. This means your benefits will be continued on the same basis as if you were continuing your employment.

Sparrow medical education trainees who fail to return to the residency are responsible for repaying the cost of health care coverage during their leave to Sparrow. When you complete your leave of absence, you will return you to the same residency position which you held before you took your leave.

For complete information about your rights and obligations under this policy, talk with the Sparrow Hospital Medical Director of Operations or request a copy of the Federal Family and Medical Leave Act to review yourself. No statement in this Handbook is intended to conflict with your rights or the obligations under the Federal Family and Medical Leave Act. If there is a conflict, the provisions of the Federal Family and Medical Leave Act will control.

Sparrow Hospital medical education trainees who elect to request leave under FMLA must recognize that this could delay the completion of their educational program. Sparrow GME strongly encourages interested graduate medical education trainees to discuss with their Program Director the impact of this decision and possible resolutions.

Holiday Pay

Sparrow grants eligible residents (6) paid holidays; Residents are eligible for holiday pay on the date of hire. Vacation days are not carried over from year to year. Trainees who leave the program before the end of the fiscal year are not entitled to payment for unused vacation time.

The benefit is not payable to residents who are on an official leave of absence without pay, worker’s compensation, or disciplinary suspension. Residents with an unexcused absence on either the day before or the day after the holiday are not eligible for holiday pay.

Residents preferring alternative religious holidays should notify the chief resident and Program Director at the start of the fiscal year (July 1st). Since religious holidays fall at various times throughout the year, requesting religious holidays other than those listed requires approval.

Fourth of July	1 day allowed

Labor Day	1 day allowed
Thanksgiving	1 day Thursday
Christmas	1 days allowed
New Year's	1 days allowed
Memorial Day	1 day allowed

Absence from Training

It is a requirement of the American Board of PM&R to complete 48 months of ACGME accredited training in order to be eligible for Board Examination. Twelve of the months (PGY1) must be used to develop fundamental skills and can be in a variety of settings. The remaining 36 months must be in an ACGME accredited PM&R residency training program.

According to the ABPMR, absence is defined as follows:

a. "A resident should not be absent from the residency training program for more than six weeks (defined as 30 working days) yearly. "This is regardless of the institutional policies regarding absences."

b. "Any leave time beyond six weeks would need to be made up by arrangement with the program director."

c. "Leave time" is defined as sick leave, vacation, maternity leave, leave for locum tenens, or work in another program that is not ACGME-accredited. A candidate for the board exam cannot accumulate leave time or vacation to reduce the overall duration of training."

d. Educational conferences, paper presentations, required courses, and examinations are considered educational leave time, and do not constitute leave time as defined above.

Partial days off for medical appointments or family issues - Residents that miss a short period of work (e.g. 1-3 hours) and stay late to make up their work and get coverage do not miss any training time. As salaried employees, this short period of time also does not count as vacation or sick time. However longer periods of time off (e.g., half days) from educational and service rotations may be counted as lost training time. This will count against the educational 30 days' absence time defined by ABPMR. Thus, this half day must be remediated, usually by extending training time. However, this could be remediated with extra weekend training time or other duties to be determined with the resident, the Program Director and the Department Chair.

Number of days missed with training time per year – Although the ABPMR allows up to 30 days' absence of training time this is not necessarily allowed nor is it the residents' "right" to miss all 30 days per year in the MSU PM&R residency without remediating and extending training. In the case where a resident misses between 20 and 30 days of training in a year, these extra training days may need to be remediated either with prolonged residency or additional duties such as weekend training. Residents in

good standing will be offered remediation and will not be dismissed from the residency for missing days due to health problems. All remediation that includes extended training time will be paid. Other remediation that does not extend training, is not paid extra and is part of the salary.

Note: The PM&R department at Michigan State University adheres strictly to this policy. The department will not deny resident rights to leave time as dictated in the contract; however, use of any leave time of 30 days or more in any academic year will result in prolongation of residency training.

If a graduate medical education trainee needs time off once all of their paid time off has been exhausted, the Program Director has the authority to allow unpaid time off. Graduate medical education trainees must realize this will impact their ability to complete their training on time and must have the request approved by their Program Director.

2017-18 Resident Annual Wages

	Annual Wage
PGY I (1st Year Resident)	$50,000
PGY II (2nd Year Resident)	$51,000
PGY III (3rd Year Resident)	$52,000
PGY IV (3rd Year Resident Chief's)	$54,000

Educational Policy Stipends for Residency

Stipend Amount	
For PGY 1- PGY4	$1,500

The stipend will be in each resident's first paycheck.

Basic required texts will be purchased by the Department for First year residents. These texts will be used for didactic purposes throughout the residency.

NOTE: *It is* ***strongly recommended*** *that residents use the above funds to attend one conference annually*

AOCPMR Mid-year or Annual Meeting

AAPMR Annual Assembly

AANEM Annual Meeting

AAP Annual Meeting

NOTE: *THERE IS* ***NO GUARANTEE*** *THERE WILL BE FUNDING AVAILABLE FOR RESIDENT TRAVEL.*

As incentive for research and presentations, residents can receive (if funding is available) additional travel money and time to present at scientific meetings approved by the Residency Committee and Residency Program Directors.

Residents may attend other meetings at their own expense and with their allowed CME and/or vacation time. Residents will be provided 5 CME days per year. Attendance at all meetings, regardless of funding source and type of leave taken, must be requested and approved (preferably 60 to 90 days in advance) by the Residency Program Directors, Chief Residents, Residency Committee and applicable attending physicians. Final approval must be obtained from the Department Chairperson.

Parking

Michigan State University parking permits are available from the MSU Department of Public Safety (Phone: 355-8440; Address: 87 Red Cedar Road, MSU Campus, East Lansing, MI 48824). The cost depends on the term of the permit. MSU DPS personnel will tell you where you are allowed to park.

A gate card is available from McLaren Lansing Greenlawn through the Medical Education Office (which will allow access into the Greenlawn Campus Physicians Parking Lot. Parking McLaren Orthopedic Campus or the Pennsylvania Campus is available at the rear of the hospital - no permit is required. The hospital will ask you to register your vehicle with the Engineering/Security Office. Residents are expected to do this as soon as possible.

A Sparrow Hospital ID badge is available at the Security Office at Sparrow. This badge will allow access into the parking ramp on the corner of Pennsylvania/Michigan Avenue and Jerome Street. Parking is permitted for residents on the 4th floor and above. You will also have to apply for a sticker to place on your car. Residents are expected to obtain the ID badge and parking sticker just prior to, or on the first day of, their rotation at Sparrow Hospital. *NO PARKING IS ALLOWED IN SBP PARKING LOT FOR RESIDENTS*.

Meals

Meals are available at both campuses of McLaren Lansing (breakfast and lunch only at Pennsylvania Campus), and Sparrow Hospital. Residents will be asked by the cashiers for their physician number (given to you during orientation) or they may ask you to initial the receipt. Meals continue to be a part of your residency benefit at Sparrow and McLaren. A food allowance is not provided at Mary Free Bed Rotations.

Sparrow Meal Allowance Rules

The AOA and ACGME requires food be provided to residents only during on-call periods. There is no requirement to make food available during any other time. The Sparrow Medical Education Administration has made a decision to provide food at all times to simplify resident's lives; but with rules. A meal allowance will be electronically added to ID badges and is for personal use only and will be pro-rated for the rotations that worked at the hospital. The money will be added to your ID badges in July and again in January. Food may not be bought for others, e.g. nurses, your family, etc.

This policy has been put in place by Sparrow Medical Education and complaints/comments, if any, should be directed to Lisa Powell at 364-2767 or via e-mail to Lisa.Powell@SPARROWSPECIALTY.ORG

Cafeterias at the McLaren Lansing, Pennsylvania Campus, McLaren Lansing, Greenlawn Campus and Sparrow Hospital are all located on the lower/basement levels. A cafeteria is located at the MSU Clinical Center but you must pay for this service.

Mailboxes

Residents have mailboxes in numerous locations; *each MUST be checked weekly*:

1) MSU Mailboxes are located at the PM&R Dept. Office, B-401 West Fee Hall, East Lansing, MI 48824-1316. This mailbox is used primarily as a business address and for departmental communications. You must check your mailbox weekly.

2) McLaren: a) EMG Lab mailboxes are strictly for EMG reports that need to be reviewed and signed. You will be expected to check these regularly once you start rotations/experiences in the EMG Lab

b) SBP Suite 520 mailboxes are to receive interdepartmental mail and messages that mainly pertain to the inpatient rehabilitation unit. The mailing address for Sparrow is 1200 Michigan Avenue Suite 520 Lansing, MI 48912.

Building Access

1) Michigan State University: You will need an MSU Faculty Photo ID to access the main doors to the building the 4th floor general.

2) Sparrow Professional Building – Your Sparrow Badge will get to access to the Outpatient Rehab Clinic and the Residency Office.

BLS (CPR) and ACLS Certification

Current certification in BLS (CPR) and ACLS is mandatory for all residents. Sparrow Hospital provides the training so it is no reimbursed. Training for incoming residents is arranged by the GME office. After the initial training it is the

Medical Licenses

At all times during the term of this Agreement, Resident shall obtain and maintain licenses to practice medicine in the State of Michigan as residents and shall maintain federal and state licensure to dispense controlled substances.

Call

Residents are scheduled "on-call" on a periodic basis. As previously noted, the "call" schedule will be determined by the Chief Residents with the approval of the Residency Program Directors. Resident call is from home. Residents, when on call, are expected to be available to inpatients within 15 minutes' time. On call weekend residents will cover consults from Friday at 15:00 through Sunday at 12:00; round with the on-call Attending on either Saturday or Sunday (coordinated by the physicians involved) and be available by phone from Friday 17:00 through Monday 08:00. Residents will be required to see each patient and to provide an appropriate progress note. Residents are also expected to respond to phone calls from nursing staff in a prompt and professional matter. If necessary, due to a change in medical condition, residents are expected to provide additional evaluation and medical management of patients whenever necessary. An attending physician is always available to residents who are on-call. Additionally, in an emergency situation, residents are expected to avail themselves of services of "in-house" emergency physicians or other appropriate personnel. Significant changes in the patient's medical conditions must be reported to the appropriate on-call attending physicians. Questions concerning on-call policy should be directed to the appropriate attending physician, Chief Resident or Residency Program Director. Residents transferring care to another resident are expected to provide a detailed face-to-face, phone, or written report on all pertinent information needed to assume care.

Code Pager

PM&R residents carry the McLaren Pennsylvania Campus code pager on a predetermined schedule coordinated by the Department of Medical Education. Residents are expected to adhere to the agreed upon schedule; in case of emergency requiring a schedule change, the Chief Residents should be contacted immediately and the Department of Medical Education should be notified. Under NO circumstances is the code pager to be "un-manned" during a PM&R scheduled time.

Physical Medicine and Rehabilitation Residency Program (

Moonlighting at MGL Orthopedic Hospital – the details of this change and senior residents who moonlight have the details of this.

ALL MOONLIGHTING NEEDS TO RECIEVE PRIOR APPROVAL BY THE PROGRAM DIRECTOR.

IMPORTANT:

All weekend and Holiday shifts are converted from 12-hourshifts to 8-hour shifts: 7a-3p, 3p-11p, 11p-7a.

All paid shifts must be recorded on the time sheet located in the Code Coverage Call Room.

The code pager MUST be handed off to the next Resident on the Schedule. It MUST NEVER be left unattended.

If you need to find coverage for your shift, a contact list for all Residents participating in Code Coverage is located in the Code Coverage Call Room.

Duty Hours

Residents are expected to promptly attend to all clinical rotation responsibilities and to be present for didactic sessions. Residents are expected to be on time even if the attending physician has a conflicting schedule (unless prior arrangements have been made). Generally, residents' duty hours begin no earlier than at 7:00 a.m. (with the exception of required meetings, didactics, etc.) or as otherwise announced. The length of the duty day will vary from time to time; however, it is realized that the resident may be required to work more than 9 hours per day. It is expected that residents' responsibilities will be completely discharged before leaving the work site. The program will maintain compliance with duty hour policies of the AOA and the ACGME.

Questions concerning expected duty hours and other pertinent policies, should be directed to the appropriate attending physician, to a Residency Program Director, or to a Chief Resident.

Lab Coats

Lab coats will be provided by the Sparrow GME office. Contact will be made with incoming residents once they have matched into the program to obtain size info and how you want your name on your lab coat. You will be given three (3) Lab Coats and they will be handed out on Residency resource Day during orientation week.

New Innovations

New Innovations Evaluation System

The Department of PM&R uses an electronic evaluation system called "New Innovations". The program is set up and maintained by the Chief Residents and the MSU Department of PM&R Residency Coordinator with input from the Residency Program Directors. At the end of each rotation, the following 3 evaluation forms are required to be completed:

1. The attending physician(s) for the rotation evaluate the resident
2. The resident evaluates the rotation
3. The resident evaluates the attending physician(s)

New Innovations automatically sends an e-mail to the appropriate evaluators to remind them to log on and complete evaluations. The website address is www.NewInnov.com. You will be requested to enter the institution's login: LANSING or SPARROW. New Innovations login is case sensitive so remember to use CAPS for the institution login and a lower case for your name and password. Your login name is the first letter of your first name and your last name. The first time you sign on, your login and password are the same. The system will prompt you to change your password.

Resident Evaluations

Attending physicians may discuss the evaluation of a resident prior to, or at the time of, the evaluation. Residents are free to add their own commentary.

Annual evaluations of the residency program are expected to be completed by the resident. You will be notified by the New Innovations system. The Residency Directors will complete quarterly as well as annual evaluations on each resident, as required by the accrediting organizations.

New Innovations will automatically send an e-mail to the appropriate evaluators to remind them to log on and complete the evaluation. The website address is www.NewInnov.com. Bottom of Form

Promotion and Evaluation

Resident evaluations will be reviewed by the residency Committee and Program Director(s) semi-annually. A documented, confidential, organized and formal evaluation system is utilized to measure each resident's competency in Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice and overall performance and ability to function as a PM&R physician:

Assess competency in Patient Care, Medical Knowledge, Practice- Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice.

Rank the degree of satisfactory performance and to determine promotion/advancement to next level, graduation, probation, dismissal.

Provide formative feedback to each resident for the purpose of self- improvement in identified areas.

Assist the Program Director and faculty members in the identification of performance improvement areas needed for each resident.

Semi-annual evaluations are used as an integral component of the Program Evaluation System, for the purpose of measuring the effectiveness and efficiency of the PM&R Residency Program in meeting the educational and training needs of the residents.

The semi-annual evaluations, method of evaluation and implementation time frame, vary in order to provide the Residency Program, faculty and each resident with multiple opportunities and venues for evaluation of performance

Promotion to the Next Level

Residents are promoted to subsequent levels of training only upon achievement of satisfactory clinical performance, satisfactory progressive scholarship and satisfactory professional growth relative to the written educational objectives and requirements identified for their current level of training, including competency in Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice.

Criteria for advancement will be reviewed with each resident quarterly and during the year end evaluation to verify that a resident demonstrates sufficient achievement to advance to the next residency level. A checklist will be completed and residents, who meet the criteria and that are satisfactorily completing the residency based on evidence of satisfactory achievement that is documented in the evaluation tools listed above, will advance to the next residency level. Contract renewal will be offered based on advancement. Residents, who are not performing satisfactorily, may be offered a contract to remediate previous work without definitive advancement.

Formative feedback regarding the results of each evaluation and communication of a resident's strengths and weaknesses is provided, in person, to each resident formally by the Program Director twice a year or as needed. Attending's review and provide timely feedback to monthly rotation evaluations with residents during the completion of the evaluation. If performance or attitude is considered less than satisfactory the following steps may be taken:

1. A performance improvement remediation action plan is developed with input from the resident and attending mentor, at minimum. Areas for improvement and the time frame for demonstration of such improvement are identified in the action plan.

2. A meeting with the Program Director, involved resident and mentor may be scheduled to review the performance improvement action plan and its subsequent result(s).

3. Failure to demonstrate improvement in the specified time frame may result in disciplinary action. All evaluations and relevant counseling sessions are maintained in a permanent file for each resident. The file and/or the records contained within may be accessed by the resident and other authorized personnel in the PM&R Residency Program Director's office.

Work Environment

Sparrow GME shall provide the following work environment for each resident:

1. Adequate and appropriate food service and sleeping quarters while on duty in the hospital.

2. Patient support services, such as intravenous services, phlebotomy services, and laboratory services, as well as messenger and transporter services, in a manner consistent with educational objectives and patient care.

3. An effective laboratory and radiology information retrieval system necessary for the conduct of the educational programs and to provide quality and timely patient care.

4. A medical records system that documents the course of each patient's illness and care and that is adequate to support the education of the resident and quality assurance activities as well as provide a resource for scholarly activity.

5. Appropriate security and personal safety measures in all locations associated with Resident's employment.

ATTENDANCE

It is expected that residents will be on time to their clinical and didactic activities. The following rules apply:

1. Residents are expected to be on time to Sports, OMM, EMG, and Neuro-Rehab Conferences, Grand Rounds at Sparrow and Mary Free Bed Hospitals, inpatient team conferences, Journal Club, Board Reviews, the Functional Neuro-Anatomy Course outpatient clinics and sign-outs. At this stage, we have not required formal attendance at didactics, in part because attendance has been excellent. If this changes, we will need to alter our policy.

2. While on outside electives, residents should log all hours worked in New Innovations and communicate via e-mail with the Chief Residents and Program Directors as needed

3. While on an outside rotation at an affiliate, residents must check in with their immediate supervisor or assistant on a daily basis and log all hours into New Innovations

4. If residents cannot make it to their scheduled rotation or elective, they must notify their supervisor, a Chief Resident, the Program Coordinator, and Residency Program Director preferably by text or phone call, that day indicating the reason for the absence. Educational leave and vacations have to be approved in advance.

CLINICAL WORKLOAD:

1. The following cap on number of patients cared for by a resident physician is as follows:

    a) General ward rotation: PGY 2 residents will have a daily census of 8-15 patients

    b) Resident Consultation rotation will cover 8-12 patients per day

2. If there is an excess of the above mentioned census for the PGY 2 resident, he/she will notify the more senior resident, to determine if more coverage is needed and who will assist with coverage and admissions to maintain the census for at that cap.

3. The Chief resident and one of the Program Directors will determine coverage for a resident when that resident is not available due to vacation, sick leave, educational leave.

4. The Sparrow Inpatient resident will provide coverage for the Resident consultation service when that resident is not available due to vacation, sick leave, educational leave.

Medical Care on the Sparrow Hospital Inpatient Rehabilitation Floor:

Rehab Resident Pager: 517-226-2713 Nights and weekends 24/7. During regular weekday working hours the PM&R resident can also be reached by phone;

Senior Resident: 517-253-2711

Junior Resident: 517-253-2720

In order to continually improve patient care and to increase involvement of the Physical Medicine and Rehabilitation residents and attending, the PM&R residents and attending will be responsible to write the following orders:

- Pain Medications
- Sleep Medications
- Psychotropic medications (anti-depressants, stimulants, and neuroleptic medications for treatment of encephalopathy and traumatic brain injury, disruptive behavior and strokes)
- Bladder medications/management
- Bowel medications/management
- Spasticity medications
- Skin/would management

The PM&R resident will manage admissions, history, and physical, and the primary medications. If the primary care physician wishes to write orders in any for any of the issues noted above, then they should discuss this with the PM&R resident or attending. The types of medications list above have serious impact on a patient's cognition, and function and greatly impact a patient's participation in the therapies and the rehabilitation process.

Admissions and discharges will be a "joint" process with the admitting physician and the PM&R staff. At the time of admission and discharge the PM&R resident will write prescriptions for r the medications listed above, and the primary care physician will write for any other medications. The PM&R resident can help the primary care physician in this process if so desired by the primary care physician. The physiatrists will remain responsible for physical therapy, occupational therapy, speech pathology, and recreational therapy social work and psychology orders.

Initial: 9/25/12; Reviewed: 5/16/13; 2/20/2015, 6/23/17

Inpatient Rehabilitation Admit Note

All Sparrow Hospital inpatient documentation is done on EPIC.

All MGL inpatient documentation is done on PARAGON

All MSU outpatient documentation is done on ATHENA.

GUIDELINES FOR RESIDENT AND ATTENDING COMMUNICATION

It is important for attending and resident physicians to communicate appropriately regarding patient care. This communication is a two-way street that requires cooperation from both parties.

The following issues should be communicated whenever they occur:

1. Patients who have coded
2. Patients who have been transferred off the service
3. Patients who have died
4. Patients who are being transferred to acute care

Guidelines for transfer to acute care:

1. If the inpatient resident is contacted by the rehab ward and decides, with agreement from the internal medicine attending physician/resident, that the medical situation warrants transfer from the rehab floor to the acute care setting, the senior resident (or the junior resident with input from the senior resident) may make a decision to agree with the transfer the patient to acute care. In general, the following should always occur when transferring patients from the rehab floor:

a. Personally discuss this with the attending or resident internal medicine physician

b. Notify the PM&R Medical Director (or inpatient PM&R attending physician) of the medical situation and what has happened

c. Write a note on the patient's chart to explain why the transfer occurred. This note, at a minimum, should include:

- Date and time
- Focused, specific account of pertinent medical issues and the basis for the decision to transfer the patient to the acute care.
- Documentation that the case was discussed with the internal medicine and PM&R attending physicians (and/or other pertinent physicians such as primary care/medical management, consultants, etc.)
- Documentation that patient's family was notified and by whom
- Documentation that issues were discussed with the patient (unless cognitively impaired, in which case communication with the patient's family to ensure their concurrence with and understanding of the

plan is all the more important). DPOA status should be documented. Inform the appropriate attending physician of the transfer

Although the following issues should cause serious consideration, the decision to notify the attending physician for these reasons is a judgment call on the residents' part. These are not "emergencies" and can often could be discussed with the internal medicine attending physician after the decision was made. This allows the internal medicine attending physician to resume patient care with a reasonable knowledge of what went on with the patient.

1. The decision to start or withhold an IV
2. Significant medication changes
3. The decision to order imaging techniques
4. Significant lab abnormalities
5. The decision to consult other services
6. Significant psychosocial issues/family interactions
7. Falls

If the resident is at all unsure of what to do, obtaining another opinion and/or more information or contacting the PM&R Medical Director or appropriate PM&R attending physician is encouraged. This communication should in no way be construed as an "insult" or as "second guessing" the decision making process; rather it is an opportunity to improve communication with physicians, patients and their families in an effort to make the best decision. Please also review the McLaren, EWHS, McLaren and MFB institution policies regarding transfer of patients to or from acute care.

SUPERVISION OF RESIDENTS AND GUIDELINES FOR COMMON CIRCUMSTANCES REQUIRING FACULTY INVOLVEMENT

SUPERVISION/DELEGATION OF PROGRESSIVE AUTHORITY AND RESPONSIBILITY/CONDITIONAL INDEPENDENCE/SUPERVISORY ROLE in the physical medicine and rehabilitation residency program at Sparrow Hospital.

Goal: To develop a policy to guide the supervision, delegation of progressive authority and responsibility, conditional independence and supervisory role of PM&R residents as they progress through the training program. Faculty supervision assignments will be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Purpose: To define the scope of supervision and the duties of Physical Medicine and Rehabilitation residents on the basis of level of training, based upon ACGME and RRC criteria. It is the intent of this policy that the resident gradually will assume increasing responsibility and conditional independence based on the needs of the patient and resident's skill sets. At the beginning of the residency, all work of the resident will be closely supervised. As the resident demonstrates his/her ability to perform both clinical and non-clinical skills and supervisory activities, the amount of responsibility will be increased accordingly. Senior residents will serve in a supervisory role of junior residents commensurate with their progress towards independence. The resident must be able to demonstrate sufficient competence to practice without direct supervision by the end of the residency. In preparation for this transition, at the level of PGY-4 training, the resident should be functioning in an independent manner. However, supervision by an attending physician will be present at all times and at all levels of training, in one of the following levels of supervision: Direct Supervision, Indirect Supervision, or Oversight. The faculty of the Department of Physical Medicine and Rehabilitation believe that sound clinical decision making skills are developed through making decision guided by proper feedback on the quality of decisions made. Therefore, at all levels residents are expected to formulate a diagnosis and plan of care for patients under their care. This plan will be modified by the attending physician through constructive criticism. In preparation for independent practice, residents must develop the confidence to act on the information available to them, as well as develop a sense of when it is necessary to ask for help from colleagues.

Process: Residents must have progressive responsibility in diagnosing, assessing, and managing the conditions commonly encountered by the physiatrist in the rehabilitative management of patients of all ages in areas such as: acute and chronic musculoskeletal conditions, traumatic brain injury, hereditary, developmental and acquired central nervous system disorders, amputations, cardiac disease, pulmonary disease, rheumatological conditions as well as geriatric and pediatric populations.

Rotations: The clinical responsibilities for residents will be based upon PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. Residents will care

for patients in an environment that maximizes effective teamwork and communication. This will include working as an effective interprofessional team member that are appropriate to the delivery of care in PM&R.

a) PGY2 residents are assigned to the inpatient wards and general rehabilitation medicine clinics where they learn basic concepts of inpatient and outpatient rehabilitation medicine including: a) how to perform a rehabilitation medicine specific history and physical examination b) how to write a rehabilitation medicine prescription and c) management of patients with common inpatient and outpatient rehabilitation medicine diagnoses.

b) PGY3 residents: Rotations for the PGY 3 year commonly include traumatic brain injury, consultation, geriatric rehabilitation, electrodiagnosis, pain/palliative care, musculoskeletal-wound care, cardiac/pulmonary/SCI rehabilitation and sports medicine. These rotations require a more advanced level of knowledge and skills set and have more autonomy compared to the PGY2 year.

c) PGY4 year: In the PGY4 year, residents continue with some of the PGY3 year rotations if they had not been scheduled in the previous year. As mentioned above, these rotations require a higher level of knowledge and skills compared to the PGY2 year. In addition, PGY4 residents rotate through a Chief resident rotation in which they are involved in: a) an administrative role b) supervise junior residents and c) evaluate and treat pediatric patients.

Evaluation to progress from one academic year to the next:

Residents are evaluated at the end of each rotation by attending physiatrists and by the Program Director semi-annually and at the end of each academic year. This evaluation system is based on the ACGME and AOA core competencies. In order to advance from one year to the next, residents must demonstrate a satisfactory rating in each of the core competencies. These core competencies are: patient care, medical knowledge, interpersonal/communication skills, practice based learning and improvement, systems based practice and professionalism.

Date: 1/12/13; Reviewed 2/20/2015, 6/23/17

GUIDELINES FOR COMMON CIRCUMSTANCES REQUIRING FACULTY INVOLVEMENT

Goal: To develop guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, DNR or end-of-life decisions, care of a complex patient.

Process: Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. PGY-1 residents will be supervised either Directly or Indirectly with direct supervision immediately available.

PGY-2 and PGY-3 residents will be supervised either Directly, Indirectly with direct supervision immediately available or available by telephonic and/or electronic modalities, or Oversight.

Revision Date: 6/1/13; Reviewed 2/20/2015, 6/23/17

GUIDELINES FOR SCHEDULING RESIDENT ROTATIONS

Rotations will be scheduled by Chief Residents and Residency Program Directors. Call schedules will also be arranged by Chief Residents with approval of Residency Program Directors. Elective/Research Rotation scheduling must be approved in advance by Program Directors and Chief Residents.

Specific details concerning the appropriate schedule for each rotation should be directed to specific attending physicians; other questions or concerns should be directed to a Residency Program Directors.

GUIDELINES FOR RESIDENTS ON OUTSIDE ROTATIONS

These guidelines are to assist resident and attending physicians in determining appropriate behaviors while on outside rotations; and in deciding what should be done when there the inevitable schedule problem occurs

A request to rotate out of the Sparrow system has to be submitted to the Sparrow GME CIO Ted Glynn. This is for PMR required rotations i.e. Flint or for an elective rotation during your senior year. You should not finalize the rotation or make travel plans until you have received approval. Once approval has been granted the Risk Management office is contacted notifying them your mal-practice will be extended to cover the approved rotation.

If you plan to rotate in another state it is imperative that you check their medical license requirements. It is possible that you will only be an observer.

PM&R residents are extensions of our PM&R Department in relation to the community and to other physicians. Resident behavior is reflective of all the people within our Department and within MSUCOM. Needless to say, this behavior should always reflect the highest standards.

1. Residents will be given a schedule at the beginning of each rotation. If you do not get a schedule, or you see potential conflicts problems within this schedule IT IS YOUR RESPONSIBILITY to point this out to the Residency Directors or responsible attending physicians for appropriate changes.

2. When assigned for outside responsibilities, you are expected to show up at these rotations on time and prepared to work.

3. Work on outside rotations will not always be perfect and some people will be easier to work with than others. If you have constructive comments to improve the rotation, we will be happy to discuss them with you. On the other hand, some rotations will require you to work harder and to work overtime; unfortunately, this can be the risk of having an out rotation.

ELECTIVE:

PURPOSE: The purpose of the elective rotation is to allow the resident physician to pursue various aspects of the rehabilitation field in a self-directed and self-scheduled month long rotation. The elective rotation can be used to explore various subspecialties of PM&R and to allow some time to explore fellowship opportunities.

TIMEFRAME:

The elective rotation is one 1-month block of time, which can be organized by the day, week, or month. It is reserved for the PGY-4 year or the end of the PGY-3 year.

1. Residents may schedule a rotation with any clinical service at Sparrow or McLaren Hospitals, provided that an Attending physician at such location has agreed to mentor that resident. Rotations in Interventional Spine, EMG, Neurology, Sports Medicine, and Radiology are examples.

2. Offsite rotations are also permitted, but MUST be approved by the program director and DIO.

    a. Only 1 month of the elective can be in a non-ACGME accredited setting, (i.e. Private office).

    b. Elective rotations at affiliated institutions do not require any additional paperwork, other than the proposed schedule.

    c. Elective rotations at non-affiliated institutions require insurance coverage letters and may require credentialing or licensing (if out of state.) It is the responsibility of the resident to plan early and obtain all the proper paperwork PRIOR to being given approval

3. The elective rotation can be used to pursue or complete research projects. No more than the 4 weeks can be used for this purpose, an if this is chosen, the research project must be submitted on the last day of that month No more than 4 weeks can be used for this purpose, and if this is chosen, the research project must be submitted on the last day of that month.

REQUIREMENTS:

1. Your scheduled elective must be organized to be a MINIMUM of 8 hours per day (including lunch) x 5 days a week, and there must be a PLA and agreement from the preceptor to evaluate your performance. There are no other rules regarding which days or exactly what hours.

2. You MUST submit a proposed schedule PRIOR to the rotation starting date.

3. The proposal must include all of the following:

    a. Your name

    b. Dates of the rotation

c. Any expected days off (vacation, personal time, etc.)

d. Preceptor's Name, address and phone number

e. A contact number for you during this rotation.

4. Residents rotating locally, either at Sparrow, McLaren Lansing or Flint and Mary Free Bed, are required to attend didactic lectures at Sparrow on Mondays, UNLESS, the rotation requires you to miss these lectures. This must be approved IN ADVANCE!

5. If the rotation is out-of-state you are excused from all didactics lectures, provided that you are scheduled to be present at your chosen elective site.

6. It is the responsibility of the rotating resident to obtain handouts of missed lectures, as you will be responsible for the information therein.

As part of residency, residents will receive feedback on their performance, as well as, formal evaluations at the end of their clinical rotations, end of academic year and end of residency. In addition, the resident will be asked to evaluate their clinical rotations, supervising faculty and residency program.

Resident Evaluation

Residents will receive formal evaluations from: a) faculty members b) fellow residents c) nursing staff d) physical therapists e) occupational therapists f) psychologists g) administrators and h) patients. This will be in the form of paper evaluations as well as electronic evaluations on New Innovations. The residency program director will review these evaluations with the residents twice per year as well as informally whenever the resident wishes to review their performance.

The Clinical Competency Committee (CCC) will review each resident's performance using the competencies from the ABPMR twice a year. Each resident can see these reports and will be notified of the results of these meetings and any necessary remediation.

Evaluation of rehabilitation specific medical knowledge will be performed using the yearly SAE tests as well as self-assessment quizzes at the end of most modules in the didactic curriculum. The scores of these self-assessment activities will be shared with the residents both at formal semi-annual evaluations as well as informally when the resident wishes to review the test results.

Selecting Residency Candidates

1. Medical students and residents who are interested in applying to the MSU Sparrow PM&R residency program must apply through ERAS beginning September 1. Beginning September 1, the program accepts applications for the PGY-2 positions starting on July 1 of the subsequent year. The Program is accredited by AOA and ACGME for 12 positions. The deadline to complete an ERAS application is November 1. Candidates will be contacted to

arrange for a personal interview with faculty and residents. Interviews are offered November through January on designated days.

2. Application Criteria

a) US Citizenship or a Green Card

b) Passed USMLE or COMLEX Steps 1 and 2 (including Step 2 Clinical Skills),

c) 1 year of US clinical experience

d) Submitted ERAS Common Application Form containing:

i) Dean's Letter

ii) Personal Statement

iii) 3 LORs, (including 1 from PM&R faculty)

iv) Medical School Transcript

v) USMLE or COMLEX reports

vi) Curriculum Vitae

vii) ECGMG Certificate (if foreign graduate)-all foreign medical graduates must completed one year of training practicing as a physician in US. Physicians must also meet admission requirements as established by the Accreditation Council for Graduate Medical Education individual training programs and licensure requirements established by the New York State Department of Medicine

3. Due to the institutional policies, the PM&R Residency Program cannot sponsor visas.

4. Candidates must have strong interpersonal skills, strong academic and clinic

Program Directors will review all new applications and give relative ranking to each application. All factors required for a complete application will be considered in this ranking. Of paramount importance is the medical school training, and the requirements of the American Osteopathic Association and the Accreditation Council on Graduate Medical Education for residency positions.

Upon relative ranking (grouping) of applications by the Program Director(s) the determination of the number of candidates eligible for interview will be discussed by the Residency Committee. Candidates will be given a relative ranking and be invited for a formal interview at MSU-COM.

Any member of the Residency Committee has access and input to any application during this time. Additionally, Residency Committee members may allow residents, faculty or other department members to review and comment on any application received.

Decisions to offer positions outside of the D.O. match v. participating in a match program are dependent upon the various circumstances surrounding the residency at each particular time. In general, it is desirable to participate in the NRMP match or, when applicable, in the AOA match.

Resident Interview

After initial application screening, potential residents will be interviewed. Any person having contact with the resident during the interview is requested to fill out a formal evaluation form.

After interview sessions, the Resident Ranking Committee will decide when to start the ranking process.

The Resident Ranking Committee shall consist of all interested members and residents of the Department. All current residents are invited as full voting members on the Resident Ranking Committee. All attending physicians are also invited. Representatives from Ingham Regional Medical Center, Sparrow Hospital, and McLaren are also invited to the Resident Ranking Committee.

Initial ranking of residents shall include a determination as to whether or not the applicant is acceptable in the MSU-COM program; if deemed unacceptable, further ranking and discussion of the applicant is terminated.

A ranking of each acceptable resident candidate will then occur with each member of the Committee allowed one vote (by show of hands) for each rank. Applicants will be ranked in the order agreed to by Committee vote.

Guidelines for Junior Resident Supervision by Senior Residents

Senior residents are expected to assist and supervise junior residents in all aspects of the residency, inclusive of administrative and clinical issues. Senior residents may delegate work to junior residents if approved by attending physicians, and as part of scheduling. At no time should senior residents "dump" on junior residents. Additionally, senior residents are responsible to assist junior residents who are having trouble keeping up with clinical work or covering for vacations.

Senior or junior residents should request assistance from the attending physician if there are any questions regarding responsibilities or supervision level.

CHIEF RESIDENT JOB DESCRIPTION

Appointment: One year

Selection: The number of residents that serve as Co-Chief Resident, depends on who would like to serve and the division of duties, and Program Director approval. Co-Chief residents must be at a PGY-3 position in good standing at the time of selection in March of the preceding academic year. Once the names are approved by faculty, the Co-Chief Residents are appointed effective April 1st until March 31st of the next calendar year.

Duties and Responsibilities:

1. Serve as resident representative to administration and staff of the Department.

a. Attend at least 50% of Department staff meetings as directed.

b. Attend all relevant meetings concerning the residency, including meetings involving resident supervision, discipline, and personal matters. (It is understood that at least one Co-Chief Resident is expected to attend these meetings.)

c. Attend GMEC meetings for Sparrow and MSU.

2. Each Co-Chief Resident will serve for the entire appointment year, with responsibilities divided among the Chief Residents by their mutual agreement and approval by faculty.

3. Co-Chief Residents will assist Residency Program Director(s) in organization of didactic activities

Co-Chief Residents will assist with determination of didactic schedule.

Co-Chief Residents will assist with recruitment of speakers.

Co-Chief Residents will keep records of all didactic sessions (speaker names, presentation titles, dates and location) and submit this list to the residency program coordinator on a monthly basis for program documentation.

Co-Chief Residents will send speakers "Thank-you" notes.

Co-Chief Residents will work with faculty and the host facility to ensure adequate presentation facilities, ancillary equipment and supplies for lectures.

Co-Chief Residents will ensure that all Department faculty and residents, as well as students on service and rotators, are informed of location times and topics of didactics, rounds, schedule changes, cancellations, etc.

4. Co-Chief Residents will conduct/attend monthly resident business meetings and other residency related meetings as needed and will, as appropriate, report their results to Residency Program Directors and/or other faculty.

5. Co-Chief Residents will serve on the departmental Education Committee.

6. Co-Chief Residents, with the assistance of the outgoing Co-Chief Residents, will develop and maintain resident annual vacation schedules and educational leave schedules. A tentative vacation schedule will be developed to avoid excess vacation/travel on any single rotation and to ensure appropriate coverage is arranged. The annual vacation scheduled should be completed (with exception of new incoming residents) by June 15th. Additionally, the tentative educational leave schedule will be developed by August 15th of the current training year and distributed to all residents and other faculty personnel (including faculty and support staff) at that time. It is understood that an absolutely complete list of educational leave will not be possible by August 15th of the training year; however, dates of national meetings in the fall and winter (especially AAPM&R Assembly, and AAP and AOCPRM meetings) are

known years in advance. All travel, educational leave, annual vacation, and other leave are subject to approval by Residency Program Directors and Department Chairperson.

7. Co-Chief Residents will develop, with the assistance of the outgoing Co-Chief Residents, the annual resident rotation schedule, with a preliminary schedule to be completed by May 15th of the preceding training year. Changes during the year are also done by Co-Chief Residents as necessary in concert with faculty.

8. Co-Chief Residents will represent MSU/COM PM&R residents at the Annual Assembly of the American Academy of PM&R and/or at appropriate meetings of the American Osteopathic College of Rehabilitation Medicine; they will also report the content of these meetings to residents and faculty at a mutually agreed upon time. Approval for travel funds will be obtained from Residency Program Directors and Department Chairperson. Meetings attended will be funded as outlined below.

9. Co-Chief Residents will represent the MSU/COM PM&R Residency Program at local and state physiatric functions as directed and approved by Residency Program Directors.

10. Co-Chief Residents are responsible for reviewing pertinent University, Department, Hospital and other appropriate policies and procedures (personnel and otherwise) with incoming residents within 2 weeks of the beginning of their residency; other policies and procedures will be reviewed with current (not new) residents on an as-needed basis or as directed by the faculty.

Chief Resident Compensation:

1. Co-Chief Resident certificate.

2. Attendance at the Annual AAPMR conference, or the National AAP meeting, or a suitable meeting of the AOCPMR, or the Northwestern University P&O course (or other acceptable alternative). Full room rate and departmental per diem allowance (maximum $1,200 per year) will be covered for each Co-Chief Resident. Preferably, one Chief Resident will attend different meetings to avoid all being gone at the same time. EACH Co-Chief Resident will attend ONE of these national meetings. Unspent funds may be used for other CME activities or books. Should both Co-Chief Residents elect to attend the same meeting they will, unless opposite sexes, be expected to share a room.

3. Each Co-Chief Resident will have protected, authorized (by attending staff) office time while on each rotation, as appropriate, to spend on Chief Resident duties. This would not preclude absence from the rotation site, but would involve protection from patient care responsibilities for a time (i.e. approximately 2-3 hours per week) to be negotiated with attending physician. It is expected that many of the responsibilities of the Chief Resident will be done in addition to a normal clinical/teaching load.

4. Stipend (in travel, books, or other acceptable form) of $2,500 for the academic 2017-2018 has given to each co-chief residents in their first paycheck of the year.

Cancelled Clinics Policy

This policy outline what residents should do when the Clinic for their rotation is canceled, gets out early, or when a regularly scheduled patient activity is over early. This policy encompasses at least three of the core competencies: Professionalism, Patient Care and Systems Based Practice. Lack of compliance with this policy will be reflected in evaluations and may be cause for remediation.

Part of your training will be to learn what it means to be professional in regard to a group practice and "team-oriented" in your relationship with co-workers. In part, this means that you should not overlook other team members' interests. For example, if your clinic is done early and you hear that the consult service still has work to do, you should offer to help out. This implies that the resident whose primary responsibility is inpatient consults, as an example, should do their best to complete their work by working efficiently to complete as many consults as possible before attempting to ask for help. The idea is to help others when you have spare moments and in turn others will help you when you are in need. This translates into delivery of optimal patient. This should not be an opportunity for one resident to dump work on another.

When you are assigned to EMG's, other outpatient clinics, or other outside rotations there will be times (especially at Thanksgiving, Christmas and New Year's Holidays) when your attending physician is on vacation and their clinics have been cancelled. During these times, IT IS YOUR RESPONSIBILITY to contact the attending physician or resident on the inpatient rehabilitation service and/or consult service to ask if there are any consults, clinics, inpatient admissions, inpatient EMG's or other work to do. Just because the EMG/outpatient clinic has been cancelled, does not mean you have a "day off". The only time you are allowed to take time for studying or reading during regular duty hours is if your attending physician directly tells you to go to the library and read. You are a paid employee and you are expected to work. Again, you should contact the attending physician or resident responsible for the consult service that day to ask if there are consults you can help with. You should also contact the attending physician or resident responsible for inpatient rehabilitation to ask if there are any admissions, consults or other work to do.

It is YOUR RESPONSIBILITY to find work that needs to be done and to do it independently without prodding and nagging from the attending staff. Another example: If you have an EMG/clinic cancelled in the morning, and you do not contact the attending until 11:00am and there is a consult that you could have done from earlier that morning, you should plan on doing that consult after 5:00pm the same day when you are done with your afternoon responsibilities. Lack of planning and/or initiation on your part will not be rewarded with going home early or transferring work to other people.

Continuity Clinic Policy

This document serves as the MSU/COM Department of PM&R Resident Continuity Clinic Policies and Procedures. The goal of this clinic and the goals and objectives of all rotating clinics are described below. The primary goal of the Resident Continuity Clinic is to provide continuity of care to patients and continuity of education to PGY 4 residents.

1. Attending physicians will be assigned on a rotating basis.

2. Residents will have their own panel of patients to follow during their year at the continuity clinic.

3. Residents will be responsible for follow up care of new patients; they will "take ownership" of their patients and be expected to deliver excellent medical care.

4. Residents will return telephone calls and respond to messages from their Resident Clinic patients. This requires them to check their electronic medical record at least one time per week, unless they are on vacation. If they are on an out of town rotation, they are expected to log into the EMR and sign their notes and respond to telephone calls on a weekly basis.

5. At the end of each clinic, residents are expected to "clean off" their desk top, i.e. sign off on all notes and respond to all telephone calls. Attending physicians and Clinic Coordinator are usually present at that time and can help the resident accomplish this in an educational and appropriate manner.

6. The situation may arise where a resident will have to leave their rotation to attend continuity clinic. The continuity clinic should take precedent over most rotations. Residents need to look at their schedule and plan ahead to do this. At this stage of training residents will pull out of the following rotations to attend continuity clinic every week: All outpatient rotations including McLaren and Sparrow; Inpatient rotations at Mary Free Bed; Sparrow inpatient rehabilitation; McLaren consults.

   Residents will be expected to schedule one or two resident continuity clinics per month. For in-town rotations, residents should finish their work (consults or inpatient rounds or admissions) before or after the continuity clinic when possible. For out of town rotations, this will not be possible and attending physicians will need to cover this. For example, if the resident is on Sparrow inpatient, they will be expected to help out with rounds and admissions prior to the resident clinic, and after resident clinic. They should call the McLaren consults, and Sparrow inpatient attending physicians to discuss with them what work remains to be done after the Resident Continuity Clinic.

7. Vacation and absence from resident clinic - Senior residents will notify clinic staff by e-mail (with copies to the Program Directors) who will be present at the Resident Continuity Clinic approximately 6 to 12 weeks prior. Outpatient clinics are booked far out and it is inconvenient to multiple people to reschedule.

This document serves as the MSU/COM Department of PM&R Resident Continuity Clinic Policy and Procedures. MTA/JRS *Reviewed 2/20/2015, 6/23/17*

Fatigue Policy:

Purpose: To prevent, identify and manage resident fatigue. This policy supplements the Michigan State University College of Human Medicine, Medical Education Program Policy and the Accreditation Council for Graduate Medical Education Common Program Requirements.

The Accreditation Council for Graduate Medical Education (ACGME) requires all training programs to educate faculty and residents to recognize the signs of fatigue and adopt and apply policies to prevent and counteract their potential negative effects.

General Description:

A. Instruction: Physical Medicine and Rehabilitation Resident and Faculty will receive instruction on prevention, identification, and management of resident fatigue.

PGY-1 residents have instruction on resident fatigue at the institutional as well as departmental orientations. They receive a copy of the College of Human Medicine Graduate Medical Education Resident Fatigue policy and other resources including the LIFE (Learning to address Impairment and Fatigue to Enhance Patient Safety) information are available through an online link.

PGY-2-4 residents and faculty receive instruction on preventing, identifying and managing resident fatigue at least biannually based on the LIFE program.

B. Evaluation: The Residency Program Director evaluates resident fatigue in the semi-annual resident evaluation meetings. Residents evaluate fatigue in the residency during the Annual Resident Retreat with written report to the Residency Program Director.

1. Residents should report any signs of fatigue to the chief resident, residency program director, residency program coordinator throughout the day including at morning report, sign-outs and during clinical and didactic activities throughout the day.

2. Faculty monitor residents on a daily basis for signs of fatigue and discuss the issue with the resident if signs of fatigue are noted.

3. Residents are encouraged to strategically nap during period of on-call activity at the medical center in the on-call room to minimize fatigue.

4. If residents cannot safely complete call activity due to excessive fatigue, they are to notify the chief resident, residency program director so that alternative arrangements can be made.

5. If the resident complains of fatigue that impairs his ability to drive safely back home, the department of rehabilitation medicine will provide funds for car service for the resident to safely return back home, or overnight accommodations in the hospital or a hotel.

Grievance Procedure:

1. A grievance shall be defined as a dispute regarding: a) the interpretation or application of the terms of the written contract; b) regular and recurrent assignment of a resident physician to duties not appropriate to a House Staff Officer c) a question regarding the non-renewal of the appointment of resident physician d) reasonable and appropriate work schedules or e) discipline

2. A grievance may be brought by an individual resident physician to the attention of the Chief Resident, Residency Program Coordinator, Residency Program Director and Chairman of the Department of Rehabilitation Medicine. Additional forums in which the resident can raise concerns include the Residency Steering Committee that meets on a monthly basis.

3. If the grievance is not resolved satisfactorily within 15 days after its presentation, the resident physician may appeal to the GMEC.

4. It is important that there is an environment in which residents may raise and resolve issues without fear or intimidation or retaliation. Issues raised by house staff will be handled in a confidential and fair manner. Any issues pertaining to attending staff, faculty, work environment or personal matters should be brought directly to the attention of the residency program director. Any disagreement about an issue, or any issue concerning the residency program director may be brought directly to the attention of Graduate Medical Education or through house staff representatives to the GMEC. If the issue is still not resolved, the resident may bring complaint or grievance to the House staff Affairs Committee as provided by dispute resolution and grievance mechanism between Committee of Interns and Residents and GME.

5. The PMR Residency Program at MSU/Sparrow follows the grievance procedure as outlined in "Institutional Policies for Graduate Medical Education Program at Michigan State University College of Human Medicine."

A. A resident in a MSU/CHM sponsored program initiating a grievance is required to use the MSU/CHM grievance process.

B. Good faith efforts shall be made to resolve problems through informal means between the parties. The program director should be included as part of this informal process.

C. In the event that the matter cannot be resolved at the level of the program director, the resident may file a written grievance and seek relief with the chairperson of the affected academic department, and request a review of the issue. A grievance must be initiated within 90 days of the action that is being grieved.

1. The chairperson shall attempt to mediate a resolution to the complaint.

2. The chairperson will put his/her proposed resolution in writing to the resident with copies to the program director and the Assistant Dean for GME.

3. It shall be assumed that the resident accepts the chairperson’s resolution of the complaint if the chairperson is not informed to the contrary within fifteen calendar days of communicating a resolution to the concerned parties.

D. In the event that the resolution instituted by the chairperson of the affected academic department is not acceptable to the resident, s/he may request, in writing, a formal hearing of the grievance. The resident must state the basis for the grievance, and the request must be received by the chairperson no later than fifteen calendar days after the date the resident is informed by the chairperson of his/her suggested resolution.

E. The chairperson and the Assistant Dean for GME shall impanel a grievance hearing committee within fifteen calendar days of the receipt of the grievance letter.

F. The members of the hearing panel shall consist of five members including: two physician faculty members from the involved clinical department, one faculty member from the GMEC from a clinical department not involved in the action, one senior resident from the involved program and one senior resident from another MSU/CHM sponsored residency program.

G. The hearing panel shall select a panel chair that will chair the meeting(s) and draft the report of findings and the recommendation of the panel.

H. The panel shall first meet to hear the resident's complaint within fifteen calendar days of being impaneled.

I. The resident and the individual grieved against (respondent) will have the right to challenge any member of the hearing panel for bias. The challenge must be in writing. The panel shall confer and decide the validity of a challenge. The panel's finding shall be final.

J. The hearing panel shall endeavor to establish a collegial atmosphere in the hearing. The resident or the respondent may choose to invite an advisor to be present during the hearing. Either the resident or the respondent may choose to have an attorney as an advisor. However, during the course of the hearing, only members of the hearing panel, the resident, and the respondent have the right to address the panel members, the respondent, the resident, or other persons brought before the panel. An advisor shall not present the resident's nor the respondent's case.

K. The report and recommendation of the grievance hearing panel shall be submitted to the Dean of the College of Human Medicine.

L. The Dean will inform the resident, the respondent, and the chairperson of the academic department, of his/her disposition on the hearing panel's recommendation within fifteen calendar days of the last hearing.

HAND-OFF POLICY:

Goal: Establish a policy and procedure for" hand-off" of clinical care issues for inpatients on the rehabilitation floor at Sparrow Hospital.

Background: Patient safety is a significant issue in the care of patients on inpatient rehabilitation units. Points of transition in care are a time when the safety risk is greatest. Lack of knowledge about the patient's medical condition, changes in medication regimens and communication gaps between medical providers at change of shifts are some reasons for the increased risks. It is essential that good communication between the providers at transition points is present and that an appropriate sign-out procedure is in place and followed on a regular basis.

1. When the rotation changes at the end of the 4-week rotation at Sparrow the transfer of the service should occur on a Friday or Monday when the service switches and should be rounding on the patients. If this rounding

cannot occur, then a verbal phone conference handoff can occur. The attending must be notified and approve of this. Ideally, a 1: 1 resident physician hand-off occurs in a quiet room with minimal interruptions between the resident physicians.

2. Hand-off occurs at 7:30 AM and 4PM Monday- Friday and 8: AM on Saturday and Sunday.

3. Hand-off also occurs between resident physicians when one leaves for vacation and one returns from vacation.

4. Key information to be included at hand-off

a) Brief medical history and physical examination of the patient

b) Active clinical issues and the management plan

c) Key medical staff involved in the care of the patient and their contact information

d) Pertinent recent laboratory values and diagnostic tests.

e) Recent procedures performed on the patient and any complications.

f) Medication list, including any "new medications" started in the previous 24-48 hours that require "first dose monitoring" and pertinent side effects to look out for.

g) Significant safety risks for the patient (i.e. falls, aspiration)

h) Patient's DNR/DNI and advanced directives status.

i) "Sickest patient"- discussion of patients that require close observation and monitoring (i.e. new patients, medically complex, critically ill) and recommended plan of action should there be a change in their medical status.

j) Discussion of "errors" and "near-misses" that occurred during the previous shift.

5. Format of Hand-offs:

a) During the Monday to Friday work-week, hand-offs will take place in the rehabilitation medicine conference room. Saturday and Sundays, ideally they should occur in the on-call room or the rehab conference room or rehab residency office.

b) "SBAR" methodology (situation, background, assessment and recommendations) will be used to discuss clinical care issues that are specific to a patient.

c) "Verbal repeat back" of key information between providers to ensure accuracy.

6. Role of attending physicians in hand-offs and at critical points in the patient's care.

a) Resident physicians are to notify the attending physicians responsible for the patient's overall care with important or critical information as soon as possible. Examples include:

i. critical lab values

ii. critical diagnostic imaging results

iii. significant negative change in the patient's medical condition (i.e. change I mental status, chest pain, shortness of breath, fall, febrile episode)

iv. Attending physicians responsible for the care of the patient) (or their covering physician) will be available by phone to discuss the patient's condition and to coordinate care and provide guidance to the residents. The attending physician may need to come in and be physically present to oversee the care of the patient or alternatively make arrangements for another attending physician to come in and oversee the care.

Root Cause Analysis Case Presentations (Morbidity and Mortality Conferences)

PURPOSE:

To educate resident physicians in self-evaluation of patient care delivered on the inpatient rehabilitation unit, traumatic brain injury unit and outpatient clinics; with the ultimate goal of identifying areas which need improvement and implementing changes to improve overall standard of care

DATE/TIME:

A review is held when the Chairman of the Department of Rehabilitation Medicine, Residency Program Director, attending physicians or resident physicians identify a patient with a negative outcome in their care. Typically this occurs once every one to two months as there is an identified need.

PROCESS:

1.The Chief Resident, Residency Program Director or Chairman of The Department of Rehabilitation Medicine assign a resident a patient who had a negative event sustained while at XXXX. The resident is expected to review the Rehabilitation Chart, in its entirety, and assess the care rendered and chart documentation with an emphasis on identifying the key systems issues that contributed to the adverse outcome. Interviews with nursing and allied health staff and collaboration with other residents is encouraged.

1. The format includes answering key questions such as: a) What happened b) What should have happened c) What were the causes for the adverse event d) How can this event be prevented from happening again?

2. Each resident will present his/her findings to the other residents and faculty using a power point presentation format.

3. Residents and Attendings will critically analyze the information, and openly discuss any deviations from the standard of care or alternative treatment options.

4. Discussions will remain professional and will focus on improving the standard of care in the future. A key emphasis will be on systems issues that led to the adverse event.

5. Examples of appropriate case discussions include: a) falls b) aspiration c) pressure ulcers d) infections e) acute transfers f) death.

Departmental Policy for Clinical Work Outside the Scope of Residency Responsibilities ("Moonlighting")

Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goal and objectives of the educational program.

The practice of "moonlighting" by residents is neither specifically prohibited nor encouraged by the program. "Moonlighting" is not a part of the MSU COM/CHM PM&R Resident's post-graduate training program.

Accordingly, there is absolutely no malpractice liability insurance coverage provided for PM&R Residents if and when they engage in this type of activity.

It is strongly recommended that you not "moonlight" if at all possible. In order to avoid problems which may have negative consequences on your post-graduate medical training and education, we advise that, prior to engaging in "moonlighting" residents should:

a) determine whether you will be considered as an independent contractor or an employee (this may have ramifications upon whether or not you need to provide your own malpractice insurance);

b) obtain written evidence securing the nature and extent of professional liability insurance coverage and the identity of the insurance carrier providing this protection;

c) at their own expense, obtain an unrestricted license to practice medicine from the State of Michigan, Department of Commerce and, potentially, a State Controlled Substance License and Federal DEA Registration.

If a resident decides to "Moonlight" a Sparrow Request to Moonlight form must be filled out, and sign by one of PDs. The form is then sent to the Sparrow DIO, once approved it must be made part of the resident's file before the outside professional activity can commence. The Moonlighting request has to be renewed yearly and the time frame for moonlighting approvals is on a January to December calendar. A resident may be prohibited from moonlighting by the Program Director at any time, if moonlighting impairs resident educational performance, or for any of the following reasons:

a) Resident is not satisfactorily progressing in the program

b) Resident has not attended a satisfactory percentage of mandatory conferences

c) Resident is delinquent in his/her records.

d) Resident has not completed a satisfactory percentage of required evaluations

e) Resident is non-compliant with the Residency Program policies

f) Other issues that, in the judgment of the program director, provide a reasonable basis on which to deny the resident moonlighting permission.

g) Moonlighting that occurs within the residency program and/or the institution or the non-hospital sponsor's primary clinical site(s), i.e. internal moonlighting, must be counted toward the 80-hour weekly limit of duty hours.

Reviewed: 6/23/17

POLICY ON SEXUAL HARASSMENT

To access the full MSU Policy on Relationship Violence and Sexual Mis-Conduct please use the following link:

https://www.hr.msu.edu/policies-procedures/university-wide/documents/RVSMPolicy.pd

This policy was issued by the Office of the President on 8/31/2016. Mandatory training can be accessed on line: http://goo.gl/pLh01o

ACADEMIC FREEDOM

Michigan State University adheres to the principles of academic freedom with correlative responsibilities as stated by the American Association of University Professors, the Association of American Colleges and other organizations:

1. The teacher is entitled to full freedom in research and in the publication of the results, subject to the adequate performance of other academic duties; but research of pecuniary return should be based upon an understanding with the authorities of the institution.

2. The teach is entitled to freedom in the classroom in discussion his or her subject, but should be careful not to introduce into teaching controversial matter which has no relation to the subject. Limitations of academic freedom because of religious or other aims of the institution should be clearly stated in writing at the time of the appointment.

3. The college or university teacher is a citizen, a member of a learned profession, and an officer of an educational institution. When speaking or writing as a citizen, the teacher should be free from institutional censorship or discipline, but this special position in the community imposes special obligations. As a person of learning and an educational officer, the teacher should remember that the public may judge one's profession and institution by one's utterances. Hence, the teacher should at all times be accurate, should exercise appropriate restraint, should show respect for the opinions of others, and should make every effort to indicate that he or she is not an institutional spokesperson.2

--The word "teacher" as used in this document is understood to include the investigator who is attached to an academic institution without teaching duties.

--" Academic Freedom and Tenure – 1940 Statement of Principles and Interpretive Comments." AAUP Bulletin, Summer 1974, pp. 269-272.

CONFLICT OF INTEREST IN EDUCATIONAL RESPONSIBILITIES RESULTING FROM CONSENSUAL AMOROUS OR SEXUAL RELATIONSHIPS

This policy was approved by the Board of Trustees on 11-08-96. This policy can be accessed on line: http://trustees.msu.edu/policy-manual/04-17-05.html

An amorous or sexual relationship between a student and a faculty member, a graduate teaching assistant or another University employee who has educational responsibilities for that student may impair or undermine the ongoing trust needed for effective teaching, learning and professional development. Because of the faculty member, graduate assistant or other employee's authority or power over the student, inherently conflicting interests and perceptions of unfair advantage arise when a faculty member, graduate teaching assistant or other employee assumes or maintains educational responsibility for a student with whom the faculty member, graduate teaching assistant or other employee has engaged in amorous or sexual relations.

It is, therefore, the policy of Michigan State University that each faculty member, graduate teaching assistant and other University employee who has educational responsibilities for students shall not assume or maintain educational responsibility for a student with whom the faculty member, graduate teaching assistant or other employee has engaged in amorous or sexual relations, even if such relations were consensual. Whether such amorous or sexual relationships predate the assumption of educational responsibility for the student, or arise out of the educational relationship, the faculty member, graduate teaching assistant or other employee shall immediately disclose the amorous or sexual relationship to the relevant unit administrator, who shall promptly arrange other oversight for the student.

In unusual circumstances, the achievement of the affected student's academic requirements may necessitate continued oversight of the affected student by the faculty member, graduate teaching assistant or other University employee who has engaged in amorous or sexual relations with that student. In such circumstances the unit administrator shall, therefore, have authority, after consulting the affected student, to permit the continued oversight of the affected student by the faculty member, graduate teaching assistant or other University employee shall not grade or otherwise evaluate, or participate in the grading or other evaluation of, the work of the affected student, and that the alternative arrangements for grading or evaluating the affected student's work treat the student comparable to other students.

--The Board of Trustees approved this policy statement on November 8, 1996. The Board of Trustees adopted a subsequent motion which emphasized the view of the Board that consensual amorous or sexual relations between faculty and students are discouraged.

--Other relevant policies include "Supervision of Academic Work by Relatives" and "Conflict of Interest in Employment".