Podiatric Medicine & Surgery Residency Manual

Loma Linda University Medical Center – MurrietaTable of Contents:

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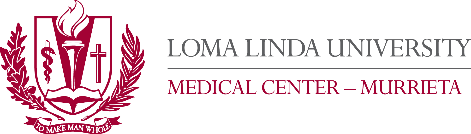
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**Podiatry Curriculum & Competencies**

**Purpose**: The purpose of this policy is to outline the anticipated training schedule, curriculum, and competencies required to successfully become a competent podiatric physician and surgeon.

**Background**: CPME 320 Section 6

***6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident’s sequential and progressive achievement of specific competencies.***

The resident must be afforded training in the breadth of podiatric health care. Completion of a podiatric residency currently leads to the following certification pathways: the American Board of Foot and Ankle Surgery (ABFAS) and the American Board of Podiatric Medicine (ABPM).

Completion of a podiatric residency with the added credential in reconstructive rearfoot/ankle surgery leads to the reconstructive rearfoot/ankle surgery certification pathway of ABFAS.

Additional educational experiences may be added to the curriculum to extend the length of the program up to 48 months. The program director must obtain the approval of the sponsoring institution and RRC prior to implementation and at each subsequent approval review of the program. Programs that extend the residency beyond 36 months must present a clear educational rationale.

The Council and RRC view the following experiences to be essential to the conduct of a residency (although experiences need not be limited to the following):

* Clinical experience, providing an appropriate opportunity to expand the resident’s competencies in the care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, biomechanical, and surgical means.
* Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident’s competencies in the perioperative care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures.
* Clinical experience, providing an opportunity to expand the resident’s competencies in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.
* Didactic experience, providing an opportunity to expand the resident’s knowledge in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

**6.1 The curriculum shall be clearly defined and oriented to assure that the resident achieves the competencies identified by the Council.**

At the beginning of the training year, all site coordinators or rotations directors must be provided the training schedule, competencies, and assessment documents for their respective rotation(s).

The curriculum must provide the resident a sufficient volume and diversity of experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below.

**A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the lower extremity.**

1. Perform and interpret the findings of a thorough history and physical exam, including neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis as indicated.
2. Formulate an appropriate diagnosis and/or differential diagnosis.
3. Understand the indication(s) for and interpret appropriate diagnostic studies, including:
   * Medical imaging (e.g., plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, and vascular imaging).
   * Laboratory tests (e.g., hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis).
   * Pathology (e.g., anatomic and cellular pathology).
   * Other diagnostic studies (e.g., electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies).
4. Participate directly in the evaluation and management of patients in inpatient and outpatient settings, including the following:
   * Perform biomechanical examination and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
   * Dermatologic conditions.
   * Neurological conditions.
   * Orthopedic conditions.
   * Arterial and venous conditions.
   * Wound care.
   * Congenital deformities (e.g., manipulation, casting, bracing of foot/ankle).
   * Trauma.
   * Office-based procedures (e.g., injections and aspirations, nail avulsion, biopsies).
   * Pharmacologic management.
   * Lower extremity health promotion and education.
5. Participate directly in the evaluation and management of the surgical patient when indicated, including the following:
   * Evaluating, diagnosing, selecting appropriate treatment, and recognizing and managing complications.
   * Progressive development of knowledge, attitudes, and skills in perioperative assessment and management in foot and ankle surgery (see Appendix A regarding the volume and diversity of cases and procedures to be performed by the resident).
6. Assess the treatment plan and revise it as necessary.

**B. Assess and manage the patient’s general medical and surgical status.**

1. Perform and interpret the findings of comprehensive medical history and physical examinations through diverse podiatric and non-podiatric experiences, including (see Appendix A):
   * Comprehensive medical history.
   * Comprehensive physical examination.
     + -  Vital signs.
     + -  Physical examination (e.g., head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, and neurologic examination).
2. Formulate an appropriate differential diagnosis of the patient’s general medical problem(s).
3. Understand the indication(s) for and interpret the results of diagnostic studies including (see also section A.3 for diagnostic studies not repeated in this section).
   * EKG.
   * Medical imaging (e.g., plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound).
   * Laboratory studies (e.g., hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, and urinalysis).
   * Other diagnostic studies.
4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education.
5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, gender, psychosocial status, and socioeconomic status.
6. Participate actively in non-podiatric surgical rotations that include surgical evaluation and management of patients including, but not limited, to:
   * Understanding management of preoperative and postoperative surgical patients.
   * Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision.
   * Understanding surgical procedures and principles applicable to non- podiatric surgical specialties.

Participate actively in a medical imaging rotation that should include musculoskeletal and non-musculoskeletal pathology and incorporates evaluating and interpreting various medical imaging modalities (e.g., plain radiography, nuclear medicine imaging, MRI, CT, and diagnostic ultrasound).

1. Participate actively in an anesthesiology rotation that includes pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to:

* Local anesthesia.
* General, spinal, epidural, regional, and conscious sedation anesthesia.

1. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.
2. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences:

* Recognizing and diagnosing common infective organisms.
* Using appropriate antimicrobial therapy.
* Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring.
* Managing patients with local and systemic infections.

1. Participate actively in a medical imaging rotation that should include musculoskeletal and non-musculoskeletal pathology and incorporates evaluating and interpreting various medical imaging modalities (e.g., plain radiography, nuclear medicine imaging, MRI, CT, and diagnostic ultrasound).
2. Participate actively in a behavioral medicine rotation that incorporates evaluation and management of patients with behavioral, mental, and/or psychosocial health issues (e.g., inpatient/outpatient psychiatric care, addiction medicine).
3. Participate actively in a vascular/endovascular surgery rotation that incorporates the evaluation and management of patients with peripheral arterial disease including, but not limited to, the following training experiences:

* Evaluating and interpreting various vascular studies.
* Understanding the indications for various vascular/endovascular revascularization procedures.

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

1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.

1. Practice and abide by the principles of informed consent.
2. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.
3. Demonstrate professional humanistic qualities.
4. Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of health-care costs.

**D. Communicate effectively and function in a multi-disciplinary setting.**

1. Demonstrate effective physician-patient communication skills.
2. Demonstrate effective physician-provider communication skills.
3. Demonstrate appropriate medical record documentation.
4. Demonstrate appropriate consultation and/or referrals.

**E. Manage individuals and populations in a variety of socioeconomic and health-care settings.**

1. Demonstrate an understanding of the psychosocial and health-care needs for patients in all life stages: pediatric through geriatric.
2. Demonstrate cultural humility and responsiveness to values, behaviors, and preferences of one’s patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender identity, and/or sexual orientation is/are different from one’s own.
3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention.

**F. Understand podiatric practice management in a multitude of health-care delivery settings.**

* 1. Demonstrate familiarity with utilization management and quality improvement.
  2. Understand health-care coding and reimbursement.
  3. Explain contemporary health-care delivery systems.
  4. Understand insurance issues including professional and general liability, disability, and Workers’ Compensation.
  5. Understand medical-legal considerations involving health-care delivery.
  6. Demonstrate understanding of common business practices.

**G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and evidence-based practice.**

1. Read, interpret, and critically analyze and present medical and scientific literature.
2. Demonstrate information technology skills in learning, teaching, and clinical practice.
3. Participate in education activities.

**6.2  The sponsoring institution shall require that the resident maintain web-based logs documenting clinical and didactic experiences related to the residency.**

The format must be approved by and accessible for review by the RRC.

The format must categorize and summarize medical/surgical diversity and experiences (refer to Appendices A and B).

**6.3  The program shall establish a formal schedule for clinical training.**

The program shall provide an anticipated rotation schedule for residents throughout the entirety of their training, including rotation lengths, rotation formats (block or sequential only), and rotation locations. Specific dates need only be included for the current academic year.

The program director is responsible for assuring that the schedule is followed; however, it may be reviewed and modified as needed to ensure an appropriate sequencing of training experiences consistent with the residency curriculum.

The residency must be continuous and uninterrupted unless extenuating circumstances are present.

The length of residency education to be conducted in a supervised podiatric private practice office-based setting must not exceed seven months or 20 percent of a 36- month training program.

**6.4  The residency program shall provide rotations that enable the resident to achieve the competencies identified by the Council and any additional competencies identified by the residency program. These rotations shall include podiatric medicine and surgery as well as non-podiatric rotations. The residency curriculum shall provide the resident patient management experiences in both inpatient and outpatient settings.**

The program director must, in collaboration with appropriate individuals, construct the program curriculum based on available resources. In developing the curriculum, the program director must consult with faculty to identify resources available to enable resident achievement of the stated competencies of the curriculum. Members of the administrative staff and the office of graduate medical education of the sponsoring institution may be involved in the development of the curriculum.

In addition to podiatric medicine and surgery, the following rotations and minimum lengths of training are required. Each of the rotations must be a minimum of two weeks of training, in block or sequential format, unless otherwise noted:

Anesthesiology.

Behavioral medicine.

Emergency medicine (minimum of four weeks of training).

Medical imaging.

Medical specialties. There is a minimum requirement of **12 cumulative weeks** of training in medical specialties.

Training must include rotations in

* Internal medicine/Family medicine (minimum 4 weeks).
* Infectious disease.

Training must also include at least **two** of the following rotations

* Burn unit, dermatology, endocrinology, geriatrics, intensive/critical care unit, neurology, pain management, pediatrics, physical medicine and rehabilitation, rheumatology, wound care, and vascular medicine.

Surgical specialties: There is a minimum requirement of **8 cumulative weeks** of training in surgical specialties. Training must include at least **two** of the following rotations, with a minimum of two weeks in endovascular/vascular surgery:

* + Endovascular/vascular surgery (at least two weeks).
  + Cardiothoracic surgery, general surgery, hand surgery, orthopedic surgery, neurosurgery, orthopedic/surgical oncology, pediatric orthopedic surgery, plastic surgery, or surgical intensive care unit (SICU), trauma team/surgery.

While a typical training week involves five working days, CPME recognizes that holidays may shorten a work week.

***Intent and Background*:** *The program should be structured so that each rotation is a minimum of the required length of time, allowing for the resident to successfully achieve the competencies of the rotation. Individual resident schedules may vary due to faculty schedules, holidays, or other unforeseen circumstances; however, the intent is that the program affords residents the necessary time required in each rotation.*

**6.5  The residency program shall ensure that the resident is certified in advanced cardiac life support for the duration of training.**

ACLS certification must be obtained as early as possible during the training year but no later than six months after the resident’s starting date.

**6.6  The residency curriculum shall afford the resident instruction and experience in hospital protocol and medical record-keeping.**

The program director must assure that patient records document accurately the resident’s participation in patient care activities.

The resident should participate in quality improvement and utilization review activities.

**6.7  Didacticactivitiesthatcomplementandsupplementthecurriculumshallbe available.**

Residents must be afforded protected time for weekly didactic activities. Didactic activities must be provided in a variety of formats. These formats may include lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds, and/or continuing education.

Training in the following must be provided to the resident at least once per year of training:

* + Falls prevention.
  + Resident well-being (e.g., substance abuse, fatigue mitigation, suicide prevention, self-harm, and physician burnout).
  + Pain management (i.e., multi-modal approach to chronic and acute pain) and opioid addiction.
  + Cultural humility (e.g., training in implicit bias, diversity, inclusion, and culturally effective components particularly regarding access to care and health outcomes).
  + Workplace harassment and discrimination awareness and prevention.
  + Foundation of and importance of coding and medical documentation.

Training in research methodology must be provided at least once during residency training (e.g., web-based training, formal lectures, or a dedicated research rotation).

The majority of didactic activities must include participation by at least one faculty member.

The program director may appoint a faculty member to coordinate didactic activities.

***Intent and Background:*** *Didactic experiences provide an opportunity to expand the resident’s knowledge in the breadth of podiatric medicine, including biomechanical assessment and surgical evaluation and management. The annual instruction may be provided during resident orientation, focused activities, and through web-based programs. CPME recognizes that holidays may interrupt regularly scheduled weekly didactic activities.*

**6.8  The curriculum shall afford the resident instruction in the critical analysis of scientific literature.**

A journal review session, with participation of faculty and residents, must be scheduled at least monthly. The resident should present current articles and analyze the content and validity of the research.

**6.9  The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences.**

The program must define levels of resident supervision appropriate for the level of training.

**6.10  The residency program shall ensure the resident is afforded appropriate clinical and educational work hours.**

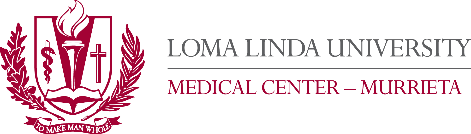
**Work Hours:** Clinical and education work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home.

**Work 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.

**In-house Call:** Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

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

**Outside Activities:** The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the resident’s ability to function in the training program.



**Podiatry Curriculum & Competencies**

**Purpose**: The purpose of this policy is to outline the anticipated training schedule, curriculum, and competencies required to successfully become a competent podiatric physician and surgeon.

**Background**: CPME 320 Section 6

***6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident’s sequential and progressive achievement of specific competencies.***

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* Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident’s competencies in the perioperative care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures.
* Clinical experience, providing an opportunity to expand the resident’s competencies in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.
* Didactic experience, providing an opportunity to expand the resident’s knowledge in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

**6.1 The curriculum shall be clearly defined and oriented to assure that the resident achieves the competencies identified by the Council.**

At the beginning of the training year, all site coordinators or rotations directors must be provided the training schedule, competencies, and assessment documents for their respective rotation(s).

The curriculum must provide the resident a sufficient volume and diversity of experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below.

**A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the lower extremity.**

1. Perform and interpret the findings of a thorough history and physical exam, including neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis as indicated.
2. Formulate an appropriate diagnosis and/or differential diagnosis.
3. Understand the indication(s) for and interpret appropriate diagnostic studies, including:
   * Medical imaging (e.g., plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, and vascular imaging).
   * Laboratory tests (e.g., hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis).
   * Pathology (e.g., anatomic and cellular pathology).
   * Other diagnostic studies (e.g., electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies).
4. Participate directly in the evaluation and management of patients in inpatient and outpatient settings, including the following:
   * Perform biomechanical examination and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
   * Dermatologic conditions.
   * Neurological conditions.
   * Orthopedic conditions.
   * Arterial and venous conditions.
   * Wound care.
   * Congenital deformities (e.g., manipulation, casting, bracing of foot/ankle).
   * Trauma.
   * Office-based procedures (e.g., injections and aspirations, nail avulsion, biopsies).
   * Pharmacologic management.
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5. Participate directly in the evaluation and management of the surgical patient when indicated, including the following:
   * Evaluating, diagnosing, selecting appropriate treatment, and recognizing and managing complications.
   * Progressive development of knowledge, attitudes, and skills in perioperative assessment and management in foot and ankle surgery (see Appendix A regarding the volume and diversity of cases and procedures to be performed by the resident).
6. Assess the treatment plan and revise it as necessary.

**B. Assess and manage the patient’s general medical and surgical status.**

1. Perform and interpret the findings of comprehensive medical history and physical examinations through diverse podiatric and non-podiatric experiences, including (see Appendix A):
   * Comprehensive medical history.
   * Comprehensive physical examination.
     + -  Vital signs.
     + -  Physical examination (e.g., head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, and neurologic examination).
2. Formulate an appropriate differential diagnosis of the patient’s general medical problem(s).
3. Understand the indication(s) for and interpret the results of diagnostic studies including (see also section A.3 for diagnostic studies not repeated in this section).
   * EKG.
   * Medical imaging (e.g., plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound).
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4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education.
5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, gender, psychosocial status, and socioeconomic status.
6. Participate actively in non-podiatric surgical rotations that include surgical evaluation and management of patients including, but not limited, to:
   * Understanding management of preoperative and postoperative surgical patients.
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Participate actively in a medical imaging rotation that should include musculoskeletal and non-musculoskeletal pathology and incorporates evaluating and interpreting various medical imaging modalities (e.g., plain radiography, nuclear medicine imaging, MRI, CT, and diagnostic ultrasound).

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* Local anesthesia.
* General, spinal, epidural, regional, and conscious sedation anesthesia.

1. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.
2. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences:

* Recognizing and diagnosing common infective organisms.
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2. Participate actively in a behavioral medicine rotation that incorporates evaluation and management of patients with behavioral, mental, and/or psychosocial health issues (e.g., inpatient/outpatient psychiatric care, addiction medicine).
3. Participate actively in a vascular/endovascular surgery rotation that incorporates the evaluation and management of patients with peripheral arterial disease including, but not limited to, the following training experiences:

* Evaluating and interpreting various vascular studies.
* Understanding the indications for various vascular/endovascular revascularization procedures.

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

1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.

1. Practice and abide by the principles of informed consent.
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* 1. Demonstrate familiarity with utilization management and quality improvement.
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The format must be approved by and accessible for review by the RRC.

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**6.3  The program shall establish a formal schedule for clinical training.**

The program shall provide an anticipated rotation schedule for residents throughout the entirety of their training, including rotation lengths, rotation formats (block or sequential only), and rotation locations. Specific dates need only be included for the current academic year.

The program director is responsible for assuring that the schedule is followed; however, it may be reviewed and modified as needed to ensure an appropriate sequencing of training experiences consistent with the residency curriculum.

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Medical imaging.

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Training must include rotations in

* Internal medicine/Family medicine (minimum 4 weeks).
* Infectious disease.

Training must also include at least **two** of the following rotations

* Burn unit, dermatology, endocrinology, geriatrics, intensive/critical care unit, neurology, pain management, pediatrics, physical medicine and rehabilitation, rheumatology, wound care, and vascular medicine.

Surgical specialties: There is a minimum requirement of **8 cumulative weeks** of training in surgical specialties. Training must include at least **two** of the following rotations, with a minimum of two weeks in endovascular/vascular surgery:

* + Endovascular/vascular surgery (at least two weeks).
  + Cardiothoracic surgery, general surgery, hand surgery, orthopedic surgery, neurosurgery, orthopedic/surgical oncology, pediatric orthopedic surgery, plastic surgery, or surgical intensive care unit (SICU), trauma team/surgery.

While a typical training week involves five working days, CPME recognizes that holidays may shorten a work week.

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Training in the following must be provided to the resident at least once per year of training:

* + Falls prevention.
  + Resident well-being (e.g., substance abuse, fatigue mitigation, suicide prevention, self-harm, and physician burnout).
  + Pain management (i.e., multi-modal approach to chronic and acute pain) and opioid addiction.
  + Cultural humility (e.g., training in implicit bias, diversity, inclusion, and culturally effective components particularly regarding access to care and health outcomes).
  + Workplace harassment and discrimination awareness and prevention.
  + Foundation of and importance of coding and medical documentation.

Training in research methodology must be provided at least once during residency training (e.g., web-based training, formal lectures, or a dedicated research rotation).

The majority of didactic activities must include participation by at least one faculty member.

The program director may appoint a faculty member to coordinate didactic activities.

***Intent and Background:*** *Didactic experiences provide an opportunity to expand the resident’s knowledge in the breadth of podiatric medicine, including biomechanical assessment and surgical evaluation and management. The annual instruction may be provided during resident orientation, focused activities, and through web-based programs. CPME recognizes that holidays may interrupt regularly scheduled weekly didactic activities.*

**6.8  The curriculum shall afford the resident instruction in the critical analysis of scientific literature.**

A journal review session, with participation of faculty and residents, must be scheduled at least monthly. The resident should present current articles and analyze the content and validity of the research.

**6.9  The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences.**

The program must define levels of resident supervision appropriate for the level of training.

**6.10  The residency program shall ensure the resident is afforded appropriate clinical and educational work hours.**

**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 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.

**In-house Call:** Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

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

**Outside Activities:** The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the resident’s ability to function in the training program.

**Individual Core Rotations with Specific Competencies:**

**ANESTHESIA/PAIN MANAGEMENT**

Rationale: The practicing podiatric physician must be familiar with the application of anesthetic and pain management techniques in the clinical and perioperative settings.

Goal: The goal of this rotation is to familiarize the resident with the principles of general, regional, spinal, and local anesthetic. Residents should be familiar with the evaluation and treatment of patients in acute and chronic pain.

Plan:  The resident will spend one month in sequential format on the anesthesia/pain management service at LLUMC-Murrieta in order to achieve the listed competencies.

Anesthesia Competencies:

-Formulate an appropriate anesthetic plan for a patient undergoing surgery.

-Manage the airway of a patient undergoing surgery including endotracheal intubation.

-Safely monitor a patient under anesthesia.

-Understand medications used during the induction, maintenance and reversal of anesthesia.

-Demonstrate proficiency in lower extremity local anesthetic blocks.

-Classify patients by the physical classification status of the American Society of Anesthesiologists.

-Understand the principles of and participate in the administration of spinal/epidural anesthesia

-Communicate effectively with anesthesia staff.

Pain Management Competencies:

-Demonstrate knowledge of appropriate and differing modalities to treat post-operative pain including indications, risks, and potential complications.

-Recognize and evaluate patients with chronic pain syndromes.

-Understand the pharmacology of centrally acting pain medications.

-Communicate effectively with anesthesia/pain management staff during the care of podiatric patients.

**BEHAVIORAL SCIENCE**

Rationale: Many patients treated by podiatric physicians are also being treated with psychiatric medications and/or have psychological or psychiatric problems.

Goal:  To improve the residents’ understanding of psychiatric diseases and medications.

Plan:  The resident will complete a one-month sequential rotation with the Behavioral Health Department at LLUMC-Murrieta in order to achieve the listed competencies.

Behavioral Science Competencies:

-Demonstrate knowledge of normal and abnormal psychological development.

-Evaluate and recognize psychological disorders

-Demonstrate knowledge of pharmacologic agents used in psychotherapeutics.

-Determine if a patient has capacity to consent for surgical or invasive procedures.

-Recognize when psychiatric consultation is necessary and/or beneficial.

-Communicate effectively with behavior science staff during the care of podiatric patients.

**EMERGENCY MEDICINE**

Rationale: Emergency medicine is an important part of the podiatric physician’s training in order to be familiar with the management of both lower extremity pathology/trauma and general pathology.

Goal: Develop experience and skill in managing the emergency department patient.

Plan:  The resident will spend one month in the emergency department at LLUMC-Murrieta to achieve the listed competencies.  This rotation is additionally expected to be supplemented by the resident taking emergency room call for the podiatry service throughout their training.

Emergency Medicine Competencies

-Understand the concept of triage.

-Perform and interpret the findings of a comprehensive history and physical examination.

-Recognize the need for and appropriately order diagnostic studies when indicated.

-Interpret laboratory, EKG, chest x-ray and other imaging findings.

-Generate a differential diagnosis based on a patient’s chief complaint, history and physical examination findings.

-Generate a treatment protocol to medically manage the ED patient including appropriate consultations and referrals.

-Perform bedside procedures on an emergency department patient including laceration repair, incision and drainage procedures, closed reductions, joint aspirations, splinting and casting.

-Communicate effectively with emergency department staff during the care of podiatric and non-podiatric patients.

**INFECTIOUS DISEASE**

Rationale: Management of infectious diseases is a vital aspect of podiatric practice.

Goal:  Develop competence in management of infections and develop knowledge of antimicrobial agents.

Plan:   The resident will spend one month on the Infectious Disease service at LLUMC-Murrieta to achieve the listed competencies.

Infectious Disease Competencies:

-Perform a comprehensive history and physical examination and interpret laboratory and imaging findings in a patient with an infectious disease.

-Diagnose and manage various infectious diseases specific to the lower extremity including cellulitis, abscesses, osteomyelitis, septic arthritis, and sepsis.

-Diagnose and manage systemic infectious diseases including bacteremia, urinary tract infections, and respiratory infections.

-Demonstrate a differential diagnosis of an infectious disease, including possible pathogens.

-Demonstrate knowledge of appropriate antimicrobial agents for specific pathogens.

-Understand the risks and complications of antimicrobial use.

-Actively participate in the academic curriculum of the Infectious Disease service.

-Communicate effectively with infectious disease staff during the care of podiatric patients.

**GENERAL SURGERY**

Rationale: A podiatric surgical practice incorporates principles also involved in a general surgical practice; therefore the resident may benefit from clinical and surgical experience gained from a general surgeon.

Goal:  Develop knowledge of the indications for general surgical procedures and further develop and improve surgical skills.

Plan:  The resident will spend at least one month on the General Surgery service at LLUMC-Murrieta in order to achieve the listed competencies.

General Surgery - Competencies:

-Perform a complete history and physical examination and assess a patient who requires general surgery services.

-Develop an appropriate treatment plan for patients with surgical needs.

-Evaluate and treat abrasions, burns, and other soft tissue defects utilizing local wound care and surgical intervention.

-Act as a first assistant for general surgical procedures.

-Demonstrate knowledge of basic wound healing principles.

 -Perform a split thickness skin graft harvest and application.

-Recognize the need for and appropriately order and interpret laboratory studies, EKGs and other diagnostic studies as necessary.

-Demonstrate competence in the medical management of the general surgical patient including in the intensive care unit setting.

-Communicate effectively with general surgery staff during the care of podiatric patients.

**INTERNAL MEDICINE**

Rationale: The practicing podiatric physician must be thoroughly knowledgeable in all aspects of general internal medicine and in the performance of a comprehensive history and physical examination.

Goal:  The goal of this rotation is to familiarize the resident with the principles of internal medicine and their application to the podiatric patient.

Plan:  The resident will spend one month on the internal medicine service at LLUMC-Murrieta in order to achieve the listed competencies.

Internal Medicine Competencies:

-Assess and manage a patient’s general medical status as an inpatient including performance of a comprehensive history and physical examination.

-Recognize the indications for and interpret results of laboratory and imaging studies.

-Generate a differential diagnosis based on a patient’s chief complaint, history and physical examination findings.

-Understand and develop knowledge of common medical conditions managed on an inpatient basis.

-Generate and implement an appropriate treatment protocol to medically manage the inpatient including consultations and referrals.

-Assist in the management of critical ill patients including those in the intensive care unit and participation of codes.

-Understand the impact of a patient’s medical conditions as it relates to the formulation of medical and cardiac operating room risk stratification.

-Communicate effectively with internal medicine staff during the care of podiatric patients.

**MEDICAL IMAGING**

Rationale: The practicing podiatric physician must be able to appropriately prescribe and interpret imaging studies required for patient care.

Goal: Familiarize the resident with hospital-based imaging modalities and their interpretation.

Plan: The resident will spend one month with the interventional radiology and outpatient radiology services at LLUMC-Murrieta to achieve the listed competencies. This rotation is additionally expected to be supplemented by monthly radiology conferences within the podiatric didactic academic curriculum.

Medical Imaging Competencies:

-Interpret lower extremity plain film radiographs.

-Interpret chest plain film radiographs.

-Understand the physics of plain film radiography, magnetic resonance imaging, computerized tomography, scintigraphy, and ultrasound.

-Recognize and identify bone tumors.

-Understand the indications for magnetic resonance imaging, computerized tomography, digital subtraction angiography, ultrasound and scintigraphy.

-Interpret lower extremity advanced imaging studies.

-Communicate effectively with radiology staff during the care of podiatric patients.

**ORTHOPEDIC SURGERY**

Rationale: The podiatric physician & surgeon treats many pathologies and deformities of the foot and ankle. A thorough understanding of the orthopedic patient in a whole-body approach will help the podiatric physician better formulate appropriate treatment plans.

Goal:  Develop familiarity with the diagnosis and management (both conservative and surgical) of orthopedic deformities.

Plan:  The resident will complete two months on the orthopedic service in order to achieve the listed competencies. This rotation is additionally expected to be supplemented by radiology didactic activities and participation in internal fixation courses provided by ACFAS

Orthopedic Surgery:

-Complete and interpret the findings of a comprehensive physical examination.

-Formulate a plan for ordering and interpreting appropriate imaging studies in orthopedic patients.

-Develop proficiency in AO techniques for internal fixation and external fixator application.

-Develop proficiency in casting techniques.

-Draw and interpret angles/axes for lower limb deformities.

-Develop a surgical treatment plan for patients with limb deformities.

-Assist in Orthopedic Surgery cases including arthroscopy, trauma, joint replacements, infections, and deformity corrections

-Communicate effectively with orthopedic staff during the care of podiatric patients.

**PODIATRIC OFFICE**

Rationale: Residents should begin to become proficient in pre- and post-operative care as well as ambulatory patient management.

Goal:  The resident will become proficient in outpatient podiatric patient management in the ambulatory care setting.

Plan:  The resident will rotate through various podiatry clinics each year.

Podiatric Office Competencies:

-Perform a comprehensive biomechanical examination including gait analysis.

-Examine a patient with a lower extremity complaint and formulate a differential diagnosis and treatment plan through a problem focused history and physical examination.

-Perform post-operative care in patients following podiatric surgical intervention.

-Perform an appropriate pre-operative work-up on a podiatric surgical candidate including appropriate referral and laboratory analysis.

-Develop the ability to obtain pre-operative consent on podiatric patients

-Perform basic podiatric bedside procedures including diagnostic and therapeutic injections, nail avulsions, laceration closure, and foreign body removal.

-Perform basic podiatric medical interventions including strapping/padding, prescription of functional orthotics and braces, and care of keratotic lesions and toenails.

 -Provide lower extremity health promotion and patient education

-Recognize and manage post-operative complications including infection, hematoma, and deep vein thrombosis.

-Appropriately manage closed fractures and dislocations.

-Understand billing and coding in clinical practice.

-Participate in podiatric medical student education.

-Communicate with other podiatric professionals and primary care physicians.

**PODIATRIC SURGERY**

Rationale: The resident must become proficient in the surgical techniques and management of both simple and complex aspects of forefoot, rearfoot, ankle and trauma surgery.

Goal: The resident will progressively learn to manage an in-patient hospital service, and to perform simple and complex closure techniques, forefoot surgery, simple and reconstructive rearfoot surgery, ankle surgery and trauma over the course of three years.

Plan:  The first-year resident will primarily focus on in-patient hospital management, management of infections both medically and surgically, and become proficient in closure techniques. They will begin to focus on proficiency of simple forefoot surgical procedures and assisting in more complex cases. They will become knowledgeable in internal fixation techniques. The second-year resident will become competent in more complex forefoot surgery, simple rearfoot surgery, and some foot and ankle trauma.  The third-year resident will demonstrate proficiency in complex forefoot and rearfoot reconstructive surgery, ankle surgery, and rearfoot/ankle trauma.

Podiatric Surgery Competencies:

**First and Second year:**

-Perform layered closure of a surgical incision.

-Perform local anesthetic blocks for podiatric surgery.

-Perform post-operative dressings and casts.

-Recognize the indication for surgical incision and drainage and competently perform the procedure.

-Understand the appropriate indications for and surgical techniques of digital surgery.

-Perform digital and metatarsal amputations.

-Perform closed reduction of lower extremity fracture/dislocations.

-Manage in-patient podiatric patients including podiatric consultation and the performance of comprehensive history and physical examinations

-Function and communicate within a multidisciplinary setting.

-Perform a range of reconstructive lesser metatarsal surgical procedures including metatarsal osteotomies and soft tissue rebalancing procedures.

-Perform transmetatarsal amputations.

-Perform basic forefoot surgical procedures including hallux abductovalgus correction.

-Perform internal fixation

-Manage in-patient podiatric patients including podiatric consultation and the performance of comprehensive history and physical examinations

-Develop proficiency in complex hallux abductovalgus procedures and forefoot reconstructions.

-Perform simple rearfoot and ankle procedures.

-Develop proficiency in forefoot trauma repair.

-Develop proficiency in AO fixation techniques.

-Develop proficiency in limb salvage techniques.

-Manage in-patient podiatric patients including podiatric consultation and the performance of comprehensive history and physical examinations

**Final year:**

-Develop proficiency in foot and ankle trauma including Lisfranc injuries, calcaneal fractures, talar fractures, ankle fractures and pilon fractures.

-Develop proficiency in tendon transfers and repairs.

-Develop proficiency in flatfoot and cavus foot reconstruction.

-Develop proficiency in arthrodesis procedures of the rearfoot and ankle .

-Develop proficiency in diagnostic and interventional ankle arthroscopy.

-Develop proficiency in Charcot reconstruction.

-Develop proficiency in external fixation application.

-Prevent, diagnosis, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.

-Assess and manage the patient’s general medical and surgical status

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

-Communicate effectively and function in a multi-disciplinary setting

-Manage individuals and populations in a variety of socioeconomic and health-care setting

-Understand podiatric practice management in a multitude of health-care delivery settings

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

-Function as a teacher and leader to patients, residents and podiatric medical students.

-Critically examine and/or produce meaningful medical literature.

**VASCULAR SURGERY**

Rationale: Many podiatric patients have a vascular disease component, and podiatrists often must work closely together with vascular surgeons. Our department also participates in the multi-disciplinary Limb Preservation Program.

Goal:  Develop familiarity with the diagnosis and management of vascular disease and the medical and surgical management of patients with vascular disease.

Plan:  The resident will complete two, one-month rotations on the Vascular Surgery service at LLUMC-Murrieta in order to achieve the listed competencies.

Vascular Surgery Competencies:

-Complete and interpret the findings of a comprehensive vascular physical examination.

-Recognize the need for and order further appropriate diagnostic studies when indicated.

-Diagnose arterial and venous vascular diseases.

-Interpret vascular diagnostic studies including ABI/PVR, arterial duplex, CT angiography, and diagnostic and interventional angiography.

-Develop a surgical treatment plan for patients with vascular disease.

-Manage patients following major vascular surgery in the intensive care unit.

-Understand the interrelationship between vascular disease and complex medical conditions including podiatric pathology.

-Participate in the surgical management of vascular pathologies including endovascular and open procedures.

-Communicate effectively with vascular surgery staff during the care of podiatric patients.

**WOUND CARE/LIMB SALVAGE**

Rationale:  It is important for podiatric residents to have exposure to lower extremity wound care and reconstructive limb salvage techniques.

Goal:  To improve the understanding of the lower extremity wounds in podiatric practice.

Plan:  The resident will spend a one-month rotation at the LLUMC-Murrieta outpatient wound care center with hyperbaric oxygen therapy.

Competencies:

-Understand the diagnosis, evaluation and treatment of lower extremity wounds.

-Treat patients with lower extremity wounds, formulate differential diagnoses, and develop treatment plans through problem focused history and physical examinations.

-Formulate and perform pre-operative work-ups on lower extremity wound patients including appropriate referral, imaging and laboratory analysis.

-Perform post-operative care in patients following lower extremity wound surgery.

-Participate in surgical cases involving lower extremity wounds.

-Participate in a multispecialty limb preservation conference.

-Understand a variety of products available for the treatment of lower extremity wounds.

-Communicate effectively with a multi-disciplinary limb preservation team.

**INTENSIVE CARE UNIT**

Rationale: It is important for podiatry physicians and surgeons to care for critically ill patients.

Goal: To improve understanding of the care of critically ill patients

Plan: The resident will spend a one-month rotation at the LLUMC-Murrieta outpatient wound care center with hyperbaric oxygen therapy

Competencies:

-Assessment and management of the airway, including optimal use of mechanical ventilation

-Pathophysiology and management of respiratory failure

-Assessment and management of hypotension and shock

-Indications for and use of invasive hemodynamic monitoring

-Indications for and use of sedatives, analgesics, and neuromuscular-blocking agents

-Indications for and use of vasopressors and inotropic agents

-Assessment and management of delirium and acute neurologic syndromes

-Assessment and management of gastrointestinal bleeding and liver failure

-Assessment and management of life-threatening infections, including appropriate antimicrobial

selection.

-Toxicologic syndromes and their management, including management of drug overdose

-Rational use of laboratory and other diagnostic tests

-Appropriate use of blood products in the critically ill

-Prevention and treatment of nosocomial infections

-Assessment and management of electrolyte disorders

-Assessment and management of endocrine emergencies

-Assessment and management of acute renal failure including use of renal replacement therapy

-Prevention of stress ulceration and thromboembolism in the critically ill patient

-Nutritional therapy in the ICU, including the use of total parenteral nutrition

-Issues in end-of-life care including the withholding and withdrawing of life-sustaining therapies,

advance directives, code status and family conferences.

**VASCULAR MEDICINE/INTERVENTIONAL CARDIOLOGY**

Rationale: Many podiatric patients have a cardiovascular disease component, and podiatrists often must work closely together with cardiologists in the management of their patients. Our department also participates in the multi-disciplinary Limb Preservation Program.

Goal:  Develop familiarity with the diagnosis and management of cardiovascular disease and the medical and interventional/surgical management of patients with cardiovascular disease.

Plan:  The resident will complete a one-month rotations on the Interventional Cardiology service at LLUMC-Murrieta in order to achieve the listed competencies.

Competencies:

-Become familiar with the care and management of patients with cardiac complications such as CAD, valvular disease, cardiomyopathy, pericarditis, congestive heart failure, etc

-Demonstrate an appropriate cardiac physical exam including auscultation & palpation

-Demonstrate an appropriate lower extremity arterial exam including use of doppler ultrasound

-Demonstrates understanding and interpretation of vascular assessment tools including arterial and venous ultrasounds, trans cutaneous oxygen measurements, and angiography

-Participate in cardiac procedures particularly within the Cath lab

-Participate in the care of patients with peripheral artery disease including use of endovascular interventions and Cath lab cases

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 01 |
| Effective | 01/01/2023 |
| Subject: Resident Remediation, Adverse Action, & Due Process | Pages | 14 |
| Reference | GME-20  GME-29  FM -01 |

**Adverse Action and Due Process Policy**

1. **BACKGROUND**

Loma Linda University Medical Center – Murrieta (LLUMC – M) Podiatric Medicine & Surgery Program endeavors to provide residents with an environment conducive with assisting the resident to work and develop professionally. LLUMC-M understands that concerns or conflicts may arise during the term of the Resident’s Graduate Medical Education Training Agreement (Agreement) with the organization. As such, this Policy and Procedure is established to assist in clarifying and/or resolving misunderstanding during the term of the Agreement.

1. **PURPOSE**

The purpose of this policy is to outline the procedures that govern adverse action decisions and due process procedures relating to residents during their appointment periods. Actions addressed within this policy shall be based on the program’s established evaluation and review system.

1. **SCOPE**

All LLUMC-M Department of Podiatric Medicine & Surgery faculty, staff, residents, and administrators and faculty of LLUMC-M departments and participating affiliates through which Podiatry residents rotate shall understand and shall comply with this policy. Residents shall be given a copy of this policy, including the Adverse Academic Decisions and Due Process policy at the beginning of their training and shall receive updates to the policy, if made, at the beginning of each postgraduate year.

1. **POLICY**

When situations requiring adverse action occur, the program follows the GME Grievance Policy (GME -20) and related LLUMC-M Human Resource policies as documented in the GME Policies link found on the LLUMC-M website or through the GME department.

**DEPARTMENT:** GENERAL MEDICAL EDUCATION **CODE:** GME - 20

**EFFECTIVE:** 03/15/2021

**CATEGORY:** GENERAL MANAGEMENT **REPLACES: 08/13/2018**

**PAGE:** 1 of 8

**SUBJECT:** RESIDENT GRIEVANCE

RELATED POLICIES:

[GME-29: Remediation](https://llu.policytech.com/docview/?docid=27459)

[GME: Annual Institutional Review (AIR)](https://llu.policytech.com/docview/?docid=30894)

[GME: Special Review Guidelines](https://llu.policytech.com/docview/?docid=27436)

[GME-03: Basic Operation](https://llu.policytech.com/docview/?docid=27442)

1. **PHILOSOPHY**
2. GENERAL PHILOSOPHY

Loma Linda University Medical Center - Murrieta (LLUMC-M) endeavors to provide Residents/Fellows (Resident) with an environment conducive with assisting the Resident to work and develop professionally.

LLUMC-M understands that concerns or conflicts may arise during the term of the Resident’s Graduate Medical Education Training Agreement (Agreement) with the organization. As such, this Policy and Procedure is established to assist in clarifying and/or resolving misunderstandings during the term of the Agreement.

LLUMC-M also endeavors to require Residentsto maintain a standard of conduct which will not be in conflict with the ethics, principles, and philosophy of the Seventh-day Adventist Church.

While LLUMC-M does not anticipate the need to discipline or terminate any Resident from the Training Program, nevertheless, in the event corrective action and/or discipline is deemed to be appropriate, this Policy and a Procedure is established.

Specifically, informal and formal due process rights are afforded Residents who request review by a neutral party of corrective action or discipline affecting the Resident relative to his/her Agreement.

1. ACADEMIC AND ACADEMICALLY RELATED ISSUES LEADING TO CORRECTIVE ACTION

Graduate Medical Education has as its goal to produce physicians capable of the competent and independent practice of a specialty. This includes the consistent demonstration of appropriate attitudes and behaviors in the areas of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

Residents at LLUMC-M are also expected to adhere to the Values of the organization: Teamwork, Wholeness, Integrity, Compassion and Excellence. Therefore, for purposes of this Policy and Procedure, issues related directly and/or indirectly to academic performance shall be viewed as “academically related.”

1. **PURPOSE**
2. GENERAL PURPOSE. THE PURPOSE OF THIS POLICY AND PROCEDURE IS:

To provide an opportunity for Residents to address and attempt to resolve issues, concerns, or dissatisfactions which may arise out of the services provided under or the interpretation of the Agreement.

To provide this opportunity in an expeditious manner that allows both resident and the program to pursue other educational opportunities.

To assure careful consideration, reasoned action, and fair treatment with due consideration and regard for the facts and circumstances which led to any corrective action/discipline recommended or taken.

To provide an opportunity for Residents to address and resolve issues related to corrective action/discipline imposed due to academically related matters.

1. USE OF POLICY AND PROCEDURE.

It is anticipated that most disagreements would be worked out between the Resident, Program Director and other involved individuals, if any, before this Policy and Procedure is utilized.

The procedures in this Policy must be utilized to completion prior to resorting to any legal action through the courts**.**

1. **DEFINITIONS**

The following terms or phrases used in this policy shall be defined as stated below:

AGREEMENT: The written contract between LLUMC-M and the Resident known as the Graduate Medical Education Training Agreement.

ARBITRARY: The will of one person

DIO DESIGNATED INSTITUTIONAL OFFICIAL (DIO): Individual appointed to Chair the Graduate Medical Education Committee.

CAPRICIOUS: Not based on sound judgement or no known standard

CORRECTIVE ACTION/DISCIPLINE: One or more of the following actions as delineated in Policy [GME-29: Remediation](https://llu.policytech.com/docview/?docid=27459):

1. Extension of Training
2. Probation
3. Suspension
4. Non-Renewal of Training Agreement
5. Termination (other than for lack of the right to practice medicine in California)

DEPARTMENT CHAIR: The Chair of the department under which the residency program is organized or his/her designee(s).

DAY: Refers to a business day and is defined as Monday through Thursday 8:30 a.m. to 5:00 p.m. and Friday 8:30 a.m. to 12:00 noon, excluding legal holidays, unless otherwise stated.

DUE PROCESS: An opportunity provided to the Resident in order to obtain a review of corrective action/discipline through an informal review and/or formal review.

FORMAL REVIEW: Formal process by a Review Committee (RC) appointed by the GMEC to whichResident and Service may present their relative positions regarding a grievance.

GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC): Committee to decide academic and academically related policy and procedural matters related to graduate medical education issues directly affecting Residents and/or the Residency Training Program.

GRIEVANCE: Any controversy, claim or concern by a Resident in the areas cited in Section 2.1.

INFORMAL REVIEW (I.E. INFORMAL DISCUSSION): Reasonable opportunity to discuss with the Chief of the Service or his/her designee, and the Program Director, any differences of opinion or dissatisfaction or grievancethat may exist.

REVIEW COMMITTEE (RC): An ad hoc committee of three (3) or more non-attorney physician members in good standing of the LLUMC-MMedical Staff. At the sole discretion of the DIO, a LLUMC-M resident physician in good standing may be selected in lieu of a LLUMC-M medical staff member. All members of the RC are appointed by the GMEC to conduct the review requested by a Resident.

***LLUMC-M or any of its affiliates:***

LLUMC-M ADMINISTRATION: CEO/DIO/Chair of the Graduate Medical Education or his/her designee.

PERSONNEL FILE DISCOVERY*:*  Resident’s Graduate Medical Education Office personnel file may be reviewed by the Resident upon written request to the Graduate Medical Education Office. After filing a grievance, a Resident may request a copy of his/her Graduate Medical Education Office personnel file. The request must be in writing and dated. Any and all documents which are deemed to be confidential by the Graduate Medical Education Office will not be available for review or copying (e.g. letters of reference), unless and until any such document is to be utilized in reference to the Resident in an informal meeting or formal review.

REPRESENTATIVE: Any non-attorney physician member of the faculty of a LLUMC-M residency program in good standing or the LLUMC-M resident physician.

RESIDENT: Member of the LLUMC-M GME office pursuant to Agreement with LLUMC-M in an accredited or recognized residency/fellowship training program. Includes physicians commonly designated as interns, residents and fellows.

# CORRECTIVE ACTION/DISCIPLINE OF RESIDENTS

Review of Proposed Corrective Action/Discipline. Prior to any corrective action/discipline formally proceeding after initiation, such proposed action must be reviewed by the Director of Graduate Medical Education or his/her designee. Corrective Action or Discipline delineated in Policy [GME-29: Remediation](https://llu.policytech.com/docview/?docid=27459) are:

1. Extension of Training
2. Probation
3. Non-renewal of the Training Agreement
4. Termination

Initiator of Corrective Action/Discipline. Those persons who may initiate corrective action/discipline are:

1. Department Chair
2. Residency Program Director
3. Chief of Staff of affiliate institution
4. Affiliated institution’s Administrators
5. The affiliate institution’s Medical Staff President

Residents Rights Regarding Corrective Action/Discipline. If corrective action/discipline is utilized, the Resident has the right to:

1. Be informed in writing of the general nature of the charges made (e.g. a notice letter).
2. Discuss, explain and/or refute the charges.
3. Receive a copy of the GME Grievance Policy and Procedure.
4. Utilize the Procedure as stated herein and must follow this Procedure to completion prior to resorting to any legal action through the courts.

1. **GRIEVANCE PROCESS**
   1. NOTIFICATION

Any notification necessary in this Policy and Procedure, whether for informal review or formal review, shall be made by email using the LLUMC-M email address.

Notification sent by email will be assumed to have occurred the day the email is sent unless the email is returned as undeliverable.

Elements of the Notice Letter is delineated in Policy [GME-29: Remediation](https://llu.policytech.com/docview/?docid=27459)

* 1. GRIEVANCE PROCEDURE REQUEST

The Resident may request that the GME Grievance Policy and Procedure be initiated after receipt of the notification of corrective action/discipline.

Such a request must be submitted to the Graduate Medical Education Office in writing within five (5) days after receipt of notification of corrective action/discipline.

Failure to appeal within the time limit shall be deemed a waiver of the right to the informal review or the formal review and acquiescence to the decision rendered.

* 1. TIME LIMITS

Time limits noted in this Policy and Procedure may be waived or may be extended at the discretion of the reviewing committee, the DIO, or LLUMC-M Administration.

* 1. POSTPONEMENT

The informal review may be postponed only on the approval of the DIO, LLUMC-M Administration or Department Chair or his/her designated appointee.

The formal review may be postponed only on the approval of the Chairperson of the RC, the DIO, or LLUMC-M Administration as appropriate.

Any recess and/or reconvening of the informal review or the formal review is permissible for the convenience of the participants or the Committee and/or for obtaining additional information or evidence as determined solely by the Chairperson of the RC, or the DIO as appropriate.

* 1. REPRESENTATION

The Resident may be accompanied to the informal review meeting with the RC by a non-attorney physician faculty member of a LLUMC-M residency program in good standing, a LLUMC-M resident in good standing, or a current faculty member of his or her residency programof his/her choosing.

The Service and/or person bringing the charges to the Committee or initiating corrective action/discipline also may be accompanied by a non-attorney physician faculty member of the LLUMC-M in good standing, a LLUMC-M resident in good standing, or a current faculty member of his or her residency programof his/her choosing.

It is understood that the person serving as a representative is doing so as part of his/her duties as a member of the faculty or GME office.

In no way is participation in this process as a representative to be construed as hostile toward the LLUMC-M nor will any adverse action be taken against such person as a result of participating in this process.[[1]](#footnote-1)

1. **INFORMAL REVIEW**
   1. CONDUCT THEINFORMAL REVIEW

The resident may request an informal review of the issue or concern by the Department Chair within which the residency program functions.

In the event that the Department Chair is also the Program Director, the DIO may appoint an alternate member of the faculty to conduct the informal review.

* 1. ATTENDANCE BY RESIDENT AT THE INFORMAL REVIEW MEETING

If an informal review is scheduled and the Resident does not attend such meeting without requesting and being granted an extension or postponement, the Department Chair may reach a decision based on the information available at the time of the meeting.

The decision of the Department Chair at the informal review would then be deemed final and binding. In such instance, the Resident will be deemed to have waived the right to a formal review and to have acquiesced to the corrective action/discipline and recommendations and/or decisions.

* 1. TIME LIMIT FOR INFORMAL REVIEW

The Informal Review shall occur prior to the time set for the Review Committee to meet.

* 1. SCOPE OF THE INFORMAL REVIEW

The Informal Review can consider:

Whether the proposed action is in accordance with LLUMC-M and residency program policy.

Whether an alternative course of action would demonstrate the resident’s competence in a reasonable length of time.

* 1. OUTCOME

The Department Chair shall notify the DIO, the Resident and the Program Director of his/her findings in writing within three (3) days of the Informal Review.

If the Resident is not satisfied with the results of the informal review and has not waived formal review rights under Section 6.2, the resident may submit a request to proceed to a Formal Review.

The GME Office must receive the request for Formal Review within five (5) days of receipt of the outcome of the informal Review.

1. **FORMAL REVIEW PROCESS** 
   1. MEMBERSHIP OF THE REVIEW COMMITTEE

The Review Committee (RC) members shall be appointed by the DIO.

The Review Committee shall consist of an ad hoc committee of three (3) or more non-attorney physician members in good standing of a LLUMC-M residency program.

At the sole discretion of the DIO, a LLUMC-M resident physician in good standing may be appointed to the Review Committee in lieu of a LLUMC-M faculty member.

All members of the RC are appointed by the GMEC to conduct the review requested by a Resident.

* 1. PROCESS

At least two of the three members of the RC shall communicate with the resident within ten (10) days of the grievance being filed.

At least two of the three members of the RC shall communicate with the Program Director or his/her designee within ten (10) days of the grievance being filed.

Failure of either the resident or the Program Director (or his/her designee) to make themselves available to the RC within this period may be construed as waiving their right to provide input to the RC.

* 1. TIME LIMIT

The RC shall meet to discuss the issue no later than twenty (20) days after acknowledgement to the Resident by the DIO of receipt of the Resident’s request of a grievance.

* 1. SCOPE

The Review Committee shall review the issues presented to it by the resident and the program to consider whether the proposed decision is in accord with LLUMC-M graduate medical education policy and has been reached appropriately.

The RC shall arrive at its conclusion by a majority opinion.

* 1. REPORT

RC shall report whether or not proposed action was capricious or arbitrary. This report shall be made to the DIO within five (5) days of the meeting of the RC.

The RC may use the Grievance Committee reporting form if desired, to report the findings of the RC to the DIO.

1. **REPORTING PROCEDURE**

LLUMC-M Administration shall consider the written report of the RC and any other relevant written material that has been provided to the RC. LLUMC-M Administration shall send a notice of the Administration’s final decision to the Resident by US mail to the home address of the resident, via email or to the resident’s departmental mailbox within ten (10) days of receipt of the report of the RC.

LLUMC-M Administration shall have final authority to impose disciplinary action as it deems appropriate.

APPROVERS: LLUMC-M Sr. VP/Administrator

**DEPARTMENT:** GRADUATE MEDICAL EDUCATION **CODE:** GME - 29

**EFFECTIVE:** 05/24/2021

**CATEGORY:** GENERAL MANAGEMENT  **REPLACES:** 08/13/2018

**PAGE:** 1 of 5

**SUBJECT:** REMEDIATION

RELATED POLICY:

[GME-20: Resident Grievance](https://llu.policytech.com/docview/?docid=27450)

The purpose of this policy is to provide an orderly structure to advance the Graduate Medical Education (GME) of trainees (residents and fellows) in the context of Loma Linda University Medical Center – Murrieta (LLUMC-M) core values.

GME has as its goal to develop trainees’ competence in all six general competencies:

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

Failure to achieve competence in any of them will preclude a trainee from practicing effectively as a physician. Thus, a trainee must demonstrate appropriate progress toward each competency throughout their graduate medical education and achieve competence in each of them by the end of their training.

Trainees can expect to receive consistent and objective evaluations from supervisors (more senior trainees, faculty members and program directors). Such evaluations may include information from other individuals such as other health care workers, patients, etc. This includes timely feedback aimed at fostering optimal attitudes, behaviors, skills and knowledge.

1. Evaluations that are provided significantly after the rotation has been completed may possess less validity and less impact in achieving these desired goals.
2. Any areas in need of improvement should be brought to the attention of the trainee as soon as possible to allow time for discussion and improvement and not be cited only in the final written rotation evaluation unless it has been first discussed with the trainee.

Trainees are appointed to graduate medical education positions for one year of educational experience in programs that may have a total educational experience that extends over three to six years. Implicit in the one-year appointment is the freedom of a resident to leave the program at the end of the year without penalty. Parallel with this resident right is the right of a program and the institution to choose to not reappoint a resident for additional educational training without attributing a reason to that decision.

FORMATIVE FEEDBACK

1. Formative feedback is appropriate for concerns that appear to be isolated and easily correctable.
2. This will usually be verbal and is not considered remedial, but rather formative and part of the expected educational process.
3. Documentation that a verbal discussion occurred may be required.
4. The effectiveness of this intervention and desired behavioral outcomes should be monitored and feedback as to the success of this process should be provided to the trainee.
5. FORMAL IMPROVEMENT PLAN
6. A formal improvement plan is appropriate for concerns that have not responded to formative feedback to concerns that appear to require intentional effort on the part of the trainee to achieve competence during the expected course of the residency program.
7. This plan is considered as resulting from demonstration of less than the expected level of performance, but is still considered a normal part of the educational process. It is not considered remediation.
8. Written documentation will be provided to the trainee and retained.

It will consist of:

* A formal plan for improvement that is clearly related to the concern
* The goal of the plan and what would demonstrate achievement of the goal
* A target time for demonstration that the goal has been achieved

1. Trainees with a formal improvement plan will receive face-to-face evaluations on a monthly to quarterly basis as appropriate from a faculty member that will include a review of all competencies. Immediate feedback shall be provided of any suboptimal performance.
2. EXTENSION OF TRAINING in one or more competencies
3. Extension of training is appropriate for concerns that have not responded to a written improvement plan to concerns that will likely require additional time in graduate medical education training in the residency program in order to demonstrate competence failure to meet educational goals and objectives.
4. This level is considered unsatisfactory and a negative evaluation. Record of extension of training will become part of the resident’s permanent record and be expected to be disclosed to entities seeking verification of residency.
5. Written documentation will be provided for the trainee.

It will consist of:

* The fact that this is remediation or required additional GME time to demonstrate competence.
* The specific reason for the extension of training
* A formal plan for improvement that is clearly related to the concern
* The goal of the plan and what would demonstrate achievement of that goal.
* A length of additional training, if any, anticipated for demonstration of the achievement of that goal
* The fact that this action can be appealed through the [GME-20: Resident Grievance](https://llu.policytech.com/docview/?docid=27450) policy.

1. Trainees during an extension of training will be monitored especially closely and will receive:

* Immediate, documented feedback of any suboptimal performance
* Regular feedback sessions (on a weekly basis to monthly basis as appropriate) with an appropriate faculty member to support progress in achieving the goal
* Formal, face-to-face evaluations no less than monthly with an appropriate faculty member to review progress in all competencies.

1. PROBATION:
2. Is appropriate for concerns that have not responded to extension of training or concerns of a nature such that failure to demonstrate sustained improvement would preclude continuation of the residency program.
3. This level is considered unsatisfactory and a negative evaluation. Probation will become part of the resident’s permanent record and be expected to be disclosed to entities seeking verification of residency. A resident is not considered to be in “good standing” while on probation.
4. Written documentation of probation will be provided to the trainee and retained. It will consist of:

* The fact that this is probation
* The specific reason for probation
* The goal of the plan and what would demonstrate achievement of that goal
* A time period during which the trainee must demonstrate sustained achievement in meeting the goal
* The fact that failure to demonstrate sustained achievement throughout the specified time period or recurrence after that time period will result in termination from the residency program.
* The fact that this action can be appealed through the grievance process.

1. Trainees on probation will be monitored especially closely and will receive:

* Immediate, documented feedback of any suboptimal performance
* Regular feedback sessions (on a weekly basis to monthly basis as appropriate)
* With an appropriate faculty member to support progress in achieving the goal
* Formal, face-to-face evaluations no less than monthly with an appropriate faculty member to review progress in all competencies.

1. SUSPENSION
2. Suspension is appropriate for:

* Investigation of a concern that poses immediate jeopardy to the safety of the trainee or others
* Represents a potential serious breach of professionalism.
* Where the trainee has failed to complete requirements (such as, by way of examples only, having an unacceptable number of medical record deficiencies or failing to maintain required certifications)

1. At the discretion of the Graduate Medical Education Office, Designated Institutional Official (DIO), the trainee may be placed on administrative leave with pay for up to two weeks while an internal investigation is conducted. Otherwise, the trainee will be placed on leave without pay.
2. Suspension is not of itself considered a negative evaluation and may not be appealed under the [GME-20: Resident Grievance](https://llu.policytech.com/docview/?docid=27450) policy. However, an action resulting from the investigation (e.g. extension of training, probation or termination), may be appealed.
3. Suspension will generally be for up to 28 days. It may be extended at the discretion of the GME Office, DIO.
4. NON-RENEWAL OF THE TRAINING AGREEMENT
5. Non-renewal of the Training Agreement is appropriate for failure to demonstrate appropriate progress toward demonstration of competence including the failure to achieve the goals of extension of training or probation.
6. Notification of the intent to non-renew the training agreement must be given four months prior to the end of the training agreement unless the issue leading to non- renewal becomes known at a time to make four months notification impossible.

It will consist of:

* The date of the notification of the non-renewal.
* The grounds on which the non-renewal is based
* The fact that this action can be appealed through the grievance process

1. The reason for non-renewal may be expected to be included in all future correspondence seeking verification of residency training.
2. If the trainee appeals within the framework of grievance process and the grievance process extends beyond the end of the training agreement, the trainee will be placed on administrative leave without pay until the grievance process is completed. However, if the trainee requests a delay in the grievance process, the trainee will be terminated effective the time such a delay is granted and be rehired if the grievance process results in such a recommendation.
3. TERMINATION
4. Termination is appropriate for

* Jeopardizing the safety of patients, co-workers or the public
* A serious breach of professionalism including any criminal charges
* Failure to achieve the goals of extension of training, probation or suspension in the required time.
* Failure to fully cooperate with any investigation
* The loss of the right to practice medicine in California. Loss of the right to practice medicine in California is not considered a negative evaluation per se and cannot be appealed.

1. Written notification of termination will be provided to the trainee and retained. It will consist of:

* The date of termination
* The grounds on which the termination is based
* The fact that this action can be appealed through the grievance process

1. The reason for termination will be expected to be included in all future correspondence seeking verification of residency training.
2. If the trainee appeals within the framework of grievance process, the trainee will be placed on administrative leave without pay until the grievance process is completed. However, if the trainee requests a delay in the grievance process, the trainee will be terminated effective the time such a delay is granted and be rehired if the grievance process results in such a recommendation.

APPROVERS: LLUMC-M Sr. VP/Administrator

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 02 |
| Effective | 01/01/2023 |
| Subject: Program Concern and Complaint Policy | Pages | 2 |
| Reference | GME-20 |

**Program Concern and Complaint Policy**

**I. BACKGROUND**

Although the Program works proactively to avoid causes for concern or complaints among residents, in the event that a resident does have a complaint or concern pertaining to personnel, patient care, the program, or the hospital training environment, the Program has developed a process that ensures that residents can raise these concerns/complaints and provide feedback without intimidation or retaliation. The policy includes a mechanism for communicating concerns and complaints confidentially, as appropriate.

**II. PURPOSE**

The purpose of this process is to outline the program’s process for addressing concerns and complaints.

**III. POLICY**

**3.1.** The process and resources available for reporting concerns and complaints are detailed below.

**3.2.** This process is reviewed annually with residents and faculty.

**3.3.** The steps of the policy are outlined below:

**3.3.1.** Discuss the concern or complaint with the chief resident, clinical service director, program manager, associate program director, and/or program director as appropriate.

**3.3.2.** If the concern or complaint involves the Program Director or Rotation Director and/or cannot be addressed in Step 1, residents have the option of discussing issues with the Designated Institutional Official, Dr. Paul Reiman at [PReiman@llu.edu](mailto:PReiman@llu.edu) or 951-290-4168. Residents may also contact the service chief of a specific hospital as appropriate.

**3.3.3.** If the resident is not able to resolve the concern or complaint within the Program or Department, the following resources are available:

* For issues involving program concerns, training matters, or the work environment, residents can contact the Graduate Medical Education Director, Dr. Paul Reiman at [PReiman@llu.edu](mailto:PReiman@llu.edu) or 951-290-4168
* For problems involving interpersonal issues, the Chief Resident is available to discuss confidential informal issues that arise outside of the Department of Podiatric Medicine & Surgery or the Program Director.
* Anonymous feedback/concerns/complaints can be provided at any time by completing the online GME Feedback form available at the following website: <https://one.lluh.org/vip/Clinical/Administrative-Desktop/Electronic-Event-Reporting>
  + Comments made on this site are anonymous and cannot be tracked back to an individual. However, a resident may elect to provide his/her name and contact information if he/she desires personal follow-up regarding how feedback/concerns/ complaints have been addressed by the Departments and/or the GME office.
  + For issues involving compliance, the LLUMC-M Compliance Hotline at (855) 279-7520 and on-line reporting portal On the Murrieta website under the Compliance tab. These are anonymous and confidential mechanisms for reporting unethical, noncompliant, and/or illegal activity and should be used to report any concern that could threaten or create a loss to the LLUMC-M community, including but not limited to the following:
* Harassment- sexual, racial, disability, religious, retaliation
* Environmental Health and Safety- biological, laboratory, radiation, laser, occupational chemical, and waste management and safety issues
* Other- misuse of resources, time, or property assets; accounting, audit and internal control matters; falsification of records; theft, bribes, and kickbacks.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 03 |
| Effective | 01/01/2023 |
| Subject: Eligibility, Selection, and Appointment Policy | Pages | 5 |
| Reference | GME -02 |

**Eligibility, Selection, and Appointment Policy**

**I. BACKGROUND**

Resident recruitment, selection, and appointment are an essential component of the LLUMC-M Podiatric Medicine & Surgery.

The Podiatric Medicine & Surgery Program adheres to all applicable LLUMC-Murrieta, CPME, and COTH regulations.

**II. PURPOSE**

The purpose of this policy is to establish a program policy regarding the selection and appointment of residents.

**III. POLICY**

**3.1.** Resident Eligibility (Adheres to CPME 320, section 3.5)

**“The sponsoring institution shall accept only graduates of colleges of podiatric medicine accredited by the Council on Podiatric Medical Education. Prior to beginning the residency, all applicants shall have passed all components of Parts I and II examinations of the National Board of Podiatric Medical Examiners.”**

1. Each resident in our programs must be a United States citizen, a lawful permanent resident, a refugee, an asylee, or must possess the appropriate documentation to allow the resident to legally train at LLUMC-Murrieta.
2. The Program Director (PD) is responsible for verification of the applicants’ credentials. Applicants who do not meet the criteria above cannot be considered for the Residency Program.
3. The PD and Associate Program Director (APD) review applicants and are responsible for selection of applicants for interview.
4. The Residency Program shall hold a meeting at the end of the interview season with the faculty members (resident selection committee) and residents who participated in the interview process to inform the final choice of applicants to be ranked in the residency match process.
5. Resident Selection

**3.5.1.** Applicants are selected on the basis of preparedness, ability, aptitude, academic credentials, communications skills, and personal qualities such as motivation and integrity.

**3.5.2.** Academic credentials include Podiatry school grades and performance as reflected in documentation received directly from the Podiatry school, and National Board of Podiatric Medical Examiners (NBPME) scores.

**3.5.3.** Prior graduate medical education training, where applicable, will also be considered.

**3.5.4.** Formal educational and/or testing results submitted by the applicant may also be considered. Letters of reference from supervisors, educators, and peers, when appropriate, serve to provide additional information on personal characteristics, and are required and evaluated as well.

**3.5.5.** Selected candidates are invited for an interview which is conducted in person via the protocols set forth via the CASPR/CRIP Centralized Residency Interview Process. The interview allows in-person confirmation of information provided in the written application as well as an opportunity to assess communication and other non-cognitive skills.

**3.5.6.** Confidential evaluations by each applicant interviewer will be collected and reviewed by the selection committee and become part of the application file.

**3.5.7.** The committee and the PD are responsible for the final ranking of candidates in the Match Program.

**3.5.8.** CASPR/CRIP/Match process:

**3.5.8.1.** The program will adhere to all policies/procedures set forth by the AACPM and COTH governing the CASPR/CRIP interview process.

**3.5.8.2.** <https://aacpm.org/podiatric-residency-program-caspr-crip/info-residency-programs/#CRIP>

**3.5.8.3.** <https://aacpm.org/wp-content/uploads/CRIP-Guidelines-Policies-Forms-Useful-Information-KC.pdf>

**3.5.8.4.** <https://natmatch.com/caspr/index.html>

**3.5.9.** All candidates who are interviewed shall be given a copy of the LLUMC-M appointment agreement, a copy of this policy, and the program’s aims. The program will document that the candidate has received a copy of the appointment agreement by obtaining his/her signature at the time of interview.

1. Appointment: The following procedure is required before any resident can officially be appointed as a resident:

**3.6.1** Primary verification of all credentials is required.

**3.6.1.1.** The Residency Program in conjunction with the Office of GME and the Human Resources office will conduct this verification.

**3.6.1.2.** It is the responsibility of the resident to provide sufficient information to allow these verifications to be conducted.

**3.6.2.** At a minimum, the LLUMC-M Podiatric Medicine & Surgery Program must be able to obtain primary source verification of the following elements:

**3.6.2.1.** Certification of graduation from any accredited podiatric medical school. This documentation must be submitted directly from the academic institution granting the degree directly to the residency program.

**3.6.2.2.** Letters of recommendation.

**3.6.2.3.** Documentation accounting for any lapses between the end of medical school and the present. Large gaps of time exceeding one month that are not verifiable will disqualify candidates for consideration for a GME program.

**3.6.2.4.** Proper documentation of employment and/or work performed since graduation from medical school. The standard for proper documentation will be imposed by the GME program.

**3.6.2.5.** Passing a criminal background check.

**3.6.2.6.** Passing of all required competencies in a summative evaluation from the program director for any resident or fellow completing training or transferring from preliminary training or another institution.

**3.6.3.** Applicants who do not meet the criteria stated above cannot be appointed to any graduate medical educational program at LLUMC-Murrieta.

**3.6.4.** Completion of primary source verifications renders an applicant eligible for acceptance but does not in and of itself result in automatic acceptance. Residents are eligible to proceed through the acceptance process.

**3.6.5.** The official start date is contingent upon the resident completing all required paperwork (demographic/tax form, etc.), clearance by employee health service (resident must submit a complete history and physical form), and appropriate visa, if applicable.

1. Monitoring: This process has been reviewed by members of the Graduate Medical Educational (GME) Committee and agreed upon as a uniform approach to evaluation and selection of residency applicants.
2. Ensuring compliance with the eligibility and selection criteria as described above is the responsibility of each program director. Oversight for GME is the responsibility of the designated institutional official (DIO) who monitors program compliance through regular annual program accreditation review and the GMEC who reviews policies and procedures on a regular basis.

**IV. TECHNICAL STANDARDS AND ESSENTIAL FUNCTIONS FOR APPOINTMENT AND PROMOTION**

**4.1.** BACKGROUND

**4.1.1.** Podiatric Medicine & Surgery is an intellectually, physically, and psychologically demanding profession. All phases of medical education require knowledge, attitudes, skills, and behaviors necessary for the practice of medicine throughout a professional career.

**4.1.2.** Those abilities that residents must possess to practice safely are reflected in the technical standards that follow.

**4.1.3.** These technical standards and essential functions are to be understood as requirements for training in all LLUMC - Murrieta residencies and are not to be construed as competencies for practice in any given specialty. Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.

**4.1.4.** Residents in Graduate Medical Education programs must be able to meet these minimum standards, with or without reasonable accommodation.

**4.2.** STANDARDS

**4.2.1.** Observation

**4.2.1.1.** Observation requires the functional use of vision, hearing, and somatic sensations.

**4.2.1.2.** Residents must be able to observe demonstrations and participate in procedures as required.

**4.2.1.3.** Residents must be able to observe a patient accurately and completely, at a distance as well as closely.

**4.2.1.4.** They must be able to obtain a medical history directly from a patient, while observing the patient’s medical condition.

**4.2.2.** Communication

**4.2.2.1.** Communication includes: speech, language, reading, writing, and computer literacy.

**4.2.2.2.** Residents must be able to communicate effectively and sensitively in oral and written form with patients to elicit information, as well as to perceive non-verbal communications.

**4.2.3.** Motor Functioning

**4.2.3.1.** Residents must possess sufficient motor function to elicit information from the patient examination by palpation, auscultation, tapping, and other diagnostic maneuvers.

**4.2.3.2.** Residents must also be able to execute motor movements reasonably required for routine and emergency care and treatment of patients.

**4.2.4.** Intellectual—Conceptual, Integrative, and Quantitative Abilities

**4.2.4.1.** Residents must be able to measure, calculate, reason, analyze, integrate, and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions, which are critical skills demanded of physicians.

**4.2.4.2.** In addition, residents must be able to comprehend three-dimensional relationships and to understand spatial relationships of structures.

**4.2.5.** Behavioral and Social Attributes

**4.2.5.1.** Residents must possess the psychological ability required for the full utilization of their intellectual abilities, for the exercise of good judgment, for the prompt completion of all responsibilities inherent to diagnosis and care of patients, and for the development of mature, sensitive, and effective relationships with patients, colleagues, and other healthcare providers.

**4.2.5.2.** Residents must be able to tolerate physically and mentally taxing workloads and function effectively under stress.

**4.2.5.3.** Residents must be able to adapt to a changing environment, display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of patients.

**4.2.5.4.** Residents must also be able work effectively and collaboratively as team members. As a component of their education and training, residents must demonstrate ethical behavior consistent with professional values and standards.

**4.2.6.** Accommodations

**4.2.6.1.** LLUMC-M will make a reasonable accommodation available to any qualified individual with a disability who requests an accommodation.

**4.2.6.2.** A reasonable accommodation is designed to assist an employee or applicant in the performance of the essential functions of his or her job or LLUMC-M’s application requirements.

**4.2.6.3.** Accommodations are made on a case-by-case basis. LLUMC-M will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in a given situation. An accommodation need not be the most expensive or ideal accommodation, or the specific accommodation requested by the individual, so long as it is reasonable and effective.

**4.2.6.4.** LLUMC-M will not provide a reasonable accommodation if the accommodation would result in undue hardship to LLUMC-M or if the employee, even with reasonable accommodation, poses a direct threat to the health or safety of the employee or other persons.

**4.2.6.5.** Any decision to deny a reasonable accommodation on the basis of cost will be reviewed and approved by the Chief Financial Officer and Senior Vice President for Administration of LLUMC-M.

**4.2.6.6.** In most cases, it is an employee’s or applicant’s responsibility to begin the accommodation process by making LLUMC-M aware of his or her need for a reasonable accommodation. See the full LLUMC-M Accommodation of Disabilities Policy for information on how to request a reasonable accommodation.

**4.2.6.7.** NOTE: It is important to note that the LLUMC-M enrollment of non-eligible residents may be cause for withdrawal of residency program accreditation.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 04 |
| Effective | 01/01/2023 |
| Subject: Clinical Environment and Educational Work Hour Policy | Pages | 7 |
| Reference | GME12 |

**Clinical Environment and Educational Work Hour Policy**

**I. BACKGROUND**

The Podiatric Medicine & Surgery Residency Program strictly follows the Work Hour Rules as mandated by the ACGME and CPME and in keeping with the GME Resident Learning and Working Environment Policy as documented in the GME Policy Manual.

CPME 320 Section 6.10

**6.10 The residency program shall ensure the resident is afforded appropriate clinical and educational work hours.**

**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 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.

**In-house Call:** Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

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

**Outside Activities:** The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the resident’s ability to function in the training program.

**II. PURPOSE**

**2.1.** The purpose of this process is to outline the program’s monitoring and oversight of work hours and document how work hour logging issues and/or violations are addressed by the Program. This policy applies to rotations assigned at all participating sites, the primary Institution, and outpatient podiatry clinics.

**2.2.** Work hours are defined as time spent on all clinical and academic activities related to the residency program, such as patient care (both in-patient and out-patient), administrative duties related to patient care, the provision for transfer of patient care, in-house call activities, and scheduled academic conferences/didactics. Work hours do not include reading and academic preparation time spent away from the work site.

**2.3.** The ACGME considers clinical and educational work hour limits to be an important element of its comprehensive approach to promote high quality education, wellness, and safe patient care. Residents must adhere to all work hour requirements as detailed below:

**2.3.1.** Maximum Hours of Clinical and Educational Work per Week

**2.3.1.1.** Clinical and educational 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, clinical work done from home, and all moonlighting.

**2.3.2.** Mandatory Time Free of Clinical Work and Education

**2.3.2.1.** The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

**2.3.2.2.** Residents should have eight hours off between scheduled clinical work and education periods.

* There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

**2.3.2.3.** Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

**2.3.2.4.** Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

**2.3.3.** Maximum Clinical Work and Education Period Length

**2.3.3.1.** Clinical and educational work periods for residents must not

* Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.
* Additional patient care responsibilities must not be assigned to a resident during this time.

**2.3.4.** Clinical and Educational Work Hour Exceptions

**2.3.4.1.** In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

* to continue to provide care to a single severely ill or unstable patient;
* humanistic attention to the needs of a patient or family; or,
* to attend unique educational events

**2.3.4.2.** These additional hours of care or education will be counted toward the 80-hour weekly limit

**2.3.4.3.** A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound clinical/educational reasoning.

* In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and determine if any work hour violations have occurred since the last review.
* Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution’s GMEC and DIO.

**III. PROGRAM WORK HOUR MONITORING AND REPORTING PROCESS**

**3.1.** Reporting of resident work hours is required by the residency accrediting agency, the CPME/Residency Review Committee, and therefore, are not optional. Daily work hour logging in MedHub is expected and logging within 5 days is required.

**3.2.** The following guidelines apply to logging duties:

**3.2.1.** Logging should be continuous with no gaps (for example for lunch or travel between clinical sites).

**3.2.2.** Conferences should be logged contiguous with other duties with no gaps in between.

**3.2.3.** For in-house call, log work type “Call”. For back-up call assignments when the resident has to go into the hospital, log work type “Back Up- Called In”. NOTE: Back-up residents do not log if they do not go into the hospital.

**3.2.4.** If your 24-hour shift is extended work to post-call transitions of patient care or mandatory conferences, avoid a violation by logging the following two work types (1) post-call and (2) conferences for the hours that extend beyond the 24-hour period. NOTE: The post-call period must not exceed 4 hours

**3.2.5.** Log appropriate work types for vacation, holiday/day off, or sick days.

**3.2.6.** Each resident must enter written justification or cause in the event of a violation.

**3.2.6.1.** Justifications apply to violations of 24+ or short break rule.

**3.2.6.2.** Causes apply to any violation.

**3.2.6.3.** These must be entered in MedHub as comments in the provided for each flagged violation

**3.3.** Work hour logging is monitored by the Program Coordinator who provides a weekly logging status report to the Program Director.

**3.3.1.** In the absence of a report, a review of the MedHub Dashboard is performed weekly to assess compliance with work hour logging.

**3.3.2.** If a resident has not logged in one week or more, he/she will receive a notification from the Program Coordinator to encourage immediate logging. If work hours are not logged after notification from the Program Coordinator, the Program Director will contact the resident and a written explanation of why the work hours have not been logged must be submitted by the resident and placed in his/her file.

**3.3.3.** Repeated or prolonged work hour logging delinquency may result in disciplinary action, as appropriate, for deficiency in the Professionalism competency.

**3.4.** In the event that a work hour violation occurs, the resident’s log is immediately flagged at which time the resident must provide a justification or explanation for the violation in MedHub.

**3.4.1.** Work hour violations are monitored and recorded in MedHub and are automatically reported to the Program Director, Associate Program Director, and Program Coordinator electronically.

**3.4.2.** The Program Director must then review the violation and the resident’s explanation of the causal circumstances to determine whether or not the violation was justified.

**3.4.3.** In the case of an unjustifiable violation, the Program Director must provide education to the resident, faculty member, and service involved to avoid future violations.

**3.5.** This procedure will allow the Program Director and/or the Program Coordinator to both provide necessary education to individual residents and to determine if there are systemic scheduling patterns that must be adjusted.

**3.6.** In the short term, however, work hour restrictions should not serve as a reason to jeopardize patient safety.

**IV. ALERTNESS MANAGEMENT & FATIGUE MITIGATION**

**4.1.** Annually, residents and faculty are provided with education on identifying and mitigating fatigue. Fatigue in a resident can be identified either by the resident him- or herself, a fellow resident, or a faculty member. In either case, when recognized, the resident may be offered time for rest, especially if he/she has been on work for more than 16 hours continuously. In this case, appropriate patient handoff must occur before respite time begins. In the case of fatigue or anticipated fatigue due to unexpected work, a resident may discuss this with his/her chief resident(s) to develop a solution which may include a call switch or coverage of a portion of a call by another resident as long as this does not cause a work hour violation for the covering resident. Additionally, when creating the night float, call, and clinic schedules, the chief resident will also assign a backup resident who is available for shift coverage when necessary or to come in to assist with in-hospital work for a resident who is overwhelmed with an unexpected increase in patient volume or acuity.

**4.2.** A “Safe Ride Home” policy addresses the situation in which a resident is excessively fatigued upon completion of his/her work. The policy is detailed below.

**4.2.1.** *Purpose* - To outline a process whereby residents who feel too fatigued to safely drive home after a rotation day can feel encouraged to call a cab/Uber/Lyft for a safe ride home from rotation and back again to retrieve their vehicle or report for work the next day and be reimbursed for the expense.

**4.2.2.** *Process* - If a situation arises in which a resident is unable to safely drive home at the end of his/her shift due to extreme fatigue or the late hour, the resident is encouraged to take a nap prior to driving home, if possible based on the physical location and access to a secure location for sleeping. In the absence of sleeping as an option, the resident should contact a local taxi or rideshare company for a safe ride home. The resident may in the absence of the ability to return to the original location to pick up his or her vehicle after appropriate rest obtain a cab ride back to the original destination and submit that receipt for reimbursement. The resident should keep the receipt from the ride and bring it to the program office within 30 days of the ride for reimbursement of 100% of the fare (tip not included). The receipt must be accompanied by a description of the circumstances that caused the fatigue and required the use of the safe drive home. All current LLUMC-Murrieta reimbursement policies apply.

**4.2.3.** *Responsibility* - The program offers this service to encourage a resident who is too fatigued to safely drive home to obtain a cab ride home by offering to reimburse the resident for cost of transportation including Uber, Lyft, etc., per LLUMC-Murrieta guidelines. The resident holds the responsibility in knowing when he or she needs to utilize this service. The system is not to be abused and must be utilized when absolutely necessary.

**V. PROGRAM CALL POLICY/GUIDELINES**

**5.1.** Night Float/Call Responsibilities:

**5.1.1.** PGY1, PGY2 and PGY3 residents are assigned to the night float schedule by the Program Director.

**5.1.2.** Night float assignments are based on resident availability and current rotation assignments.

**5.1.3.** Although every effort is made to ensure equitable assignment of night float weeks, the situation occasionally arises when one resident may have more night float sessions than another. In all cases, work hour rules are followed.

**5.1.4.** During the course of night float, the assigned resident will cover the assigned Inpatient Service at LLUMC-Murrieta from 6:00pm to 7:00am. The resident will have no more than 4 nights of assigned night float on any rotation. The night float course is assigned on a rotating basis and will vary from week to week.

**5.1.5.** During the night float shift, the night float resident assumes responsibility for the care of the patients carried by the inpatient team from the time of evening sign-out until morning handoff back to the inpatient team. Responsibilities include but are not limited to ordering and reviewing lab tests and studies, reviewing notes from consultants, evaluating patients, as needed, responding to calls from nurses and the answering service, and admitting patients to the hospitalist services in accordance with established patient cap agreements.

**5.1.5.1.** Admission from the Emergency Department: The hospitalist will contact the resident when a patient in the Emergency Department needs to be evaluated for admission.

**5.1.5.2.** After performing the history and physical, the resident must call the attending on call to discuss the history, physical, assessment, and proposed management for approval in order to finalize the admission orders.

**5.1.5.3.** Direct admissions are discouraged in the interest of patient safety. However, if an attending proposes to admit a patient directly, he/she must first discuss the patient with the inpatient attending to determine whether initial evaluation and management in the emergency department is more appropriate.

**5.1.5.5.** The night float resident is responsible for writing progress notes on all patients on the teaching service on weekend mornings and for contacting the designated member of the inpatient team to assist with progress notes if there are more than 10 patients on service.

**5.1.6.** The night float resident will spend the remaining time of the rotation block with duties divided between his or her rotation and the podiatry continuity clinic.

**5.2.** Day Call

**5.2.1.** Residents on inpatient rotations who are not assigned to night float during a given rotation are eligible to be assigned day call from 7:00am to 7:00pm

**5.2.1.3.** The responsibilities of the day call are the same as the resident responsibilities described in the Night Float section above.

**5.2.2.** In addition to the aforementioned responsibilities, the night float and day call residents are responsible for receiving, addressing, and documenting all after-hours phone calls from the Podiatry call service.

**5.2.3.** The resident will contact the Podiatry attending on call if he or she needs any assistance or has any questions.

**5.2.4.** All phone calls must be documented in the office Electronic Health Record and the patient’s primary care provider should be copied on the documentation of the conversation.

**VI. UNUSUAL RESIDENT-INITIATED EXTENSIONS – ADDITIONAL DUTY**

**6.1.** Residents must not be assigned additional clinical responsibilities after 24 hour of continuous in-house work.

**6.2.** However, in unusual circumstances, a resident on his/her own initiative may remain at the clinical site beyond the 24-hour period to provide care to a single patient. In these cases, the additional hours must be counted toward the 80 work-hour limit and the following justification for extending work must meet one of the following conditions: provision of continuity of care for a severely ill, complex, or unstable patient

**6.2.1** provision of continuity for a maternity care continuity delivery patient with whom the resident has been involved

**6.2.2** provision of humanistic attention to the needs of a patient or family

**6.2.3** to attend unique educational events

**6.2.4** the extended work must not exceed 4 hours

**6.3.** In each circumstance, the following actions must be taken:

**6.3.1.** The resident must appropriately hand over the care of all other patients to the team responsible for their continuing care

**6.3.2.** The resident must document the reasons for remaining to care for the patient in MedHub

**6.3.3.** The Program Director must review each submission of additional service and track both individual resident and program-wide episodes of additional work.

**6.3.4.** This program policy is consistent with LLUMC-Murrieta GME policies.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 05 |
| Effective | 01/01/2023 |
| Subject: Leave Policy | Pages | 5 |
| Reference | GME – 22  CPME 320 3.6 |

**Leave Policy**

**I. BACKGROUND**

**1.1.** The CPME Program Requirements dictate that no more than 30 days may be taken away from the program during a single program year. Time away from the program for more than thirty days during a program year will result in an extension of training dates.

**1.2.** Leave time is any time away from the residency training program not related to educational purposes. Leave time does not carry over from one contract year to another.

**II. PURPOSE**

The purpose of this policy is to outline the leave time that residents are eligible for and highlight the processes and procedures that need to be undertaken with various leave types.

**III. POLICIES**

**3.1.** The LLUMC-Murrieta Podiatric Medicine and Surgery Residency Leave Policies are consistent with the LLUMC-Murrieta Human Resources and GME Leave Policies. Please reference the GME Policy Manual available in Policy Tech.

**3.2.** Holidays

**3.2.1.** LLUMC-Murrieta observes the following seven days as official holidays: New Year Day, President’ Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

**3.2.2.** All LLUMC-Murrieta Healthcare clinics and administrative offices are closed on these days.

**3.2.3.** Time off for a holiday is based on a resident’s rotation assignment. When rotating on a clinic or service that closes due to a holiday, the resident may take that time off as paid holiday. Conversely, if a clinic or service is open on a holiday, the resident will be required to report to the clinical site if assigned for work on that day.

**3.2.4.** As hospitals are considered essential services, a resident may be required to work on a holiday.

**3.2.5.** The resident must clarify with his/her assigned service whether or not he/she is required to work on a holiday.

**3.3.** Vacation

**3.3.1.** Each resident is eligible for 20 days of vacation in the PGY1 year. In the PGY2 and PGY3 year residents are eligible for 20 days of vacation.

**3.3.2.** Vacation may be taken in 5-day increments (Monday – Friday)

• The Saturday and Sunday before and after the 5-day vacation period are not guaranteed days off.

**3.3.4.** Vacation cannot be taken during the following restricted rotations:

• Inpatient Adult Medicine Service

• ICU

• Emergency Room

**3.3.5.** Vacation dates must be requested and assigned before the start of each academic year

**3.3.6.** Vacation change requests must be submitted 90 days prior to the requested change and are subject to approval by the PD

**3.3.7.** Leave requests must be submitted 100 days prior to the anticipated leave or immediately in the event of an emergency per guidelines set by Human Resources.

**3.3.8.** A fair and equitable approach will be used when approving time off requests.

**3.3.9.** Vacations must be taken in the academic year for which the vacation is granted; vacation periods do not carry over from one year to another.

**3.4.** Sick Time

**3.4.1.** Compensated Sick Leave is 10 days per year.

**3.4.2.** This time can be taken for resident illness or for the care of an “immediate” family member.

**3.4.3.** Sick leave is not accrued from year to year.

**3.4.4.** Extended Leave: In the event of the need to care for a serious health condition of oneself or an immediate family member, residents must first use his/her unused sick and vacation leave for paid time off. If additional time off is needed after all sick and vacation time has been exhausted, the additional time off will be unpaid leave. Residents must work with Human Resources (HR) and follow HR policy regarding unpaid time off and/or eligibility for short term disability

**3.5.** Administrative Leave

**3.5.1.** Administrative leave may be granted at the discretion of the program director.

**3.5.2.** Administrative leave may not exceed ten (10) days per twelve-month period.

**3.5.3.** Due to the CPME Program Requirements regarding time way from the program, Administrative leave granted after vacation and sick leave have been exhausted may result in extension of training dates.

**3.5.4.** Third-year residents can take up to five (5) days for exploring employment opportunities. This requires prior approval by the program director or designee.

**3.5.4.1.** Time needed in excess of five (5) days should be taken from vacation time.

**3.6.** Educational Leave

**3.6.1.** Time away from the residency program for educational purposes, such as workshops, Board exams/in-training exams, or CME activities, are not counted as absences, but should not exceed five days annually.

**3.6.2.** The Program Director must approve educational conferences three (3) months (90 days) before the month in which the conference is to take place.

**3.6.3.** The total time away within any academic year cannot exceed 30 days as per CPME requirements.

**3.7.** Family and Medical Leave

**3.7.1.** LLUMC-Murrieta provides job-protected family and medical leave to eligible residents for up to 12 work weeks of unpaid leave during a 12-month period based on the following qualifying events:

**3.7.1.1.** Incapacity due to pregnancy, prenatal medical care, or child birth;

**3.7.1.2.** Care for the employee’s child after birth, or placement for adoption or foster care;

**3.7.1.3.** Care for the employee’s spouse, son, daughter, or parent, who has a serious health condition; or

**3.7.1.4.** A serious health condition that makes the employee unable to perform the employee’s job.

**3.7.2.** Residents are eligible for FMLA leave if they have worked for LLUMC-Murrieta for at least one (1) year, have worked 1,250 hours over the previous 12 months, and have a qualifying event as outlined above.

**3.7.3.** Residents must direct all questions about FMLA leave to the Human Resources Department.

**3.8.** Leave Without Pay

**3.8.1.** Leave required beyond available compensated sick and/or vacation leave will be uncompensated leave without pay

**3.8.2.** Requests for leaves of absence without pay shall be submitted in writing to the Program Director and reviewed by the HR Department for disposition and approval no less than 90 days in advance of any planned leave. Such requests must include the reason and duration for the proposed leave.

**3.8.3.** Leave without pay, when approved, shall not exceed 2 months in duration.

**3.8.4.** The Program Director must discuss the implications of the leave, including possible prolongation of the program and should ensure that the resident understands these implications.

**3.8.5.** If the resident decides to move forward with the request, the LLUMC-Murrieta Human Resources Department shall advise both the resident and the residency program director on applicable policies and procedures.

**3.9.** Other Types of Leave

**3.9.1.** All other leave types (e.g., military, bereavement, jury duty, etc.) are explained in detail in LLUMC-Murrieta’s HR Policy Manual which is available on the Human Resources Department Intranet webpage.

**3.10.** The resident must complete a Leave Request form for any unplanned time off, including vacation changes, conference attendance, or administrative leave. Forms must be completed by the resident and submitted to the program director for schedule review and determination of feasibility. The form then must be submitted to the Program Coordinator for review and final approval by the Program Director. It is the resident’s responsibility to obtain the chief resident’s signature and forward the forms to the residency program coordinator and the director for approval.

**3.11.** If any changes in night call schedule are necessitated by the leave time, it is the resident’s responsibility to contact the program director and arrange for coverage.

**3.11.1.** The names of the physicians covering call and clinic responsibilities must appear on the Leave Request Form and must be signed by the resident(s) agreeing to cover the call or clinic responsibility. Notification must be given to the appropriate contact person(s) at the affected clinical site(s) or Podiatric Medicine & Surgery Program Coordinator.

**3.11.2.** Third-year residents are advised that there may be no leave during the last three weeks of residency except for extreme circumstances. Director approval is required.

**3.12.** Return to Duty

**3.12.1.** For leave due to child birth or serious health conditions of the resident or a family member, a physician's written “Release to Return to Duty” or equivalent is required with the date the resident is expected to return to resume his or her residency. This information is submitted to the Human Resources Department (HRD).

**3.12.2.** A Release to Return to Duty statement signed by the treating physician must also be submitted to the HR Department if a resident’s illness requires an absence of more than 3 days.

**3.13.3.** When applicable, the residency program director will record in writing the adjusted date required for completion of the PGY and/or the program because of extended resident leave. One copy is placed in the resident’s educational file and a copy is submitted to the Office of Graduate Medical Education (GME) to process the appropriate Personnel Action.

**3.13.** Program Leave Limitations

**3.13.1.** Leave away from the training program includes the total of all leave categories taken within an academic year. This includes uncompensated Federal Family and Medical Leave and other Leave without Pay (LWOP).

**3.13.2. The resident may be required to make up some portion of his or her share of call nights upon return to work.** Advanced notification of anticipated leave will enable the chief resident to incorporate the resident’s absence into the clinic and call schedule and attempt to arrange full coverage. The chief resident will make any reassignments of call, as needed.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 06 |
| Effective | 01/01/2023 |
| Subject: Evaluation Policy | Pages | 17 |
| Reference | GME-05,  GME-09,  GME-29 |

**Evaluation Policy**

**I. BACKGROUND**

The ACGME and CPME requires that faculty provide performance feedback to residents in a timely manner during rotations, outpatient clinics, and other educational assignments, and must submit a formal written evaluation at the completion of the assignment.

**II. PURPOSE**

The purpose of this policy is to outline the procedures and processes for evaluation of residents, faculty, and the program per ACGME and CPME evaluation requirements.

**III. POLICY**

**3.1.** Resident Performance Evaluation

**3.1.1.** The Program assures that all residents are systematically evaluated on their knowledge, skills, performance, and professional growth on an ongoing basis throughout their training.

**3.1.2.** Each form of evaluation is designed to assess the resident using the 6 core competencies of Patient Care, Medical Knowledge, Systems Based Practice, Practice-Based Learning, Professionalism, and Interpersonal and Communication Skills and assesses progression along the ACGME required Milestones.

**3.1.3.** While on clinical rotations all residents receive written and/or verbal formative evaluations and written and verbal summative evaluation. Residents also receive feedback on their performance globally through semi-annual evaluations which provide formative evaluation throughout the course of residency training and a summative evaluation at the end of training. All information is compiled in MedHub.

**3.1.4.** The Program has numerous evaluations in place to help assess the acquisition of the knowledge, skills, and abilities needed to independently practice clinical medicine. Evaluation tools include:

* Direct observation
  + During podiatry clinic and inpatient encounters
  + During OSCE
* Multi-Source 360 Evaluations
  + Peer to Peer
  + Clinic Staff of Resident
  + Medical Student of Resident
  + Self-Evaluation
  + Patient Satisfaction
* Faculty Evaluation of Residents on clinical rotations
* Faculty Evaluation of Resident Clinical Performance
* Milestone Evaluation/Assessment
* Semi-annual evaluation using tools listed above, ITE performance, advisor input, and resident log data
* Summative Evaluation (final evaluation of performance prior to completion of training)
* QI project participation and performance

**3.2.** Clinical Competency Committee (CCC)

**3.2.1.** The LLUMC-MURRIETA Podiatric Medicine & Surgery Residency Program’s Clinical Competency Committee (CCC) is charged with monitoring resident performance and making appropriate recommendations to the Program Director for a formative milestone-based evaluation of each resident based on a review of all forms of resident evaluations every six months.

**3.2.2.** At all times the policies and procedures of the CCC will comply with those of the Loma Linda University Medical Center - Murrieta (LLUMC-Murrieta) Office of Graduate Medical Education (GME) regarding promotion and dismissal and the requirements of the ACGME and CPME.

**3.2.3.** CCC Composition and Membership

**3.2.3.1.** The program director appoints all members and the chairperson of the CCC.

**3.2.3.2.** The members are key faculty members involved in direct resident teaching, one of whom must be the associate or assistant program director.

**3.2.3.3.** The members are appointed for one (1) year and membership may be renewed annually.

**3.2.4.** Committee Responsibilities: The Podiatric Medicine & Surgery Residency Clinical Competency Committee members will:

**3.2.4.1.** Attend all standing and ad hoc CCC meetings.

**3.2.4.2.** Sign the confidentiality policy prior to the first CCC meeting of each academic year and must abide by said policy at all times.

**3.2.4.3.** Review the following documentation of resident performance at each standing meeting: evaluations by all evaluators, In-Training Exam scores, OSCE performance, research progress, advisor documentation, program director documentation, procedure logs, teaching activity, and record of remediation where applicable.

**3.2.4.4.** Make recommendations to the program director and associate program director (APD) for resident progress including promotion, remediation, and dismissal, in accordance with GME policies as outlined in the LLUMC-MURRIETA GME Policy Manual.

**3.2.5.** The committee chairperson will:

**3.2.5.1.** Comply with all responsibilities described above.

**3.2.5.2.** Review and edit, as needed, minutes of meetings as prepared by the Program Coordinator and disseminate the minutes to all committee members, the program director and the department chairperson.

**3.2.5.3.** Prepare a written recommendation of progression, promotion or adverse action to the program director.

**3.2.5.4.** Report the required semi-annual milestone assignment recommendations of each resident’s performance for each Milestone to the Podiatric Medicine & Surgery program director who will review the recommended Milestone assignments, revise as needed, and submit to the CPME by CPME established deadlines.

**3.2.6.** The Podiatric Medicine & Surgery Residency program coordinator will maintain a file of all CCC reports and recommendations for each resident.

**3.2.7.** Meeting Frequency

**3.2.7.1.** The CCC will meet four (4) times per year, usually on the fourth Thursday of the month. Standing meeting dates shall be established at the beginning of each academic year.

**3.2.7.2.** Additionally, the committee chair may schedule ad hoc meetings at the request of the program director to address urgent matters that must be handled before the next regularly scheduled meeting.

* Reasons for ad hoc meetings may include but are not limited to consistently low performance or unsatisfactory evaluation scores of a resident; repeated lack of adherence to program requirements; or a specific incident that requires CCC review for possible probation or dismissal.

**3.2.7.3.** The residency program manager or designee will document each CCC meeting with meeting minutes. Minutes will be reviewed for accuracy at subsequent meetings.

**3.2.7.4.** In addition, the CCC’s review and recommendation of each resident will be documented in the online residency management system, MedHub.

**3.2.8.** Procedure for Review

**3.2.8.1.** The CCC shall evaluate the residents on a quarterly basis in order to produce a consensus recommendation on each resident.

**3.2.8.2.** In reviewing each resident, the CCC shall consider the following evaluation tools:

* Rotation evaluations
* 360 evaluations (including peer, self, clinical staff)
* In-Training Exam scores
* OSCE performance reports
* Research progress
* Advisor documentation
* Program director documentation
* Procedure logs
* Conference attendance
* Teaching activity
* Any reports of unprofessional behavior as submitted by the program director, faculty, hospital staff, or peers
* Record of remediation, where applicable

**3.2.8.3.** Additionally, if any resident is having academic problems, he or she will be reviewed in discussion at the meeting.

**3.2.8.4.** The CCC can set thresholds for remediation, probation, and dismissal.

**3.2.8.4.1.** The CCC may recommend to the PD and APD that a “Notice of Deficiency” be given to any resident who performs below milestone benchmarks

**3.2.8.4.2.** The PD or designated APD will meet with each resident and communicate the recommendation and design a remediation or improvement plan.

**3.2.9.** Recommendations—Based on the comprehensive review of each resident’s record of performance, in the case of inadequate performance, the CCC may recommend probation with remediation or delay or deny promotion or board recommendation as appropriate for the deficiencies identified. In accordance with LLUMC-Murrieta’s “Resident Promotion Policy” and “Adverse Academic Decisions and Due Process Policy”, the CCC may make the following recommendations to the PD and APD:

**3.2.9.1.** Progression—Resident is performing appropriately at current level of training with no need for remediation. Resident should continue with the current curriculum.

**3.2.9.2.** Promotion—Resident has demonstrated performance appropriate to move to the next level of training without the need for remediation. Resident should progress with next PGY level as scheduled.

**3.2.9.3.** Notice of Deficiency—Resident has demonstrated performance below the expected level in a specific competency across multiple evaluations, but does not require remediation.

**3.2.9.3.1.** The resident must submit a corrective action plan to eliminate the deficiency.

**3.2.9.3.2.** The CCC will prepare a statement for the grounds for Notice of Deficiency, including identified deficiencies or problem behavior.

**3.2.9.3.3.** Notice of Deficiency may be removed from the resident file if the resident is performing at satisfactory level and deemed to have corrected his or her deficiency within a time frame defined by the CCC, not to exceed six (6) months.

**3.2.9.4.** Notice of Deficiency with Remediation—Resident has demonstrated performance below the expected level in a specific competency and requires remediation.

**3.2.9.4.1.** Notice of Deficiency REQUIRES the resident (in conjunction with the PD and advisor) to develop a REMEDIATION plan to cure the deficiency.

**3.2.9.4.2.** The CCC will prepare a statement for the grounds for Notice of Deficiency and Remediation, including identified deficiencies or problem behaviors.

**3.2.9.4.3.** The CCC or PD must review the resident’s performance every three (3) months to determine if the resident is meeting the terms of the remediation plan.

**3.2.9.4.4.** Remediation (total time) shall not exceed six (6) months in an academic year.

**3.2.9.4.5.** This recommendation remains on the resident’s permanent record.

**3.2.9.4.6.** Failure to successfully remediate and cure the deficiency could result in extended remediation, additional training time, non-renewal, or dismissal from the program.

**3.2.9.5.** Immediate Suspension—Resident has performed serious misconduct or has posed a threat to colleagues, faculty, staff, or patients.

**3.2.9.5.1.** This may result from gross unprofessional or unethical behavior, misconduct, or the serious threat to the safety of patients such that continuation of clinical activities by the resident is deemed potentially detrimental or compromising to patient safety or the quality of patient care, or threatening to the well-being of staff or the resident.

**3.2.9.5.2.** The PD will prepare a statement for the grounds for suspension, including the identified deficiencies or problem behaviors.

**3.2.9.5.3.** Suspension shall not exceed 30 days. The CCC must conduct a review in 30 days if additional time is recommended.

**3.2.9.5.4.** This recommendation remains on the resident’s permanent record.

**3.2.9.6.** Probation—Resident has demonstrated challenges in specific competencies that are disruptive to the program.

**3.2.9.6.1.** This may result when, after documented counseling, a resident continues not to perform at an adequate level of competence; demonstrates unprofessional or unethical behavior; engages in misconduct that could bring harm to patients, negatively impact the function of the healthcare team, or cause residency program dysfunction; or otherwise fails to fulfill the responsibilities of the program.

**3.2.9.6.2.** The CCC or PD will prepare a statement for the grounds for probation, including identified deficiencies or problem behaviors.

**3.2.9.6.3.** Probation (total time) shall not exceed six (6) months in a calendar year.

**3.2.9.6.4.** This recommendation remains in the permanent record.

**3.2.9.7.** Non-Promotion—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. Resident’s current level of training will be extended. Action remains in permanent record.

**3.2.9.7.1.** Based on repeated demonstration of deficiency(ies), the resident will not be promoted to the next level of training.

**3.2.9.7.2.** The CCC will prepare a statement for the grounds for non-promotion, including identified deficiencies or problem behaviors.

**3.2.9.7.3.** The resident’s current level of training will be extended as recommended by the CCC.

**3.2.9.7.4.** The resident’s contract shall be renewed for the next academic year.

**3.2.9.7.5.** This recommendation remains in the permanent record.

**3.2.9.8.** Non-Renewal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies.

**3.2.9.8.1.** Based on repeated demonstration of deficiency(ies) the resident will not be promoted to the next level of training.

**3.2.9.8.2.** The CCC will prepare a statement for the grounds for non-renewal, including identified deficiencies or problem behaviors.

**3.2.9.8.3.** The resident’s contract shall expire at the end of the academic year, without renewal.

**3.2.9.8.4.** This decision may be appealed by the resident in accordance to GME policies of Due Process (“Adverse Academic Decisions and Due Process Policy”).

**3.2.9.8.5.** This recommendation remains on the resident’s permanent record.

**3.2.9.9.** Dismissal—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies; the resident will be dismissed from the program. Action remains in permanent record.

**3.2.9.9.1.** Based on repeated demonstration of deficiency(ies) the resident will be immediately dismissed from the program.

**3.2.9.9.2.** The CCC will prepare a statement for the grounds for dismissal, including identified deficiencies or problem behaviors.

**3.2.9.9.3.** The decision may be appealed by the resident in accordance to GME policies of due process (“Adverse Academic Decisions and Due Process Policy”).

**3.2.9.9.4.** This recommendation remains on the resident’s permanent record.

**3.2.9.10.** The CCC consensus recommendation for each resident will be submitted to the residency program director using the Clinical Competency Committee Report Form as completed by the CCC chair.

**3.2.9.11.** All residents who receive an adverse recommendation shall also receive written notice of the CCC recommendation of adverse action form.

**3.2.9.12.** The program director shall review all recommendations, and the PD and APD will meet with each resident to communicate his or her recommendation.

**3.2.9.13.** A copy of all adverse decisions shall also be sent to the affected resident’s advisor for review.

**3.2.9.14.** The advisor will then work in concert with the program director and resident to develop the remediation plan.

**3.2.10.** Faculty Development

**3.2.10.1.** In order to ensure the greatest usefulness of the data reviewed by the CCC, the CCC will conduct, with the assistance of the Loma Linda University Medical Center-Murrieta Office of Graduate Medical Education; two faculty development sessions will be held annually.

**3.2.10.1.1.** One will cover completing resident evaluations

**3.2.10.1.2.** One will cover the Podiatric Medicine & Surgery residency milestones.

**3.2.10.2.** Prior to each evaluation session, a faculty committee meets to discuss the resident’s performance and to arrive at the summary with specific recommendations.

**3.2.10.3.** The results of the faculty appraisal are shared with each resident individually by the resident faculty advisor.

**3.2.10.4.** The resident is asked to sign the summary form to acknowledge discussion of the evaluation.

**3.2.10.5.** Information used in assessment of resident performance is derived from multiple sources, which may include:

**3.2.10.5.1.** If any time, at or between the formal six-month evaluations a problem is identified with any portion of the resident’s performance and educational growth, this information will be shared promptly with the resident.

**3.2.10.5.2.** The information will be documented. If there is a deficiency that the faculty or the program director decides requires further action, a future meeting will be arranged with the appropriate faculty members and the resident to devise a plan of corrective action. Such plans will contain measurable goals and a specific timeframe for re-evaluation.

**3.2.10.5.3.** If the resident fails to show progress in correcting the deficiencies or fails to adhere to the plan of corrective actions, further recommendations, including possible probation or dismissal from the program, may ensue.

**3.2.10.5.4.** Any time formal discipline is invoked, the resident has the right to due process, as outlined in the Loma Linda University Medical Center-Murrieta Graduate Medical Education Policies and Procedures.

**3.3.** Semi Annual Evaluations

**3.3.1.** Semi-annual evaluations are conducted by the PD and/or APD with each resident and are required by the ACGME and CPME.

**3.3.2.** These are formal sessions in which feedback is provided to the resident regarding his/her overall performance from July to December and from January to June.

**3.3.2.1.** During the Semi-annual evaluation, the resident must also be prepared to discuss his/her self-evaluation and individualized education plan.

**3.3.2.2.** The Semi-annual evaluation session also provides an opportunity for resident to provide feedback to the program.

**3.3.3.** At the final summative semi-annual evaluation prior to graduation (May or June of graduation year), the resident’s complete performance will be reviewed and the residency director will verify whether the resident has demonstrated sufficient competence to enter practice without direct supervision. This evaluation becomes part of the resident’s permanent record maintained by the institution and is accessible for review by the resident in accordance with institutional policy.

**3.4.** Resident Advancement & Promotion

**3.4.1.** The LLUMC-Murrieta Podiatric Medicine & Surgery Residency Promotion Policy is consistent with the LLUMC-Murrieta Graduate Medical Education Promotion Policy which can be accessed in the GME Policies & Procedures on the Office of Graduate Medical Education Electronic Folder.

**3.4.2.** Promotion Criteria from PGY-1 to PGY-2

**3.4.2.1.** Following at least twelve (12) months of training, the CCC will make a recommendation for promotion to PGY-2 status based on the following criteria:

**3.4.2.2.** Patient Care

**3.4.2.2.1.** Role-model competent whole person care to other residents and medical students.

**3.4.2.2.2.** Demonstrate the ability to independently perform a complete history and physical exam, write appropriate orders, and appropriately document the hospital course for inpatients.

**3.4.2.2.3.** Have demonstrated competency in basic procedures of podiatric medicine & surgery as confirmed by clinical preceptors.

**3.4.2.3.** Medical Knowledge

**3.4.2.3.1.** Satisfactorily pass all required rotations.

**3.4.2.3.2.** Have achieved at least 10th percentile on the APBM and/or ABFAS In-Training Exam or demonstrated equivalent level performance on a program-administered reassessment.

**3.4.2.3.3.** Have met a minimum activity volume that is consistent with a timeline of full completion prior to graduation.

**3.4.2.3.4.** Have taken the NBPME Part III examination by the last day of the 12th month of training.

**3.4.2.4.** Practice-Based Learning and Improvement

**3.4.2.4.1.** Demonstrate the ability to give and receive feedback and make improvements in his/her patient care.

**3.4.2.4.2.** Demonstrate an ability to assimilate and apply medical information to patient care.

**3.4.2.4.3.** Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

**3.4.2.5.** Interpersonal and Communication Skills

**3.4.2.5.1.** Demonstrate the ability to communicate respectfully and effectively with patients, faculty, staff, and colleagues in a manner that will be conducive to assuming a supervisory role by October of the second year.

**3.4.2.5.2.** Demonstrate adequate documentation skills to include checkouts, on- and off-service notes, and outpatient charting.

**3.4.2.6.** Professionalism

**3.4.2.6.1.** Have demonstrated adequate participation in academic and professional activities such as conferences, rounds, and meetings, and pursuit of certification exam completion.

**3.4.2.6.2.** Model professional behavior to students in clinic and rotations.

**3.4.2.6.3.** Have attended all required educational conferences unless excused

**3.4.2.6.4.** Demonstrate adherence to policies regarding procedural documentation.

**3.4.2.7.** Systems-Based Practice

**3.4.2.7.1.** Demonstrate ability to coordinate care with case managers and other resources.

**3.4.2.7.2.** Demonstrate cooperation within the medical system to ensure excellent patient care as seen by timely completion of medical records, charting, and follow-up.

**3.4.3.** Promotion Criteria from PGY-2 to PGY-3

**3.4.3.1.** Following at least 20 months of training, the Clinical Competency Committee will make a recommendation for promotion to PGY-3 status based on the following criteria:

**3.4.3.2.** Patient Care

**3.4.3.2.1.** Be a role-model of competent and compassionate whole person care to junior residents and medical students.

**3.4.3.2.2.** Have documented participation in the continuity care of the podiatric surgical patient, including appropriate preop evaluation/workup, surgical management, and postoperative follow up care.

**3.4.3.2.3.** Demonstrate the ability to supervise a complete history and physical exam and oversee appropriate orders for hospital care.

**3.4.3.2.4.** Assume an active role in diagnosis and treatment plans which is based on sound medical knowledge.

**3.4.3.2.5.** Have documented adequate procedural competency to supervise the in-patient team adequately, including competency on knowledge and skill domains on EKG interpretation, ICU management, code management, etc.

**3.4.3.3.** Medical Knowledge

**3.4.3.3.1.** Complete and pass all required PGY2 rotations. Evaluations from each rotation must be received. A verbal report from the preceptor of his or her intent to give a passing grade may be taken for the final rotation of the year, if the committee meets prior to the completion of that rotation.

**3.4.3.3.2.** Have achieved at least 25th percentile on the composite score of the ABPM and/or ABFAS In-Training Exam OR be participating in a program for academic enhancement.

**3.4.3.4.** Practice-Based Learning and Improvement

**3.4.3.4.1.** Demonstrate the ability to give and receive feedback and make improvements in their patient care and practice.

**3.4.3.4.2.** Demonstrate an ability to independently locate, assimilate, and apply medical information to patient care.

**3.4.3.4.3.** Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

**3.4.3.5.** Interpersonal and Communication Skills

**3.4.3.5.1.** Have the ability to role-model respectful and effective communication with patients, faculty, staff, and colleagues.

**3.4.3.5.2.** Facilitate continuity of care through communication and documentation skills such as patient handoffs, on- and off-service notes, and telephone/message documentation.

**3.4.3.5.3.** Demonstrate teaching and management skills to effectively coordinate the teaching service and to teach junior residents and student learners

**3.4.4.** Program Graduation Criteria

**3.4.4.1.** The following graduation criteria apply to the PGY-3 level. The resident must:

**3.4.4.1.1.** Complete and pass all required rotations.

**3.4.4.1.2.** Not have any professionalism or ethical issues that preclude him or her from being an independent practicing physician in the opinion of the CCC.

**3.4.4.1.3.** Be continually eligible to practice medicine on an unrestricted license at the date of graduation.

**3.4.4.1.4.** Be compliant with all LLUMC-Murrieta Podiatric Medicine & Surgery Residency Program policies including, but not limited to, being up to date with his or her work hour logging.

**3.4.4.1.5.** Have completed and presented an approved research project.

**3.4.4.1.6.** Have completed and logged all required procedures.

**3.4.4.1.7.** Have met the Minimum Activity Volume (MAV) per CPME guidelines for all PMSR/RRA categories.

**3.4.4.1.8.** Have completed all clinic patient notes and be cleared by the medical records department.

**3.4.4.1.9.** Complete the GME, HR, and LLUMC-Murrieta Podiatric Medicine & Surgery exit procedures.

**3.4.4.1.10.** Have achieved milestone levels for all competencies and sub-competencies demonstrating the ability to practice independently.

**3.4.4.2.** The program director must determine that the resident has had sufficient training to practice independently; evidenced by meeting the goals above and a final summative assessment.

**3.4.4.3.** Upon fulfilment of these criteria, the program director must certify that the resident has fulfilled criteria, including the program-specific criteria, to graduate. The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities in an academic and/or clinical environment. The resident must satisfactorily meet all CPME standards as outlined in the program requirements.

**3.4.4.4.** To signify completion of the listed criteria, the program director will certify that the resident has completed all CPME and program-specific requirements for graduation and that he/she has been determined by the Program faculty, faculty advisor, and CCC to be competent for independent practice.

**3.5.** Faculty Evaluations and Program Self-Assessment (CPME 320, section 7)

**3.5.1.** CPME Requirement

**3.5.1.1.** As per the CPME requirements, at least annually, the program must evaluate faculty performance and program self-assessment as it relates to the educational program.

**3.5.1.2.** These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the education program, clinical knowledge, professionalism, and scholarly activities.

**3.5.1.3.** This evaluation must include at least annual written confidential evaluations by the residents.

**3.5.1.4.** In compliance with this requirement, the LLUMC-Murrieta Podiatric Medicine & Surgery Residency Program follows the following process for faculty evaluation.

**3.5.2.** Program-Specific Process

**3.5.2.1.** Departmental residency faculty members are evaluated by residents on a quarterly basis using the Resident Evaluation of Faculty tool in MedHub.

**3.5.2.2.** Individual means for each domain are calculated for each faculty member and are compared to the overall faculty means.

**3.5.2.3.** Inpatient attendings are also evaluated by residents each time they rotate on an inpatient service using the Attending Evaluation Form.

**3.5.2.4.** Written feedback is provided to each faculty member annually in the form of the Annual Evaluation of Faculty Member by Residency Program form.

**3.5.2.5.** The evaluation is designed to assess faculty members’ clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activity.

**3.5.2.6.** Annually, during the months of April-June, the Program Director discusses the form with each Program faculty member and a faculty development plan is devised as needed based on the content of the evaluation.

**3.5.2.7.** These evaluations and development plans are remitted to the Department Chair for integration as part of the faculty members’ evaluations by the Chair.

**3.5.2.8.** Quarterly batching of evaluations and semi-annual reporting to faculty of aggregated evaluations is done to assure residents of the anonymity of their evaluations.

**3.5.2.9.** Residents are encouraged to immediately communicate pressing concerns regarding attending performance to the Program Director or, if anonymity is desired, by placing the typed documentation of the concern in the concern box located in the residency office.

**3.5.2.10.** Such reports are handled with the individual faculty member or the faculty as a whole as is appropriate to provide necessary faculty development by the Program Director.

**3.5.2.11.** Serious concerns may require intervention by the Department Chair.

**3.5.2.12.** This exception is intended to allow for timely correction of faculty member deficiencies.

**3.6.** Program Director Evaluations

**3.6.1.** The program director reports directly to the Designated Institutional Officer and indirectly to the Associate Dean for Graduate Medical Education.

**3.6.2.** The Program Director is evaluated by the residents through the annual Institutional GME Survey and by the Designated Institutional Officer. Both are confidential evaluations.

**3.7.** Program Evaluations

**3.7.1.** The LLUMC-Murrieta Office of Graduate Medical Education maintains oversight of the program evaluation process, as detailed in the section 4.2.3 of the LLUMC-Murrieta GME Policy Manual.

**3.7.2.** All LLUMC-Murrieta programs are evaluated confidentially and anonymously by the residents and the faculty on an annual basis under the oversight and direction of the GME Office.

**3.7.3.** The results of this annual evaluation are used by the Podiatric Medicine & Surgery Residency Program to develop an annual program improvement plan which is monitored and, when appropriate, adjusted by the Program Evaluation Committee, which meets quarterly.

**3.7.4.** The Program Evaluation Committee (PEC), along with the Program Director, is responsible for generating the Annual Program Evaluation and Improvement Report which documents the program’s extensive review of resident performance, faculty development, graduate performance, program quality, and program compliance with CPME Requirements based on its ongoing monitoring process.

**3.7.5.** The PEC then uses this document over the course of the year as a guide for its ongoing evaluation of program effectiveness, compliance, quality, and efficiency.

**3.8.** LLUMC-Murrieta Podiatric Medicine & Surgery Residency Program Evaluation Committee

**3.8.1.** The CPME requires that the program performs self-evaluation. The program director shall appoint a Program Evaluation Committee (PEC) to assist in reviewing the program on an annual basis.

**3.8.2.** The purpose of the Program Evaluation Committee (PEC) for the Loma Linda University Medical Center-Murrieta (LLUMC-Murrieta) Podiatric Medicine & Surgery Residency Program is to oversee and participate actively in all aspects of the program quality and improvement process.

**3.8.3.** At all times, the procedures and policies of the PEC will comply with those of the Graduate Medical Education Committee as outlined in the Graduate Medical Education Policy and Procedure Manual and with those stipulated by CPME in the Program Requirements.

**3.8.4.** Membership

**3.8.4.1.** The program director shall appoint all members of the PEC, including the committee chairperson.

**3.8.4.2.** The committee shall consist of no fewer than two (2) core program faculty members and at least one (1) resident.

**3.8.5.** Responsibility of Members

**3.8.5.1.** Committee members are expected to participate actively in the following duties in accordance with the CPME program requirements:

**3.8.5.1.1.** Planning, developing, implementing, and evaluating educational activities of the program;

**3.8.5.1.2.** Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;

**3.8.5.1.3.** Addressing areas of non-compliance with CPME standards; and

**3.8.5.1.4.** Reviewing the Program annually using evaluations of faculty, residents, and others, as specified below:

• Resident performance

• Faculty development

• Graduate performance, including performance of program graduates on the certification examination

• Program quality

• Progress on the previous year’s action plan(s).

• The Program, through the PEC must:

**3.8.5.1.4.1.** Document formal, systematic evaluation of the curriculum at least annually, and render a written and Annual Program Evaluation (APE) based on its review and analysis of tracking in each of the following areas

**3.8.5.2.** Prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored; and attain approval of the action plan by the teaching faculty.

**3.8.5.3.** Review and address deficiencies in the following program metrics.

**3.8.5.3.1.** At least 95 percent of the program’s eligible graduates from the preceding five (5) years must have taken either the ABFAS and/or ABPM certifying examination(s).

**3.8.5.3.2.** At least 90 percent of the program’s graduates from the preceding five (5) years who take the ABPM and/or ABFAS certifying examination for the first time must pass.

**3.8.5.3.3.** Every five-year survey of program graduates.

**3.8.5.3.4.** Assessment of resident attrition and the presence of a critical mass of residents with a goal of no more than 15%.

**3.8.6.** Meetings

**3.8.6.1.** Scheduled Meetings

**3.8.6.1.1.** The PEC will meet a minimum of two times per year.

**3.8.6.1.2.** The PEC, in entirety or in subcommittees, will meet at least annually to document the systematic and formal evaluation of the curriculum and produce a written APE.

**3.8.6.2.** Ad Hoc Meetings

**3.8.6.2.1.** The program director or committee chairperson may request an ad hoc meeting of the PEC or subcommittee to address urgent resident performance issues and those who are engaged in the grievance process for an adverse academic decision.

**3.8.6.2.2.** At all times, the committee will adhere to the GME policies and procedures of the “Adverse Academic Decisions and Due Process Policy.”

**3.8.7.** PEC Procedures

**3.8.7.1.** The PEC shall evaluate the Program on an ongoing basis and make recommendations to the Program.

**3.8.7.2.** All PEC meetings shall be documented with agendas and meeting minutes as appropriate.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 07 |
| Effective | 01/01/2023 |
| Subject: Physician Impairment and Well-Being Policy | Pages | 3 |
| Reference | GME - 10 |

**Physician Impairment and Well-Being Policy**

1. **Background**

As published by the ACGME, in the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring and resilient physician. Self-care is an important component of professionalism. Programs, in partnership with their sponsoring institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

1. **Purpose**

**2.1.** This policy defines the ways in which Residents are supported in their efforts to become competent, caring, and resilient physicians while completing CPME and/or Accreditation Council for Graduate Medical Education (ACGME)-accredited training programs

1. **Definitions**

**3.1. Burnout:**

3.1.1. Long-term exhaustion and diminished interest in work.

3.1.2. Dimensions of burnout include emotional exhaustion, depersonalization, and feelings of lack of competence or success in one’s work.

3.1.3. Burnout can lead to depression, anxiety and substance abuse disorders.

**3.2.** **Resident:**

3.2.1. Any physician in an ACMGE-accredited graduate medical education program including residents and fellows.

**3.3. Resilience:**

**3.3.1.** The ability to withstand and recover quickly from difficult conditions or situations

**3.3.2.** Residents may face difficult patient care, educational or personal events which have the ability to negatively affect their Well-being.

**3.3.3.** Decompressing after such situations, through conversation with peers, mentors or family, and self-care activities, can increase Resilience

**IV. Policy Statement:**

**4.1.** Residents’ physical, psychological and emotional Well-being is of paramount importance to LLUMC-Murrieta and our ACGME-accredited training programs. Residents are encouraged to lead healthy lives and make healthy choices that support them in their personal and professional growth. To that end, we provide the following strategies to support trainee health, Well-being and Resilience

**4.1.1.** Institutional Support

**4.1.1.1.** ***Living Whole* Employee Wellness Program** provides LLUMC-Murrieta employees and their families with resources and services that motivate, encourage, and promote healthy lifestyles and foster Resilience. Services include:

* Health Improvement and Employee Wellness: including Health Risk and Wellness Assessment, mindfulness training, health and lifestyle coaching, diet and nutrition resources.
* Employee Spiritual Care and Wholeness promotes a Christ-centered environment by nurturing spirituality and encouraging wholeness in Loma Linda University Medical Center employees and supports them as they care for others. Residents my access this resources through the Loma Linda University Health One Portal <https://one.lluh.org/vip/Departments/LLUMC-Departments/Employee-Spiritual-Care-and-Wholeness>
* Employee Assistance Program (EAP): Confidential and free counseling services which include up to six in-person visits/year and 24/7 telephonic counseling. Additional information about the program is available in the Human Resources Department at 951-704-1962 or via the LLUMC-Murrieta Portal at <https://one.lluh.org/vip/Departments/LLUSS-Departments/employee-student-assistance-program>
* Live Well/Work Well Primary Care: Coordinated, small team primary care option for LLUMC-Murrieta insured employees and their dependents.
* Occurrence Reporting: Patient and employee safety reporting for actual events and near misses

**4.1.1.2.** Residents have access to healthy food and beverage options at the physician lounges where refrigerators are stocked with food and drinks.

**4.1.1.3.** All Residents participate in a half-day Safety Behaviors for Error Prevention Didactic during training.

**4.1.2.** Graduate Medical Education Support

**4.1.2.1.** The Office of GME is a safe place where Residents can ask for and receive help with various needs including academic counseling, coaching, and mentoring.

**4.1.2.2.** The Office of GME sponsors Resident and Fellow activities where Residents have the opportunity to participate in wellness activities.

**4.1.2.3.** The LLUMC-MURRIETA seminar series provides Residents with an opportunity to learn and ask questions about topics of interest to their professional lives and future

**4.1.2.4.** The Office of GME delivers coffee, fruit and snacks to the Resident call rooms/lounges. Residents are provided meals while in-house during the entirety of their residency.

**4.1.2.5.** Residents may take advantage of transportation to and from the hospital in the event that they are too fatigued to drive home after a clinical shift. Residents will be reimbursed for any transportation services such as Uber, Lyft, taxi, etc.

**4.1.2.6.** All Residents and core faculty complete an annual learning module on sleep alertness and fatigue mitigation

**4.1.3.** Program Support:

**4.1.3.1.** There are circumstances in which Residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. The Family Medicine program has policies and procedures in place to ensure coverage of patient care in the event that a Resident may be unable to perform their patient care responsibilities. These polices will be implemented without fear of negative consequences for the Resident whom is unable to provide the clinical work.

**4.1.3.2.** Residents have the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their work hours. Residents must follow the program’s procedures for scheduling and notification of these appointments.

**4.1.3.3.** Residents are encouraged to alert the Program Director, a faculty mentor or Chief Resident when they have a concern for themselves, a Resident colleague or a faculty member displaying signs of Burnout, depression, substance abuse, suicidal ideation or potential for violence.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 08 |
| Effective | 01/01/2023 |
| Subject: Supervision Policy | Pages | 5 |
| Reference | GME - 10 |

**Supervision**

1. **Background**

Loma Linda University Medical Center – Murrieta (LLUMC – M) is committed to providing a learning and working environment that emphasizes excellence in safety, quality care, and professionalism rendered to patients by residents through faculty modeling and supervision. This policy is designed to define key members in the training program, supervision and accountability, and a practice model in which to achieve the above.

1. **Purpose**

**2.1.** The purpose of this supervision policy is to ensure oversight of resident supervision and progressive levels of authority and responsibility.

**2.2.** The program uses the following classifications of levels of supervision, consistent with ACGME guidelines.

**2.2.1.** Direct Supervision—

**2.2.1.1** the supervising physician is physically present

with the resident during the key portions of the

patient interaction; or,

PGY-1 residents must initially be supervised directly, only as described in PR VI.A.2.c).(1).(a).

**2.2.1.2** the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology

**2.2.2.** Indirect Supervision—the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

**2.2.3.** Oversight—The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

1. **Definitions**

**3.1. Resident:**

3.1.1. A physician who is engaged in a graduate training program in Podiatric Medicine & Surgery, and who participates in patient care under the direction of attending physicians.

3.1.2. As part of their training program, residents are given graded and progressive responsibility according to the individual resident’s clinical experience, judgment, knowledge, and technical skill.

3.1.3. Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.

3.1.4. Residents are responsible for asking for help from a supervising physician or other appropriate licensed practitioner when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care.

3.1.5 Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

**3.2.** **Attending Physician (Attending):**

3.2.1. An identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for the management of the individual patient and for the supervision of residents involved in the care of the patient.

3.2.2. The attending delegates portions of care to residents based on the needs of the patient and the skills of the residents.

3.2.3. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in provision of care.

**3.3. Supervision:**

**3.3.1.** To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized **(PR VI.A.2c)**:

**3.3.1.1.** Direct Supervision – the supervising physician is physically present with the resident during the key portions of the patient interaction. PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a).**PRVI.A.2.c).(1).(a)**

the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology**. [PRVI.A.2.c).(1).(b)]**

**3.3.1.2.** Indirect Supervision- The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. **PRVI.A.2.c).(2)**

**3.3.1.3.** Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

**3.3.2**. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. **[PR VI.A.2.d)]**

**3.3.2.1** The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones.

**3.3.2.2** Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.

**3.3.2.3** Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

**IV. Clinical Responsibilities:**

**4.1.** Residents: The clinical responsibilities for each resident are based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. The specific role of each resident varies with their clinical rotation, experience, duration of clinical training, the patient's illness and the clinical demands placed on the team. The following is a guide to the specific patient care responsibilities by year of clinical training.

**4.1.1.** PGY- 1 (Junior Residents / Interns):

**4.1.1.1.** PGY-1 residents are primarily responsible for the care of patients under the guidance and supervision of the attending physician and senior residents.

**4.1.1.2.** PGY-1 should generally be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising residents and/or the attending physician should be contacted in a timely fashion.

**4.1.1.3.** PGY-1 residents are initially directly supervised and when merited will progress to being indirectly supervised with direct supervision immediately available (see definitions above) by an attending or senior resident when appropriate.

**4.1.2.** PGY- 2 (Intermediate Residents):

**4.1.2.1.** Intermediate residents may be directly or indirectly supervised by an attending physician or senior resident but will provide all services under supervision.

**4.1.2.2.** They may supervise PGY-1 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient.

**4.1.3.** PGY- 3 (Intermediate Residents):

**.1.3.1.** Senior residents may be directly or indirectly supervised.

**4.1.3.2.** They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited.

**4.1.3.3.** They must provide all services ultimately under the supervision of an attending physician.

**4.1.3.4.** Senior residents should serve in a supervisory role of medical students, junior and intermediate residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior resident; however, the attending physician is ultimately responsible for the care of the patient.

**4.2.** Attendings: In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient’s care. [**PRVI.A.2.a).(1)]**

**4.2.1.** The attending physician is responsible for assuring the quality of care provided and for addressing any problems that occur in the care of patients and thus must be available to provide direct supervision when appropriate for optimal care of the patient and/or as indicated by program policy

**4.2.1.1.** The availability of the attending to the resident is expected to be greater with less experienced residents and with increased acuity of the patient’s illness. **[(PR VI.A.2.a).(1)]**

**4.2.1.2.** The attending shall be notified and must be available for residents at all times during the rotation. The residents will notify the attendings for: **[PRVI.A.2.e)]**

All new admits

Transfer of patients to higher acuity setting (floor to ICU, etc.)

End-of Life decisions

Transfer of patients to another facility or service

Change in patient’s clinical status

Family/patient meetings

Adverse Events

Any situation in which the resident feels support and guidance is needed.

**4.2.1.3.** Residents and faculty members (attending) must inform each patient of their respective roles in that patient’s care when providing direct patient care **PRVI.A.2.a).(1).(b)**

**4.2.2.** The attending may specifically delegate portions of care to residents based on the needs of the patient and the skills of the residents and in accordance with hospital and/or departmental policies.

**4.1.2.1.** The attending may also delegate partial responsibility for supervision of junior residents to senior residents assigned to the service, but the attending must assure the competence of the senior resident before supervisory responsibility is delegated.

**4.1.2.2.** Over time, the senior resident is expected to assume an increasingly larger role in patient care decision making.

**4.1.2.3.** The attending remains responsible for assuring that appropriate supervision is occurring and is ultimately responsible for the patient’s care.

**4.2.3.** PGY- 3 (Intermediate Residents):

**4.1.3.1.** Senior residents may be directly or indirectly supervised.

**4.1.3.2.** They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited.

**4.1.3.3.** They must provide all services ultimately under the supervision of an attending physician.

**4.1.3.4.** Senior residents should serve in a supervisory role of medical students, junior and intermediate residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior resident; however, the attending physician is ultimately responsible for the care of the patient.

**V. Resident Performance Evaluation**

**4.1.** Resident evaluations are quintessential to appropriate progression and advancement in training. All supervising attendings shall provide the resident feedback of their performance either verbal or in writing midway the rotation and a formal summative evaluation at completion of the rotation. This information will be used by the CCC and the Program Director to assess overall resident performance and will be included in the resident’s semi-annual evaluation.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 09 |
| Effective | 01/01/2023 |
| Subject: Transitions in Care Policy | Pages | 3 |
| Reference | GME – Transitions in Care |

**Transitions in Care Policy**

**I. BACKGROUND**

**1.1.** The primary objective of a “hand-off” is to provide accurate information about a patient’s care from one physician to another physician who is assuming responsibility for the care of the patient to ensure safe continuity of care. Information transmitted in the handoff includes treatments, services, current condition, any recent or anticipated changes, and a to-do list for tasks that should be completed during the time that the resident will be caring for the patient.

**1.2.** The information communicated during a hand-off must be accurate in order to ensure patient safety goals.

**1.3.** This policy conforms to the Joint Commission’s National Patient Safety Goal 2E.

**II. SCOPE**

**2.1.** This policy applies to Podiatric Medicine & Surgery resident physician hand-offs whenever there is a change in medical personnel charged with the medical care of the patient. Information transmitted during physician hand-off is stated in the “Background” section. Opportunities to ask and respond to questions must be provided during hand-off.

**III. HAND-OFF COMMUNICATION PROCEDURE**

**3.1.** Assignment of the newly admitted patient to the inpatient service.

**3.1.1.** When a patient is admitted to the inpatient service, the Emergency Department (ED) attending contacts the service Attending to provide handoff.

**3.1.2.** If the attending accepts the patient to the service based on sign-out from the ED physician, he/she will contact the resident on duty to evaluate and admit the patient.

**3.1.3.** In the event that the appropriateness for admission is not clear based on the report from the ED attending, the attending will contact the resident on duty to evaluate the patient and discuss the patient with the attending who will determine whether admission or clinic follow-up and outpatient management is most appropriate.

**3.1.4.** Upon accepting the patient, the attending will formally assume responsibility for the care of the patient and transfer of care from the ED to the appropriate hospital unit occurs.

**3.1.5.** On Monday to Friday, between 7:00 a.m. and 6:00 p.m. the admitting resident will be the resident designated to admit the next patient as agreed by the team. On Monday to Friday between 6:00 p.m. and 7:00 a.m., this will be the night float resident.

**3.2.** Transfer of patients between the daytime team and night float resident.

**3.2.1.** Hand-off communication occurs at 6:00 p.m. and at 7:00 a.m. between the daytime and night float teams (daytime team signs off to the night resident at 6:00 p.m. and vice-versa at 7:00 a.m.).

**3.2.2.** Both verbal and written communication is conducted. All patients are documented in the electronic sign-out list and distributed to the covering team. This will also be an opportunity to ask and respond to questions.

**3.3.** Transfer of patients to new rotating residents.

**3.3.1.** On the last day of the rotation, the inpatient team writes “off service notes” on all patients. The note includes each patient’s initial presentation, hospital course, pertinent lab and study results, and current status including any pending results or consults.

**3.3.2.** A verbal sign-out is also given at 6:00 p.m. on the night before the new team begins.

**3.3.3.** The outgoing senior resident signs out all patients to the oncoming senior resident and highlights the patients that he or she is following.

**3.3.4.** The junior resident also signs out his or her patients to the oncoming junior resident.

**3.3.5.** Any changes that occur overnight will be communicated by the night float resident to the oncoming day team as previously described.

**IV. EVALUATION METHODS**

**4.1.** The Attending must observe at least two change of shift handoffs in person and must be present for all other change of shift hand-offs by phone at the discretion of the supervising physician.

**4.2.** Each resident is evaluated based on hand-off expectations in the following areas: environment, standard handoff time, use of the SBAR transition of care presentation format, appropriately identifying patient details requiring special attention by the receiving resident, and confirmation that receiving resident understands the SBAR content on all patients by presenting back.

**4.3.** The Attending is expected both to give immediate informal feedback on the witnessed handoffs and to complete the formal Hand-off evaluation form and submit it to the Program Coordinator. The Program Coordinator will transfer data from the Hand-off evaluation into MedHub.

**4.4.** If any resident is not considered to be competent to give or receive handoff after the required minimum of observed handoffs by the attending, the senior resident and attending must provide additional education to the resident. The attending must continue to observe handoffs until each inpatient team resident demonstrates the ability to give hand off competently. The ability to give competent handoff is a requirement of passing the rotation.

**4.5.** Residents should anonymously report breakdowns/problems in the handoff process for continued improvement by reporting the feedback and dropping it off in the comment/suggestion box located in the resident area located in the GME office. Feedback will be collected on a regular basis and reviewed at the following PEC meeting.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 10 |
| Effective | 01/01/2023 |
| Subject: NBPME Examination Policy | Pages | 1 |
| Reference | GME - 16 |

**NBPME Examination Policy**

**I. PURPOSE**

**1.1.** The purpose of this policy is to ensure that the quality of Graduate Medical Education (GME) programs at Loma Linda University Medical Center-Murrieta (LLUMC-Murrieta) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and the Podiatric Medicine & Surgery Residency Program goals and objectives.

**1.2.** A resident who will be prepared to undertake independent medical practice shall have completed requirements to obtain a physician’s license.

**II. SCOPE**

All Loma Linda University Medical Center-Murrieta (LLUMC-Murrieta) administrators, faculty, staff, residents, and accredited affiliates shall understand and support this policy and all other policies and procedures that govern both GME programs and resident appointments at LLUMC-Murrieta.

**III. POLICY**

**3.1.** Podiatric Medicine & Surgery residents must sit for the NBPME Part 3 by their 12th month of residency.

**3.1.1** Residents are encouraged to sit for the earliest available exam in the fall of the PGY-1 year to allow for re-test by the 12th month, if necessary.

**3.2.** Podiatric Medicine & Surgery residents must present the official results of their NBPME Part 3 examination to the residency program before the last working day of the resident’s 20th month, which is February in a normal appointment cycle.

**3.2.1.** Podiatric Medicine & Surgery residents who have not passed Step 3 by the end of the 20th month will receive a letter of non-renewal of contract on March 1st in a normal appointment cycle.

**3.2.2.** Podiatric Medicine & Surgery residents who pass Step 3 between the 21st and 24th month, will receive a reappointment letter to the residency program at the time of receipt of the results, if this is the sole reason for non-renewal.

**3.2.3.** Residents transferred from other programs will be reviewed and addressed on an individual basis.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD - 12 |
| Effective | 01/01/2023 |
| Subject: Program Evaluation Committee | Pages | 3 |
| Reference |  |

**Program Evaluation Committee Policy**

**I. BACKGROUND**

**1.1.** The CPME requires that all programs implement formal processes of program curriculum planning and program evaluation. It is the responsibility of the Program Director to appoint a Program Evaluation Committee (PEC), which is to participate actively in both aspects of the program.

**II. PURPOSE**

**2.1.** The role of the Program Evaluation Committee (PEC) is to ensure continuous

improvement of the residency program through regular and systematic review of the

curriculum, goals and objectives, program evaluations, and other outcomes data.

**2.2.** This committee is being established in compliance with CPME requirements for residency program evaluation/self-assessment. The PEC of this department will do the following:

**2.2.1.** Review program evaluations semi-annually

**2.2.2.** Review educational curriculum semi-annually

**2.2.3.** Prepare a written Annual Program Evaluation based on review of the above

**2.2.4.** Prepare a written plan of action annually, documenting initiatives to improve the program including how they will be measured and monitored in one or more of the following areas:

* Resident Performance
* Faculty Development
* Graduate Performance
* Program Quality

**III. POLICY**

**3.1.** Membership

**3.1.1.** Members of the Program Evaluation Committee will be appointed by the Program Director

**3.1.2.** Membership is as follows:

* Program Director
* Associate Program Director
* Resident representation from each class selected by their class peers.
* Chief Resident
* Faculty members: At least one Core Faculty Member and One Key Faculty member as defined by the Program Requirements.

**3.2.** PEC Duties:

**3.2.1.** Participate actively in planning, developing, implementing, and evaluating educational activities of the program

**3.2.2.** Participate in the review of the current curriculum and make recommendations for revision of competency-based curriculum goals and objectives

**3.2.3.** Review the program annually using evaluations of faculty, residents/fellows, and others and seek additional feedback from other faculty members and residents/fellows regarding program curriculum, quality, and educational initiatives when needed

**3.2.4.** Participate in preparation of the written Annual Program Evaluation and the written action plan for program improvement;

**3.2.5.** Address areas of non-compliance with CPME standards

**3.2.6.** Attend semi-annual program evaluation meetings

**3.2.7.** Documentation of formal, systematic evaluation of the curriculum at least annually

**3.2.8.** Preparation of a written Annual Program Evaluation (APE)

**3.3.** Process

**3.3.1.** The Program Evaluation Committee will meet two times per year (August and February).

**3.3.2.** Prior to the meetings, committee members may be assigned to review and present materials to be discussed on that date.

**3.3.3.** The Chair of the PEC will be a faculty member appointed by the Program Director.

**3.3.4.** Once materials for review become available (e.g. annual program evaluations from faculty and fellows, CPME evaluations, Resident Board Certification performance to date, etc.), they may be distributed to PEC members.

**3.3.5.** In August, following the completion of the previous academic year, the committee will provide input into the substance of the written Annual Program Evaluation (APE) and the written Action Plan for program improvement. All program evaluations (faculty and fellow by program and CPME) will be taken into consideration. The PEC Chair will complete final preparation of these documents using the PEC’s input.

**3.3.6.** In February, a review of the action plan will occur as well as discussion of program developments since the completion of the APE.

**3.4.** Annual Program Evaluation Parameters

**3.4.1.** Program goals and objectives

**3.4.2.** Resident performance

**3.4.3.** Faculty development

**3.4.4.** Graduate performance, including performance on the certification examination

**3.4.5.** Program quality – as assessed by residents’ confidential written evaluations of the program (at least once/year), faculty members’ confidential written evaluations of the program (at least once/year), and other program evaluation results.

**3.4.6.** Previous APE and Action Plan

**3.4.7.** If applicable, Periodic Program Review Report and Action Plan or Special Review Report and Action Plan

**3.4.8.** When new deficiencies are identified, or prior deficiencies are noted to recur, the group should prepare an explicit plan of action.

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program | Policy Number | POD – ACGME & CPME |
| Effective | 01/01/2023 |
| Subject: Resident Remediation, Adverse Action, & Due Process | Pages | 1 |
| Reference | GME-20  GME-29  FM -01 |

**ACGME and CPME Policies**

The purpose of this notice is to recognize that institutional and GME policies affecting residency programs at LLUMC-Murrieta have been developed in accordance with ACGME policies and procedures. To the extent that is applicable, all appropriate ACGME policies will be in effect with the podiatry residency program as well.

Requirement 1.3 – Affiliation Agreements Reference to CPME and ACGME in Institutional Documents (March 2012) If an institution sponsors programs with ACGME approval and a program(s) with CPME approval, then a form can be included in the residency manual stating the following: This acknowledges that the PMSR program is approved by the Council on Podiatric Medical Education (CPME). All references to the Accreditation Council for Graduate Medical Education (ACGME) throughout documents referring to the training of podiatric residents shall infer the program is approved by CPME and must follow the standards and requirements of CPME. Standard 2 – F

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| H:\Murrieta\murrieta logo.png | Loma Linda University Murrieta Podiatric Medicine & Surgery Residency Program |
|
| Subject: Training Schedule & Curriculum |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
| PGY 1 | POD | E.R. | Internal Med | Anesthesia | POD | Behavioral medicine | Infectious Disease | Radiology/Medical imaging | POD | Vascular Medicine | ICU | Wound Care |
| PGY 2 | POD | Orthopedic Surgery | POD | Orthopedic Surgery | POD | General Surgery | POD | General Surgery | POD | Vascular Surgery | POD | Vascular Surgery |
| PGY 3 | POD | POD | POD | POD | POD | POD | POD | POD | POD | POD | POD | POD |

Podiatry rotations will combine the following into one rotation:

1. Residents will be the “first point of contact” for the podiatry call service
2. Coverage of inpatient and elective surgical cases
3. Office based/clinical patient encounters
4. Podiatry research rotation – total of 4 weeks/year for each year of training (Dr. Todd Hasenstein – research coordinator)

Points of contact for off-service rotations:

|  |  |  |
| --- | --- | --- |
| Emergency Room | Kevin Flaig, MD | 951-505-0046  k.flaig@verizon.net |
| Internal Medicine | Jeff Edmunds, DO | 562-841-0023  jedmunds2727@gmail.com |
| Anesthesia | Paul N. Wilson, MD  Or  Brian Telesz, MD | 530.902.2788  Pnwilson1978@hotmail.com |
| Behavioral Medicine | Steve Graves, MD | 951-225-6845  sgraves@llu.edu |
| Infectious Disease | Thuan Le, MD | 951.326.4487  [thuanple@yahoo.com](mailto:thuanple@yahoo.com) |
| Radiology/Medical Imaging | Shahrouz Tahvilian, MD | 760-848-8176  stahvili@gmail.com |
| Vascular Medicine/Cardiology | Niraj Parekh, MD | 951.522.0980  [nparekh@csmedicalgroup.com](mailto:nparekh@csmedicalgroup.com) |
| ICU | David Hecht, DO | 917-359-9062  Dhecht2@gmail.com |
| Wound Care | Yoshinobu Mifune, MD | 610-442-1270  [ymifune@llu.edu](mailto:ymifune@llu.edu) |
| Orthopedic Surgery | Bradley Baum, MD | 951-201-0645  Blbaum1@gmail.com |
| General Surgery | Matthew Wilson, MD | 310-925-1829  ([construct.tm4prop@verizon.net](mailto:construct.tm4prop@verizon.net)) |
| Vascular Surgery | Xiu-Jie Wang, MD | 203-982-6256  Xiujie\_w@yahoo.com |

**Scheduled Didactic Academic Activities:**

Academic didactic activities will be coordinated between the various residency programs at LLUMC-Murrieta. Podiatry residents will be expected to participate in the family medicine and/or internal medicine didactic activities when they are scheduled on any “non-Podiatry” rotations during their first-year curriculum. Podiatry specific academic and didactic activities will take place during any scheduled “Podiatry” rotations and all surgical rotations during each year of training. The program directors of each GME program and the chief residents meet annually to derive an academic plan for the year, and then periodically to review upcoming events.

Annual topics include:

-Monthly journal club

-At least monthly radiology conferences in three different formats: review of pre-operative radiographs, post-operative radiographs, and post-operative radiographic complication cases.

-Monthly grand rounds featuring resident and medical/surgical attending lectures

-Semi-annual Morbidity and Mortality (M&M) conference

-Board Review sessions with Boards-by-Numbers and Boards Vitals software

-Hands-on sawbones, cadaveric, and surgical hardware sets workshops

-Miscellaneous annual resident presentations including presentations for annual conference attendance

-Semi-annual evaluations with PRR log review

-Research Design and Methodology lecture series from LLU library/research faculty

-Miscellaneous lectures featuring non-podiatric faculty

Written attendance is maintained for each academic session via an attendance sheet. These are then kept on file by the podiatric surgery GME coordinator.

*-Journal Review Schedule*

Journal club is held monthly and attended by all residents and participating faculty. Journal is managed by Dr. Greene and is divided into “formal” and “informal” components.

During formal journal club, each resident is assigned an entire recent journal for review with a critical analysis of one specific article. Dr. Greene will drive the discussion and approach the article through the eyes of the peer review and journal editing process. Both medical and surgical topics are included. The journal and article should be approved by Dr. Greene at least one week ahead of the event.

During informal journal club, each resident presents and leads discussion on a single article.

*-Research Methodology*

Residents are provided with exposure to research methodology in a formal lecture setting. Additionally, all residents are provided with an opportunity to actively participate in the research process, and residents will be encouraged to graduate with at least one peer-review publication.

**PODIATRY ACADEMIC DIDACTIC SCHEDULE\*:**

**\*Schedule is obviously tentative and subject to change**

**PODIATRY MONTH 1**

Week 1

* Team Meeting and Residency Manual Review
* Intern Orientation Lectures and Quarterly Reviews

Week 2

* Pre-Operative X-Ray Review
* Welcome Barbecue/Social event

Week 3

* Journal Club

Week 4 (7/24-7/28)

* Hands on Workshop/surgical skills workshop

**PODIATRY MONTH 2**

Week 1

* Faculty lecture - Concepts of internal fixation presentation
* SOCIAL OUTING

Week 2

* Pre-Operative X-Ray Review

Week 3

* Journal Club
* Post-Operative X-Ray Review/Plan B Cases

Week 4

* Hands on surgical skills workshop
* Board Review

**PODIATRY MONTH 3**

Week 1

* Grand Rounds

Week 2

* First Ray workshop
* Journal club

Week 3

* Faculty lecture – Diabetic foot surgery

Week 4

* Critiquing the literature

Assessment Documents:

Sample assessments that will be performed through MedHub are included below:







Podiatry Evaluation Form:

Anesthesia Rotation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |
| **ANESTHESIA COMPETENCIES** |  |  |  |  |  |
| -Formulate an appropriate anesthetic plan for a patient undergoing surgery. |  |  |  |  |  |
| -Manage the airway of a patient undergoing surgery including endotracheal intubation. |  |  |  |  |  |
| -Safely monitor a patient under anesthesia. |  |  |  |  |  |
| -Understand medications used during the induction, maintenance, and reversal of anesthesia. |  |  |  |  |  |
| -Demonstrate proficiency in lower extremity local anesthetic blocks. |  |  |  |  |  |
| -Classify patients by the physical classification status of the American Society of Anesthesiologists. |  |  |  |  |  |
| -Understand the principles of and participate in the administration of spinal/epidural anesthesia |  |  |  |  |  |
| -Communicate effectively with anesthesia staff. |  |  |  |  |  |
| -Demonstrate knowledge of appropriate and differing modalities to treat post-operative pain including indications, risks, and potential complications. |  |  |  |  |  |
| -Recognize and evaluate patients with chronic pain syndromes. |  |  |  |  |  |
| -Understand the pharmacology of centrally acting pain medications. |  |  |  |  |  |
| -Communicate effectively with anesthesia/pain management staff during the care of podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

Behavioral Medicine Rotation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **BEHAVIORAL SCIENCE COMPETENCIES** |  |  |  |  |  |
| -Demonstrate knowledge of normal and abnormal psychological development. |  |  |  |  |  |
| -Evaluate and recognize psychological disorders |  |  |  |  |  |
| -Demonstrate knowledge of pharmacologic agents used in psychotherapeutics. |  |  |  |  |  |
| -Determine if a patient has capacity to consent for surgical or invasive procedures. |  |  |  |  |  |
| -Recognize when psychiatric consultation is necessary and/or beneficial. |  |  |  |  |  |
| -Communicate effectively with behavior science staff during the care of podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

Emergency Medicine Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| **EMERGENCY MEDICINE COMPETENCIES** |  |  |  |  |  |
| -Understand the concept of triage. |  |  |  |  |  |
| -Perform and interpret the findings of a comprehensive history and physical examination. |  |  |  |  |  |
| -Recognize the need for and appropriately order diagnostic studies when indicated. |  |  |  |  |  |
| -Interpret laboratory, EKG, chest x-ray and other imaging findings. |  |  |  |  |  |
| -Generate a differential diagnosis based on a patient’s chief complaint, history and physical examination findings. |  |  |  |  |  |
| -Generate a treatment protocol to medically manage the ED patient including appropriate consultations and referrals. |  |  |  |  |  |
| -Perform bedside procedures on an emergency department patient including laceration repair, incision and drainage procedures, closed reductions, joint aspirations, splinting and casting. |  |  |  |  |  |
| -Communicate effectively with emergency department staff during the care of podiatric and non-podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

General Surgery Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| **GENERAL SURGERY COMPETENCIES** |  |  |  |  |  |
| -Perform a complete history and physical examination and assess a patient who requires general surgery services. |  |  |  |  |  |
| -Develop an appropriate treatment plan for patients with surgical needs. |  |  |  |  |  |
| -Evaluate and treat abrasions, burns, and other soft tissue defects utilizing local wound care and surgical intervention. |  |  |  |  |  |
| -Act as a first assistant for general surgical procedures. |  |  |  |  |  |
| -Demonstrate knowledge of basic wound healing principles. |  |  |  |  |  |
| -Perform a split thickness skin graft harvest and application. |  |  |  |  |  |
| -Recognize the need for and appropriately order and interpret laboratory studies, EKGs and other diagnostic studies as necessary. |  |  |  |  |  |
| -Demonstrate competence in the medical management of the general surgical patient including in the intensive care unit setting. |  |  |  |  |  |
| -Communicate effectively with general surgery staff during the care of podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

ICU Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **INTENSIVE CARE UNIT COMPETENCIES** |  |  |  |  |  |
| -Assessment and management of the airway, including optimal use of mechanical ventilation |  |  |  |  |  |
| -Pathophysiology and management of respiratory failure |  |  |  |  |  |
| -Assessment and management of hypotension and shock |  |  |  |  |  |
| -Indications for and use of invasive hemodynamic monitoring |  |  |  |  |  |
| -Indications for and use of sedatives, analgesics, and neuromuscular-blocking agents |  |  |  |  |  |
| -Indications for and use of vasopressors and inotropic agents |  |  |  |  |  |
| -Assessment and management of delirium and acute neurologic syndromes |  |  |  |  |  |
| -Assessment and management of gastrointestinal bleeding and liver failure |  |  |  |  |  |
| -Assessment and management of life-threatening infections, including appropriate antimicrobial selection |  |  |  |  |  |
| -Toxicologic syndromes and their management, including management of drug overdose |  |  |  |  |  |
| -Rational use of laboratory and other diagnostic tests |  |  |  |  |  |
| -Appropriate use of blood products in the critically ill |  |  |  |  |  |
| -Prevention and treatment of nosocomial infections |  |  |  |  |  |
| -Assessment and management of electrolyte disorders |  |  |  |  |  |
| -Assessment and management of endocrine emergencies |  |  |  |  |  |
| -Assessment and management of acute renal failure including use of renal replacement therapy |  |  |  |  |  |
| -Prevention of stress ulceration and thromboembolism in the critically ill patient |  |  |  |  |  |
| -Nutritional therapy in the ICU, including the use of total parenteral nutrition |  |  |  |  |  |
| -Issues in end-of-life care including the withholding and withdrawing of life-sustaining therapies, advance directives, code status and family conferences. |  |  |  |  |  |

Podiatry Evaluation Form

Infectious Disease Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **INFECTIOUS DISEASE COMPETENCIES** |  |  |  |  |  |
| -Perform a comprehensive history and physical examination and interpret laboratory and imaging findings in a patient with an infectious disease. |  |  |  |  |  |
| -Diagnose and manage various infectious diseases specific to the lower extremity including cellulitis, abscesses, osteomyelitis, septic arthritis, and sepsis. |  |  |  |  |  |
| -Diagnose and manage systemic infectious diseases including bacteremia, urinary tract infections, and respiratory infections. |  |  |  |  |  |
| -Demonstrate a differential diagnosis of an infectious disease, including possible pathogens. |  |  |  |  |  |
| -Demonstrate knowledge of appropriate antimicrobial agents for specific pathogens. |  |  |  |  |  |
| -Understand the risks and complications of antimicrobial use. |  |  |  |  |  |
| -Actively participate in the academic curriculum of the Infectious Disease service. |  |  |  |  |  |
| -Communicate effectively with infectious disease staff during the care of podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

Internal Medicine Rotation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| **INTERNAL MEDICINE COMPETENCIES** |  |  |  |  |  |
| -Assess and manage a patient’s general medical status as an inpatient including performance of a comprehensive history and physical examination. |  |  |  |  |  |
| -Recognize the indications for and interpret results of laboratory and imaging studies. |  |  |  |  |  |
| -Generate a differential diagnosis based on a patient’s chief complaint, history and physical examination findings. |  |  |  |  |  |
| -Understand and develop knowledge of common medical conditions managed on an inpatient basis. |  |  |  |  |  |
| -Generate and implement an appropriate treatment protocol to medically manage the inpatient including consultations and referrals. |  |  |  |  |  |
| -Assist in the management of critical ill patients including those in the intensive care unit and participation of codes. |  |  |  |  |  |
| -Understand the impact of a patient’s medical conditions as it relates to the formulation of medical and cardiac operating room risk stratification. |  |  |  |  |  |
| -Communicate effectively with internal medicine staff during the care of podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

Orthopedic Surgery Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **ORTHOPEDIC SURGERY COMPETENCIES** |  |  |  |  |  |
| -Complete and interpret the findings of a comprehensive physical examination. |  |  |  |  |  |
| -Formulate a plan for ordering and interpreting appropriate imaging studies in orthopedic patients. |  |  |  |  |  |
| -Develop proficiency in AO techniques for internal fixation and external fixator application. |  |  |  |  |  |
| -Develop proficiency in casting techniques. |  |  |  |  |  |
| -Draw and interpret angles/axes for lower limb deformities. |  |  |  |  |  |
| -Develop a surgical treatment plan for patients with limb deformities. |  |  |  |  |  |
| -Assist in Orthopedic Surgery cases including arthroscopy, trauma, joint replacements, infections, and deformity corrections |  |  |  |  |  |
| -Communicate effectively with orthopedic staff during the care of podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

Podiatric Surgery Rotation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **PODIATRIC SURGERY COMPETENCIES** |  |  |  |  |  |
| -Perform layered closure of a surgical incision. |  |  |  |  |  |
| -Perform local anesthetic blocks for podiatric surgery. |  |  |  |  |  |
| -Perform post-operative dressings and casts. |  |  |  |  |  |
| -Recognize the indication for surgical incision and drainage and competently perform the procedure. |  |  |  |  |  |
| -Understand the appropriate indications for and surgical techniques of digital surgery. |  |  |  |  |  |
| -Perform digital and metatarsal amputations. |  |  |  |  |  |
| -Perform closed reduction of lower extremity fracture/dislocations. |  |  |  |  |  |
| -Manage in-patient podiatric patients including podiatric consultation and the performance of comprehensive history and physical examinations |  |  |  |  |  |
| -Function and communicate within a multidisciplinary setting. |  |  |  |  |  |
| -Perform a range of reconstructive lesser metatarsal surgical procedures including metatarsal osteotomies and soft tissue rebalancing procedures. |  |  |  |  |  |
| -Perform transmetatarsal amputations. |  |  |  |  |  |
| -Perform basic forefoot surgical procedures including hallux abductovalgus correction. |  |  |  |  |  |
| -Perform internal fixation |  |  |  |  |  |
| -Manage in-patient podiatric patients including podiatric consultation and the performance of comprehensive history and physical examinations |  |  |  |  |  |
| -Develop proficiency in complex hallux abductovalgus procedures and forefoot reconstructions. |  |  |  |  |  |
| -Perform simple rearfoot and ankle procedures. |  |  |  |  |  |
| -Develop proficiency in forefoot trauma repair. |  |  |  |  |  |
| -Develop proficiency in AO fixation techniques. |  |  |  |  |  |
| -Develop proficiency in limb salvage techniques. |  |  |  |  |  |
| -Develop proficiency in foot and ankle trauma including Lisfranc injuries, calcaneal fractures, talar fractures, ankle fractures and pilon fractures. |  |  |  |  |  |
| -Develop proficiency in tendon transfers and repairs. |  |  |  |  |  |
| -Develop proficiency in flatfoot and cavus foot reconstruction. |  |  |  |  |  |
| -Develop proficiency in arthrodesis procedures of the rearfoot and ankle . |  |  |  |  |  |
| -Develop proficiency in diagnostic and interventional ankle arthroscopy. |  |  |  |  |  |
| -Develop proficiency in Charcot reconstruction. |  |  |  |  |  |
| -Develop proficiency in external fixation application. |  |  |  |  |  |
| -Prevent, diagnosis, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity. |  |  |  |  |  |
| -Assess and manage the patient’s general medical and surgical status |  |  |  |  |  |
| -Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion |  |  |  |  |  |
| -Communicate effectively and function in a multi-disciplinary setting |  |  |  |  |  |
| -Manage individuals and populations in a variety of socioeconomic and health-care setting |  |  |  |  |  |
| -Understand podiatric practice management in a multitude of health-care delivery settings |  |  |  |  |  |
| -Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice. |  |  |  |  |  |
| -Function as a teacher and leader to patients, residents and podiatric medical students. |  |  |  |  |  |
| -Critically examine and/or produce meaningful medical literature |  |  |  |  |  |

Podiatry Evaluation Form

Podiatric Office Rotation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| **PODIATRIC OFFICE COMPETENCIES** |  |  |  |  |  |
| -Perform a comprehensive biomechanical examination including gait analysis. |  |  |  |  |  |
| -Examine a patient with a lower extremity complaint and formulate a differential diagnosis and treatment plan through a problem focused history and physical examination. |  |  |  |  |  |
| -Perform post-operative care in patients following podiatric surgical intervention. |  |  |  |  |  |
| -Perform an appropriate pre-operative work-up on a podiatric surgical candidate including appropriate referral and laboratory analysis. |  |  |  |  |  |
| -Develop the ability to obtain pre-operative consent on podiatric patients |  |  |  |  |  |
| -Perform basic podiatric bedside procedures including diagnostic and therapeutic injections, nail avulsions, laceration closure, and foreign body removal. |  |  |  |  |  |
| -Perform basic podiatric medical interventions including strapping/padding, prescription of functional orthotics and braces, and care of keratotic lesions and toenails. |  |  |  |  |  |
| -Provide lower extremity health promotion and patient education |  |  |  |  |  |
| -Recognize and manage post-operative complications including infection, hematoma, and deep vein thrombosis. |  |  |  |  |  |
| -Appropriately manage closed fractures and dislocations. |  |  |  |  |  |
| -Understand billing and coding in clinical practice. |  |  |  |  |  |
| -Participate in podiatric medical student education. |  |  |  |  |  |
| -Communicate with other podiatric professionals and primary care physicians. |  |  |  |  |  |

Podiatry Evaluation Form

Radiology/Medical Imaging Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **MEDICAL IMAGING COMPETENCIES** |  |  |  |  |  |
| -Interpret lower extremity plain film radiographs. |  |  |  |  |  |
| -Interpret chest plain film radiographs. |  |  |  |  |  |
| -Understand the physics of plain film radiography, magnetic resonance imaging, computerized tomography, scintigraphy, and ultrasound. |  |  |  |  |  |
| -Recognize and identify bone tumors. |  |  |  |  |  |
| -Understand the indications for magnetic resonance imaging, computerized tomography, digital subtraction angiography, ultrasound and scintigraphy. |  |  |  |  |  |
| -Interpret lower extremity advanced imaging studies. |  |  |  |  |  |
| -Communicate effectively with radiology staff during the care of podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

Vascular Medicine/Cardiology Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **VASCULAR MEDICINE/INTERVENTIONAL CARDIOLOGY COMPETENCIES** |  |  |  |  |  |
| -Become familiar with the care and management of patients with cardiac complications such as CAD, valvular disease, cardiomyopathy, pericarditis, congestive heart failure, etc |  |  |  |  |  |
| -Demonstrate an appropriate cardiac physical exam including auscultation & palpation |  |  |  |  |  |
| -Demonstrate an appropriate lower extremity arterial exam including use of doppler ultrasound |  |  |  |  |  |
| -Demonstrates understanding and interpretation of vascular assessment tools including arterial and venous ultrasounds, trans cutaneous oxygen measurements, and angiography |  |  |  |  |  |
| -Participate in cardiac procedures particularly within the Cath lab |  |  |  |  |  |
| -Participate in the care of patients with peripheral artery disease including use of endovascular interventions and Cath lab cases |  |  |  |  |  |

Podiatry Evaluation Form

Vascular Surgery Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **VASCULAR SURGERY COMPETENCIES** |  |  |  |  |  |
| -Complete and interpret the findings of a comprehensive vascular physical examination. |  |  |  |  |  |
| -Recognize the need for and order further appropriate diagnostic studies when indicated. |  |  |  |  |  |
| -Diagnose arterial and venous vascular diseases. |  |  |  |  |  |
| -Interpret vascular diagnostic studies including ABI/PVR, arterial duplex, CT angiography, and diagnostic and interventional angiography. |  |  |  |  |  |
| -Develop a surgical treatment plan for patients with vascular disease. |  |  |  |  |  |
| -Manage patients following major vascular surgery in the intensive care unit. |  |  |  |  |  |
| -Understand the interrelationship between vascular disease and complex medical conditions including podiatric pathology. |  |  |  |  |  |
| -Participate in the surgical management of vascular pathologies including endovascular and open procedures. |  |  |  |  |  |
| -Communicate effectively with vascular surgery staff during the care of podiatric patients. |  |  |  |  |  |

Podiatry Evaluation Form

Wound Care/Limb Salvage Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

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| **WOUND CARE/LIMB SALVAGE COMPETENCIES** |  |  |  |  |  |
| -Understand the diagnosis, evaluation and treatment of lower extremity wounds. |  |  |  |  |  |
| -Treat patients with lower extremity wounds, formulate differential diagnoses, and develop treatment plans through problem focused history and physical examinations. |  |  |  |  |  |
| -Formulate and perform pre-operative work-ups on lower extremity wound patients including appropriate referral, imaging and laboratory analysis. |  |  |  |  |  |
| -Perform post-operative care in patients following lower extremity wound surgery. |  |  |  |  |  |
| -Participate in surgical cases involving lower extremity wounds. |  |  |  |  |  |
| -Participate in a multispecialty limb preservation conference. |  |  |  |  |  |
| -Understand a variety of products available for the treatment of lower extremity wounds. |  |  |  |  |  |
| -Communicate effectively with a multi-disciplinary limb preservation team. |  |  |  |  |  |

Podiatry Evaluation Form TEMPLATE

\*\*\* Rotation

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| --- | --- | --- | --- | --- | --- |
|  | Critical Deficiencies | Below Expected | Satisfactory | Above Expected | Exceptional |
| **PATIENT CARE** |  |  |  |  |  |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings |  |  |  |  |  |
| Cares for patients with chronic conditions |  |  |  |  |  |
| Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care |  |  |  |  |  |
| **MEDICAL KNOWLEDGE** |  |  |  |  |  |
| Recognizes, synthesizes, and integrates medical knowledge into clinical decision making |  |  |  |  |  |
| Applies critical thinking skills in patient care |  |  |  |  |  |
| **SYSTEMS-BASED PRACTICE** |  |  |  |  |  |
| Promotes cost-conscious and efficient medical care and resource utilization |  |  |  |  |  |
| **PRACTICE-BASED LEARNING AND IMPROVEMENT** |  |  |  |  |  |
| Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems, using evidence-based medicine |  |  |  |  |  |
| **PROFESSIONALISM** |  |  |  |  |  |
| Maintains appropriate and professional behavior |  |  |  |  |  |
| Demonstrates humanism and cultural proficiency |  |  |  |  |  |
| **COMMUNICATION** |  |  |  |  |  |
| Communicates and collaborates effectively with physicians, other health professionals, and healthcare teams |  |  |  |  |  |
| **GLOBAL ASSESSMENT** |  |  |  |  |  |
| Please provide a global assessment and recommendations for resident |  |  |  |  |  |
| Does the resident sufficiently meet the expectations and competencies of this rotation? (Yes/No) |  |  |  |  |  |

Links to CPME 320 and CPME 330 Documents

<https://www.cpme.org/residencies/content.cfm?ItemNumber=2444&navItemNumber=2245>

<https://apma.cms-plus.com/files/2023-2c_CPME_320_Council_Approved_October_2022_Feb_15_edits.pdf>

<https://www.cpme.org/files/CPME/CPME_330_Procedures_for_Approval_of_Podiatric_Medicine_and_Surgery_Residencies.pdf>

1. [↑](#footnote-ref-1)