ROGER WILLIAMS MEDICAL CENTER
DIVISION OF PODIATRY
PODIATRIC RESIDENCY MANUAL

Revised and Updated 10/2024 JSD

The Division of Podiatry, Department of Surgery, Roger Williams Hospital, welcomes you to our hospital.

Roger Williams Medical Center, an affiliate of CharterCARE Health Partners, and Prospect Medical Holdings, Inc currently maintains a fully approved three year Podiatric Medical and Surgical Residency (PMSR) with the added credential in Rearfoot/Ankle Reconstructive Surgery. The most recent evaluation of the program occurred in November 2018 by the Joint Residency Review Committee and the Council on Podiatric Medical Education (CPME). The program is approved for three residents in each of the three years of training and determines annually whether to accept either two or three entry-level residents in an attempt to ensure high quality training.

The following guidelines and protocols have been designed and established to ensure compliance with Council requirements, as well as provide a rewarding educational experience. These regulations are supplemented by rules and regulations in the general resident manual for this hospital. Your signature/date upon annual receipt of this manual acknowledges your understanding and acceptance of the contents within. We hope that the following protocols ease your transition to our "Staff."

Jordan S. DeHaven, DPM
Director, Podiatric Residency Program

RESIDENCY TRAINING COMMITTEE

Nathalia Doobay, DPM; Divisional Chief of Podiatry
Jordan S. DeHaven, DPM, Director of Podiatric Medical and Surgical Education (DPMSE)
James Appleton, DPM
David Greenberg, DPM
Sara Cathcart, DPM

ROGER WILLIAMS HOSPITAL
PROTOCOL: PODIATRIC RESIDENT

RULES AND REGULATIONS

GENERAL GUIDELINES:

1. Familiarize yourself with this protocol and that for Roger Williams Medical Center podiatric externs. The resident should make every effort to involve himself/herself in the Roger Williams Podiatric Residency Program by pursuing the objectives, rules and guidelines as described in this syllabus.

2. The resident shall demonstrate at all times, the qualities of professionalism consistent with the goals of this program and as defined by the bylaws, rules and regulations of all governing bodies and agencies of the Roger Williams Medical Center and the Podiatric Residency Training Program.

   The resident shall at all times maintain a professional relationship with all hospital staff and personnel as well as physicians and attendings.

   Residents are expected to dress in a professional manner. Scrubs are appropriate. Name badge needs to be displayed.

   All residents are expected to be well groomed and maintain good personal hygiene.

3. As a resident of Roger Williams Medical Center, you are a hospital employee directly responsible to the hospital administration. The Director of Podiatric Medical and Surgical Education (DPMSE) is your principal trainer and has authority and accountability for your training, scheduling and hospital performance. He is assisted by the Podiatric Education Committee. The Divisional Chief will assume the responsibilities of the DPMSE in his absence. Please contact either of these individuals, the Chairman of the Division of Podiatry, or the Chair of the Department of Surgery if a question or problem arises.

4. The podiatric resident shall possess and demonstrate at all times the moral character, manner and ethical conduct of a medical professional and function with an attitude that is conducive to a cooperative team effort.

5. Conflicts, criticisms and other problems involving other residents and other hospital personnel, departments, staff members or situations shall be brought to the attention of the DPMSE. The DPMSE and Education Committee members shall work with the resident in the resolution of the problem and will follow the appropriate channels of communication as necessary. (See Remediation Policy – "attitude")

6. An orientation period (approx. one week) is mandated prior to the start of the program. This period is designed to acquaint the resident with operating rules, policies, and procedures of Roger Williams Medical Center and the Division of Podiatry. The podiatric resident will meet at the beginning of his orientation with the Operating Room Supervisor for a review of the OR protocol. The resident must be "cleared" by the Operating Room Supervisor prior to the start of the residency.

7. The resident is to enhance the profession during the course of training by contributing to medical/podiatric literature.

8. Residents are prohibited from patient care and/or attendance at surgeries at institutions other than approved program affiliated facilities. Currently approved/affiliated institutions include Roger Williams Medical Center, Our Lady of

Fatima Hospital, Miriam Hospital, Rhode Island Hospital, St. Anne's Hospital Corporation Satellite Surgery Center, and Blackstone/HealthSouth. Surgical coverage of any other case must be requested in writing and approved by the DPMSE in advance.

10. Vacation requests are to be submitted to the DPMSE in writing ideally 3 months prior. Requests need to state the date(s) requested, assigned service/rotation, number of other residents on podiatry service and the number of vacation days remaining. *Following such approval, the resident will submit a VACATION TIME-OFF REQUEST signed by the DPMSE, to the Medical Education Office.* The same condition is placed on seminar time. The resident is expected to coordinate vacation requests with other residents. Residents are allowed fifteen (15) days of vacation. Third year residents are allowed twenty (20) days of vacation. The following is to be used as a guide for which rotations will be allowed vacation. All vacation requests are subject to DPMSE discretion. No vacation shall be longer than 5 consecutive work days.
    a. Rotations/months that vacation is prohibited
        i. Medicine, Orthopedics, the month of July, any 2 week rotations
    b. Rotations that vacations are allowed
        i. Elective, vascular, general surgery (depending on need)

11. Attendance at the designated rotation must be strictly adhered to. Mitigating circumstances will be considered on an individual basis and must be discussed and approved in advance with the DPMSE. The resident must keep his rotation chief and the DPMSE informed of any expected absence. If the resident is not busy during a rotation, he/she is responsible for initiating and utilizing educational resources.

    Surgical case assignments as determined by the DPMSE and Chief Resident must be strictly followed to achieve expected training as well as to ensure equitable exposure of all residents to varied pathology and procedures, and to allow for all residents to work with all attending surgeons. Residents are not to accept case assignments specifically by request of podiatric staff.

    Failure to adhere to these and other policies regarding attendance, logging, and assignments will result in disciplinary measures including notation in your hospital file.

12. The resident is responsible for working up all patients assigned for inpatient/outpatient surgery or medical admission i.e. pre-op orders, admission notes, pre-op notes, operative report and discharge summary. All work is to be done in a thorough, meticulous, and timely manner. This shall include suggesting appropriate consultations, ensuring that the pre-op history and physical is completed and reviewed by the admitting physician; that all pre-op tests are reviewed in an appropriate period of time prior to surgery, and that the attending is kept apprised of any and all matters pertaining to their patient. **It is mandatory that operative**

reports be completed by the assigned resident within 24 hours of the surgical case; and that discharge summaries are completed by the end of the day.

13. Be responsible for presenting all podiatric surgical and medical hospital cases on morning rounds or when called upon.

14. Residents are not allowed to perform consultations on patients independently. Consultations need to be requested of a staff podiatrist or the podiatrist on-call who may include resident participation. Residents may perform the consult before the attending sees the patient, but the staff podiatrist is the consultant.

15. A copy of the competencies and assessments for the program will be given to the resident at the start of the program. The resident is expected to become familiar with these and is encouraged to offer suggestions for addition, subtraction or modification throughout the course of his/her training. The resident is required to familiarize himself/herself with each rotation's objectives and the initiation of that rotation.

16. A rotational schedule will be published and disseminated at the beginning of each training year and may be modified. The resident is expected to become familiar with CPME documents # 320 and 330 for an explanation of training requirements. All pertinent forms can be found here: https://www.cpme.org/residencies/residency-documents-and-forms/

    Certain extenuating circumstances may require changes, alterations, deletions, or additions of scheduled rotations.

17. Remediation through renewal of training experiences will be recommended and instituted following any unsatisfactory evaluation. This will be at the discretion of the DPMSE in consultation with a rotational supervisor, the Divisional Director, Podiatric Education Committee, and Chairman, Department of Surgery. Satisfactory performance and evaluation through assigned remediation is a requirement before completion of the program and granting of the residency certificate. Please read the separate remediation policy. Residents shall sign off with staff in the office of Medical Education that the remediation policies have been received and reviewed at the start of each training year.

18. At no time shall the resident engage in the practice of podiatric medicine or any other form of outside employment (without permission from the DPMSE). Under no circumstances shall the resident receive fees from patients or others for services rendered. At no time shall the resident complete or file insurance forms. At no time shall the resident provide any form of patient information to any individual, agency or party without the permission of the patient's admitting physician. All requests for this type of information must be referred to the patient's attending immediately. At no time shall the resident obtain, compile or publish patient records, documents or other information without appropriate authorization in cooperation with the attending physician.

19. All employees and medical staff have the right to be free from racial or ethnic slurs, unwelcome sexual advances, or any other verbal or physical conduct, which creates a hostile work environment and constitutes harassment. Any complaints or instances of such harassment must be reported immediately to the Vice President of Human Resources or the Employee Relations Manager. See the separate Hospital policy pertaining to this topic.

20. Residents are regularly surveyed for stress-management and well-being. If there is need, the Human Resources department has an Employee Assistance Program with benefits that can aid in stress mitigation and well-being management. In addition, the hospital, through GMEC, offers a well-being program with activities, lectures and programs throughout the year to support the residents well-being.

21. The resident is requested to refer to the contract for a listing of benefits. The hospital residency manual may be utilized as well. Specific questions may be discussed with the Office of Medical Education.

22. The resident should be receptive to, and respect different methods as practiced by different attendings in the program. Each member of the attending staff will have the choice to use assigned resident(s) to participate in the care of their patient. The level of resident participating may include observation of procedures, academic discussion, floor management, and surgical case involvement. Residents will address the attending staff as "Doctor" at all times in the course of patient care.

    Residents will be "on-call" based on the call schedule and be immediately available on a 24-hour basis for all ER foot and ankle cases, post-operative complications and floor management of in-house patients.

23. Work Hours: Clinical and education work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. Work hours will be logged through New Innovations. These must be done completely and accurately.

    Work Periods: (A) Except as provided in (B) below, clinical and educational work periods for residents must not exceed 24 hours of continuous in-house activity and must be followed by at least eight hours free of clinical work and education. (B) The 24-hour work period may be extended up to four hours of additional time for necessary patient safety, effective transitions of care, and/or resident education.

    At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

24. The resident must cooperate with the Office of Medical Education regarding procurement of limited licenses in RI and MA, as well as hospital and surgicenter credentialing. This includes Federal DEA and malpractice coverage.

25. The podiatric resident will be evaluated regularly by podiatric and medical staff. Sample evaluation forms will be given to the resident at the start of their program:

    a. Podiatric Surgery: These forms measuring progress in general technique, hospital performance and interpersonal development, as well as specific skills in patient evaluation, case management and surgical techniques will be completed by the podiatric staff on a no less than semi-annual basis. These skills will be congruent with stated competencies.

    b. Other Rotations and Podiatric Clinic: Evaluation forms congruent with stated competencies will be filled out by non-podiatric staff at the end of each rotation. Such forms must be provided by the resident to the rotation supervisor prior to the last week in the rotation. Residents are expected to ensure that evaluations are completed and returned to the Med Ed office in a

timely manner. Residents are expected to review these evaluations and sign and date them in a timely manner (within one week of their receipt in the office of Medical Education) and to discuss any unsatisfactory evaluations with the evaluator. All evaluations will additionally be reviewed jointly by the resident and the DPME who will sign and date them as well. Residents who fail to perform adequately on a rotation will be notified of the need for remediation (See remediation policy).

24.

a. Supervision, control and discipline of the podiatric resident are vested in the DPMSE. Due process for management of all incidents may proceed through appropriate channels for resolution as noted in hospital disciplinary policy. These channels include the DPMSE with assistance of the Residency Training Committee, hospital administration with the guidance of the Divisional Director, and Chair of the Department of Surgery, and the Medical Education Committee.

b. When it is determined that a resident is not meeting the standards of the training program, and/or the Medical Center, both verbal and written notice of that fact will be communicated to the resident by the DPMSE. Such notice may include specific measures that must be taken to correct the performance deemed substandard. In cases where patient care may be immediately and adversely affected, or behavior wholly inappropriate, notice may be waived and the resident may be disciplined immediately.

c. Failure to follow specific direction and/or policy from the DPMSE may result in an immediate disciplinary action including remediation, restriction of clinical functioning, suspension and/or report in the hospital file.

d. Within a reasonable amount of time, and no later than three months following the initial notice of deficiencies, the resident shall be re-evaluated in writing by the DPMSE in conjunction with the Residency Training Committee to determine whether the substandard performance/behavior has been corrected pursuant to this notice. The resident shall be afforded the opportunity to respond to this evaluation. (See remediation policy – "knowledge").

e. If for any reason the resident has an adverse reaction taken against them, i.e. remediation, restriction of clinical function, suspension and/or termination, the resident has the right to an appeal for this action. (Please see Exhibit F in resident contract for this policy.)

26. Residents will become familiar with the electronic logging format through the website Podiatric Residency Resource (PRR). Residents will log all training opportunities, exposures, procedures, and cases as well as didactic experiences experienced no later than weekly under the activity and clinical log categories.

Residents will become familiar with case/procedure/exposure requirements, minimums, and instruction for logging as discussed in CPME document #320 and CPME addendums, and follow the listed guidelines. Please consult with the DPMSE regarding any questions on logging.

Logging as noted above should be completed on a daily basis, and must be completed no later than one week following the encounter. Failure to do so can result in non-verification, and other disciplinary measures including suspension from scrubbing cases. Resident logs need to be completed by June 30, or the end of each training year to avoid non-verification. Their satisfactory fulfillment is a requirement for graduation.

27. Residents must at the beginning of each training year, sign/initial for receipt and acknowledgment of the rotation schedule, residency manual, rotation competencies and assessment documents, CPME Documents # 320 and #330, remediation policy, and due process provisions. These may be distributed to the residents electronically.

28. Residents will plan and attend the quarterly divisional Quality Assurance Meetings under the direction of the DPMSE and Divisional Chief. This will include preparation and presentation of selected cases on a regular basis. The DPMSE and Divisional Chief will provide a list of criteria for case consideration. Residents will also need to attend quarterly Surgical M&M meetings.

29. All rotations/facilities/offices/electives outside RWMC must have an approved and signed affiliation agreement pre-existing to attendance. Please inform the DPMSE and Medical Education several months prior to any planned clinical time at a new facility to arrange for an affiliation agreement. *Residents on elective rotati*ons *are expected to be present at least for a M-F schedule. Should a day be canceled on such rotation ie. Attending vacation, or weather, then the resident needs to return to the podiatry service or spend time at another office with the approval of the DPME. Additionally, on rare occasions residents on elective office rotation in the geographic area of the sponsoring institution may be asked to attend hospital clinic and/or cover surgical cases/house patients.*

30. All protocol items are subject to immediate revision, addition and deletion.

31. Daily Logs Re: Location of resident training will be kept accurately and completed daily through New Innovations.

32. All clinic/chart notes will be completed on the same day.

EDUCATIONAL RESPONSIBILITIES:

1. Attend all educational conferences; lectures open to medical students and interns, except when in surgery. Attendings and rotation chiefs should generally allow for absence during rounds and other matters for these responsibilities.

2. The resident is to update on a daily basis an activity log maintained through the PRR. This includes didactic activities. The resident shall additionally enter all podiatric cases and procedures on a daily basis through the PRR surgical log. The DPMSE and chief residents will instruct the resident in completing the process. The DPMSE and the Training committee will regularly review all activity and surgical logs. This review will be on a quarterly or more frequent basis. Their satisfactory fulfillment is a requirement for graduation.

3. Residents will be provided with evaluation forms pertaining to the podiatric faculty encountered during the training cycle as well as the rotations completed. These evaluation forms may be completed by the residents as individuals or as a group.

4. The resident is expected to make use of the hospital library as needed. This includes computer-assisted retrieval resources. Please see the DPMSE for further research resources as needed.

5. You are responsible for the daily oversight, education, and performance of RWMC podiatric externs. They will be responsible to you. You will be familiar with the extern manual and will assist in extern evaluation at the conclusion of each month. All breaches of extern protocol are to be immediately discussed with the Clerkship Director or the DPMSE.

6. Residents may attend educational portions of the Rhode Island Podiatric Medical Association meetings as held. These are usually held on the third Wednesday quarterly at 6:00PM. Please see the DPMSE or the Divisional Director for details.

7. You are expected to receive certification in basic CPR prior to initiation of the residency program. You are expected to receive certification in Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) as required of other hospital interns and residents. Please see the Office of Medical Education for information regarding these matters.

8. You are to confirm with the DPMSE that satisfactory instruction in performing comprehensive H&Ps has been completed during the first year rotation on internal medicine.

9. You are expected to escort visiting students on a tour of the hospital and answer relevant questions. These students are expected to call you in advance and

receive an appointment. A list of visitors and an assessment of their visit shall be kept.

10. Weekly academic discussion and general presentations will be scheduled coordinated with the DPMSE. Residents are expected to keep a daily activity log of any and all academic discussion and presentation encountered of either a medical or podiatric nature and enter these through PRR. These would include discussions held at Roger Williams Medical Center or off site. Formal presentations at RWMC should be monitored with an attendance sheet.

11. Residents are responsible for covering the Podiatric Outpatient Clinic at Roger Williams Medical Center and completing all charting and notes prior to being discharged at the end of the clinic session. An attending podiatrist will be assigned to the clinic and the resident will perform under the direction of that Attending for the clinic session.

12. Residents will participate in divisional education conferences, such as journal club, radiology rounds, and review of quality assurance events.

13. Residents are encouraged to attend the RIPMA Surgical Seminar each Spring in Newport and to attend all didactic sessions unless on hospital assignment or allowed otherwise by the DPMSE.

14. Residents will be allowed an additional yearly stipend for an educational seminar. Usage of this stipend must be approved by the DPMSE/Divisional Chair. Residents will be provided with recommended annual conferences suitable for their training level.

15. There will be a daily morning report coordinated by the chief/senior resident attended by all residents and externs.

16. Residents are encouraged to schedule and participate in cadaver surgery labs and surgical skill (sawbone, suture) workshops. Cadaver dissection should have an academic and surgical mission. Operative skills should be practiced and staff attendings invited to assist in teaching. Guidelines for the use of the pathology lab will be adhered to for any cadaver limb session.

17. Residents will register and take annual In-Training Exams in Podiatric Surgery as determined annually by the DPMSE. Residents not meeting peer level scoring averages shall formulate a remediation plan with the DPME to improve their knowledge base.

18. Residents must be aware of and meet all numerical and diversity requirements for clinical training exposures and surgical procedures as stated in CPME# 320, including Reconstructive Rearfoot/Ankle, Pediatric, Trauma, Complete H&P's,

and Biomechanical Examinations, as a requirement for graduating from the program.

RESIDENT PROTOCOL:

Chief Resident: A third year resident(s) appointed by the Director of Podiatric Education. The Chief Resident will assist the DPMSE and the Residency Training Committee in the administration of educational and training programs at the hospital. The Chief Resident will fulfill this responsibility through the regular communication of information from the DPMSE to all residents and externs. The Chief Resident will assist in the orientation, guidance and instruction of the other residents and externs. The Chief Resident will be responsible for the satisfactory completion of daily resident and extern activities and compliance of all protocols/regulations.

The status of Chief Resident is not guaranteed to any resident, regardless of training year. The DPMSE will select the Chief in consultation with the Division Chief and training committee. The selection will be based upon a combination of performance, academic knowledge, surgical skills, director's trust, leadership, and ability to work well with others.

1st/2nd Year Residents: First/Second year residents will defer to the Chief/third-year residents in all questions of protocol, responsibilities and duties, unless discussed with the DPMSE. First-year residents will defer to second-year residents in all questions of patient care, unless discussed with the patient's attending or DPMSE.

RESIDENT DESIGNATION FOR SURGICAL AND PATIENT CARE ASSIGNMENTS:

The intent of the following policy is to ensure equitable and competent training of all residents in a progressive and timely manner, consistent with rotational objectives approved by the Council on the Podiatric Medical Education. The protocol is designed to maximize appropriate surgical training for all residents at the respective levels of training in accordance with fulfillment of rotational objectives in podiatric surgery.

1. Residents assigned on the Podiatric Surgery rotation will be designated as Residents on Podiatric Service for that month. All will be mutually responsible for the completion of subsequent responsibilities within this section. Residents will defer to the Chief/Third Year Resident(s) for direction, and assignment of specific duties and responsibilities, unless modified by the DPMSE.

   All surgical case assignments will be made by the Chief/Third Year Residents in close consultation with the DPMSE at the beginning of each week. Changes to the OR schedule should be brought immediately to the attention of the DPMSE for modification as necessary.

2. Residents not assigned to the monthly service rotations as noted in #1 will be designated as a Rotating Resident for that month.

3. Residents on Podiatric Service are assigned as First Surgical Scrub Assistant on all podiatric cases, unless instructed by the DPMSE. Such changes are likely to occur in the following two instances:

    a. The Resident on Podiatric Service is a First/Second year resident, and the case in question involves pathology and/or surgical treatment satisfying particular needs or skills of a more senior Resident or the Chief Resident who will scrub the case as First Assist.

    b. The Resident on Podiatric Service is a Senior or Chief Resident, and the case in question involves relatively minor and/or frequently encountered pathology and/or surgical treatment for which the senior or Chief Resident has demonstrated regular and satisfactory competence. In this case, the senior/Chief resident will be a second assist, while a junior resident serves as First Assist.

4. A Rotating Resident may be allowed to leave his/her non-podiatric rotation as needed. The DPMSE must approve these individual circumstances. This would include times when coverage is needed such as during boards, etc.

5. A Rotating Resident will, if available and needed, serve as a First or Second Surgical Scrub Assistant at the discretion of the attending physician and DPMSE.

    Residents who wish to observe patient care/cases outside of program affiliated facilities, need the permission of the DPMSE.

    Residents who present preoperatively to any case and are presented with altered scrubbing/first assist participation by an attending are to call the DPMSE immediately preoperatively for direction.

6. All Operation Room assignments for podiatric cases will be made on the Friday prior as noted above taking into account communication and responsiveness by participating OR's. Add On cases for any given week will be brought to the attention of the DPMSE who will approve all assignments. In the case where podiatric surgical cases are scheduled for several operating rooms simultaneously, the attending podiatrist who will not have a podiatric resident available will be contacted as soon in advance as possible so that they may allow for an extern if available or private attending to serve as First Assistant. The Chief Resident is required to review the upcoming OR schedule on a daily basis to prepare for the

possibility of simultaneous podiatric surgical rooms being scheduled. The surgical residents will prepare the upcoming week's schedule by each Friday including the location, attending, procedure and start time.

7. Residents on Podiatric Service will be expected to also function in the capacity of "Podiatric Houseofficer." These residents are responsible for the overall paperwork and disposition of patient care for all podiatric house patients at the sponsoring institution and those affiliates approved by the DPMSE. These residents are expected to try to accompany all attendings making rounds.

8. All residents not scrubbed on cases will be responsible for floor management, ER cases *and inpatient consults*.

9. Pre-operative injection, post-operative orders, and outpatient post-operative prescriptions and instruction are the responsibility of the resident serving as the First Surgical Assistant. Should more than one resident be available for a case, a senior or Chief Resident and/or the attending may designate responsibility to another resident or extern.

10. Paperwork and disposition of patient care for relevant orthopedic and other surgical cases are the responsibility of the resident who scrubbed that case, or at the discretion of the Chief Resident with approval of the attending. Discharge summaries are the responsibility of the podiatric resident when there is a staff podiatrist admitting with medicine.

11. Residents are asked to complete all dictations including operative reports in a timely fashion in compliance with individual hospital regulations and guidelines. Please consult with the Department of Medical Records regarding guidelines for this. **It is mandatory that operative reports be dictated within 24 hours of the case**.

12. Residents are required to contact attending to which cases the resident is assigned at minimum 2 days prior to the case. This is to allow for preparation, to ask questions and to review appropriate case information and imaging.

DAILY RESIDENT SIGNOUT/TRANSITION OF CARE:

1. The Chief/Senior resident will direct a daily meeting at approximately 6:45AM attended by residents on podiatric service, available residents on other rotations, and podiatric externs. This meeting should discuss rounds of all inpatients, this will also serve as a transition of care for on-call resident from previous evening.

2. The residents will also direct an in-person daily signout each evening to review inpatients, new consults, surgical schedule the following day and allow for appropriate transition of care to on-call resident.

3. This signout/transition of care will address the following in sequence:

   1st: Summary presentation of the status of all in-house patients on service (podiatry, relevant ortho, relevant other med/surgical cases). These cases will be presented by an assigned resident on Podiatric service for that month, in the following order:

   2nd: Surgical cases scheduled for that day and resident/extern assignment/participation. This is to include, when available, pre-operative review of all laboratory and radiographic data, as well as discussion towards anticipated procedural choices and delivery of care.

   3rd: Listing of patients for pre-admission testing/history and physicals that day.

   4th: Listing of patients scheduled for special imaging or radiologic/nuclear medicine procedures that day.

   5th: Anticipated daily schedule for residents/externs: Including possible office rotations, rounds, discharges, etc.

GENERAL RESPONIBILITIES:

1. An "On-Call" schedule will be made in advance by the Chief Resident and approved by the DPME. This will include backup call as indicated. All residents are expected to participate in the on-call schedule.

2. Residents are expected to keep their pager with them at all times and in the ON position at any time that they are expected to take call in addition to the service pager.

3. Residents who are new to the residency program are expected to discuss cases received on call with a second/third resident during the first 3 months of the program.

4. A schedule for weekend assignments will be made available one year in advance.

5. Clinic coverage takes precedence on scheduled Tuesdays and Wednesdays starting at 1:00pm. Residents may only miss clinic to scrub approved cases with the permission of the DPMSE and the clinic director.

6. Arrive at hospital at approximately 6:30AM on weekdays, unless specific rounds, surgeries, lectures, preparations mandate earlier times. Rotating Residents may leave the hospital at 5:00PM weekdays, unless a Rotating Chief dictates otherwise, or should specific clinical or academic situations occur. This departure time, or course, does not apply when on office rotation where you attend at the time directed by the individual podiatrist. The Resident on Podiatric Service is expected to remain at the hospital until 5:00PM. On weekends, the on call resident will round on all in patients that morning in a timely manner, and must be available as needed. Weekend assignments for Rotating Residents are to be in accordance with the requirements of the specific rotation as well as the weekend "On-Call" schedule.

7. Familiarize yourself with each case pre-operatively. A podiatric history and physical including biomechanical examination is to be performed on every podiatric patient (inpatient or outpatient). This part of the medical record will be kept on a separate form within the patient's chart. The resident will be given copies of suggested guidelines as well as hospital quality including the notification of all attendings regarding abnormal pre-admission testing, as well as the results of special tests, i.e. bone scan, performed on their patients. Residents are expected to incorporate assessment of the following findings on the podiatric history and physical form: Involvement with complete history and physical examination, podiatric history and physical examination, differential diagnoses when appropriate, rationale for proposed surgical intervention, assessment of abnormal pre-operative lab tests, radiographic findings when appropriate, biomechanical exam when appropriate. Residents are expected to check post-op x-rays and discuss pertinent findings with the attending.

8. Effort should be made to have infected wounds needing dressing changes to be handled by residents not scrubbing that morning when feasible.

9. Participate in post-op care to the fullest extent under the direction of the surgeon, i.e., recovery room monitor, x-ray evaluation, inpatient visits, telephone calls to discharge planners or social services, etc.

10. Review each podiatric admission and remain knowledgeable of condition through discharge. All residents should be involved with in-house patients to gain knowledge and assist the attending.

11. A **minimum** of twice-daily rounds on inpatients and all post-op surgical admissions by the primary resident is expected.

12. Externs are not to examine patients, or provide treatment without direct resident/attending supervision.

13. While on the podiatric surgical rotation, daily responsibilities will be assumed in the following order of priority:

    1st - Attendance at podiatric surgical cases
    2nd – Urgent Consults or Attendance at other pertinent surgical case
    3rd - ER patient call
    4th - Rounds with attending podiatrists
    5th - Attendance at pre-admission testing/history and physicals and/or radiologic procedures
    6th - Rounds with Internist/other physician
    7th - Non-urgent consults

14. Office visitation outside scheduled rotation times is encouraged. Office visitations during slow schedule periods are permitted following approval from the DPMSE. Afternoon assignments, including office rotations as determined by Rotation Chief(s), with non-podiatric rotations take precedence over podiatric office rotations. You are not expected to routinely scrub on podiatric cases when you are the Rotating Resident. Your Rotational Chiefs will be contacted to allow for your general absence for podiatric cases when appropriate. Office visits to follow surgical post-op patients or review charts/x-rays is encouraged.

15. Podiatry Clinic is scheduled on alternating Tuesdays and Wednesdays on East One of RWMC. Residents on podiatric surgery for that month, along with the podiatric externs will attend the podiatry clinic. Drs. Doobay and DeHaven will oversee the clinic on a rotating basis and will be responsible for that session.

Resident Rules & Guidelines (per Chief Resident)

- **Call**
  - Ask your co-resident first to switch weekends on call, prior to asking 2nd and 3rd years
  - Resident on-call is responsible for updating sign-out over the weekend prior to rounding on Monday morning and checking and updating the surgery schedule on Sunday night
  - **On-call resident to call third year on service on Sunday** to discuss census and determine rounding time for Monday morning. Once plan is formulated, the on-call resident is responsible for notifying other residents. This should be done by early Sunday evening.
    - ER
      - **The first 2 months on call, report all ER patients seen to the backup call resident, especially before writing orders/performing tx**
      - Mark all cellulitis and take pics of everything
      - Trauma - Interns must run assessment and plan by back up person prior to finalizing consult
  - The chief resident/third year resident makes the monthly call schedule
  - During the month of July when each first year resident is on call, the back up call resident is **REQUIRED** to round as well.
  - During the month of August when each first year resident is on call, a phone call is **REQUIRED** to the back up resident.
  - Otherwise, the back up call person is available by phone for questions, recommendations, etc. The back up person comes in if there are multiple surgeries/urgent clinical obligations going on at the same time. Generally, if you have to be in 2 places at once, call the backup.
  - If patient undergoing general anesthesia is being admitted, person on call is expected to post round on patient 4 hours after surgery for post-op check. Auscultate lungs!
  - Off service call: It is the off-call resident's responsibility to contact the on-service residents to find out the rounding time for the day of their call. If there are patients on RWMC service, resident on call must round the morning of call to introduce him/herself to patient and familiarize him/herself with

patient labs/studies/records, etc

- **Rounds**
  - **Be present and on time for rounds, no exceptions. Resident on call overnight is responsible for having dressings bedside prior to team's arrival.**
  - Attendings to be called/texted with patient update immediately after rounds
    - Update should include pertinent lab/micro/radiology results, exam findings, consults obtained, medication changes. Have this ready before you contact attending!
    - Get a plan! (abx, dressings, WB status, dc plan)
  - Chart check patients at the end of the day
  - Contact/Discuss with attending each day's rounding plans
  - Attendings are to be accompanied by a resident when rounding.
  - Get plan from attending on Friday if attending is planning on rounding over the weekend- ie time, etc- to put on sign out for resident on call that weekend
  - **SIGN-OUT:**
    -Make sure signout is updated in the AM and PM
    -Include laterality and DOS
    -Update attending once patient has been discharged

- **Surgery**
  - Be prepared for cases.
  - **DICTATIONS are to be done within 24 hrs. If not, may result in not being permitted to scrub cases and possibly temporary suspension from that surgical facility.**
  - Electronic prescriptions at Miriam need to be printed with written DEA number in the appropriate spot
  - **Blackstone (1526 Atwood Ave #300 Johnston, RI; 401-459-3800) ***CURRENTLY NO PODIATRY CASES HERE ANYMORE BUT MAY RETURN IN THE FUTURE*****
    - Call Blackstone daily and ask for Podiatry surgery schedule for the week.
    - Confirm that patient has signed the resident consent form, then introduce yourself. If patient does not consent, you cannot be present in surgery.
    - Your responsibilities include introducing yourself to patient, maybe filling out some pre-op paperwork, applying tourniquet, performing block and assisting in case, and dictations.
    - Lunch is free when they order.
  - **SNESC (738 Washington St. Attleboro, MA; 508-761-6025)**
    - Either text Deb Tuesday AM or ask to look at surgery schedule for the rest of the week & following week when present at the surgery center.
    - Responsibilities: Complete patient post-op instructions, medication sheet, post-op note, perform dictation (Pontarelli dictates for himself), sometimes have to do pre-op H&P & consent depending on attending.
    - All scripts must now be electronically sent. Attendings should call their office staff to do so or send it pre-op. We DON'T write paper scripts anymore, especially for narcotic pain medication.
  - **Miriam**
    - Outpatient surgery

- Complete post-op discharge prompts:
    - Diagnosis (if not already entered)
    - Brief op note
    - Med reconciliation (d/c fluids/intra-op meds, continue pre-op meds and add any pain meds as needed. Use Imprivata ID app for narcotics)
    - Order post-op portable radiographs in PACU for any surgery involving hardware placement.
- Inpatient surgery
    - Complete pre-op prompts:
        - Consent (use the COWs on each floor)
        - NPO order (can place order yourself if primary team forgets to)
        - Booking form (type in "Case Request" under Orders section)
    - Complete post-op to floors prompts:
        - Diagnosis (if not already entered)
        - **Brief op note (Include all pertinent intra-op findings such as blood loss, quality of bone, soft tissue structures, intra-op cultures, etc)**
        - Med reconciliation (continue all pre op meds, d/c all intra op meds)
        - Remember nursing orders, vac orders, WB status, activity restrictions, diet, etc if applicable
        - **Contact the medicine doctor responsible for pt to update them on pt's condition and plan immediately post op. Can send them a secure chat on EPIC.**
        - Try to get plan from attending at the end of the case (dressing changes, antibiotics, need for further surgery, weightbearing status, consults, etc).

- PATs to be completed the day before for all RWMC surgeries: includes H&P and fax Abx order sheet to pharmacy
    - Doobay does her own outside patients' H&P and orders; she also dictates her own cases
    - Doobay likes full H&P physical exam- ie heart, lungs, etc
- RWMC: Brief-op note, operative report (within 24 hours), Podiatry post-op order set, prescribe meds through Meditech.
- You are expected to be present in pre-op area 20-30 minutes prior to surgeries at RWMC & Miriam, and no less than 15 minutes prior at surgery centers
- Post-Op check all patients who have undergone general anesthesia 4 hours after completion of surgery if admitted
    - Write note, must include cardio and lung exam
- Surgical Schedule
    - Check surgical schedule daily and make adjustments

- **Admissions**
    - RWMC
        - Podiatry Service:

- Patients are co-admitted to podiatry attending and medicine attending
- Co-admission goes to the hospitalist. Call the operator to see which hospitalist is on call and then give them detailed history and plan.
- All diabetics get TID fingersticks and insulin sliding scale
- Admission note is a FULL history and physical
- Check allergies!
- When ordering medications, remember to also include prn meds to address pain, insomnia, nausea, constipation, etc (neumonic: ABCDEFGH)
- DVT prophylaxis: Heparin 5000 units subQ BID/TID depending on weight
    - Unless pt has history of HIT, then use lovenox
- Renally dose all meds if necessary
- If prescribing Vancomycin, make sure dose is correctly calculated
    - Get loading dose in ED, then maintanence dose; call pharmacy to calculate
    - Order trough!
    - Order random vanc or new trough if Cr changes
- Consider nursing orders to reinforce dressing, elevate foot, etc.
- Chart check all patients on podiatry service in afternoon to apply any recommendations made by hospitalist/PCP/consultants
- Pt's going to surgery will need EKG, chest x-ray if >45 yrs old or hx of smoking/lung disease, T&S
- If unsure of patient's home meds, and to confirm doses, call patient's pharmacy; ask what has been filled recently if question of compliancy

▪ Medicine Service

- Pt's with extensive and unstable medical histories, requiring telemetry, abnormal BMP, non-surgical candidate, and/or with blood sugar of >450 mg/dL generally should be admitted to medicine
- Consult note to be completed
- Communicate all recommendations to medicine resident directly at a timely manner

o Miriam

▪ Admissions usually done after surgical cases
▪ Call operator and ask for "admitting IMIS doctor." Page that doctor and give him/her full sign out.
▪ The IMIS attending will complete H & P. You are responsible for post-op note and all orders (admission order, WB status, dressing change instructions, pain control)
▪ Order all outpatient and prn meds, activity and WB status as relevant to podiatry

- **Discharges**
    - COC to be completed prior to discharges

        - Include all outpatient meds, detailed dressing change and follow-up instructions
    - All new medications require prescriptions
        - Unless patient is going to nursing home. Then only narcotics or other controlled substances require scripts.
    - Discharge note is required on all patients within 24hrs
    - Resident performing discharge is responsible for dictating discharge summary
        - This is now required even for 23h obs admissions
    - Miriam
        - Complete discharge instructions for all patients under "non-surgical" tab

- **Dictations**
    - Resident performing patient discharge is responsible for dictating discharge summary
    - All dictations to be completed within 24 hours
        - Miriam suspends the attending in 24 hours if dictations not completed
    - Dr. Pontarelli usually dictates at SNESC
    - Dr. Volpe usually dictates at Blackstone
    - Dr. Doobay dictates non-clinic patients at RWMC
    - Blackstone dictation service does not generate confirmation code
    - Sample: SAPPPPAHEMIC, Indications for procedure, Procedure in detail

- **Miriam**
    - As a consult service, we make recommendations only. IMIS or the teaching team perform all consult requisitions, orders, etc. We typically enter dressing and nursing orders only.
    - All consults must be called to attending on call first.
        - If you get a call from a medicine resident or attending who wants to place a consult and has not gone through the podiatry attending first, take down the consult info and put on sign out, but inform them that the consult must go through the attending on call; this is to ensure that attending on call is able to keep track of all consults
    - Resident who performs surgery on inpatient must put patient orders back in (if cancelled) and send text page to managing service with patient update. It's your responsibility to re-admit patient. (See instructions above)
- **QA**
    - Scheduled approx. every fquarter
    - QA cases will be assigned by Divisional Chief
    - Maintain "QA running list" updated on google docs; See QA criteria document on google drive for more info
    - On the morning of QA, have an attending sign in sheet and list of presentations ready, as well as laptop and projector
    - Have presentation available on thumb drive

- **Consults**
    - Nail consults performed at RWMC ONLY if concern for infection. WE DO NOT DEBRIDE NAILS AS A COURTESY AS WE ARE A SURGICAL SERVICE.

- Consults on the weekend must be performed within 24 hours at ALL locations
- Always ask if patient already has a podiatrist before assigning to on-call physician

- **Clinic**

  -All notes are to be written on the same day (no later than 24 HOURS)
  -Click under the correct encounter when writing notes
  -Students should check regularly if patients are in the waiting room
  -Notes should be done AFTER all patients have been seen.
  -Get clinic schedule from Kasey daily Monday/Tuesday.
  -Bring Kasey xray orders before clinic & make copies.

- **Educational Conferences**

-Every resident is permitted one educational conference per year for reimbursement (July 1st-June30th)
First years are recommended to attend an approved Basic A-O course, second years an advanced A-O course, and third years an approved Arthroscopy course or ACFAS.

- **Daily logging**

-Daily logs are to be completed on a **DAILY** basis with accurate times, and locations

-Logs need to be turned in on a weekly basis to Susan S. or Barbara O.

- **Applicable to 3rd years ONLY**

-Third year residents will be given a total of **20 days of vacation**. These 5 extra days can be utilized for additional conferences, so please use them at your discretion.

Council on Podiatric Medical Education

9312 Old Georgetown Road
Bethesda, Maryland 20814
P 301.581.9200
www.cpme.org

July 2023

TO: Program Directors and Residents
FROM: Council on Podiatric Medical Education
SUBJECT: Proper Logging Guide

- The new guidelines are effective July 1, 2023, to allow for updates to the CLAD report in Podiatry Residency Resource.
- New sections added include the following:
  - Category 6 – Other Podiatric Procedures
  - Category 11 – Lower Extremity Wound Care
  - Category 13 – Other Clinical Experiences

All logged procedures, biomechanical examinations, and comprehensive history and physical exams must comply with these guidelines beginning July 1, 2023.

Proper Logging Guide
(*Effective July 1,2023*)

GENERAL GUIDELINES:

1) For the procedure codes listed below, the program director must review each entry to determine proper usage. The following surgical codes may only be used if a more appropriate procedure does not exist. A full documentation in the "Procedure Note" is required to justify use.

    1.13 other osseous digital procedure not listed above
    2.3.10 other first ray procedure not listed above
    3.14 other soft tissue procedures not listed above (limited to the foot)
    4.18 other osseous procedures not listed (distal to the tarsometatarsal joint)
    5.1.9 other elective reconstructive rearfoot/ankle soft-tissue surgery not listed above
    5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above
    5.3.7 other non-elective reconstructive rearfoot/ankle soft tissue surgery not listed above
    5.4.8 other non-elective reconstructive rearfoot/ankle osseous surgery not listed above

2) In cases where a subchondroplasty procedure is performed as part of another procedure, only the index procedure must be logged. For example, a talar dome or distal tibial subchondroplasty may only be logged as:

    5.2.1 Operative arthroscopy without removal of loose body or other osteochondral debridement

    5.2.7 open management of talar dome lesion (with or without osteotomy) or

    5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement.

    If subchondroplasty is performed in isolation, the appropriate logging mandates use of the following subcategories: 5.2.7, 5.2.8

        1.13 other osseous digital procedure not listed above
        2.3.10 other first ray procedure not listed above
        4.18 other osseous procedures not list (distal to the tarsometatarsal joint)
        5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above

3) Laterality (left or right) must be selected for all surgical procedures in categories 1 through 5.

4) The "Procedure Notes" must always reflect additional procedures that were performed but not logged individually.

5) Procedures may not be fragmented or unbundled into individual component parts to allow more than one resident to claim first assist.

6) Any reference in this document to "midfoot" entails any osseous or soft tissue procedure that is performed proximal to but not including the tarsometatarsal/Lisfranc joint.

Category 1: Digital Surgery (lesser toe or hallux)

A procedure performed at the PIPJ and DIPJ can only be logged once. Include both procedures in the procedure notes.

- ❖ A resident may only log one category 1 procedure per toe (the Procedure Note may reflect additional procedures performed) and no more than one resident may claim a first assistant on a single toe.
- ❖ The digit (toe) number must be documented for all digital surgical procedures.

1.6 Phalangeal Osteotomy

- ➢ **May not** be used in conjunction with:
  - 2.1.1 bunionectomy (partial ostectomy/Silver procedure) – (use 2.1.3 bunionectomy with hallux osteotomy)
  - 2.1.3 bunionectomy with phalangeal osteotomy
  - 2.1.7 metatarsophalangeal joint (MPJ) fusion
  - 2.1.8 MPJ implant (with phalangeal implantation)
  - 2.2.1 cheilectomy
  - 2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
  - 2.2.6 MPJ fusion
  - 2.2.7 MPJ implant (with phalangeal implantation)
  - 2.3.4 amputation

- ➢ **May** be used as an "add on" in conjunction with:
  - 2.1.4 bunionectomy with distal first metatarsal osteotomy
  - 2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
  - 2.1.6 bunionectomy with first metatarsocuneiform fusion
  - 2.1.8 MPJ implant (when used, a metatarsal component implantation only)
  - 2.1.9 MPJ arthroplasty
  - 2.1.10 bunionectomy with double correction with osteotomy and/or arthrodesis
  - 2.2.3 joint salvage with distal metatarsal osteotomy
  - 2.2.4 joint salvage with first metatarsal shaft or base osteotomy
  - 2.2.5 joint salvage with first metatarsocuneiform fusion
  - 2.2.7 MPJ implant (when used, a metatarsal component implantation only)
  - 2.2.8 MPJ arthroplasty
  - 2.3.1 tendon transfer/lengthening/procedure
  - 2.3.2 osteotomy (e.g., dorsiflexory)
  - 2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
  - 2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
  - 2.3.7 open management of fracture or MPJ dislocation
  - 2.3.8 corticotomy/callus distraction
  - 2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
  - 2.3.10 other first ray procedure not listed above (only as indicated)

1.8 Amputation

- **May not** be used in conjunction with the following procedures if in reference to the same numerical ray:
  - 1.10 management of bone/joint infection
  - 2.3.4 amputation
  - 2.3.6 management of bone/joint infection (with or without bone graft)
  - 3.8 incision and drainage of soft tissue
  - 4.4 metatarsal head resection (single or multiple)
  - 4.10 amputation (lesser ray, transmetatarsal amputation)

1.10 Management of Bone/joint Infection

- **May not** be used in conjunction with:
  - 1.8 amputation (if done on the same digit)
  - 3.8 incision and drainage of soft tissue infection (includes foot, ankle or leg)

Category 2: First Ray Surgery

In general:

- The soft tissue component **of *all* First Ray Surgery** repair is inclusive and is **not** separately claimed as an additional procedure for all subcategories. The use of 2.1.1 is limited to isolated soft tissue repair/partial ostectomy of the first MPJ when no other osteotomy or fusion procedure is completed on the first ray.

- A resident **may** only log one 2.2.1-2.3.10 procedure per foot and no more than one resident may claim a first assistant procedure per foot.

Hallux Valgus Surgery

- Osteotomy (Akin) of the proximal phalanx treatment, see above in Digital Surgery
- Use of suture and button construct as the primary method to repair a bunion deformity should be logged as 2.1.1
- 2.1.10 can only be used when two separate osteotomies and/or arthrodesis are performed on the same first ray to correct the bunion deformity. EXAMPLE: A first tarsometatarsal arthrodesis and a head osteotomy on the same metatarsal should be logged as 2.1.10.

Hallux Limitus Surgery

- All of these procedures **shall be inclusive** and count as **one First Ray Surgery** procedure

Other First Ray Surgery

2.3.1 Tendon Transfer/lengthening Procedure

- The soft tissue component of all first ray surgery repair is inclusive and is not separately claimed as an additional procedure.

2.3.4 Amputation

- **May not** be used in conjunction with:
  2.3.6 management of bone/joint infection (with or without bone graft)
  3.8 incision and drainage of soft tissue infection (includes foot, ankle or leg)

2.3.5 Management of Osseous Tumor/neoplasm (with or without bone graft)

- **May not** be used for removal of simple bone cyst

2.3.6 Management of Bone/joint Infection (with or without bone graft)

- **May not** be used in conjunction with:
  1.8 amputation (if the amputation involves the great toe)
  2.3.4 amputation
  3.8 incision and drainage of soft tissue infection (includes foot, ankle, or leg)

2.3.10 Other First Ray Procedures Not Listed Above

- When two separate procedures are performed on the same first ray to correct the bunion deformity, please use 2.1.10.
- **EXAMPLE**: A first tarsometatarsal arthrodesis and a head osteotomy on the same metatarsal should be logged as 2.1.10.

Category 3: Other Soft Tissue Foot Surgery:

3.1 Excision of Ossicle/sesamoid

- Can only be used if it is performed as an isolated primary procedure
- **May not** be used in conjunction with First Ray Surgery or tendon transfer/augmentation
- **May not** be used in conjunction with Other Osseous Foot Surgery
- **EXAMPLES**: os peroneum, os tibiale externum, os vesalianum

3.4 Plantar Fasciotomy

- May include open, endoscopic, or minimal incision approach
- TOPAZ and PRP injection are logged as 6.14
- Includes localized lipectomy and associated soft tissue excision
- Includes plantar heel spur/exostosis resection
- Includes local nerve (i.e. Baxter's nerve) release or ablation
- **May not** be claimed as Reconstructive Rearfoot/Ankle Surgery
- May not be used in conjunction with:
  3.9 plantar fasciectomy /plantar fibroma resection

3.5 Lesser MPJ Capsulotendon Balancing

- Excludes percutaneous tenotomy/capsulotomy
- **May not** be used in conjunction with:

  3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
  3.7 open management of dislocation (MPJ/tarsometatarsal)
  4.2 lesser MPJ arthroplasty
  4.3 bunionectomy of the fifth metatarsal without osteotomy
  4.5 lesser MPJ implant
  4.6 central metatarsal osteotomy
  4.7 bunionectomy of the fifth metatarsal with osteotomy

3.6 Tendon Repair, Lengthening, or Transfer Involving the Forefoot (including digital flexor digitorum longus transfer)

- **May not** be used in conjunction with
  3.5 lesser MPJ capsulotendon balancing
  3.7 open Management of dislocation (MPJ/tarsometatarsal)
  4.2 lesser MPJ arthroplasty
- **May not** be used if percutaneous

3.7 Open Management of Dislocation (MPJ/tarsometatarsal)

- **May** be claimed as an additional procedure in conjunction with Digital Surgery.
- Includes plantar plate repair and soft tissue repair of LisFranc injury
- **May not** be used if percutaneous
- **May not** be used in conjunction with
  3.5 lesser MPJ capsulotendon balancing
  3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
  4.2 lesser MPJ arthroplasty
  4.13 open management of tarsometatarsal fracture/dislocation
  4.15 tarsometatarsal fusion
- Can be used with digital procedure and lesser metatarsal osteotomy

3.8 Incision and Drainage/wide debridement of Soft Tissue Infection (includes foot, ankle, or leg)

- Full documentation in the "Procedure Note" to justify use of procedure 3.8 with another procedure is required.
- If an I&D performed at a different site as an amputation, can be logged separately.

EXAMPLE: an I&D of a first interspace with a 5th digit amputation

- If the I&D, amputation, and bone biopsy are all occurring at the same surgical site, only one of these procedures may be logged.

- **May not** be used in conjunction with:
  - 1.8 amputation
  - 1.10 management of bone/joint infection
  - 2.3.4 amputation
  - 2.3.6 management of bone/joint infection (with or without bone graft)
  - 3.12 plastic surgery techniques
  - 3.17 decompression of compartment syndrome (includes foot or leg)
  - 4.4 metatarsal head resection (single or multiple)
  - 4.10 amputation (lesser ray, tarsometatarsal amputation)
  - 4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
  - 5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
  - 5.4.6 management of bone/joint infection (with or without bone graft)
  - 5.4.7 amputation proximal to the tarsometatarsal joints

- This is inclusive of distal plantar space infection and therefore **may not** be claimed as Reconstructive Rearfoot/Ankle Surgery

3.9 Plantar Fasciectomy

- Includes localized lipectomy or soft tissue excisions and includes the heel spur (exostectomy) resection
- **May not** be claimed as Reconstructive Rearfoot/Ankle Surgery
- TOPAZ and PRP injection are logged as 6.14
- **May not** be used in conjunction with:
  - 3.4 plantar fasciotomy

3.10 Excision of Soft Tissue tumor/mass (without reconstructive surgery; includes foot, ankle, or leg)

- **EXAMPLE**S: Excision of a ganglion cyst in the foot, sinus tarsi decompression
- Excision of verrucae or other skin lesion is excluded (use 6.2)

3.12 Plastic Surgery Techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)

- Excludes synthetic/Biologic grafts (use 6.7)
- Excludes elliptical or wedge excisions such as a derotational 5th toe arthroplasty
- Full documentation in the Procedure Note to justify the extent of 3.12 is required
- The harvesting and application of skin graft/flap count as one procedure
- **May be** used in conjunction with Digital Surgery and in conjunction with 3.5 (lesser MPJ capsulotendon balancing), when **extensive**, such as to correct severe digital deformities, i.e. Muir-Ruiz
- Wound bed preparation/debridement is included in this procedure

3.13 Microscopic Nerve/vascular Repair (forefoot only)

- Requires the use of microscopic equipment / loupes

3.14 Other Soft Tissue Procedures Not Listed Above (limited to the foot)

- Harvesting of split thickness skin grafts (STSG) from any source (i.e., foot, ankle, leg, or thigh) and application of the graft to the foot or ankle should be logged as 3.12, 5.1.1 or 5.3.4

3.16 External Neurolysis/decompression (including tarsal tunnel)

- Multiple nerve decompressions of the same extremity are logged as **one** procedure

Category 4: Other Osseous Foot Surgery:

- **One procedure per metatarsal. Exceptions are noted below.**

4.1 Partial Ostectomy (includes foot, ankle, or leg)

- **May** include calcaneal ostectomies, i.e. simple Haglund's excision, retrocalcaneal exostectomy and resection of os trigonum (see 4.19 below)

- **May not** be used in conjunction with:
  - 3.4 plantar fasciotomy if associated with plantar calcaneal exostosis (see 3.4 above)
  - 3.9 plantar fasciectomy if associated with plantar calcaneal exostosis (see 3.9 above)
  - 4.2 lesser MPJ arthroplasty, if associated with the same metatarsal
  - 4.3 bunionectomy of the fifth metatarsal without osteotomy, if associated with the same metatarsal
  - 4.5 lesser MPJ implant, if associated with the same metatarsal
  - 4.6 central metatarsal osteotomy, if associated with the same metatarsal
  - 4.7 bunionectomy of the fifth metatarsal with osteotomy, if associated with the same metatarsal

4.2 Lesser MPJ Arthroplasty

- **May not** be used in conjunction with:
  - 3.5 lesser MPJ capsulotendon balancing
  - 3.6 tendon repair, lengthening, or transfer involving the forefoot
  - 3.7 open management of dislocation (MPJ/tasometatarsal
  - 4.1 partial ostectomy (includes foot, ankle or leg)
  - 4.3 bunionectomy of the fifth metatarsal without osteotomy
  - 4.4 metatarsal head resection (single or multiple)
  - 4.5 lesser MPJ implant
  - 4.6 central metatarsal osteotomy
  - 4.7 bunionectomy of the fifth metatarsal with osteotomy

4.4 Metatarsal Head Resection (single or multiple)

- single, multiple, or adjoining metatarsal head resections are considered as one procedure
- non-adjoining metatarsal head resections can be counted as two procedures with procedure note documentation.

EXAMPLE: 1st and 5th metatarsal head resection

- adjoining metatarsal head resections are considered as one procedure

4.6 Central Metatarsal Osteotomy

- May be used in conjunction with 3.7, plantar plate repair, if performed at the same location

4.8 Open Management of Lesser Metatarsal Fracture(s)

- Repair of multiple metatarsal fractures is logged as individual procedures

4.10 Amputation (lesser ray, transmetatarsal amputation)

- Transmetatarsal amputation is considered as one procedure
- Amputation of adjoining metatarsals or rays are considered one procedure
- Non-adjoining metatarsal ray amputations can be counted as two procedures

EXAMPLE, 1st and 5th ray amputations

- Lesser ray amputation **includes** the amputation of the toe(s) and metatarsal(s) segment(s)
- **Includes** the incision and drainage

4.11 Management of Bone/joint Infection Distal to the Tarsometatarsal Joints (with or without bone graft)

- Full documentation in the "Procedure Note" to justify use of procedure 4.11 with another procedure is required.

4.13 Open Management of Tarsometatarsal Fracture/dislocation

- Claimed as one procedure for repair of the metatarsal cuneiform and cuboid joints. Also inclusive of the first metatarsal cuneiform joint
- Cannot be logged with 3.7 open management of dislocation (MPJ/tarsometatarsal) or 4.15 tarsometatarsal fusion

4.14 Multiple Metatarsal Osteotomy Management of Metatarsus Adductus

- One procedure for the correction of metatarsus adductus (independent of the number of osteotomies performed)

4.15 Tarsometatarsal Fusion

- Fusion of the tarsometatarsal joints (complete or partial) is **one** procedure
- This code is to be used in cases of Lisfranc joint ORIF or osteoarthritis. **Cannot** be logged with 3.7 open management of dislocation (MPJ / tarsometatarsal) or 4.13 open management of tarsometatarsal fracture dislocation.
- This code is not to be used for bunion correction (use 2.1.6 or 2.2.6 or 2.3.3)

4.17 Revision/repair of Surgical Outcome in the Forefoot

- Full documentation in the "Procedure Note" to justify use of procedure 4.17 with another procedure is required.

4.19 Detachment/reattachment of Achilles Tendon with Partial Ostectomy

- **May not** be used in conjunction with:
  4.1 partial ostectomy (includes foot, ankle or leg)
  5.3.1 repair of acute tendon injury

Category 5: Reconstructive Rearfoot/Ankle Surgery:

- Any reference in this document to "midfoot" entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.

- The rule of thumb to follow when logging ankle procedures is, "an ankle is an ankle." This means that all procedures performed within a single case must be logged as a single procedure, even if one could log multiple procedures if they were performed at different times. Exceptions are noted below.

Elective – Soft tissue:

5.1.1 Plastic Surgery Techniques Involving the Midfoot, Rearfoot, or Ankle

- **May not** include skin plasty repair that utilizes just ellipses/wedges.
- Documentation of details in the procedure note is required.
- The harvesting and application of skin graft/flap count as **one** procedure.
- Wound bed preparation/debridement is included in this procedure

5.1.2 Tendon Transfer Involving the Midfoot, Rearfoot, Ankle, or Leg

- Any tendon transfer except plantaris with an Achilles tendon repair is acceptable (logged as two procedures)
- **May not** be used in conjunction with:
  5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)

<u>See 5.1.5</u>

- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc.

5.1.3 Tendon Lengthening Involving the Midfoot, Rearfoot, Ankle, or Leg

- **May** include percutaneous or "stab" type lengthening (e.g., percutaneous tendon Achilles lengthening)
- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc.

5.1.5 Primary or Secondary Repair of Ligamentous Structures

- **Repair of multiple ligaments in the same ankle are logged as one procedure**
- **May** be used in conjunction with:
  5.1.2 tendon transfer involving the midfoot, rearfoot, ankle or leg
  5.1.6 ligament or tendon augmentation/supplementation/restoration

5.1.6 Tendon Augmentation/supplementation/restoration

- Includes excision of an ossicle or ostectomy

EXAMPLE: Os peroneum with a peroneal tendon repair and Os tibiale Externum with a kidner

- Repair of both peroneal tendons at the same time is counted as one procedure
- **May not** be used in conjunction with:
  5.1.2 tendon transfer involving the midfoot, rearfoot, ankle or leg
- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc. (see 3.6 above)

5.1.7 Open Synovectomy of the Rearfoot/ankle

- **May not** be used in conjunction with:
  5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
  5.2.7 open management of talar dome lesion (with or without osteotomy)
  5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement
  5.2.9 ankle implant

Elective – Osseous:

5.2.1 Operative Arthroscopy without removal of loose body or other osteochondral debridement

- Cannot be separately counted when converted into an open ankle procedure

- Can be logged with medial or lateral ankle stabilization as long as the ankle stabilization was not performed through the scope
- **May not** be claimed as a diagnostic arthroscopy or if the arthroscopy results in an "open" procedure.
- **May not** be claimed in conjunction with:
  5.1.7 open synovectomy of the rearfoot/ankle
  5.2.7 open management of talar dome lesion (with or without osteotomy)
  5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement
  5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e.subchondroplasty)

5.2.4 Midfoot, Rearfoot, or Ankle Fusion

- multiple procedures count as one procedure
- Midfoot entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.

- **EXAMPLE**S: double arthrodesis, triple arthrodesis, pan talar arthrodesis, talonavicular with a calcaneocuboid arthrodesis are all logged as one procedure
  NOTE: 5.2.4 can be claimed in conjunction with 5.2.5, 5.2.7 and 5.2.9 when an osteotomy was done to correct RRA deformity.

5.2.5 Midfoot, Rearfoot or Tibial Osteotomy

- Midfoot entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.
- **May not** be claimed in conjunction with the following procedures if the osteotomy was performed to access pathology:
  5.2.4 midfoot, rearfoot or ankle fusion
  5.2.7 open management of talar dome lesion (with or without osteotomy)
  5.2.9 ankle implant

NOTE: 5.2.5 can be claimed in conjunction with 5.2.4, 5.2.6, 5.2.7 and 5.2.9 when an osteotomy was done to correct RRA deformity.

May be logged more than once if separate osteotomies are performed to correct a deformity i.e. Evans and Cotton or Evans and medial sliding calcaneal osteotomy

5.2.6 Coalition Resection

- **Cannot be** used if it is done as part of an arthrodesis or arthroeresis procedure
- **May not** be claimed in conjunction with:
  5.2.3 subtalar arthroeresis
  5.2.4 midfoot, rearfoot, or ankle fusion

- **5.2.4, 5.2.5 may** be claimed when an arthrodesis or osteotomy was done to correct RRA deformity not at the coalition site

5.2.7 Open Management of Talar Dome Lesions (with or without osteotomy)

- **Includes associated:**
  5.2.1 operative arthroscopy (does not include STJ arthroscopy)

  May not be used in conjunction with
  5.2.4 midfoot, rearfoot, or ankle fusion (may be used other than with ankle fusion)
  5.2.5 malleolar osteotomy
  5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement
  5.2.9 ankle implant
  5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e. subchondroplasty)

5.2.8 Ankle Arthrotomy / Arthroscopy with Removal of Loose Body or Other Osteochondral Debridement

May not be used in conjunction with

5.2.4 midfoot, rearfoot, or ankle fusion (may be used other than with ankle fusion)
5.2.5 malleolar osteotomy
5.2.9 ankle implant
5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e.subchondroplasty)

5.2.9 Ankle Implant

May not be used in conjunction with

5.1.5 primary or secondary repair of ligamentous structures
5.1.7 open synovectomy of rearfoot / ankle
5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
5.2.7 open management of talar dome lesion (with or without osteotomy)
5.2.8 ankle arthrotomy
5.3.2 repair of acute ligament injury
5.4.3 open repair of acute ankle fracture

Non-Elective – Soft Tissue:

5.3.2 Repair of Acute Ligament Injury

- **May not** be used in conjunction with fracture repair or ankle implant

  5.2.9 ankle implant
  5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
  5.4.1 open repair of adult midfoot fracture
  5.4.2 open repair of adult rearfoot fracture
  5.4.3 open repair of adult ankle fracture
  5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations

- **Claim** only **one** procedure per foot/ankle even if multiple ligaments are repaired

5.3.4 Excision of Soft Tissue Tumor/mass of the Foot, Ankle or Leg (with reconstructive surgery)

- The harvesting and application of related skin graft/flap count as **one** procedure

5.3.6 Open Repair of Dislocation (proximal to the tarsometatarsal joints)

- **May not** be used in conjunction with fracture repair
  - 5.4.1 open repair of adult midfoot fracture
  - 5.4.2 open repair of adult rearfoot fracture
  - 5.4.3 open repair of adult ankle fracture
  - 5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations

- **May not** be used in conjunction with
  - 5.3.2 repair of acute ligament injury

- **Claim** only **one** procedure per foot/ankle

Non-Elective – Osseous:

5.4.1 Open Repair of Adult Midfoot Fracture

- **Claim** only **one** procedure per foot

5.4.2 Open Repair of Adult Rearfoot Fracture

- **Claim** only **one** procedure per foot

5.4.3 Open Repair of adult Ankle Fracture

- Repair of ligaments is included in the repair
- Repair of syndesmosis is included in the repair
- Uni/Bi/Tri malleolar fracture repairs are considered one procedure
- **Claim** only **one** procedure per ankle

5.4.4 Open Repair of Pediatric Rearfoot/ankle Fracture or Dislocation

- **Claim** only **one** procedure per foot/ankle

Additional Guidelines

Category 6: Other Podiatric Procedures

6.2 Excision or destruction of skin lesion (i.e. verruca) by any means. Includes biopsy of skin lesion.

6.3 Nail avulsion (partial or complete)

6.4 Matrixectomy (partial or complete, by any means). Use this for procedures performed in the clinic or operating room.

6.5 Removal of hardware. Includes Internal and External Fixation removal.

6.6 Repair of simple laceration / delayed primary closure. Use this for procedures performed in clinic, emergency department or operating room.

6.8 Extracorporeal shock wave therapy

6.9 Taping/ padding/ splinting / casting (limited to the foot and ankle

6.10 Orthotics / prosthetics (limited to the foot and ankle -casting, scanning, impressions for foot and / or ankle orthoses

6.14Percutaneous procedures (i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma).

6.15 Foot care (nail debridement, callus paring)

6.16 Therapeutic / diagnostic injections (without sedation)

6.17 Incision and drainage (performed outside of the operating room)

6.18 Closed reduction of fracture or dislocation

6.19 Removal of foreign body (not performed in the operating room)

6.20 Acpplication of any type of external fixation device

Category 7: Biomechanical Examinations

A biomechanical case is identified as procedure code 7. 1

- Biomechanical case must include diagnosis, evaluation (biomechanical and gait examination), and treatment.
  - Demonstrates understanding of pathomechanics of biomechanical condition
  -
  - Biomechanical cases should be performed in a variety of settings (surgical and non-surgical) and should include diverse pathology and treatment methods. Biomechanical exams should be a representation of the learning experiences of the residents.

- A biomechanical exam includes static and dynamic exam of the area of chief complaint.

- The biomechanical exam and gait analysis must be comprehensive **relative to the diagnosis** and consistent with the clinical findings.

- Patient encounters such as taping and padding, orthotics, prosthetics, and other biomechanical experiences that do not include a biomechanical examination and gait analysis are not counted as biomechanical cases.

- Gait analysis may range from basic visual gait analysis to complex computerized gait analysis. An interpretation of the gait analysis must be documented.

- Treatment plans must be justified and supported by findings of the biomechanical exam.

Category 8: History and Physical Examinations

8.1 Comprehensive History and Physical Examination:

- Comprehensive medical history: Past medical history, past surgery history, family history, social history, medications, allergies, and review of systems
- Vital signs
- Physical exam: Head, Eyes, Ears, Nose, Throat, Neck, Chest/breast, Lungs, Abdomen, GU, rectal, upper extremity, and neurological
- At least 25 of the 50 required comprehensive H&P's must be performed during non-podiatric rotations under the direction of MD or DO faculty. Comprehensive H&P's must be performed in variety of settings including admission, preoperative, emergency department or during medicine / surgical consultation in the inpatient or outpatient setting. **A focused history and physical examination does not fulfill this requirement.**

8.2 Problem-Focused History and Physical Examination:

- Problem-focused history
- Problem focused exam: vascular, dermatological, neurological, and musculoskeletal exam
- Biomechanical examination
- Gait analysis

Category 11: Lower Extremity Wound Care

11.1 excisional debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal

11.2 advanced wound care modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based products, total contact casting, multi-layer compression therapy / Unna boot)

11.3 hyperbaric oxygen therapy

Category 13: Other Clinical Experience

13.1 other clinical experiences (i.e. mission trips; procedure performed outside the United States)

APPENDIX B: SURGICAL PROCEDURE CATEGORIES AND CODE NUMBERS

The following categories, procedures, and codes must be used for logging surgical procedure activity:

1 Digital Surgery (lesser toe or hallux)

1.1 partial ostectomy/exostectomy
1.2 phalangectomy
1.3 arthroplasty (interphalangeal joint [IPJ])
1.4 implant (IPJ) (silastic implant or spacer)
1.5 diaphysectomy
1.6 phalangeal osteotomy
1.7 fusion (IPJ)
1.8 amputation
1.9 management of osseous tumor/neoplasm
1.10 management of bone/joint infection
1.11 open management of digital fracture/dislocation
1.12 revision/repair of surgical outcome
1.13 other osseous digital procedure not listed above

2 First Ray Surgery

Hallux Valgus Surgery

2.1.1 bunionectomy (partial ostectomy/Silver procedure), with or without capsulotendon balancing procedure
2.1.2 (procedure code number no longer used)
2.1.3 bunionectomy with phalangeal osteotomy
2.1.4 bunionectomy with distal first metatarsal osteotomy
2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
2.1.6 bunionectomy with first metatarsocuneiform fusion
2.1.7 metatarsophalangeal joint (MPJ) fusion
2.1.8 MPJ implant
2.1.9 MPJ arthroplasty
2.1.10 bunionectomy with double correction with osteotomy and/or arthrodesis

Hallux Limitus Surgery

2.2.1 cheilectomy
2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
2.2.3 joint salvage with distal metatarsal osteotomy
2.2.4 joint salvage with first metatarsal shaft or base osteotomy
2.2.5 joint salvage with first metatarsocuneiform fusion
2.2.6 MPJ fusion
2.2.7 MPJ implant
2.2.8 MPJ arthroplasty

Other First Ray Surgery

2.3.1 tendon transfer/lengthening/procedure
2.3.2 osteotomy (e.g., dorsiflexory)
2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
2.3.4 amputation
2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
2.3.6 management of bone/joint infection (with or without bone graft)
2.3.7 open management of fracture or MPJ dislocation
2.3.8 corticotomy/callus distraction
2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
2.3.10 other first ray procedure not listed above

3 Other Soft Tissue Foot Surgery

3.1 excision of ossicle/sesamoid
3.2 excision of neuroma
3.3 removal of deep foreign body (excluding hardware removal)
3.4 plantar fasciotomy
3.5 lesser MPJ capsulotendon balancing
3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
3.7 open management of dislocation (MPJ/tarsometatarsal)
3.8 incision and drainage/wide debridement of soft tissue infection (includes foot, ankle or leg)
3.9 plantar fasciectomy/ plantar fibroma resection
3.10 excision of soft tissue tumor/mass (without reconstructive surgery; includes foot, ankle or leg)
3.11 (procedure code number no longer used)
3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)
3.13 microscopic nerve/vascular repair (forefoot only)
3.14 other soft tissue procedures not listed above (limited to the foot)
3.15 (procedure code number no longer used)
3.16 external neurolysis/decompression (including tarsal tunnel)
3.17 decompression of compartment syndrome (includes foot or leg)

4 Other Osseous Foot Surgery

4.1 partial ostectomy (including the talus and calcaneus) (includes foot, ankle, or leg)
4.2 lesser MPJ arthroplasty
4.3 bunionectomy of the fifth metatarsal without osteotomy
4.4 metatarsal head resection (single or multiple)
4.5 lesser MPJ implant
4.6 central metatarsal osteotomy
4.7 bunionectomy of the fifth metatarsal with osteotomy
4.8 open management of lesser metatarsal fracture(s)
4.9 harvesting of bone graft (includes foot, ankle, or leg)
4.10 amputation (lesser ray, transmetatarsal amputation)
4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)
4.13 open management of tarsometatarsal fracture/dislocation
4.14 multiple osteotomy management of metatarsus adductus
4.15 tarsometatarsal fusion
4.16 corticotomy/callus distraction of lesser metatarsal
4.17 revision/repair of surgical outcome in the forefoot
4.18 other osseous procedures not listed above (distal to the tarsometatarsal joint)
4.19 detachment/reattachment of Achilles tendon with partial ostectomy

5 Reconstructive Rearfoot/Ankle Surgery

Elective - Soft Tissue
5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg
5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg
5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)
5.1.5 delayed primary or secondary repair of ligamentous structures
5.1.6 tendon augmentation/supplementation/restoration
5.1.7 open synovectomy of the rearfoot/ankle
5.1.8 (procedure code number no longer used)
5.1.9 other elective rearfoot reconstructive/ankle soft tissue surgery not listed above

Elective - Osseous

5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
5.2.2 (procedure code number no longer used)
5.2.3 subtalar arthroeresis
5.2.4 midfoot, rearfoot, or ankle fusion
5.2.5 midfoot, rearfoot, or tibial osteotomy
5.2.6 coalition resection
5.2.7 open management of talar dome lesion (with or without osteotomy)
5.2.8 ankle arthrotomy/arthroscopy with removal of loose body or other osteochondral debridement
5.2.9 ankle implant
5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia
5.2.11 other elective rearfoot reconstructive/ankle osseous surgery not listed above

Non-Elective - Soft Tissue

5.3.1 repair of acute tendon injury
5.3.2 repair of acute ligament injury
5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle
5.3.4 excision of soft tissue tumor/mass of the foot, ankle, or leg (with reconstructive surgery)
5.3.5 (procedure code number no longer used)
5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
5.3.7 other non-elective rearfoot reconstructive/ankle soft tissue surgery not listed above
5.3.8 (procedure code number no longer used)

Non-Elective - Osseous

5.4.1 open repair of adult midfoot fracture
5.4.2 open repair of adult rearfoot fracture
5.4.3 open repair of adult ankle fracture
5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations
5.4.5 management of bone tumor/neoplasm (with or without bone graft)
5.4.6 management of bone/joint infection (with or without bone graft)
5.4.7 amputation proximal to the tarsometatarsal joints
5.4.8 other non-elective rearfoot reconstructive/ankle osseous surgery not listed above
5.4.9 (procedure code number no longer used)

6 Other Podiatric Procedures

6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)
6.3 nail avulsion (partial or complete)
6.4 matrixectomy (partial or complete, by any means)
6.5 removal of hardware (internal or external fixation)
6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement); includes simple delayed wound closure
6.8 extracorporeal shock wave therapy
6.9 taping/padding/splinting/casting (limited to the foot and ankle)
6.10 orthotics/prosthetics (limited to the foot and ankle casting/scanning/impressions for foot and/or ankle orthosis)
6.14 percutaneous procedures (i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma, digital tenotomy)
6.15 foot care (nail debridement, callus paring)
6.16 therapeutic/diagnostic injections (without sedation)
6.17 incision and drainage (performed outside of the operating room)
6.18 closed reduction of fracture or dislocation
6.19 removal of foreign body (not in the operating room)
6.20 application of external fixation

7 Biomechanics

7.1 biomechanical case; must include diagnosis, evaluation (biomechanical and gait examination), and treatment

8 History and Physical Examination

8.1 comprehensive history and physical examination
8.2 problem-focused history and physical examination

9 Surgery Specialties

9.1 general surgery
9.2 orthopedic surgery
9.3 plastic surgery
9.4 vascular surgery
9.5 cardiothoracic surgery
9.6 hand surgery
9.7 neurosurgery
9.8 orthopedic/surgical oncology
9.9 pediatric orthopedic surgery
9.10 surgical intensive care unit (SICU)
9.11 trauma team/surgery
9.12 other

10 Medicine and Medical Subspecialty Experiences

10.1 anesthesiology
10.2 cardiology
10.3 dermatology
10.4 emergency medicine
10.5 endocrinology
10.6 family practice
10.7 gastroenterology
10.8 hematology/oncology
10.9 imaging
10.10 infectious disease
10.11 internal medicine
10.12 neurology
10.13 pain management
10.14 pathology
10.15 pediatrics
10.16 physical medicine and rehabilitation
10.17 psychiatry/behavioral medicine
10.18 rheumatology
10.19 sports medicine
10.20 wound care (non-podiatric)
10.21 burn unit
10.22 intensive/critical care (ICU/CCU)
10.23 geriatrics
10.24 vascular medicine
10.25 other

11 Lower Extremity Wound Care

11.1 excisional debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal)
11.2 advanced wound care modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based product, total contact casting, multi-layer compression therapy/Unna boot)
11.3 hyperbaric oxygen therapy

13 Other Clinical Experiences

13.1 other clinical experiences (i.e. mission trips; procedure performed outside the United States)

Anesthesiology Competencies

The Resident is expected to:

1. Obtain knowledge in local anesthesia physiology.
2. Obtain knowledge in spinal anesthesia physiology.
3. Obtain knowledge in general anesthesia physiology.
4. Demonstrate ability in perioperative assessment and management.
5. Obtain knowledge and demonstrate limited ability in induction techniques.
6. Demonstrate ability in Recovery Room management.
7. Demonstrate ability in different intubation techniques.
8. Obtain experience in starting IV's and fluid management intra-operatively.
9. Obtain knowledge in regional anesthesia.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **ANESTHESIA**

EVALUATOR'S NAME: _____

Below Average 1-2	**Average 3-4**			**Excellent 5**		**N/B (no basis for judgment)**
1. Obtain knowledge in local anesthesia physiology	1	2	3	4	5	N/B
2. Obtain knowledge in spinal anesthesia physiology	1	2	3	4	5	N/B
3. Obtain knowledge in general anesthesia physiology	1	2	3	4	5	N/B
4. Demonstrate ability in pre-operative assessment and management	1	2	3	4	5	N/B
5. Obtain knowledge and demonstrate limited ability in induction techniques	1	2	3	4	5	N/B
6. Demonstrate ability in recovery room management	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____ _____

Resident **Director Podiatric Education**

_____ _____

Date **Date**

COMPETENCIES
ELECTIVE ROTATION
PODIATRIC OFFICES

Objective:

The resident, under the supervision of podiatric physicians, will evaluate and access office and pre-surgical patients and gain hands-on experience with podiatric physicians in the office setting.

The resident is expected to:

1. Demonstrate ability to understand the financial aspects of a practice
2. Demonstrate ability to understand the fees and patients scheduling
3. Demonstrate ability to understand the billing department within a practice as well as proper coding for diagnosis and treatment
4. Demonstrate ability to understand insurance co-pay, claims and reimbursements
5. Demonstrate ability to understand the dynamic of an employer/employee relationship and how to select and train an office staff
6. Demonstrate ability to understand what is included in an overhead and how to manage it to become cost-efficient
7. Demonstrate ability to understand handling, sterilization and turnover of instruments and office equipment
8. Demonstrate ability to perform a good history and physical examination of a patient
9. Demonstrate ability to properly diagnose patients, using appropriate diagnostic tools
10. Become proficient at treating patients
11. Become proficient at casting patients for orthotics therapy and adjusting these orthotics in the office
12. Demonstrate ability to understand diverse strategies for advertisement of a practice

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **ELECTIVE ROTATION PODIATRIC OFFICES**

EVALUATOR'S NAME: _____

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

1. Demonstrate ability to understand the financial aspects of a practice.	1	2	3	4	5	N/B
2. Demonstrate ability to understand the fees and patients scheduling.	1	2	3	4	5	N/B
3. Demonstrate ability to understand the billing dept. of a practice as well as proper coding for diagnosis and treatment.	1	2	3	4	5	N/B
4. Demonstrate ability to understand insurance co-pay, claims and reimbursements	1	2	3	4	5	N/B
5. Demonstrate ability to understand the dynamic of an employer/employee relationship and how to select and train an office staff	1	2	3	4	5	N/B
6. Demonstrate ability to understand what is included in an overhead and how to manage it to become cost-efficient	1	2	3	4	5	N/B
7. Demonstrate ability to understand handling, sterilization and turnover of instruments and office equipment	1	2	3	4	5	N/B
8. Demonstrate ability to perform a good history and physical examination of a patient	1	2	3	4	5	N/B
9. Demonstrate ability to properly diagnose patients, using appropriate diagnostic tools.	1	2	3	4	5	N/B
10. Become proficient at treating patients	1	2	3	4	5	N/B
11. Become proficient at casting patients for orthotics therapy and adjusting these orthotics in the office	1	2	3	4	5	N/B

12. Demonstrate ability to understand diverse strategies for advertisement of a practice	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT: _____ _____

Resident **Director Podiatric Education**

Emergency Room Competencies

The Resident is expected to:

1. Demonstrate proficiency in on-site management of emergency pedal conditions.
2. Demonstrate proficiency in laceration management.
3. Demonstrate proficiency in tetanus management.
4. Demonstrate proficiency in splinting and casting for LE musuclosketal trauma.
5. Demonstrate proficiency in history taking for trauma, including triage.
6. Obtain knowledge in signs and symptoms of myocardial infarction.
7. Obtain knowledge in signs and symptoms of diabetic ketoacidosis.
8. Obtain knowledge in signs and symptoms of hypoglycemia.
9. Demonstrate proficiency in management of anaphylaxis, chest pain, SOB, GI upset.
10. Obtain knowledge in recognition of DVT and PE and appropriate tests for each.
11. Obtain knowledge in advanced life support.
12. Obtain knowledge in closed reduction techniques.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **EMERGENCY ROOM**

EVALUATOR'S NAME: _____

Below Average 1-2 **Average 3-4** **Excellent 5** **N/B (no basis for judgment)**						
1. Demonstrate proficiency in onsite management of emergency pedal conditions.	1	2	3	4	5	N/B
2. Demonstrate proficiency in laceration management.	1	2	3	4	5	N/B
3. Demonstrate proficiency in tetanus management.	1	2	3	4	5	N/B
4. Demonstrate proficiency in fracture splinting/casting LE trauma.	1	2	3	4	5	N/B
5. Demonstrate proficiency in history taking for trauma, including triage.	1	2	3	4	5	N/B
6. Obtain knowledge in signs and symptoms of myocardial infarction.	1	2	3	4	5	N/B
7. Obtain knowledge in signs and symptoms of diabetic ketoacidosis.	1	2	3	4	5	N/B
8. Obtain knowledge in signs and symptoms of hypoglycemia.	1	2	3	4	5	N/B
9. Demonstrate proficiency in management of anaphylaxsis, chest pain, SOB and GI upset.	1	2	3	4	5	N/B

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

10. Obtain knowledge in recognition of DVT and PE and appropriate tests for each.	1	2	3	4	5	N/B
11. Obtain knowledge in advanced life support.	1	2	3	4	5	N/B
12. Obtain knowledge in closed reduction techniques.	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____ _____

Resident **Director Podiatric Education**

_____ _____

Date **Date**

General Surgery Competencies

The Resident is expected to:

1. Be able to achieve satisfactory understanding in general surgical anatomy.
2. Obtain thorough knowledge in fluid replacement physiology and blood loss management.
3. Demonstrate proficiency in use and knowledge of instrumentation.
4. Demonstrate proficiency in wound handling techniques.
5. Demonstrate thorough knowledge of sutures, suturing, and wound closure techniques.
6. Demonstrate competency in drain placement and surgical dressings.
7. Demonstrate thorough knowledge of pre-operative assessment.
8. Demonstrate thorough knowledge of recognition of post-operative complications.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **GENERAL SURGERY**

EVALUATOR'S NAME: _____

Below Average 1-2	**Average 3-4**			**Excellent 5**		**N/B (no basis for judgment)**
1. Be able to achieve satisfactory understanding in general surgery anatomy.	1	2	3	4	5	N/B
2. Obtain thorough knowledge in fluid replacement physiology and blood loss management.	1	2	3	4	5	N/B
3. Demonstrate proficiency in use and knowledge of instrumentation.	1	2	3	4	5	N/B
4. Demonstrate proficiency in wound handling techniques.	1	2	3	4	5	N/B
5. Demonstrate thorough knowledge of sutures, suturing, and wound closure techniques.	1	2	3	4	5	N/B
6. Demonstrate competency in drain placement and surgical dressings.	1	2	3	4	5	N/B
7. Demonstrate thorough knowledge of pre-operative assessment.	1	2	3	4	5	N/B
8. Demonstrate thorough knowledge of recognition of post-operative complications.	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____ _____

Resident **Director Podiatric Education**

_____ _____

Date **Date**

Infectious Disease Competencies

The Resident is expected to:

1. Gain increased proficiency in taking a history and physical where they focus on infectious diseases.

2. Gain increased proficiency in learning the presentation and management of infectious diseases.

3. Gain increased proficiency in learning the utility and interpretation of pertinent laboratory tests.

4. Gain increased proficiency in understanding antibiotic spectra and pharmacology.

5. Gain increased proficiency in using references and current literature in infectious diseases to formulate a differential diagnosis and treatment plan.

6. Gain increased proficiency in the understanding of evidence-based pharmacologic management of skin and soft tissue infections, including diabetic foot infections.

7. Gain increased understanding of pharmacologic management of osteomyelitis.

8. Gain increased understanding of pharmacologic management of community-based and hospital-based MRSA infections.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **INFECTIOUS DISEASES**

EVALUATOR'S NAME: _____

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

1. Gain increased proficiency in taking history and physical where they focus on infectious diseases.	1	2	3	4	5	N/B
2. Gain increased proficiency in learning the presentation and management of infectious diseases.	1	2	3	4	5	N/B
3. Gain increased proficiency in learning the utility and interpretation of pertinent laboratory tests.	1	2	3	4	5	N/B
4. Gain increased proficiency in understanding antibiotic spectra and pharmacology.	1	2	3	4	5	N/B
5. Gain increased proficiency in using references and current literature in infectious diseases to formulate a deferential diagnosis and treatment plan.	1	2	3	4	5	N/B
6. Gain increased proficiency in the understanding of evidence-based pharmacologic management of skin and soft tissue infections, including diabetic foot infections.	1	2	3	4	5	N/B
7. Gain increased understanding of pharmacologic management of osteomyelitis.	1	2	3	4	5	N/B
8. Gain increased understanding of pharmacologic management of community-based and hospital-based MRSA.	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____	_____
Resident	**Director Podiatric Education**
_____	_____
Date	**Date**

Internal Medicine Competencies

The Resident is expected to:

1. Demonstrate ability in the preoperative medical assessment in the recognition of suitability for elective podiatric surgery.
2. Recognize pathologic lab values and their significance.
3. Demonstrate ability in the general physical examination and history recording.
4. Obtain knowledge in electrocardiogram administration and interpretation.
5. Obtain knowledge of therapy for uncontrolled Diabetes Mellitus, HTN and CHF
6. Demonstrate ability in the preoperative, perioperative and postoperative management of patients undergoing podiatric surgery.
7. Obtain knowledge in preoperative, perioperative and postoperative fluid management.
8. Demonstrate an understanding of proper protocol for prophylactic antibiosis.
9. Learn medical treatment of patients with DVT.
10. Obtain knowledge in the implications of long-term steroid use.
11. Learn basic pharmaco dynamics of commonly prescribed medications, Rx, and O.T.C.
12. Manage in-house patients with common medical problems.
13. Able to understand why and when and what labs and diagnostic studies for patients.
14. Be able to be a "team member" while on Internal Medicine rotation and accept all responsibilities associated with this rotation.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **INTERNAL MEDICINE**

EVALUATOR'S NAME: _____

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

1. Demonstrate ability in pre-operative medical assessment in the recognition of suit-ability for elective podiatric surgery.	1	2	3	4	5	N/B
2. Be able to recognize pathologic lab values and diagnostic studies and their significance.(EKG, CT, CXR, Blood work)	1	2	3	4	5	N/B
3. Be able to demonstrate ability in general physical examination and history recording.	1	2	3	4	5	N/B
4. Obtain knowledge in electrocardiogram interpretation.	1	2	3	4	5	N/B
5. Obtain knowledge of therapy for uncontrolled diabetes mellitus, HTN and CHF.	1	2	3	4	5	N/B
6. Be able to demonstrate ability in pre-operative and post-operative management of diabetic patients undergoing surgery.	1	2	3	4	5	N/B
7. Obtain knowledge in pre-operative, peri-operative and post-operative fluid management.	1	2	3	4	5	N/B
8. Demonstrate an understanding of proper protocol for prophylactic antibiosis.	1	2	3	4	5	N/B
9. Learn medical treatment for osteomyelitis as an adjunct to surgical management.	1	2	3	4	5	N/B

Below Average 1-2	**Average 3-4**	**Excellent 5**			**N/B (no basis for judgment)**	
10. Obtain knowledge in the implications of long-term steroid therapy.	1	2	3	4	5	N/B
11. Learn basic pharmaco dynamics of commonly Prescribed medications, Rx and OTC.	1	2	3	4	5	N/B
12. Demonstrate ability to manage in-house patients with common medical problems (pulmonary, cardiac, renal)	1	2	3	4	5	N/B
13. Able to understand why, when and what labs and Diagnostic studies for patients.	1	2	3	4	5	N/B
14. Be able to be a "team member" while on Internal Medicine rotation and accept all responsibilities associated with this rotation.	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____ _____

Resident **Director Podiatric Education**

_____ _____

Date **Date**

MUSCULOSKELETAL MRI COMPETENCIES

The resident is expected to:

1. Demonstrate proficiency in radiographic examination techniques for the foot and ankle.
2. Understand when further diagnostic work-up besides imaging may be helpful.
3. Learn the indications and rationale for MRI exams with/without contrast.
4. Demonstrate proficiency in the interpretation of Radiographs, CT scans, and MRI exams of the foot/ankle.
5. Demonstrate proficiency in the use of MRI in the diagnosis of connective tissue disorders.
6. Demonstrate proficiency in the use of MRI in the assessment of fracture healing.
7. Demonstrate an understanding of the use of MRI in the differentiation of benign from malignant lesions.
8. Demonstrate proficiency in evaluating osteomyelitis, and soft tissue infection using MRI.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

ROTATION: **MUSCULOSKELETAL MRI** DATE OF ROTATION: _____

EVALUATOR'S NAME: _____

Below Average 1-2	**Average 3-4**	**Excellent 5**					**N/B (no basis for judgment)**
1. Demonstrate proficiency in radiographic examination techniques for the foot/ankle		1	2	3	4	5	N/B
2. Understand when further diagnostic work-up besides imaging may be helpful		1	2	3	4	5	N/B
3. Learn the indications and rationale for MRI exams with/without contrast		1	2	3	4	5	N/B
4. Demonstrate proficiency in the interpretation of Radiographs, CT scans, and MRI of the foot/ankle		1	2	3	4	5	N/B
5. Demonstrate proficiency in the use of MRI in the diagnostic of connective tissue disorders		1	2	3	4	5	N/B
6. Demonstrate proficiency in the use of MRI in the assessment of fracture healing		1	2	3	4	5	N/B
7. Demonstrate an understanding of the use of MRI in the differentiation of benign from malignant lesions		1	2	3	4	5	N/B
8. Demonstrate proficiency in evaluating osteomyelitis, and soft tissue infection using MRI		1	2	3	4	5	N/B

COMMENTS: _____

_____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____	_____
Resident	**Director Podiatric Education**
_____	_____
Date	**Date**

ORTHOPEDIC SURGERY COMPENTENCIES

Orthopedics Competencies specific to the Rotation: Prevent, diagnose, and manage diseases, disorders, and injuries of adult musculoskeletal system.

Resident is expected to:

1. Perform an appropriate history and physical examination
2. Develop a differential diagnosis
3. Formulate an appropriate treatment plan
4. Develop an understanding of the principles of orthopedic surgery
5. Demonstrate knowledge of the principles of fracture management
6. Demonstrate knowledge of fixation techniques and applications
7. Recognize signs and symptoms of postoperative complications including infection of soft tissue and bone
8. Function effectively as a member of the orthopedic service teams

Updated: 5/24 JSD

ORTHOPEDIC SURGERY EVALUATION

Please use the following scale to evaluate the resident's performance: 5 = excellent 4 = above average 3 = average 2 = below average 1 = poor*

The Resident: _____

Can perform an appropriate history and physical exam. _____
Can develop a differential diagnosis. _____
Can formulate an appropriate treatment plan. _____
Has developed an understanding of the principles of orthopedic surgery. _____
Has demonstrated knowledge of the principles of fracture management. _____
Has demonstrated knowledge of fixation techniques and applications. _____
Can recognize signs and symptoms of postoperative complications. _____
Has functioned effectively as a member of the orthopedic service team. _____

Additional comments concerning the resident's performance (*please explain any performance that was rated as poor):

Comments as to the goals and objectives for this rotation and suggestions for improvement:

Plastic Surgery Competencies

The Resident is expected to:

1. Evaluate and recognize the various types of pathologies requiring plastic surgery repair.

2. Be exposed to the various surgical techniques that a plastic surgeon performs.(i.e., STSG, full thickness skin graft, transpositional flaps, free flaps, etc.)

3. Be skilled in the various suturing techniques of the plastic surgeon.

4. Obtain a patient's history and present the case to the attending physician in an orderly fashion.

5. Observe and assist the plastic surgeon in the practice of the surgeon's specialty.

6. Acquire knowledge in wounds/wound dressings/wound classifications.

7. Acquire knowledge in skills with suturing and suture types.

8. Acquire knowledge in laceration work-up and treatment.

9. Acquire knowledge in hand anatomy and pathology.

10. Demonstrate ability to perform as a "team member" while on plastic surgery rotation and accept all responsibilites associated with the rotation.

11. Be exposed to cosmetic plastic surgery techniques.

November 1, 2017

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **PLASTIC SURGERY**

EVALUATOR'S NAME: _____

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

1. Evaluate and recognize the various types of pathologies requiring plastic surgery repair.	1	2	3	4	5	N/B
2. Be exposed to the various surgical techniques that a plastic surgeon performs (i.e. STSG, full thickness skin graft, transpositional flaps, free flaps, etc.)	1	2	3	4	5	N/B
3. Be skilled in the various suturing techniques of the plastic surgeon.	1	2	3	4	5	N/B
4. Obtain a patient's history and present the case to the attending physician in an orderly fashion.	1	2	3	4	5	N/B
5. Observe and assist the plastic surgeon in the practice of the surgeon's specialty.	1	2	3	4	5	N/B
6. Acquire knowledge in wounds/wound dressings/wound classifications.	1	2	3	4	5	N/B
7. Acquire knowledge in skills with suturing and suture types.	1	2	3	4	5	N/B
8. Acquire knowledge in laceration work-up and treatment.	1	2	3	4	5	N/B

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

9. Acquire knowledge in hand anatomy and pathology.	1	2	3	4	5	N/B
10. Demonstrate ability to perform as a "team member" while on plastic surgery rotation and accept all responsibilities associated with the rotation.	1	2	3	4	5	N/B
11. Be exposed to cosmetic plastic surgery techniques.	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____ _____

Resident **Director Podiatric Education**

_____ _____

Date **Date**

PODIATRIC CLINIC/OFFICE

Goals and Competencies

Rationale:

The primary practice of a podiatrist is within an office setting. This rotation is designed to provide patient experience within the clinical setting, allowing for training in surgical and non-surgical intervention, as well as an opportunity for direct participation and treatment of musculoskeletal oriented pathology. This rotation will be designed to provide these experiences in bi-monthly blocks throughout the training year. The resident is directed in these experiences by practicing podiatrists and will be exposed to all facets of a podiatric practice/clinic.

Objectives:

The resident, under the supervision of the podiatric department, will evaluate and assess each patient, and gain hands-on experience doing podiatric procedures, as determined by the appropriate personnel.

The resident is expected to:

1. Obtain knowledge and become proficient in developing podiatric practice skills and an accurate history and physical examination (vascular, neuro, derm, musculoskeletal/biomechanical).
2. Obtain knowledge and different practice philosophies from various podiatric staff attendings.
3. Develop exposure and detailed understanding of the common podiatric drugs and their doses.
4. Obtain knowledge in practice management and billing.
5. Develop a differential diagnosis for each pathology encountered.
6. Obtain knowledge in the art of developing beneficial physician/patient relationships in an office setting.
7. Become proficient in reading radiographic imaging studies such as radiographs, CAT scans, and MRI's.
8. Develop an understanding of the preoperative evaluation and discussion, performed prior to the surgical treatment rendered in a hospital setting.
9. Gain exposure in the follow-up for patients treated at Roger Williams Medical Center operating room and emergency room.
10. Gain exposure and become proficient in diagnosing and treating podiatric pathology, seen commonly within an office setting.
11. Demonstrate an understanding in appropriate use of diagnostic modalities available within an office setting, as well as ordering and interpreting laboratory data, and correlating this data with clinical findings.
12. Gain experience in administration of varied injections, bandaging, casting, and splinting techniques.
13. Gain experience in delivery of palliative podiatric care and diabetic wound care.
14. Recognizing, diagnosing, and treating dermatologic conditions of the lower extremity.
15. Diagnosing and treating patients suffering from vascular conditions of the lower extremity.
16. Diagnosing and treating patients with excessive pronation or supination and application of orthotic devices for such conditions.

17. Obtain knowledge in the development of patient-physician communication skills.

18. Gain skills in performing problem-focused histories and physical examinations on patients from diverse populations and socio-economic backgrounds.

19. Perform biomechanical examinations on patients with varying foot types and pathologies utilizing orthoses, bracing, and footwear.

20. Utilize appropriate diagnostic tests including imaging and laboratory tests to assist in patient management.

21. Gain skill in establishing differential diagnoses.

22. Formulate and implement under supervision appropriate management plans.

23. Gain skill in assessing patient response to treatment plans with the ability to effectively modify the plan as needed.

24. Gain understanding in providing podiatric care in diverse community and healthcare settings.

Tasks:

The resident will actively participate in evaluating and treating patients.
The resident will partake in the delivery of care under supervision.
The resident will write appropriate SOAP notes, which will be reviewed and co-signed by the supervising attending.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **Podiatric Clinic/Office**

EVALUATOR'S NAME: _____

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

1. Obtain knowledge in developing a podiatric practice and establishing a new office.	1	2	3	4	5	N/B
2. Knowledge in different practice philosophies from varied podiatric staff attendings.	1	2	3	4	5	N/B
3. Knowledge in practice management, including internal organization, employee relationships, billing and ethical promotion.	1	2	3	4	5	N/B
4. Knowledge in the art of developing beneficial physician/ patient relationships in an office setting.	1	2	3	4	5	N/B
5. Understands the pre-operative evaluation and discussion performed prior to the surgical treatment rendered in the hospital setting.	1	2	3	4	5	N/B
6. Gain exposure in the post-operative care for patients treated at Roger Williams Hospital.	1	2	3	4	5	N/B
7. Gain exposure to and become proficient in diagnosing and treating podiatric pathologies seen commonly within an office setting.	1	2	3	4	5	N/B
8. Understands the appropriate use of diagnostic modalities available within the office setting.	1	2	3	4	5	N/B
9. Experienced in the administration of varied injections, casting, and splinting techniques.	1	2	3	4	5	N/B

10. Experienced in taking and developing foot and ankle x-rays.	1	2	3	4	5	N/B
11. Experienced in the delivery of palliative podiatric care.	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____	_____
Resident	**Director Podiatric Education**
_____	_____
Date	**Date**

Podiatric Surgery Competencies

The Resident is expected to:

1. Come to surgical cases prepared, having contacted attending prior to discuss case and participated in pre-operative workup.
2. Communicated regularly with attendings and provide thorough appropriate sign-out.
3. Become proficient in pre-operative planning
4. Become proficient in post-operative planning.
5. Be self-aware and have the ability to self-assess to improve weaknesses.
6. Be a motivated, driven learner.
7. Prepare and willing to teach fellow residents and students.

PGY-1:

1. Practice and work to improve dexterity, suturing, instrument handling and knot tying.
2. Practice and work to improve making osteotomies and implantation of internal fixation.
3. Become proficient in wound debridement and amputations.
4. Improve knowledge base of anatomy and surgical procedures.

PGY-2:

1. Become proficient in instrumentation handling, making osteotomies and implanting internal fixation.
2. Become proficient in first ray and forefoot surgery.
3. Practice and work to improve midfoot and rearfoot surgery.
4. Practice and work to improve critical thinking and handling of complications in the operating room.

PGY-3:

1. Become proficient in first ray and forefoot surgery.
2. Become proficient in midfoot and rearfoot surgery.
3. Increase and become proficient with regards to surgical skills and speed during cases.
4. Become proficient with handling of difficult situations and complications in the operating room.
5. Become proficient in planning complex procedures and corrections.

Subject Name
Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by: **Evaluator Name**
Status
Employer
Program

Resident Evaluation - PGY-1 Podiatry Surgery

1 Resident comes prepared for every case, including pre-operative work up.

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

2 Resident communicates on a regular basis and gives appropriate sign-out on in patients

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

3 The resident is proficient in pre-operative planning, ie monitoring patient status, understanding equipment needs, preparing the OR and procedural planning

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

4 The resident is proficient in post-operative care, floor management and discharge

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

5 The resident demonstrates appropriate ability to self-assess

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

6 Rate the level of self-motivation to improve knowledge and skills

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

7 The resident is willing to teach fellow residents and students

◯ Yes
◯ No

8 Rate the resident's Dexterity/Suturing/Instrument Handling/Knot tying

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

9 Rate the resident's dexterity of making osteotomies/ implanting internal fixation

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

10 Rate the resident's proficiency in wound debridement/amputations

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

11 Rate the resident's knowledge of anatomy/surgical procedures

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

12 Rate the resident's teach-ability

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

13 Rate the resident's ability to take criticism and instruction

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

14 Comments (Any negative comments above, please clarify)

Subject Name
Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by: **Evaluator Name**
Status
Employer
Program

Resident Evaluation - PGY-2 Podiatry Surgery

1 Resident comes prepared for every case, including pre-operative work up.

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

2 Resident communicates on a regular basis and gives appropriate sign-out on in patients

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

3 The resident is proficient in pre-operative planning, ie monitoring patient status, understanding equipment needs, preparing the OR and procedural planning

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

4 The resident is proficient in post-operative care, floor management and discharge

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

5 The resident demonstrates appropriate ability to self-assess

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

6 Rate the level of self-motivation to improve knowledge and skills

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

7 The resident is willing to teach fellow residents and students

◯ Yes
◯ No

8 Rate the resident's competency and knowledge of First Ray and Forefoot Surgery

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

9 Rate the resident's competency and knowledge of Midfoot and Rearfoot Surgery

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

10 Rate the resident's dexterity of instrumentation/making osteotomies/implanting internal fixation

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

11 Rate the resident's critical thinking and handling of difficult situations/complications in the OR

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

12 Rate the resident's teach-ability

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

13 Rate the resident's ability to take criticism and instruction

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

14 Comments (Any negative comments above, please clarify)

Subject Name
Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by: **Evaluator Name**
Status
Employer
Program

Resident Evaluation - PGY-3 Podiatry Surgery

1 Resident comes prepared for every case, including pre-operative work up.

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

2 Resident communicates on a regular basis and gives appropriate sign-out on in patients

3 The resident is proficient in pre-operative planning, ie monitoring patient status, understanding equipment needs, preparing the OR and procedural planning

4 The resident is proficient in post-operative care, floor management and discharge

Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
◯	◯	◯	◯	◯

5 The resident demonstrates appropriate ability to self-assess

6 Rate the level of self-motivation to improve knowledge and skills

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

7 The resident is willing to teach fellow residents and students

◯ Yes
◯ No

8 Rate the resident's competency and knowledge of First Ray and Forefoot Surgery

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

9 Rate the resident's competency and knowledge of Midfoot and Rearfoot Surgery

1	2	3	4	5	6	7	8	9	10	N/A
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

10 Rate the resident's surgical skills/speed during surgical cases

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

11 Rate the resident's critical thinking and handling of difficult situations/complications in the OR

12 Rate the resident's planning and knowledge of complex deformities and correction

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

13 Rate the resident's teach-ability

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

14 Rate the resident's ability to take criticism and instruction

15 Comments (Any negative comments above, please clarify)

Psychiatry Competencies

The Resident is expected to:

1. Knowledge of admission procedures including involuntary admissions

2. Knowledge of admissions orders for psychiatric inpatients.

3. Knowledge of inpatient treatment standards, procedures, and psychopharmacology and the differences from outpatient.

4. Understand the effective intervention to minimize risk including psychopharmacologic and mechanical restraints.

5. Knowledge on proper implementation of prevention methods for self-harm and harm to others.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **Psychiatry**

EVALUATOR'S NAME: _____

Below Average 1-2	**Average 3-4**			**Excellent 5**		**N/B (no basis for judgment)**
1. Gain an understanding of involuntary admissions procedures.	1	2	3	4	5	N/B
2. Gain an understanding of admissions orders for psychiatric inpatients.	1	2	3	4	5	N/B
3. Gain an appreciation for the need for a multidisciplinary approach to successful management of psychiatric pathology.	1	2	3	4	5	N/B
4. Gain an understanding of inpatient standards, procedures, psychopharmacology and differences from outpatient.	1	2	3	4	5	N/B
5. Understand the use of effective intervention to mitigate risk for pharmacological and mechanical restraints.	1	2	3	4	5	N/B
6. Understand the use of proper implementation of prevention methods for self-harm and harm to others.	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT: _____ _____

Resident **Director Podiatric Education**

_____ _____

Medical Imaging Competencies

The Resident is expected to:

1. Review conventional radiographs, CT scans, including CT angiography, MRI, nuclear medicine, sonography, and bone densitometry exams, dependent on the type and volume of cases that are performed during the resident's rotation.

2. Learn about the radiographic examination techniques for the foot and ankle.

3. Learn to know when further work-up beyond radiographs maybe necessary.

4. Learn the rationale and administration for the for the following: Bone scan, Arthrography, Sonography, CAT scan, and MRI.

5. Learn about the interpretation of the following regarding pedal conditions: Radiographs, Bone scans, CAT scans, and MRI.

6. Learn about Doppler ultrasound use for DVT.

7. Learn about radiographic diagnosis of arthritides.

8. Learn about radiographic diagnosis of fracture healing.

9. Learn how to differentiate malignant from benign lesions by radiographic assessment.

10. Learn about how to evaluate standard Chest X-rays.

11. Learn about normal and abnormal pathology and clinical correlation of foot and ankle CAT scans and MRI's.

12. Learn about the technique and need for lower extremity vascular procedures.

Rheumatology Competencies

The Resident is expected to:

1. Identify pedal clinical manifestations of common rheumatologic disease.
2. Identify pedal radiologic manifestations of common rheumatolgic disease.
3. Identify indications for rheumatologic lab tests.
4. Obtain knowledge in rheumatological test interpretations.
5. Identify indications for synovial fluid analysis.
6. Demonstrate proficiency in the technique of synovial fluid analysis and interpretation.
7. Obtain knowledge in non-steroidal anti-flammatory drug therapy.
8. Obtain knowledge in general pharmacologic basis of treatment.
9. Learn general rehabiliative therapy for patients with rheumatologic disorders.
10. Learn peri-operative considerations in the arthritic patient.
11. Identify and differentiate pedal involvement in inflammatory diseases.
12. Demonstrate proficiency in he musculoskeltal physical exam of the body/lower extremity.
13. Obtain knowledge and learn the implications of long term steroid therapy.
14. Be able to act as a "team member" while on Rheumatology rotation and accept all responsibilities associated with the rotation.

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **RHEUMATOLOGY**

EVALUATOR'S NAME: _____

Below Average 1-2	**Average 3-4**			**Excellent 5**		**N/B (no basis for judgment)**
1. Identify pedal and general manifestations of common rheumatologic diseases.	1	2	3	4	5	N/B
2. Identify pedal and other radiologic manifestations of common rheumatologic diseases.	1	2	3	4	5	N/B
3. Identify indications for rheumatological lab tests.	1	2	3	4	5	N/B
4. Obtain knowledge in rheumatological test interpretations.	1	2	3	4	5	N/B
5. Identify indications for synovial fluid analysis.	1	2	3	4	5	N/B
6. Demonstrate proficiency in lab interpretation of synovial fluid analysis.	1	2	3	4	5	N/B
7. Obtain knowledge in non-steroidal anti-inflammatory drug therapy.	1	2	3	4	5	N/B
8. Obtain knowledge in general pharmacologic basis of treatment.	1	2	3	4	5	N/B
9. Learn the role of physical and occupational therapy, including splinting, heat and exercise in the treatment of rheumatic disorders.	1	2	3	4	5	N/B

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

10. Identify indications for bone scanning, arthrography, computerized tomography and magnetic resonance imaging in arthritic disease.	1	2	3	4	5	N/B
11. Obtain knowledge of pedal involvement in inflammatory diseases.	1	2	3	4	5	N/B
12. Obtain knowledge in musculoskeltal physical exam of the body/lower extremity.	1	2	3	4	5	N/B
13. Learn the implications of long term steroid therapy.	1	2	3	4	5	N/B
14. Be able to be a "team member" while on Rheumatology rotation.	1	2	3	4	5	N/B

COMMENTS: _____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT:

_____	_____
Resident	**Director Podiatric Education**
_____	_____
Date	**Date**

VASCULAR MEDICINE AND SURGERY
COMPETENCIES FOR PODIATRIC RESIDENTS

The Resident is expected to:

1. Demonstrate an understanding of various peripheral vascular disorders, especially those that commonly occur in the lower extremities.

2. Demonstrate an understanding in evaluating vascular status of the lower extremities via manual palpation of pulses, usage of Doppler and correlation of findings with physical appearance and patient's chief complaint and history.

3. Demonstrate the ability to perform non-invasive vascular studies.

4. Demonstrate an understanding of state of the art surgical reconstructive vascular procedures available to, and commonly performed in patients with severe PVD of lower extremities and diabetic tibioperoneal disease.

5. Demonstrate an understanding of the perioperative care of the vascular surgery patient and floor management as part of the vascular surgery rotation team.

6. Demonstrate an understanding of the principles and techniques employed by the vascular surgeon in distal limb bypass and endovascular therapies.

7. Observe and assist the vascular surgeon in the practice of his surgical specialty.

8. Demonstrate an understanding towards peripheral vascular pathology presenting in the podiatric patient, with attention towards appropriate and timely referral.

9. Demonstrate an understanding of vascular consideration and involvement with prospective pedal surgery in pre-operative planning in elective podiatric cases.

10. Understand the team approach to diabetic limb salvage and the podiatric physician's role with the vascular surgeon.

11. Demonstrate an understanding of the application and evaluation of invasive and non-invasive vascular examination, and evaluate arteriograms.

12. Demonstrate the ability to understand and interpret a non-invasive lower extremity vascular exam.

13. Demonstrate the ability to understand an invasive vascular exam i.e., arteriogram and its application in LE bypass.

14. Demonstrate an understanding of LE angioplasty techniques and their role in foot revascularization.

15. Demonstrate ability to peri-operatively manage patients with diabetes mellitus undergoing vascular lower extremity surgery.

16. Demonstrate ability to perform as a "team member" while on vascular surgery rotation and accept

all responsibilities associated with the rotation.

Updated: 5/23 JSD

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION: **VASCULAR SURGERY**

EVALUATOR'S NAME: _____

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

1. Demonstrate an understand of various peripheral vascular disorders, especially those that commonly occur in the lower extremities.	1	2	3	4	5	N/B
2. Demonstrate an understanding in evaluating vascular status of the lower extremities via manual palpation of pulses, usage of doppler and correlation of findings with physical appearance and patient's chief complaint and history (medical & social).	1	2	3	4	5	N/B
3. Demonstrate an understanding of surgical reconstructive vascular procedures available to and commonly performed in patients with severe PVD of lower extremities.	1	2	3	4	5	N/B
4. Demonstrate an understanding of the perioperative care of the vascular surgery patient.	1	2	3	4	5	N/B
5. Demonstrate an understanding of the application and evaluation of invasive and non-invasive vascular examination.	1	2	3	4	5	N/B
6. Demonstrate an understanding of the principles and techniques employed by the vascular surgeon.	1	2	3	4	5	N/B

Below Average 1-2	Average 3-4	Excellent 5	N/B (no basis for judgment

7. Observe and assist the vascular surgeon in the practice of his specialty.	1	2	3	4	5	N/B
8. Demonstrate an understanding towards peripheral vascular pathology presenting in the podiatric patient, with attention towards appropriate and timely referral.	1	2	3	4	5	N/B
9. Demonstrate an understanding of vascular considerations involvement with prospective pedal surgery.	1	2	3	4	5	N/B
10. Demonstrate an understanding of vascular principles dictating open vs. closed vs. auto amputation, as well as appropriate timing.	1	2	3	4	5	N/B
11. Demonstrate ability to work independently as a "team member" of the vascular surgery department.	1	2	3	4	5	N/B
12. Demonstrate ability to manage inhouse patients peri-operatively undergoing concomitant vascular and foot reconstruction/salvage.	1	2	3	4	5	N/B
13. Demonstrate ability to understand an invasive exam.	1	2	3	4	5	N/B
14. Demonstrate an understanding of LE angioplasty techniques and their role in foot revascularization.	1	2	3	4	5	N/B
15. Demonstrate ability to peri-operatively manage patient with diabetes mellitus undergoing vascular lower extremity surgery.	1	2	3	4	5	N/B
16. Demonstrate the ability to perform an ABI at bedside.	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT: _____ _____

Resident **Director Podiatric Education**

_____ _____

Date **Date**

Wound Care Competencies

The Resident is expected to:

1. Manage basic and complex wounds and infections – wound debridement, dressings, off-loading techniques including total contact casting, negative pressure dressings (wound vac) and nutritional assessment.

2. Knowledge in the comprehensive team approach to medical & surgical management of diabetic foot ulcers.

3. Recognize the need for, and the appropriate ordering and interpretation of additional diagnostic studies, including appropriate medical imaging & vascular studies (both invasive & noninvasive)

4. Be proficient in the various techniques of soft tissue coverage, i.e. skin grafts, bioengineered skin substitutes/biologic dressings

5. Understand the indications for and determination of appropriate patient selection for hyperbaric oxygen treatment

6. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity

7. Assess and manage the patient's general medical status

8. Practice with professionalism, compassion and concern in a legal, ethical, and moral fashion

9. Communicate effectively and function in a multi-disciplinary setting

10. Manage individuals and populations in a variety of socioeconomic and healthcare settings

11. Understand podiatric practice management in a multitude of healthcare delivery settings

12. Be professionally inquisitive, life-long and teachers utilizing research scholarly activity, and information technologies to enhance professional knowledge and clinical practice

13. Accept criticism constructively

14. Continue self study and literature review

15. Be punctual – attendance and appearance

16. Be proficient in Charting, Dictation and Record Keeping

Updated: 5/24 JSD

RESIDENT EVALUATION

RESIDENT'S NAME: _____

DATE OF ROTATION: _____ ROTATION:

WOUND CARE ROTATION

EVALUATOR'S NAME: _____

Below Average 1-2 Average 3-4 Excellent 5 N/B (no basis for judgment)

1. Perform formal wound care assessment including focused history and physical examination.	1	2	3	4	5	N/B
2. Understand the principles of wound healing and management of the following types of wounds.						
a. Diabetic						
b. Venous						
c. Arterial	1	2	3	4	5	N/B
d. Decubitus	1	2	3	4	5	N/B
e. Traumatic	1	2	3	4	5	N/B
	1	2	3	4	5	N/B
3. Understand the role and show proficiency of debridement in wound healing.	1	2	3	4	5	N/B
4. Understanding the role of noninvasive testing in the patient with a lower extremity wound.	1	2	3	4	5	N/B
5. Understanding the role of hyperbaric oxygen and wound healing.	1	2	3	4	5	N/B
6. Understanding the indications and pharmacology of various wound care products.	1	2	3	4	5	N/B
7. Understand the team approach and the involvement of multiple specialties for treatment of lower extremity wounds.	1	2	3	4	5	N/B
8. Practice with professionalism, compassion and concern.	1	2	3	4	5	N/B
9. Demonstrate the ability to communicate effectively in oral and written form.	1	2	3	4	5	N/B
10. Maintain appropriate medical records and understand medical-legal considerations involving healthcare delivery.	1	2	3	4	5	N/B
	1	2	3	4	5	N/B

COMMENTS: _____

_____

EVALUATOR'S SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT: _____ _____

Resident **Director Podiatric Education**

Updated 5/2024 JSD

Rotation Schedule 2024-2025

Resident	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Nicole Curreri PGY-3	Podiatry	Podiatry (w)	Elective	Ortho	Podiatry	Podiatry (w)	Podiatry	Podiatry	Podiatry	Podiatry (MSK 2wks 1-13)	Elective	Podiatry
Janice Bautista PGY-2	Podiatry (w)	Podiatry	Podiatry	Podiatry	Podiatry	Gen surg	ID	Podiatry (w)	Podiatry	Ortho	Podiatry	Rheum
Hannah Hanks PGY-2	Podiatry	Podiatry	Podiatry (w)	Podiatry	ID	Podiatry	Gen Surg	Podiatry	Rheum	Podiatry	Ortho	Podiatry (w)
Marta Burgos PGY-1	Podiatry	Medicine	ED	Anesthesia /Podiatry	Podiatry(w)	Podiatry Rad (1-15)	Podiatry (w)	Podiatry (pysch 2wks (1-16)	Vascular	Podiatry (w)	Podiatry	Podiatry
Ed Gallucci PGY-1	Medicine	Podiatry	Anesthesia/ Podiatry	Podiatry (w)	ED	Podiatry Rad (16-31)	Podiatry	Vascular	Podiatry (w)	Podiatry (pysch 2wks 14-27)	Podiatry (w)	Podiatry
On Service	4	4	3	4	3	3	3	4	3	4	3	4

Off service rotations:
PGY 1: Medicine (1M) , Vascular (1M), Anesthesia (1M), Radiology (2 weeks), ED (1M), Psych (2wks) Wound care (**3**M-wed AM)

PGY 2: Ortho (1M), ID (1M), Rheumatology (1M), Gen Surg (1M), wound care (**2**M-wed AM)

PGY 3: Elective (2M), Ortho (1M), MSK (2 weeks 1/2 half day PM), wound care (**2**M- Wed AM)

ACADEMICS

Every Wednesday 6AM (Paulino Conference Room)

- Presentation by residents or students on assigned topic.
- 10-15 min presentation based off of McGlammarys and other evidence-based sources. Should include/discuss 1-2 journal articles on the topic during the presentation.
- In Paulino conference room

12 PM Academics (Paulino Conference Room)

- Tuesday or Wednesday prior to clinic as seen on this schedule.
- Radiology Rounds and Diagnostic Imaging – read and discuss xrays/MRI/CT, diagnose and make tx/surgical plan
- Practice management
- Kahoot Quizzes (boards review/prep)

Journal Club

- 1 day during the month, TBD each month. (cathcart)

Questions:

- Kahoot Quizzes (boards review/prep)
- 4th Tuesday every month.

Topics are assigned below on the monthly calendars
Students will be asked to present one presentation at the 6AM Wednesday meeting and present one journal article on the specified day for journal club

ACADEMICS

6AM Every Wednesday
-Wed, July 3: Anesthesia/PreOp (Janice)
-Wed, July 10: Antibiotics (Nicole)
-Wed, July 17: No academics
-Wed, July 24: OM workup and treatments (Mia)
-Wed, July 31: Open fractures (Ed)

12PM 1st Wednesday (Doobay)
-Wed, July 3: Radiology Rounds

12PM 3rd and 4th Tuesday (Dehaven)
-Tues, July 16: Diagnostic Imaging/clinic
-Tues, July 30: Questions

JULY 2024 (FIRST YEAR GENERAL TOPICS)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3 PreOp Management + anesthesia (Janice) Radiology Rounds at 12 Clinic	4 Independence Day (off)	5	6
7	8	9	10 Antibiotics (Nicole)	11	12	13
14	15 Integra Workshop Needs time and place**	16 Diagnostic Imaging Clinic	17 OM work up and treatments (Mia)	18	19	20
21	22	23	24 No academics Dr. DeHaven vacation.	25	26	27
28	29	30 Questions (DeHaven)	31 Open Fractures and Puncture Wounds (Ed)			

ACADEMICS

6AM Every Wednesday
-Wed Aug 7: AO principles (Hannah)
-Wed Aug 14: Biomechanics (Dr. DeHaven)
-Wed Aug 21: Bracing and Orthotics (Melinda)
-Wed Aug 28: Vascular workup (Marta)

12PM 1st Wednesday (Doobay)
-Wed Aug 7: radio rounds

12PM 3rd and 4th Tuesday (DeHaven)
-Tues, Aug 13: diagnostic imaging
-Tues, Aug 27: diagnostic imaging

August 2024 (Assorted Boards Topics)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7 AO Principles (Hannah) Radiology Rounds at 12 Clinic	8	9	10
11	12 VJ Day (off)	13	14 Biomechanics (Dr. DeHaven)	15	16	17
18	19	20 Diagnostic Imaging Clinic	21 Orthotics/Bracing (Melinda)	22	23	24
25	26	27 Questions (DeHaven)	28 Vascular workup (Marta)	29	30	31

ACADEMICS

6AM Every Wednesday
-Wed Sept 4: Cavus (Nicole)
-Wed Sept 11: Flatfoot (Qi)
-Wed Sept 18: Ankle/TCC (Priya)
-Wed Sept 25: TAR (Janice)

12PM 1st and 3rd Wednesday (Doobay)
-Wed Sept 4 - Note Formatting
-Wed Sept 18 - Bone stim rep lunch

12PM 2nd and 4th Tuesday (Dehaven)
-Tues, Sept 10 Diagnostic Imaging
-Tues, Sept 17: Diagnostic Imaging

September 2024 (Assorted Boards Topics)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2 Labor Day (Off)	3	4 Cavus (Nicole)	5	6	7
8	9	10	11 Flatfoot/PTTD (Qi)	12	13	14
15	16	17	18 Ankle/TCC fusions (Priya)	19	20	21
22	23	24 Questions (DeHaven)	25 TAR (Janice)	26	27	28
29	30					

ACADEMICS

6AM Every Wednesday
-Wed Oct 2: Bunion workup (Ed)
-Wed Oct 9: Bunion procedures (Christina)
-Wed Oct 16: HR/HL (Daniel)
-Wed Oct 23: Juvenile HAV/Hallux varus (Marta)
-Wed Oct 30: 1st ray complications (Hannah)

12PM 1st and 3rd Wednesday (Doobay)
-Oct 2: radio rounds
-Oct 16: practice management

12PM 3rd Tuesday (Dehaven)
- Tues 15 diagnostic imaging

October 2024: First Ray

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2 Bunion work up (Ed)	3	4	5
6	7	8	9 Bunion Procedures (Christina)	10	11	12
13	14 Columbus Day (Off)	15	16 HR/HL (Daniel)	17	18	19
20	21	22	23 Juvenile HAV/Hallux varus (Marta)	24	25	26
27	28	29 Questions	30 1st ray complications (Hannah)	31		

ACADEMICS

6AM Every Wednesday
-Wed Nov 6: PRR + Freibergs (Ed)
-Wed Nov 11: Hammertoe (Stephanie)
-Wed 20: Met adductus (Jacob)
- Wed 27: Tailor's bunion (Janice)

12PM 1st and 3rd Wednesday (Doobay)
-Wed Nov 6 Radiology Rounds
-Wed Nov 20 Practice Management

12PM 2nd and 4th Tuesday (Dehaven)
-Tues Nov **14** Diagnostic Imaging
-Tues Nov 21 Diagnostic Imaging

November 2024: Digit Deformities and centralray procedures

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6 PPR + Freibergs (Ed)	7	8	9
10	11 Veteran's Day (Off)	12	13 Hammertoes + Digital Deformities (Stephanie)	14	15	16
17	18	19	20 Met adductus (Jacob)	21	22	23
24	25	26 Questions	27 Tailors (Janice)	28 Thanksgiving (Off)	29 (Off)	30

ACADEMICS

6AM Every Wednesday
-Wed Dec 4 - Tendon Transfers (Marta)
-Wed Dec 11 - Achilles disorders (Victoria)
-Wed Dec 18 - Lateral ankle (Aaliyah)
-Wed Dec 25 - Off

12PM Wednesday (Doobay)
-Wed Dec 6 Radiology Rounds

12PM Tuesday (Dehaven)
-Tues Dec 19 Diagnostic Imaging

December 2024: Tendon Pathology

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4 Tendon Transfers (Marta)	5	6	7
8	9	10	11 Achilles disorders (Victoria)	12	13	14
15	16	17	18 Lateral Ankle + Peroneal (Aaliyah)	19	20	21
22	23	24 Questions	25 Christmas (Off)	26	27	28
29	30	31				

ACADEMICS

6AM Every Wednesday
-Wed Jan 1: Off New Years
-Wed Jan 8: digital/Met Fxs (Nicole)
-Wed Jan 15: lisfranc Fx/dis (Hannah)
-Wed Jan 22: Calcaneal fractures (Ed)
-Wed Jan 29: Talar/Nav fx (Marta)

12PM 1st and 3rd Wednesday (Doobay)
-Wed Jan Radiology Rounds
-Wed Jan Practice Management

12PM 2nd and 4th Tuesday (Dehaven)
-Tues Jan 9 Diagnostic Imaging
-Tues
Jan 23 Diagnostic Imaging

January 2025: Trauma part 1

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 New Years Day (Off)	2	3	4
5	6	7	8 Digital/Met fractures (Nicole)	9	10	11
12	13	14	15 Lis Franc Fx/Dislocation (Hannah)	16	17	18
19	20	21	22 Calcaneal Fractures (Ed)	23	24	25
26	27	28 Questions at 12	29 Talar/Navicular fractures (Marta)	30	31	

ACADEMICS

6AM Every Wednesday
-Wed Feb 5: Talar/Navicular fx(Janice)
-Wed Feb 12: Ankle Fx
-Wed 19: OCD lesions
-Wed Feb 26: Ankle Scopes

12PM 1st and 3rd Wednesday (Doobay)
-Wed Feb 7 Radiology Rounds
-Wed Feb 21 Practice Management

12PM 2nd and 4th Tuesday (Dehaven)
-Tues Feb 13 Diagnostic Imaging
-Tues Feb 27 Diagnostic Imaging

February 2025: Rearfoot trauma

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5 Ankle Fx (Nicole)	6	7	8
9	10	11	12 Pilon fx (Hannah)	13	14	15
16	17	18	19 OCD lesions + Ankle Scopes (Mark)	20	21	22
23	24	25 Questions	26 Compartment syndrome (Marta)	27	28	

ACADEMICS

6AM Every Wednesday
-Wed March 5th: wounds/flaps
-Wed March 12th: Nail path
-Wed March 19th: Biopsies, skin benign/cancerous lesions
-Wed March 26th:, Questions

12PM 1st and 3rd Wednesday (Doobay)
-Wed March 5th: Radio Rounds
-Wed March 19th: Practice Management

12PM 2nd and 4th Tuesday (Dehaven)
-Tues March 12th, Diagnostic Imaging
-Tues March 26th, Diagnostic Imaging

March 2025: Dermatology

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5 Wounds/Flaps (Hannah)	6	7	8
9	10	11	12 Nail pathology (Nicole)	13	14	15
16	17	18	19 Tinea pedis (Ed)	20	21	22
23	24	25 Questions	26 Biopsies, skin, Benign/cancerous (Janice)	27	28	29
30	31					

ACADEMICS

6AM Every Wednesday
-Wed April 2nd: Sero+
-Wed April 9th: RA
- Wed. April 16: Newport Presentations
- Wed April 23: Seronegative
-Wed April 30th: Clubfoot

12PM 1st and 3rd Wednesday (Doobay)
-Wed April 2nd: Radio rounds
-Wed April 16: Practice Management

12PM 2nd and 4th Tuesday (Dehaven)
-Tues April 9th: Diagnostic Imaging
-Tues April 23rd: Diagnostic Imaging

April 2025: Rheum + other topics

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2 Gout and Septic Arthritis (Marta)	3	4	5
6	7	8	9 RA/Psoriatic arthritis/Ankylosing spondylitis (Ed)	10	11	12
13	14	15	16 Newport Presentations	17	18	19
20	21	22	23 Bone Tumors (student/Janice)	24	25	26
27	28	29 Questions	30 Entrapment/Tarsal tunnel/Neuromas /CRPS (Hannah)			

ACADEMICS

6AM Every Wednesday
-Wed May 7th:CVT, CV
-Wed May 14th: Tarsal Coalitions
-Wed May 21st: Met adductus
-Wed May 28th: Peds foot/ankle fx

12PM 1st and 3rd Wednesday (Doobay)
-Wed May 7th: radio rounds
-Wed May 21st: practice management

12PM 2nd and 4th Tuesday (Dehaven)
-Tues May 7th Diagnostic Imaging
-Tues May 21st Diagnostic Imaging

May 2025: Peds

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7 CVT and Calcaneal Valgus (Nicole)	8	9	10
11	12	13	14 Clubfoot (Janice)	15	16	17
18	19	20	21 Tarsal Coalitiions (Student/Ed)	22	23	24
25	26 Memorial Day (Off)	27 Questions	28 Pediatric foot and ankle fx (Marta)	29	30	31

ACADEMICS

6AM Every Wednesday
-Wed June 4: TAR
-Wed Jun 11th:
-Wed June 18th:
-Wed June 25t:

12PM 1st and 3rd Wednesday (Doobay)
-Wed June 5th: radio rounds
-Wed ?: Practice Management

12PM 2nd and 4th Tuesday (Dehaven)
-Tues June 11th, Diagnostic Imaging
-Tues June 25th, Diagnostic Imaging

June 2025: Miscellaneous

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4 Charcot (Hannah)	5	6	7
8	9	10	11 Ex fix (student/Janice)	12	13	14
15	16	17	18 SMO (Student/Marta)	19	20	21
22	23	24	25 Plantar fasciitis (student/Ed)	26	27	28
29	30					