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NORTH BAY CONSORTIUM FOOT AND ANKLE SURGERY RESIDENCY PROGRAM

RESIDENT MANUAL

2025-2026

Contents

Introduction

Welcome! The goal of this manual is to provide information critical to your training experience. There is a lot of information in this document and change is inevitable; if you see that there is missing or erroneous information, please notify Drs. Willson or Omlin.

Although we cannot include absolutely everything, hopefully you will find this document to be full of useful information. You can access the electronic copy on MedHub from anywhere while a printed version is in each Resident's office for quick reference.

An important note on Professional Development:

Your career as a Podiatrist will be more rewarding in the long run if you embrace lifelong learning and dedicate yourself to personal and professional development. Here are a few concepts to consider:

"Touch-It-Once" Principle

- Complete your charts while you are in them whenever possible.
- *Complete surgical and clinical logs on the day of the experience. This will make your logs more accurate and increase your case numbers throughout your residency.*
- Empty your Health Connect Inbox every day before you go home.

Diagnostic Eloquence and Therapeutic Parsimony

As you make clinical decisions and ponder the array of options for treating your patients, always remember that the more you do, the more your patient will be exposed to risk. You must also consider cost and utilization issues for both diagnostic and therapeutic interventions. The complexity of this medical decision-making process will require your full attention and careful analysis. In the end, you will prove that computerized algorithms and artificial intelligence cannot replace the "Doctor-Patient" relationship. If you are talking with your patients and making sure you align diagnosis and treatment decisions with the patient's goals and needs, you will be an effective communicator and healer. This is the essence of "the art of medicine" that you will refine throughout your career.

Gaining Administrative Skill

Multiple aspects of resident activity are used to increase administrative experience and training for residents. These include incorporating e-mail response times, fulfilling online

safety training, duty hours logging, timeliness, and thoroughness of logging, and chief resident organization skills into the Podiatry Rotation evaluations. Pay attention to these tasks and complete them efficiently to prepare you for practice after residency.

Important Websites:

MedHub: **Kaiser Permanente Northern California - MedHub**

Podiatry Residency Resource: https://www.podiatryrr.com/

HR: https://hrconnect.kp.org/wps/portal/hr

Nor Cal Residency Programs: https://residency-ncal.kaiserpermanente.org/programs/podiatry/

Governing Documents:

- **COUNCIL OF PODIATRIC MEDICAL EDUCATION 320:** Standards and Requirements for Approval of Podiatric Medicine and Surgery Residency https://apma.cms-plus.com/files/320%20Council%20Approved%20October%202022%20%2D%20May%202023%20edits.pdf

- **COUNCIL OF PODIATRIC MEDICAL EDUCATION 330:** Procedures for Approval of Podiatric Medicine and Surgery Residency https://www.Council of Podiatric Medical Education .org/files/2023-2a_COUNCIL OF PODIATRIC MEDICAL EDUCATION 330_Procedures_for_Approval_of_Podiatric_Medicine_and_Surgery_Residencies_7_2023.pdf

Leadership Structure:

Kyle Willson, DPM, MBA - Residency Program Director

Ninveh Omlin, DPM - Associate Program Director & Clerkship Director

Program Manager III — Shirley Arce

Ronald Paterno, DPM - Department Chief, Vallejo/Vacaville

Nina Babu, DPM - Program Site Director, Department Chief, Santa Rosa

Danny Choung, DPM — Orthopedic Surgery Department Chief & Site Director, San Rafael

Heike Van Nellen - Manager of Medical Staff Services

Marissa Devera - Department Manager, Vallejo

Antonio Lopez- Department Manager, Vacaville

Hasini Perera - Department Manager, San Rafael

Alicia Wiebmer - Department Manager, Santa Rosa

Do's and Don'ts (a quick guide to behavior, communication and training priorities)

Do:

Behavior Practice excellent hand hygiene at all times. (See Patient Safety and Infection Control)

- Strive to always be a team player.
- Avoid us/them thinking. This is not social media politics! As easy as it is for all humans to slip into this thinking, Podiatry is not in mortal battle with nurses, staff, or other services. "We" is everyone involved with taking care of our patients.
- Employ patient safety priorities with side and site verification, timeout and proper handoffs for excellent **Transitions of Care.**
- Practice good sleep hygiene. (See "Resident Wellness")
- Personal hygiene, too, please. (See Professional Appearance Policy)
- Speak up when excessively fatigued or sick.
- Wear your badge above the waist.

Communication (see Communication and Transition of Care section for more detail)

- Be highly vigilant with your phone especially on call so you never miss messages and compromise patient care or excellent communication.
- Check emails every day.
- Empty your Health Connect Inbox before you go home every day.
- Notify the appropriate team members as soon as possible if you are running late, sick or have schedule conflicts.
- Check in with the on-call doctor when transitioning between care areas or duties and as appropriate.
- Introduce yourself to patients and family stating your role as appropriate to the situation. "Hello Mr. Doe. I'm Dr. So-and-So. I'm a **rd year podiatry resident working with Dr. X. She will be in shortly."
- Be warm and courteous when answering calls. "Jane Doe, Podiatry Vallejo, how may **I** help?"
- Elevate any conflict with other services to the supervising attending, site director and/or program director.
- Strive to always use specific and accurate language.
- Present patients orally with 2 patient identifiers and SBAR format
  (Situation) The nurse from the 5th floor is calling because Jim Jones (1 identifier) with gas gangrene (2nd identifier) has excessive bleeding. (Background) He had a TMAlast night that was packed open. The nurse said blood is soaking through the bandages and he left footprints going to the bathroom. (Assessment) **I'm** concerned that this is active bleeding so

(Recommendation) I asked the nurse to remove and replace the ace wrap and outer Kerlix roll, reinforced the need for strict bedrest elevation and non-weightbearing and ordered a stat CBC. I'll call back in an hour to see if I need to go in."

- Notify the KFH Manager of any injury as soon as practical on the same day.
- Involve an attending immediately for vasovagal episodes or adverse reactions of any kind.
- Call code blue for any patient LOC or not breathing. Announce Code Blue with room number 3 times.

Training Be proactive with placing students, junior residents, and yourself into the best learning opportunity for their level of training.

- Prepare ahead for surgery and ask attending to discuss cases well ahead of time — not as they are leaving the day before.
- Log surgery and clinic cases the same day they happen.
- Keep reading.

Do Not:

...examine a patient without gloves on.
...leave a computer workstation without logging out.
...wear perfume or cologne.
...wear scrubs to and from work.
...drink alcohol on call.
...refuse to see a patient when called in to the ER.
...change your schedule without notifying chief resident, manager or department chief.
...leave sharps on the tray in clinic.
...recap needles.
...carry sharps of any kind on your person between patient care areas.
...preload injectable medications that are not going to be used right away.
...access questionable content of any kind on a Kaiser computer or phone.
...email patient information of any kind outside of the system. Do write "PHI" in the subject line when emailing patient info within the system.
...express your opinion of care from another provider in the medical record.
...expose patient information to social media (see social media Policy in P&P Manual).
...delay responses for TB testing or other administrative requests. Lack of timely response makes lots of unnecessary work for the team.

Employment and Professionalism

a. Employment Requirements

Before you start your training, you need:

i. California State Residency License

ii. Immunizations and TB clearance

iii. CPR/ACLS certification

iv. NOTE: PASS your NBPME Boards III by the end of your 1st year in training

NOTE: DEA/Radiology and Fluoroscopy licenses are all applied for during your 3rd year of training if you want them to be ready for you upon graduation and finding a permanent job. The program does NOT reimburse for these costs.

b. Workplace injury reporting requirements:

1. If in normal business hours call Shirley Arce or Heike Van Nellen immediately after incident occurs
2. If after hours, send an email to Heike and Shirley cc'ing Dr. Willson or Omlin with the following information (email must be sent as soon as possible following the incident).

   Description of what happened

   Body part injured

   Who was present?

   What could have been done differently to avoid the incident?

   A number that you can be reached at the following day for additional information.

For sharps injuries:

Immediately following a sharps injury, the resident assesses if the needle was contaminated.

If contaminated, go to the ED for testing and arrange testing of the source patient. Follow steps 1-2.

If not contaminated, do not go to the ED, but follow steps 1-2.

a. Heike van Nellen MSO Manager (707) 246-5897 Heike.C.Vannellen@kp.org

b. Shirley Arce, Podiatry Program Manager (707) 204-8245 Shirley.X.Arce@Kp.org

Time Off

Please refer to the KPNC Resident & Fellow Policy & Procedure Manual document in MedHub, under the Human Resources Policy section (pgs. 2-4). In addition to the details in that document, the following explains our local process:

Vacation

Please refer to the Regional P&P Manual for specifics.

To support work-life balance, pre-determined vacation weeks have been integrated into the PGY1 block schedule during longer rotations. Prior to your start date, please contact Shirley to inform her of any specific weeks you must have off. She will make every effort to incorporate these requests into the rotation schedule, if feasible. Every attempt will be made to accommodate your request.

There are minimum shifts required for each rotation and taking planned vacation during 2- and 4-week rotations is not supported. Make sure to consult with the chief resident and/or Site Director then formally submit an absence request in MedHub. Absence Requests are subject to approval. Unscheduled emergencies happen but, whenever possible, plan and notify as far ahead as possible.

- If you miss days on 2- or 4-week rotations, these days will need to be made up later in your residency. This means missing out on learning opportunities for your 2nd or 3rd year podiatry rotations.
- 2nd and 3rd year residents should spread their vacation days as evenly as practical between rotation sites. In general, there should never be two residents scheduled off simultaneously at the same site. In emergency situations, make sure to contact Drs. Willson, Omlin and Shirley Arce.

Education & Sick Leave

See Regional P&P Manual for additional details on Education and Leave of Absence: Human Resources Policy section

Reimbursements

- You are responsible for your own reimbursement process. You will save your expense report and notify your GME Program Manager for review. Once given the okay, you may submit for reimbursement. If it's not in OneLink, you will not be reimbursed.

For more information regarding expenses and policies, you may visit the Kaiser Permanente Financial Services Operations website at: http://kpnet.kp.org/fso/travel/policies/index.html.

Remediation/Corrective Action Policy

Residents are required to complete all rotations at a satisfactory level. If unsatisfactory performance is determined by the Rotation Coordinator or other members of the teaching faculty, the Program Director will review the matter with the designated Rotation Coordinator and they will determine appropriate remediation, discuss it with the resident and ensure that it is carried out in a timely fashion. The remediation methods may include requiring that the resident repeat the rotation, complete additional assigned reading to facilitate achievement of the stated deficiency or provide a lecture pertaining to the subject matter of the rotation. Failure to satisfactorily complete the remediation will result in academic probation until it is completed. Failure to complete remediation within three months of completion of the program will result in further action based on the nature of the deficiency. Examples of such action may include Administrative Leave or withholding of the residency certificate until satisfactory completion.

Additional corrective action may be necessary to address performance deficits, misconduct, or failure to meet professional standards by a resident. In particular, practicing under the influence of nonprescription drugs or alcohol as well as behavior or actions which endanger patients are grounds for immediate dismissal. Additional details including the resident appeal process are detailed in the Kaiser Permanente Regional Residency Policy and Procedure Manual which is updated annually and can be located here: https://residency-ncal.kaiserpermanente.org/current-residents/licensing-onboarding/

The appeals process is detailed in Appendix D.

Professional Appearance Policy

Residents are expected to maintain a professional appearance with good basic grooming and appropriate attire. You are required to wear your ID badge at all times when on the medical center campus. It is your door access key. You may wear scrubs for clinical and surgical duties. They should not be worn to and from work. For infection control purposes, you should change out of scrubs after contaminated surgeries or procedures. It is a general medical practice not to wear cologne or perfume.

Relationship to Industry

You will experience various levels of inappropriate influence from the medical device and pharmacy industries in your professional experience. It is our policy and goal to eliminate the unethical use of money to influence medical decision making. At the clinical level, do not talk to industry representatives who are not scheduled for a specific meeting in the clinic. Industry representatives must be registered and scheduled to discuss their products. They may not provide ANYTHING of economic value — including pens and food — so do not accept their gifts.

Patient Safety and Transitions of Care

Transitions of Care are a critical part of the care of patients in a variety of settings. Resident evaluations include a question to rate your ability to execute handoffs and Transitions of Care. Pay attention to this aspect of the care of each patient as this is when mistakes are most likely, and patients are at risk.

Inpatient handoffs—residents are responsible to stay updated on all inpatients at their current facility and report to faculty on call throughout the day as needed. Contact the faculty member on call to arrange a time to round the evening before; be ready to present the essential information on each patient and lead rounds each morning. It is best practice to "run the list" with fellow residents and supervising faculty at the end of the day.

Inpatient Consults — Notify the supervising call faculty at the point of care when you are seeing an inpatient consult. After hours and on weekends, you should notify the supervising faculty before you go in for a consultation. Early in your training, you should also notify faculty of calls that did not include a request for in-person consultation to insure that you have managed the call effectively; you can expect increased autonomy as you progress through your training but do plan to discuss the faculty member's preferences on how often they want to be updated on various types of calls. Make sure to fully understand the medical complexity of the patient before presenting to supervising faculty.

It is expected that non-urgent, after-hours consultation requests from HBS do not receive a direct call from them; they typically appear on our Patient List and should be seen sometime on the day received —usually during the next rounding time. Urgent consultation requests should receive a Cortext or call at the time of the consultation request, day or night. When a patient had urgent needs and there was no notification by the consulting service, report this the on-call faculty immediately.

KPHC InPatient Handoff Summary and Handoff To Do — Write a Handoff Summary in the Patient List at the time of consultation or admission; this is a brief statement of the situation and reason for consultation. Also write any needed action items in the Handoff To Do section of the Patient List; plan to update this on an ongoing basis, typically at the end of the day.

Emergency Room Consults—As with inpatient consultations, notify supervising faculty at the point of care when you see an ER consult. After hours and on weekends, you should notify the supervising faculty before you go in. Make sure to review the patient's chart before presenting. After a consultation is completed, always verbally discuss the case with the Emergency Room physician.

Discharge from Outpatient Surgery — Key issues after outpatient surgery include appropriate printed instructions, clear plans for weightbearing status and how to navigate into and within the home environment or next level of care. Necessary equipment and human support must be considered and

addressed for each patient's situation. Safe and appropriate medication management also must be considered.

Admission after Surgery — Patients admitted to the hospital after surgery must be transferred to the correct level of care, admitting service and attending on that service. Continue any pertinent orders. Update podiatry orders as needed based on surgical needs (ie. If a drain was placed, orders for the drain must be updated in the patient's chart), ensure you give the appropriate diet and pain control regimen. For inpatients admitted to Podiatry as the primary service, ensure level of care, and appropriate attending from podiatry service is on the transfer order. Again restart patients' inpatients orders, and adjust any orders that need updating, discontinuing, or starting after the surgery (ie. If a delayed primary closure, discontinue the wound care orders and start a reinforce dressing order.) Key orders for podiatry must be checked every time: patient activity status, physical therapy restrictions / referral, wound care orders, weight bearing status, dressing orders, drain orders, antibiotic, pain and diet orders. Code status orders should be carefully considered and documented.

Infection Control

Hand hygiene cannot be overemphasized as it is a truly lifesaving habit that you MUST establish to limit transmission of deadly hospital acquired infections (like C. diff), nosocomial infections and the spread of a host of dangerous infections (like M RSA) in the setting of ever-increasing antibiotic resistance. Always cleanse your hands — wash or apply foam cleanser - before and after patient contact in the clinic and hospital setting. Always use gloves when you examine a patient. Observe posted contact precautions in the hospital with vigilance. Podiatry is a dirty business; clean up after yourself and do not leave work areas untidy or messy. Always take responsibility to dispose of sharps before you leave the patient care area.

You must never leave any **sharps** behind after doing a procedure. Use the "Touch It Once" principle and make a habit out of putting sharps and infectious waste in their proper containers before you remove your gloves or leave a room. YOU are responsible for disposing of ANY sharps after performing a procedure in clinic—do NOT expect your medical assistant or another to do it.

There are many different receptacles for disposal of various material in the modern hospital setting. Ask for help when you have questions regarding red bag, regular trash, sharps, medicine bottles, phenol applicators, patient marking pens, etc.

Resident Well-Being

Residency is a time of stress and change. You are in a new, ever-changing environment and working long hours so make sure to take care of yourself. *Use* your vacation time. When you are feeling overly tired, stressed or fatigued, PLEASE let someone know (see EAP below). You have a right to attend medical and mental health appointments during regular hours. We are all here for you as we have been through the rigorous training at one point too.

Fatigue Mitigation — Our local policy for residents who stay late for cases or ER call-ins includes the following:

Minimize number of residents — avoid keeping the "buddy call" resident unless it is highly educational

Use the call rooms or other sleeping arrangements available at each facility.

In **Vallejo** there are two call rooms which are located on the first of the hospital in the hallway leading to the main entrance to the ER (facing Sereno Drive). The room number is 1220 and the keypad code for the Podiatric resident's room is **3540#**. The additional room is a Float call room (room 1219) that keypad code remains 1379#

For Vacaville; Residents have access to float call room that is located on the 1st floor in the ED, next to Radiology. Residents can access with their badge

For **Santa Rosa**, the Podiatry call room is located in the resident work room on the lower level of the hospital and you must use the sign in/out sheet on the call room door. Please sign in when you use the room.

No call room is available for **San Rafael.** You may use nearby hotel for which you will be reimbursed per KP travel policy limits.

Speak up to faculty when you are feeling fatigued; they may not know if you have had multiple late nights and they want to support your health and safety.

Plan to start late the next day when you stay up late. Notify your chief resident and faculty on-call to make the necessary arrangements.

Faculty will cancel cases which are not truly emergent and reschedule the next day

Employee Assistance Program (EAP) offers assessment, short-term counseling, and referral for all Kaiser Permanente, physicians, employees, and their dependent family members. All EAP services are free and strictly confidential. EAP professionals are licensed, trained clinicians that can help you address work-related or personal problems before they become too serious:

- work or personal stress
- family and relationship difficulties
- domestic violence
- financial and legal referrals
- depression, anxiety, or other emotional support
- alcohol and drug addiction
- dependent care referrals
- past trauma / PTSD

For employees who want to speak with an EAP counselor immediately, please call the 24/7 line at 877-801-5751. To schedule an appointment for counseling, please reach out directly to a local EAP Consultant:

Vallejo - Deborah Cagnon at 707-6511-3668
Vacaville — Crystal Luna-Yarnell at 707-624-2390
Santa Rosa —Erika Vadopalas, PhD, 707-566-5466
San Rafael-- Pamela Lister, LMFT (415) 833-3336

Additional institutional wellness activities provided each year include:
Regional Orientation: Physician discusses recognizing fatigue and overall wellness

- Professional Life coach: Provides one-on-one coaching support to residents who are identified by Program Directors in need of additional support
- Continuous monitoring of work hours by Regional GME
- Even more resources are available as detailed on our website

https://residency-ncal.kaiserpermanente.org/current-residents/wellness/

Training

a. Rotation and Competencies

PGY1

Podiatric Surgery: 5 months

Anesthesiology: 2 weeks

Behavioral Medicine: 2 weeks

Dermatology: 2 weeks

Emergency Medicine: 4 weeks

Hospital Based Medicine (HBS): 6 weeks
Infectious Disease: 2 weeks
Orthopedic Surgery: 4 weeks
Medical Imaging: 2 weeks
Rheumatology: 2 weeks
Vascular Surgery: 4 weeks

PGY2

Podiatric Medicine and Surgery Vallejo/Vacaville: 4 months

Podiatric Medicine and Surgery Santa Rosa: 4 months

Podiatric Medicine and Surgery San Rafael: 4 months

PGY3

Podiatric Medicine and Surgery Vallejo/Vacaville: 3 months

Orthopedic Trauma Surgery Vacaville: 1 month

Podiatric Medicine and Surgery Santa Rosa: 4 months

Podiatric Medicine and Surgery San Rafael:4 months

b. IT (iPhones, Laptops and Computers)

The program provides you with a personal iPhone and Laptop. These are Kaiser's property intended solely for business use but have access to the breadth of the internet and will be returned at the end of your training. Because they contain Protected Health Information (PHI), it is **critical** that they are not lost or stolen. You will be held personally responsible and should exercise great care to prevent theft and/or loss (i.e., never

leave these devices in your car and/or anywhere in the "open" where there is temptation for another to steal it).

You should also be careful not to access content of an inappropriate nature with these devices. Kaiser Permanente has full rights to access your use history within the device if you are under investigation for misuse of electronic media or information. The use of iPhones and laptops facilitate a very high level of convenience in patient care especially with respect to weekend and evening call. They will be returned at the end of your training. It is your responsibility to not damage these devices. If such should occur, please notify the GME Coordinator immediately.

iPhone Apps

- **Lightning Bolt:** This is the app we use to see who is on alpha/beta and resident call for podiatry department (Username: nsaorthopod, PW: kaiser)
- **ClinConnect:** This is for checking who is on call for all the Kaiser departments. Helpful for when we need to talk to other specialties (ID, vascular, etc.)
- **PingiD/Global Protect:** This is a number generator that helps you log into your laptop and Haiku when you're at home
- **Haiku:** Access to patient charts (a little limited but good for when you're away from your computer, can't see XR though), also good for taking pics to put in patient charts
- **MedHub:** For logging your work hours
- **Cortext:** Good for texting PHI to different providers/attendings. Also, if you want to send something non-urgent or FYI to another specialty doc it's easier to cortext vs call. **If** it's going to be a longer conversation, then call.
- **Receiver:** Allows you to access the entire patient chart as you see on the computer (can be difficult to zoom in/out of and type but helpful for trying to look at XR on your phone)

Protected Health Information (PHI)

All written communication detailing PHI *must* be sent via secure Staff Message in Health Connect or using the Cortext app on the Kaiser iPhone. You may discuss patient information including name and MR only if you include "PHI" in the reason field. These emails must not be sent outside Kaiser Permanente. The system will recognize this immediately and notify you of the violation.

Regular text messages (i.e., NOT Kaiser-issued iPhone) are only allowed to include patient initials or room number — no additional PHI should be included
If sending a photo use the Kaiser iPhone and crop/zoom into image so that no patient identifiers are included (i.e., no upper left-hand corner patient info on radiographs), no faces in background of the foot wound photo, etc.) You may only send clinical photos or x-rays via Cortext.

Curriculum/Rotation Goals and Objectives Appendix A

Review the Curriculum document before you start each rotation. This is especially critical during your first-year rotations. The Curriculum - including Goals and Objectives and Evaluation documents - can be found on the MedHub

Home page under resources tab. Many hours have gone into the development of these documents so make sure you understand what you are supposed to learn and what you will be evaluated on, so you can maximize your educational opportunities. In order to improve the curriculum, you will also complete an evaluation of each rotation. This is YOUR education, so your feedback is absolutely critical.

Evaluations

Residents are provided with written evaluations by the Rotation Director or Key Faculty at the end of each rotation. For Vallejo and Vacaville this is Dr. Kernbach and Dr. Willson; Santa Rosa is Dr. Babu; San Rafael is Dr. Choung.

Annual Program Evaluation-The curriculum and achievement of the competencies are reviewed and evaluated by multiple metrics. These include formal scheduled reviews as listed below as well as by the PD monitoring scoring trends on ABPOPPM and ABPS In-Training Exams, Board Pass Rates, Job Placement Success and the recent addition of Kaiser Permanente's Member-Patient Surveys. Resident input from the Annual Program Review (see below) is added to input and review with attending faculty and administrative support staff and reported back to the COUNCIL OF PODIATRIC MEDICAL EDUCATION on an annual basis.

Annual Program Review—The residency training program is reviewed formally by the residents and Program Director at the program's annual retreat which includes incoming and outgoing residents and reviews each rotation individually.

Resident Evaluation of Rotation — Residents evaluate each rotation as they complete it and the results are reviewed on an ongoing basis. These evaluations are kept in the Program Binder in the GME office and used in the Program Director's Annual Report and Annual Program Review to ensure that the program and curriculum are structured in a way that most effectively achieves the competencies.

Regional GME Resident Survey —Kaiser Permanente's regional GME offices distribute and collect an annual survey to all residents in Northern California KP programs. The results and comments are reviewed by the Program Director (PD) and incorporated into the Annual Program Director's Report.

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Rotation Evaluations - Residents are evaluated by the rotation director at the end of each rotation using the PRR forms which match the core competencies with the rotation evaluation specifics ensuring that each resident achieves the competencies.

Program Director Evaluation of Residents —the PD evaluates each resident in person semi-annually discussing their rotation evaluations, Clinical Competency Committee (CCC) evaluation, ABPOPPM and ABPS In-Training Exams and results of Kaiser Permanente's Member-Patient Surveys for outpatient clinic visits. Additionally, residents are encouraged to give feedback on their educational experience for the previous period. The PD does a final evaluation of graduating residents compiling feedback from all faculty in the CCC.

Faculty and Program Director Evaluation by Residents- Residents complete anonymous podiatry faculty and program director evaluations which are collated and distributed to the individual faculty members by the Program Coordinator at the end of the year. The Program Director discusses with each faculty member to review the results of the Resident Evaluations as well as the Program Director evaluation of the faculty.

CCC Evaluations—The CCC is made up of all podiatry faculty and is designed specifically to discuss each resident's progress in completion of the podiatric surgery competencies. It is held near the end of the 4-month block and serves to communicate and improve teaching by discussing individual resident progress amongst the Attendings before they switch to a new facility. The CCC is chaired by the Program Director and is made up of all podiatric surgery Attendings in the program; it meets via teleconference approximately 2 weeks before the end of each 4-month block. The goal of the CCC is to discuss the progress of each resident in achieving the competencies and facilitate effective teaching as resident's transfer between facilities. An evaluation form is used which reviews all seven core competencies and invites discussion of strengths and weaknesses in a constructive fashion. Results of the committee discussion are reviewed with the resident during the Site Director Evaluation as well as the Semi-Annual Program Director Evaluation.

CCC Example of Resident John Smith, PGY-1:

"John has very good hand-skills in the operating room for his first year. He does tend to have problems with charting and often has charts that are incomplete. Is open to criticism but can be hard on himself when critiqued. Knowledge base, he is good with trauma, but weak with general medicine topics. Overall, he continues to improve as the rotation continues."

The above would be summarized and shared with the Resident by the Program Director with a goal of providing feedback to encourage the things they are doing well and to improve on the things that warrant it.

Logging Guidelines

Documentation of the residency experience is critical to regulation and accreditation of the training provided. This means you will spend a significant amount of time logging both surgical and clinical experiences in the Podiatry Residency Resource and if you don't stay on top of it you will get buried by the work (https://www.podiatryrr.com/). The COUNCIL OF PODIATRIC MEDICAL EDUCATION actively reviews your logs, and it is important that case numbers in all areas show consistency amongst the residents and over time.

Clinical case logs are a critical component of the required documentation. Specific emphasis is placed on **Complete H&Ps** and Biomechanical Cases and you will NOT graduate from the program if your logs for these items are incomplete.

To qualify as a complete H&P, full documentation of a complete physical exam is required. Plan to log all complete H&Ps in your first-year rotations so they are supervised by MDs/ DOs as much as possible; this too must be clearly documented. **Biomechanical cases** must be completed on an ongoing basis with 25 cases completed per each year of training. You must use the full biomechanical evaluation template embedded in KPHC for the case to count.

All logs are reviewed remotely by the COUNCIL OF PODIATRIC MEDICAL EDUCATION so it is critical that they are done accurately and completely. Failure to keep up with the logging of Complete H&Ps and Biomechanical cases may result in formal academic probation so plan to keep up with logging on an ongoing basis. Dr. Willson will review your progress in all these issues during your Biannual Program Director Evaluation meeting.

Non-Podiatry Rotation Logs:

Plan to document your training in some way on every rotation. **ER, HBS, Infectious Disease** inpatient cases can all contribute to your Comprehensive H&Ps. All **Vascular surgery, Ortho Trauma** cases that you scrub in the OR are to be logged under their appropriate category. **Dermatology, Rheumatology** and focused H&Ps in other rotations should be recorded at a rate of 2-3 per day. A simple activity log recording what you saw and what you learned is required for **Anesthesiology, Behavioral Medicine .** PRR functionality exists for each rotation type.

Surgical Case Logs:

These are critical to your training and must be maintained diligently. The policy is that you log surgical cases on the same day as the cases are done. They are verified on at least on a monthly basis. Residents who delay logging always have lower numbers by the end of their training. You will receive reminder emails from Dr. Willson if your logs are not current when he verifies them. Ongoing failure to maintain logs may result in corrective action and will certainly be documented in your Training Binder.

Fragmentation/Unbundling: This is when you take a surgery and make multiple procedures out of it. Generally, you can avoid this by applying the "One Incision — One Procedure" Rule. The opposite is not true — An ankle ORIF with 2 incisions is still only one procedure. A triple arthrodesis is one procedure. A pan-metatarsal head resection with a fusion of the 1st mpj, removal of met heads 2-5 and hammertoe corrections across the board is 2 procedures — the first ray fusion and the pan met.

Again, it is important to avoid 2 common errors: The first is called "Splitting," which is the breakdown of a single surgery into multiple procedures to show more surgical activity. **The general rule is that there is only one procedure per incision.** For example, a Lapidus bunionectomy with a bicorrectional osteotomy and an Akin is all done through one incision and should be logged as a single procedure. However, a pa nmetatarsa I head resection done through 5 incisions is not 5 procedures. Please review the resources in the PRR for the details. We have no problem getting our numbers so, when in doubt, don't split. The second problem is called bundling and involves multiple residents claiming "2"" assist" activity on the same surgery. It is easy for the COUNCIL OF PODIATRIC MEDICAL EDUCATION to check for this, so whenever there is a question, ask your fellow resident or the attending involved.

The resident who dictated the op report is the resident who claims '1st (primary) assist activity.

Logging Recommendations

- My strong recommendation is that you keep up on your logs by getting into a **daily habit.** When you are in the OR for the day, consider logging your cases before you even return to your office.
- Log something in every rotation that has patient contact: during your first year - you should log your H&Ps while on rotations such as HBS.
- Pediatric foot and ankle cases can be either clinic or surgery and usually also double as biomechanical cases.
- You must use the Biomechanical evaluation form (in electronic files packet) in Health Connect if you log a biomechanics case; all reconstructive rearfoot and ankle cases are excellent candidates for Biomechanical cases so make sure to work them up as such. Also, you will be doing a separate Biomechanical rotation at Santa Rosa (SRO) so log all those cases — you need a lot of cases so don't wait until you get to SRO or else you WILL NOT MEET THIS CRITERA, which can jeopardize you graduating.
- Chief residents (3rd years) MUST log attendance for EACH program educational event at their own hospital site. If you attend a meeting, make sure that it appears on the PRR calendar and Microsoft Teams Channel under KPNC Residents and do not forget to take attendance in for both Residents present AND Attendings. *(Please, reach out to Shirley if you are having any trouble with this).*
- Ex: chief at Vallejo/vac must log/take attendance every Tuesday am RADIOLOGY rounds AND didactic teaching time in PRR and MedHub if for some reason the Teams channel is unavailable.
- Ex. Chief at SRF must log/take attendance every journal club they are hosting at SRF in PRR and MedHub
- Ex. Chief at SRO must log/take attendance at every radiology rounds or any educational session at SRO in PRR/MedHub
  Don't forget to log any other teaching moments, such as Pharm Rep lectures/presentations, etc.
- If possible, Log Case Discussions any time you discuss a case from your clinic with an attending; this shows both that attendings are teaching you and that you are being supervised.

In a nutshell, there are 3 general areas that you must document: Surgical cases, clinical experiences and academic activities. You should be familiar with the Minimum Activity Volumes ("MAV") with regard to the various areas of surgery as well as the requirements for Biomechanical, Pediatric and Trauma cases. They are listed in the COUNCIL OF PODIATRIC MEDICAL EDUCATION 320 and appended below:

Volume and Diversity Requirements:

- Patient Care Activities Requirement MAV (Abbreviations are defined in section B below.) Case Activities
- Podiatric clinic/office encounters 1000 Podiatric surgical cases 300
  Trauma cases - 50
  Podopediatric cases - 25
  Biomechanical cases - 75
  Comprehensive medical histories and physical examinations - 50

Procedure Activities

First and second assistant procedures (total) 400
First assistant procedures, including:

Digital 80

First Ray 60

Other Soft Tissue Foot Surgery 45
Other Osseous Foot Surgery 40

Reconstructive Rearfoot/Ankle (added credential only) 50

Definitions

- **Levels of Resident Activity for Each Logged Procedure**

First assistant: The resident participates actively in the procedure **under direct supervision of the attending.** Ie, >50% of the case was performed by you

Second assistant: The resident participates in the procedure. Participation may include retracting and assisting or performing limited portions of the procedure **under direct supervision of the attending.** Ie, <50% of the case was performed by you

- **Minimum Activity Volume (MAV)**

MAVs are patient care activity requirements that assure that the resident has been exposed to adequate diversity and volume of patient care. MAVs are not minimum repetitions to achieve competence. For some residents, the minimum repetitions may be higher or lower than the MAVs. It is incumbent upon the program director and the faculty to assure that the resident has achieved a compe tency, regardless of the number of repetitions.

Required Case Activities

A *case* is defined as an encounter with a patient that includes resident activity in one or more areas of podiatric or non-podiatric evaluation or management. Multiple procedures or activities performed on the same patient by a resident at the same time constitute one case. An individual patient can be counted towards fulfillment of more than one activity.

- *Podiatric clinic/office encounters.* This activity includes direct participation of the resident in the clinical evaluation and management of patients with foot and ankle complaints. The sponsoring institution must document the availability of at least 1,000 encounters per resident
- *Podiatric surgical cases.* This activity includes participation of the resident in performing foot and ankle (and their governing and related structures) surgery during a single patient encounter.

  Trauma cases. This activity includes resident participation in the evaluation and/or management of patients who present immediately after traumatic episodes. Trauma cases may be related to any procedure. Only **one resident** may take credit for the encounter. Medical histories and physical examinations are components of trauma cases and can be counted towards the volume of required cases. At least 25 of the 50 required trauma cases must be foot and/or ankle trauma.

  Surgical management of foot and ankle trauma may count towards 25 of the 50 trauma cases even if the resident is only active in the immediate perioperative care of the patient. This data may be counted as both a surgical case and a trauma case by one resident or one resident may log the surgery and one resident may log the trauma. The resident must participate as first assistant for the surgery to count towards the requirement.
- *Podopediatric cases.* This activity includes resident participation in the evaluation and/or management of patients who are less than 18 years of age.
- *Biomechanical cases.* This activity includes direct participation of the resident in the diagnosis, evaluation, and treatment of locomotor disorders caused by congenital, neurological, and heritable factors. These experiences include, but are not limited to, performing comprehensive lower extremity biomechanical I examinations and gait analyses, comprehending the processes related to these examinations, and understanding the techniques and interpretations of gait evaluations of neurologic and pathomechanical disorders. Ex: orthotic evaluation and casting performed at Santa Rosa during your 3rd year

(do not rely on this as your only biomechanical logging source as you will need more, so perform exams also during bunion work ups, preop exams, etc. at other rotations)
Comprehensive medical history and physical examinations: Admission, preoperative, and outpatient medical H&Ps may be used as acceptable forms of a comprehensive H&P. A focused/limited history and physical examination does not fulfill this requirement.

- The resident must demonstrate competency through a diversity of comprehensive history and physical examinations that also include evaluations in the diagnostic medicine evaluation categories. The resident must develop the ability to utilize information obtained from the history and physical examination and ancillary studies to arrive at an appropriate diagnosis and treatment plan. Documentation of the approach to treatment must reflect adequate investigation, observation, and judgment.

Programs with Multiple Residents or Fellows

- Only **one** resident may take credit for **first** assistant participation on any one procedure.
- When multiple procedures are performed on a single patient, more than one resident or fellow may participate actively, but first assistant activity may be claimed by only one resident or fellow per procedure.

- **More than one** resident may take credit for **second** assistant participation.
  - The activity of a fellow (if present in your program) should not be allowed to jeopardize the case or procedure volume or diversity of a resident at the same institution.

See also COUNCIL OF PODIATRIC MEDICAL EDUCATION 320 Logging Guidelines

Research

Katherine "Kat" Dang is our Research Project Manager. She provides research training modules at the beginning of the first year as you develop a research question with your fellow residents. You will be assigned a faculty member as Primary Investigator with a goal of having a manuscript completed by the end of your 3rd year of training. Plan to develop a poster of your project and present at the ACFAS Annual Meeting as well as present your research progress at the Kaiser Permanente Annual Resident Research Symposium on an annual basis.

Kat's Research Training Modules:

Session Topic	Time Duration (Hours)	Learning Objectives	
Introduction to Conducting Resident Research at Kaiser	1		
Focusing your Research Question	1	Understanding the Types of	1

Variables	1	Understanding the nuts and bolts of conducting a clinical research project in residency
Finalizing your Hypothesis (Workshop) Developing your Codebook (Workshop)	1	Understand how to conduct a literature review and to operationalize your research topic to a feasible research question using FINER and PICOT
Calculating Power and Sample Sizes (Workshop)	1	Discuss the various types of categorical and numerical variables and how they are assessed and used in a clinical research study
	1	Create and finalize the research project hypothesis by going over the measurable outcomes, predictors/risk factors and exposure groups with the designated PI
Introduction to Clinical Study Designs		Create the codebook of variables that will be used and assessed by the biostatician
		Understand the factors needed to calculate power and sample size of a study
		Understand the different types of clinical research studies, their strengths and weaknesses and how to apply to research hypotheses.
		Understand how to apply cross-sectional, case-control, cohort and case studies in practice

Workshop: Introduction to Proposal Development	1	Discuss and work on the different parts of the IRB protocol for Kaiser
Project Time; Work on IRB Protocol	1	and Objectives, Codebook and Methods (partial)
Interpreting Results Demystifying Biostatistics in Clinical Research	2	Understand how to interpret a p-value, 95% confidence interval, mean, standard deviation, median, range and quartiles
Interpreting Results Part 2: Prevalence, Incidence & Risk Ratios	2	risk ratios for cohort and cross-sectional studies Learn how to create a summary table of patient
Interpreting Results Part 3: [illegible] Ratios	2	Understand how to interpret the results of odds ratios for case-control studies
Dissemination Part 1: Write an Abstract	2	Learn the major components of writing an abstract for research conference
Dissemination Part 2: Presenting a Research Poster and Oral Presentation	2	Learn the major components of creating a research posterfor a conference Learn the major components of creating a research oral presentation fora research conference
Dissemination Part 3: Putting together a		Understand the process of manuscript submission to a peer-reviewed journal

Clerkship

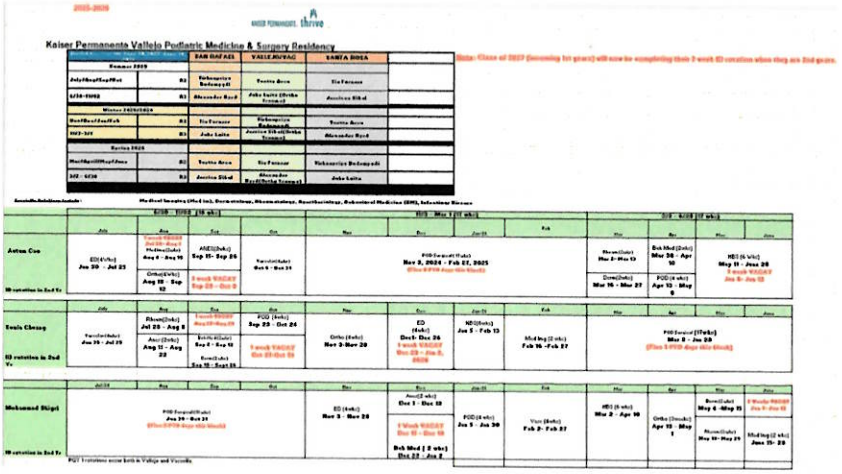
Dr. Omlin is the Clerkship Director. Residents are responsible for the practical aspects of day-to-day training and supervision of Clerks (i.e., Externs) at Kaiser Vallejo, Vacaville and Santa Rosa. Make sure to orient them as well as make them feel welcome. Direct them into the most educational opportunities throughout the day. Do not let them sit in the resident office when there are patients being seen in the clinic. They can always volunteer to shadow Attendings or other clinical experiences. Introduce them as students to patients whenever possible. The reason they are here is primarily as a long-term interview so make sure to fill out an evaluation — Dr. Omlin will provide via email - at the end of their time with us.

Clerks will be expected to do a presentation at Journal Club on a topic assigned to them on arrival. It will be 5- 7 minutes in length with a hard stop timer just like how we used to do in interviews. They can do it however they want (i.e., using PowerPoint, getting help from residents, etc.). The goal is to see how they prepare, present and wrap their head around a topic. If there are 3 Clerks that month, then they all will do a presentation on the SAME topic assigned to them. This will provide us with a good side-by-side comparison of the Clerks (without them feeling like that is the case) with regards to how well they prepared, their presentation style, etc.

Schedules

Annual Rotation Block Schedule

We create a yearlong schedule of rotations in a graphic form as below which shows where all 9 residents will be throughout the year. This document lives on MedHub and I recommend saving it to your personal files for easy access. A copy will be posted in the resident offices at all 4 sites. Keep an eye out for revisions.



Of importance, please note the following:

Your medical practice life will be ruled by schedules in a way that has not been true for you in the past. Any change in your schedule affects patients, your fellow residents, attendings and support staff. Clinic schedules are built by the podiatry departments 3+ months in advance while vacation schedules are planned a year ahead. Do your best to plan ahead and minimize last minute changes. When you do have an urgent need, make sure to think carefully about who will be affected and who to notify to minimize mayhem. In general, we strive to only have one Resident absent from a rotation at a time while on Podiatric Surgery rotations.

Daily Schedules & Duty Hours

*The most up to date call schedules are found on the **Lightning Bolt** app on your Kaiser iPhone, so make sure you have this downloaded in advance.*

Residents typically start their day at 7:15am, weekdays. You will usually report in the resident's room and gather the morning patient round's relevant overnight chart data and lab work and be prepared to visit patients on the hospital floor with your assigned on-call Attending.

Lunch is usually mid-day around 12:30pm-1:30pm and can vary slightly before or after depending on whether you are in the operating room or not. We strongly encourage our Residents to eat a complete breakfast and lunch while at the hospital.

The Resident's day ends around 5:30pm. If the Resident is on-call, there may be some extra events happening after 5:30pm, of which you are encouraged to grab a compensated dinner as well.

Call is divided amongst residents with first year residents taking "Buddy Call" to learn under supervision of a

more senior resident. The KNBC Residency Channel is used in Microsoft Teams. Call calendars for Vallejo/Vacaville, Santa Rosa and San Rafael are updated by chiefs on a regular basis.

CPME 320 Standard 6.10:

Duty/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.

Duty hours are consistently monitored by the region be sure to stay on top of those logs as well. MedHub has an app that makes this easier, don't forget to download.

What if you have personal schedule changes that need to be made?

Making clinic schedule changes is a risky endeavor that affects a lot of things in the background. Do your best *not* to do it and definitely don't initiate schedule changes on your own. There is a particular process, so make sure to discuss your schedule needs with the department chief, department manager and/or ask for help from the chief resident.

Didactics and Conference Schedules

The didactic program includes, but is not limited to, the following activities:

Weekly Academic Half Days - Vallejo/Vacaville

Monthly Journal Clubs — See Journal Club Topics and Annual Schedule below

- Weekly Radiology Rounds—Vallejo/Vacaville
- Clinical Teaching Time and Supervision
- Teaching Rounds on Wards
- Cadaver Workshops
- Regionally sponsored Educational Workshops

The Didactics Schedule is found and maintained on Microsoft Teams. Attendance is taken automatically depending on who owns the meeting invitation. If it isn't Shirley then please ensure to send her list of all who attended including faculty, hours and title of didactic subjects. It is critical that we capture every educational activity that you attend. For group events, the chief (3rd year) resident is expected to take attendance and each corresponding hospital site. SRO Chief will take attendance for the SRO/SRF radiology rounds and any teaching that took place during the rotation and send to Shirley The SRF Chief will take attendance for all Journal Clubs (in addition to setting this up initially) and any lectures provided. New schedule for 2025-2026 has not been completed at the time of this printing. It will be distributed via email and provided on Teams. This manual will be revised to include annual schedule and redistributed to residents.

Attendance must be taken (and include names of the Attendings present as well) for events such as: department Rounds, formal and informal lectures, Pharmaceutical Company presentations, regionally sponsored educational activities, ACFAS and other outside conferences and electronically accessed educational activities such as VuMedi videos.

SRF MANUAL

Resident Duties:

On Call:

1. **All inpatient rounding is to be completed prior to 8:30 am on regular clinic days and prior to 7:30 am on operating days.**

2. **On clinic days, residents are to report to the attending on call first thing in the morning to review inpatients and consultations. Residents are obligated to discuss their plans for the day, whether assisting seeing patients or shadowing.**

3. **There is no such thing as down time. If you do not have any clinic patients or surgical cases, the following is mandatory:**
    a. **Look at the attendings' schedule for shadowing and assisting opportunities.**
    b. **Review the upcoming surgical cases and discuss with the attending.**
    c. **Preparation for radiology rounds or journal club is to be done outside of working hours.**

4. **Contact the on-call attending for post op complications. Additionally, contact the surgeon that did the surgery as an FYI (even if that particular attending is not on call).**

5. **Call attending for fracture reduction if help is needed.**

Off Call:

1. **All inpatient rounding is to be completed prior to 8:30 am on regular clinic days and prior to 7:30 am on operating days.**

2. **On clinic days, residents are to report to the attending on call first thing in the morning to review inpatients and consultations. Residents are obligated to discuss their plans for the day, whether assisting seeing patients or shadowing.**

3. **There is no such thing as down time. If you do not have any clinic patients or surgical cases, the following is mandatory:**
    a. **Look at the attendings' schedule for shadowing and assisting opportunities.**
    b. **Review the upcoming surgical cases and discuss with the attending.**

c. **Preparation for radiology rounds or journal club is to be done outside of working hours.**

OR Days:

1. **Not every case requires both residents to scrub. Check with the attendings in clinic to offer any help. If help is not needed, then feel free to scrub.**
2. **Please be sure to check on any add-on elective surgery days that may not be on the original master schedule.**
3. **The residents are required to be thoroughly prepared for all cases. This includes:**
    a. **Reviewing the chart and imaging studies**
    b. **Discussion with the attending at least one day before the surgery**

Rounding:

1. If you are meeting with an attending to round on a specific patient, it is expected that any dressings, if applicable, be taken down prior to the attending's arrival, and new dressing material be at bedside. If there are other inpatients can be seen without an attending, they should be addressed beforehand.

2. Inpatient surgical patients need to be rounded on every day, even if we are not the primary service.

Weekend Calls:

1. You are required to see all images of fractures in the ER. Please do not rely on the ER physician's assessment.

2. Present all weekend fractures, injuries, or inpatient consultations to the attending on-call Monday morning (especially any that require surgery and/or pediatrics)

3. If you have any questions or concerns during the weekend, please do not hesitate to contact the attending on-call.

***Any issues with HBS or ED attendings, bring up to Dr. Choung.

Important Numbers:

Kaiser phones

Choung - 628-888-4466

Lin - 628-888-4447

Graham - 415-720-3616

OR surgery schedulers for add on cases - 2180

Nursing supervisor needs to be called for any cases added on the weekends.

Recovery PACU - 2190

House Supervisor - 4015

Operator from outside line 415-444-2000

No tie lines within San Rafael.

Code for cabinet in clinic rooms C 3322 'key"
Code for female OR changing rooms 512

Surgeon Preferences:

Images up. Mini C arm on same side as operating side, Big C arm on opposite side.

Local/Mac Injection: 1.1 ratio of 0.25% marcaine plain and 1% lidocaine plain

Tourniquet - thigh or sterile ankle depending on case.

Sterile ankle - make sure sterile tubing extension is up on back table.

Esmarch for ankle tourniquets.

Graham and Choung will elevate leg for thigh tourniquets.

Usually all tourniquets at 250 mmHg (ankle) or 275 mmHg (thigh).

Make sure surgical sites are shaved in the preop area.

Total Ankles:

Minimize traffic in and out of OR.

Make sure Big C arm is ready/on way.

Pull out lead, hoods and battery.

No local needed if adductor and popliteal block is performed.

Uses pulsavac for irrigation.

Switch gloves after irrigation, make sure army navys are rinsed.

Plaster posterior splint.

KAISER PERMANENTE®

KAISER SANTA ROSA

FOOT AND ANKLE SURGERY DEPARTMENT

RESIDENT'S SURVIVAL GUIDE

Department Chief
Nina Babu, DPM

Rotation Coordinator
Nina Babu, DPM

Faculty
Lex Barte, DPM
Kenneth Lopez, DPM
Ed Lopez, DPM
Katie Pettibone, DPM

Department Manager
Alicia Wiebmer

Welcome to Kaiser Santa Rosa. This manual is meant to make your life here easier and to delineate your expected responsibilities while you are on our service This manual should be read and studied prior to the start of the rotation. In addition, I recommend reading this manual after you have been present for one week on the rotation. There is no excuse for not knowing the information that is contained within this manual. If you do not understand anything that is contained within this manual, then contact Dr. Babu.

This manual is a work in progress at all times. If you feel that there is something that is missing or unclear in this manual, please inform Dr. Babu.

Kaiser Santa Rosa – Credentialing and Privileging Policies and Procedures

KAISER PERMANENTE

The schedule

Schedules are available through Lightning Bolt Application

X, R2AM,R2PM,R3AM,R3PM, = clinic time, see appendix for further explanation

Shadow = All schedules means you are shadowing an attending (Dr) or the cast tech (tech)
You will be assigned to an attending during your shadow time, during your shadow time you will likely have orthotic visits or IGNs. If there is no blue room scheduled cases then you can determine who to shadow on Thursday's.

T = teaching session

- You should give the attending as much advanced notice if you would like to request a specific topic to be covered.
- Usually not pre-built in the schedule but will arise during un-used Thursday (Blue Room)OR time.
- Location of these sessions are variable

- Formats include lectures, case discussions, and hands on workshops.

M = Department meeting

- Use this time to work on research, on occasion you will be expected to join

2nd call = on call

- For the attendings only, this means they are oncall.

AD/AF = Administrative time (only for attendings)
OR = Operating room.
H = Holiday
ATO = Personal Time off VAC = Vacation time EL = Education Leave

Appointment types

HR15/HR20 - Diabetic foot screen. Do not schedule pt to return for follow-up routine care unless
they have PVD, neuropathy, or history of amputation/ulceration. These are medicare guidelines. Speak with an attending if you don't already have a firm understanding of this. Risk assessment should be in HC
SD - Same Day appointment
TCON - This is a phone consultation.
PMT – patient management time (non-bookable time)
OCV/ODV – orthotic casting visit, orthotic dispense visit (no copays for these)
VAV/VCON- video visit, please let us know if you need training on this
Wound care appts with Ed are 30 min appts

SMW-WOCF is now the new dept that Ed Lopez is listed under, please add him to your preferences

Clinic

Clean up after yourself after all procedures. All sharps in sharps containers, and instruments should be placed into an emesis basin/metal container. Anything less than this will not be tolerated. Violation of this principle relates your lack of basic surgical knowledge and will force attending staff to treat you as such in the main OR. In addition, please clean up after yourself after casting.

Some general rules on treating patients in this clinic:

- All ingrown toenails that have appropriate vascular status should receive a matricectomy. A simple discussion of normal postoperative healing is all that is necessary. Unless there are extenuating circumstances a follow-up appointment should not be made for an ingrown toenail.
- All peripheral vascular disease patients should only receive an avulsion/wedge resection. A follow-up appointment for these patients can be considered.
- Any case that you are unsure of treatment should be reviewed with the SD or with the doctor that has been following this case with you historically.
- Any time you have a conversation regarding patient care with the on call doctor you should document this in the patient's chart. This will protect you if the patient's clinical condition does not improve as expected.
- In addition, any case that you feel confident treating, but feel is high risk for a poor outcome should be reviewed with the on call doctor as well.

MA's room the patients for you and are a great source of information regarding policy. Treat them with the utmost respect.

Use the wound care supplies from the drawers when possible. The supplies in the storage closet are for back up. A 3 day supply can be given for dressings but you will need to order additional supplies through generic DME in HC.

Nurse Response

#300, wait for 2 beeps, press 00 and Announce "Nurse Response Room Number X". Repeat this three times. Remember all people in the building will hear you.

- If you are in a room without a phone ask for assistance from MA, LVN, RN, or Attending and they will initiate the necessary steps

Simple vasovagal episodes

- All vasovagal episodes must have an attending involved immediately.

General flow of clinic

The patient's location is communicated to the entire team via the dot system as noted below:

Pt sent to X-ray by anyone (including physician) = red dot
Pt is in waiting area and ready to be roomed = yellow dot
Pt is in treatment room and ready to be seen by physician = green dot
Pt is in treatment room and awaiting f/u appt, repeat BP check or delivery of AVS by MA = white dot.

***Instructions to the MA can be placed in the "Schedule Comments" section of HC with a white dot ***

The staff is now 'scrubbing' the schedule so you will see that evolve during your time here

Clinic attire with white coats while seeing patients. Scrubs are ok now.

Didactics

Currently there **is Chapter review** generally the **1st and/or 2nd Monday** of the month and **Radiology Rounds** on the **3rd Wednesday** of the month.

Chapter Review

Residents will provide big picture overview of the chapter or Journal article(s)
Residents will provide questions to the group that they had

a. I don't understand ...
b. Do you apply this principle in real life practice...

Residents will also provide insight of what they found was a good piece of information they learned by reading the chapter.

Please have the chapter picked the Monday prior and send the information via email to the attendings.

Radiology Rounds

This is done the 3rd Wednesday of the month with San Rafael .
The 1st ~8 minutes are spent with a lecture by one of the 4 residents so in a 4 month cycle, each resident from SRO and SRF with perform one lecture.
The remainder of the time is spent presenting interesting cases worthy of discussion.

Academics will also occur on an ongoing bases when cases are not booked in Thursday's Blue Room time

IT

E-mail – Outlook

- This is the main way schedule changes, announcements, and policy changes are distributed.
- "I haven't checked my email for a while" is not an excuse for not knowing about an email message.
- You are expected to review DAILY.
- It is your responsibility to inform us that you do not have access to email

Lightning Bolt

- This is our online scheduling system. You should have a Username and Password to gain access prior to your starting but if not, let us know

eConsult

- Post booking review needs to be completed daily
- Review response needed daily with the on call or SD attending
- This how you will make consultations to vascular surgery, physical therapy, etc.
- Review with on call doctor prior to making any consultations. This helps you and your patient avoid unnecessary delays in receiving these consults.

Cast Room

If a pt has a cast on, or will have one placed, they need to be placed in the cast technicians schedule. They will place on all casts. However, we recommend you observe and learn from our cast technicians as they have a lot of experience to share.

Durable Medical Equipment

- This is equipment that is provided to the patient by the Kaiser insurance.
- Examples of these items include: Extra depth shoes with total contact inlays, custom shoes, wheelchair, walker, Lenard Splint, and AFO's.
- Items that are not covered by durable medical equipment include custom orthotics, multipodus boot, foam heel protectors, compression stockings.
- You should send your durable medical equipment prescriptions to the on call Dr..

Custom Orthotics

**currently sending to Sierra for $425

- These are not covered by Kaiser insurance
- A custom orthotic is $300. If you are prescribing an orthotic, it is your responsibility to inform the patient that this is a fee-for-service item. Do not expect the staff of the department to perform this for you.
- Once it is determined that an orthotic is necessary, you should complete a prescription and review this with the on call attending.
- Turnaround time from the date of orthotic casting is three-four weeks.
- Jack Rabbit can be a back up option
- 3rd year residents are now trained to scan and have 9 AM scanning appts during shadow days
- 2nd year residents still cast for orthotics
- Dr. Ed Lopez does a teaching workshop at the beginning of the rotation to educate you on the process and expectations.

Operating room

Please confirm with the attending if the add on case has been submitted and if special equipment is needed

Location - 2nd floor of main hospital for main OR.

Male locker = # 49 Female locker = combo is BOB

Outpatient surgery center is 2nd floor of MOB 5 –

Day before surgery

- Ensure all electronic documentation is present: consent, H and P, orders.

PRE-OP

- Prior to surgery make sure all interval H&P's, consent forms, orders are completed so that paperwork is not the cause of a delay.
- If a full H&P has not been completed then you must complete the H&P.
- Meet and greet the patient. Introduce yourself as the physician assisting the attending. Remember you are **not** the surgeon.
- Confirm the following
    - Side/site of surgery. (your are not allowed to sign the site of surgery)
    - Arrangements for post op pain management have been made
    - Pt is aware of post-op appointment
    - COVID testing

OR - Before attending enters room

- Have stentor images up on computer
- Have anesthetic drawn up if it is going to be used for preop
- Have all equipment necessary for patient setup in room (bumps, tourniquet, etc.)

- Review back table equipment and if you think a piece of equipment is missing then review with attending for its need. Do not have tech wastefully open instrumentation if attending has not requested it.

POST-OP

- Complete all admission orders, post op instructions, post op note, and dictation unless attending tells you they will do some or all of this. Please include the post-op plan at the end of the dictation.
- Order post op X-rays when necessary (ask attending after each case)
- Always have a time and a date on post op instructions so that patient will know exactly when/where to follow-up.

Division of Responsibilities between residents

When you are on-call is when you acquire patients. Once the patient is acquired by you, you are given the first option for being involved with the surgery.

- To acquire a case you must be the first resident to have performed the outpatient history and physical, by admitting the patient, or by performing the consultation.
- Once you are involved with the surgery, then you are required to follow the patient while they are in the hospital. The only exception to this is on weekends and holidays, at which point you're allowed to sign out to your co-resident if you wish.
- This means that if you admit a patient on the day that you are on-call, and the surgery is not performed until a day that you are not on-call, then you are given the first option to perform that procedure. It is your decision to hand off any surgery to your co-resident when the surgery is performed on the day that you are not on-call.
- Exceptions to this rule can be made by THE ATTENDING if it is felt that the case should be performed by the Chief resident due to complexity (i.e. pilon fracture, severely comminuted calcaneal fracture, etc.)

Admitting a patient:

- contact nurse supervisor to let them know of the admission
- Go to "Preadmit patients" and find your patient and open the "direct admission" navigator.
- In the navigator complete the H and P, orders, and consult requests.
- Never consult another physician level service without having direct communication first. An order for HBS consult without a physician to physician conversation is not a professional nor efficient way of managing the patients.
- Do not forget code status and D/C planner consult if necessary.
- Send patient to admitting department on first floor of main hospital.

Rounding on Patients

- Patients must be rounded on daily unless instructed otherwise by your attending.
- ***Communication between you and the respective attending is key***. Each day you should have a discussion with the attending physician of your patient as well as with the on-call physician for that day. The on-call physicians are routinely called by the nursing staff for these patients during after hours.
- Ensure that all hospitalized patients show up in the "foot and ankle list"
- When changing orders or other plans associated with your patients in the hospital please review with the attending prior to performing this function.
- Communication with discharge planners/HBS/nursing staff is key to successful hospital management

How to Discharge a patient:

- You should be thinking about the discharge of the patient at the moment the patient is admitted.
- If being d/c'd to a SNF or nursing home, you must have the completed d/c summary prior to the patient leaving.
- Write d/c orders in health connect, including Home Health, medications, DME, and f/u podiatry appt.
- Review all discharge orders with attending.
- If D/C to SNF is necessary then the discharge instructions in HC is where you place the SNF orders.

Dr. Babu's OR Preferences for Residents

Preop:

Review H&P and radiographs.

- Introduce yourself to the patient before the surgery and perform interval H&P
- If ORIF, cut the anterior aspect of the splint for skin/blister check if it has been more then a couple days since last assessment
- Place Images up on the computer in the OR.
- Local anesthetic:
    - 0.5% Marcaine plain for all MAC cases, drawn up during turnover
    - 0.5% Marcaine on the back table for Gen cases

Tourniquet:

- ankle: 250 thigh: 275
- apply ankle tourniquet sterilely on top of stockinette
- apply thigh tourniquets after anesthetized and with splint still on, if an ORIF
- Get the OK from the anesthesia provider prior to placing a thigh tourniquet
- foam tape around distal border of tourniquet

Patient positioning:

- Supine: Foot rectus toes pointing up
- Lateral Decubitus with bean bag: ORIF calcaneus, peroneal
- Prone: Posterior mal fractures. Achilles repair, AICT procedures-no pillows for positioning legs
- If in doubt, secure the contra-lateral limb with 3" cloth tape
- With large c-arm place blanket bump on operative leg
- Plan on sitting for case-foot of bed can be lowered in isolation if needed

Fixation:

- DMO: 2.7 screws
- 1st MTPJ fusion: Smith and Nephew variable angle set
- PIPJ fusions: 0.045/0.062 k-wires
- Metatarsal ORIFs: mod foot with extras
- ORIF ankle: mod foot with extras
- Calcaneal ORIFs: Synthes calc tray
- Rearfoot fusions/Calc slide: Synth 6.5mm headless cannulated

Bandaging/Casting:

- Local anesthetic block if appropriate (0.5% Marcaine)
- Betadine soaked Adaptic

Soft dressing :

- Dry gauze usually 4 x 4, kerlix, then coban or ace

Splint:

- 2 sets of 10 layers of 5" x 30" plaster splint
- 6" bias cut stockinette with medipore tape

Postop:

- I will communicate with you on that day as to who does the 'paperwork'
- Xrays: on all osseous cases unless otherwise indicated. MAKE SURE YOU REVIEW XRAYS IF YOU ORDER THEM

Basic principles while working with me:

- Attention to detail
- I am very generous with the knife but surgery is a privilege not a right
- I have high expectations and I will lay them out for you and give you feedback when necessary. I'm a big believer in immediate feedback so you can correct your mistakes.
- I am here to help facilitate the best learning environment so use me as a resource

Dr. Jordan's OR Preferences for Residents

Preop:

- Review H&P and radiographs.
- Introduce yourself to the patient before the surgery and perform interval H&P
- If ORIF, cut the anterior aspect of the splint for skin/blister check if it has been more then a couple days since last assessment
- Place Images up on the computer in the OR.
- Local anesthetic:
  0.5% Marcaine plain for all MAC cases drawn up during turnover
  0.5% Marcaine on the back table for Gen cases

Tourniquet:

- ankle: 250 thigh: 275
- Sterile tourniquets if available (apply to the impervious stockinette)
- apply thigh tourniquets after anesthetized and with splint still on, if an ORIF
- Get the OK from the anesthesia provider prior to placing a thigh tourniquet
- foam tape around distal border of tourniquet

Patient positioning:

- Supine: Foot rectus toes pointing up
- Lateral Decubitus with bean bag: ORIF calcaneus, lateral ankle stab, peroneal
- Prone: Posterior mal fractures. Achilles repair, AICT procedures
- If in doubt, secure the contra-lateral limb with 3" cloth tape

Fixation:

- DMO: mini frag
- 1st MTPJ, MC, medial column arthrodesis: small frag or modular foot
- PIPJ fusions: 0.045/0.062 k-wires
- Metatarsal ORIFs: modular hand set
- For ORIF ankle: Synth small fragment set (locking rare occasion), Synth large fragment on standby for all ankle ORIF.
- Calcaneal ORIFs: DePuy tray
- Rearfoot fusions/Calc slide: Synth 6.5mm headless cannulated

Bandaging/Casting:

- Local anesthetic block if appropriate (0.5% Marcaine)
- Betadine soaked Owen's silk
- Soft dressing :
  - Dry gauze usually 4 x 4, conform, then coban
- Splint:
  - 2 sets of 10 layers of 5" x 30" plaster splint
  - 6" and 4" Ace and 1" cloth tape

Postop:

- Jordan will communicate with you on that day as to who does the D/C sum, post-op orders, discharge instructions, and dictation. The resident will usually be asked to do the inpatient orders, inpatient rounds/progress notes, and D/C sum on inpatient cases.
- Xrays: most osseous post op cases.

Dr. KT Lopez's OR Cheat Sheet

Pre- op - Know my cases before the day of surgery. Ask me the day before surgery if you don't understand the rationale of the case or the technique we are going to do. This is the #1 way to keep me happy.

Set up my OR. Make sure my instrumentation and pt positioning equipment is there. If it isn't or if you don't know what I want, then ask me.

Place stentor images up on the computer.

I use 0.5% Marcaine plain for local.

Lack of these "minor" preparation details does not give me confidence in the resident, and hence results in greater percentage of the resident perfecting their retracting skills.

Do not ask me if you can do the case! I will give up the knife as I see appropriate. Constant asking of this, will have the opposite effect with me.

Tourniquet - Always apply

Thigh cuff = 275 Ankle cuff = 250

Pt positioning -All rearfoot cases, patient should be taped down with cloth tape to allow for easy and secure airplaning of OR bed during surgery.

All cases that you would want foot rectus, then use a bump if necessary under the hip, yes even for hammertoe cases.

Dissection – Cut through skin then blunt dissection with Metz is rule until past all neurovascular structures.

Dressings – listed on preference card in OR

Fixation

- I don't like bone staples, these are good for holding paper together.
- For forefoot work I usually use synthes.
- For rearfoot/ankle I usually use synthes small frag. I currently use tightrope for syndesmotic fixation.
- For anchors I usually use arthrex corkscrew/tenodesis screws.

Diabetic ulcers/open fractures

- Always keep a dirty and a clean environment during the procedure. Do not reuse instrumentation. You need to be thinking about this at the beginning of the procedure.

<u>Post Op Films</u>

- I will always acquire x-rays whenever a bone was cut, a foreign body was removed, a bone anchor was placed, or a soft tissue procedure for release of a severe contracture of the joint.

General Expections

- Perform all H and P's and consent forms for all add-ons.
- Perform all interval H and P's on all pts..
- Dictate all discharge summaries for all inpatients.
- Use your downtime wisely. Research, shadow attendings, etc.
- Be aware of all cases prior to meeting the pt. You should look at preop H and P or clinic notes for any case so that you know the rationale for operating. Understanding the indication is more important than knowing how to perform a surgery. Inform the attending if you do not understand the procedure selection.

General attitude in clinic/hospital

- Pt's/staff will view you as an extension of the attending. Treat these pt's as if they are your family.
- If you want to instigate a new plan on a pt (i.e. change antibiotics, debride a wound when we haven't reviewed this, take down a surgical dressing when we haven't reviewed this) contact the attending first. You have our numbers.
- Be courteous to all staff. Remember it is not your place to be mean to anyone even if they are completely incompetent. Inform your attending so they can deal with it if necessary.

General points to be made

- None of the staff is paid to teach. We all do this because we enjoy this.
- A lot can be learned by assisting. Some of best learning cases are watching attendings do both good and bad maneuvers.
- Shadow the attendings on your downtime. This is a large luxury to have. Don't be afraid to be selective of the cases you follow the attending with the majority of time; but be sure to still see a few heel pain, bunion, hammertoe, warts, routine complaints so that you can see how we conservatively manage these. Who knows you might actually learn this way.

Dr Ed Lopez clinic expectations/tips/pearls

Resident Wound Care Treatment & Documentation
Ed Lopez, DPM

- All wounds must have a pre- debridement and post-debridement photo
- Photos are a very important tool for evaluating wound healing. If you don't take a photo and measure the wound you are not doing proper wound care.
- Try to take photo perpendicular to the foot. The photo must be labeled indicating where the wound is, i.e., "Left sub 5th MPJ wound"
- The first photo should show where the wound(s) is on the foot. The 2nd photo should of the wound.
- If possible, use natural light. If photo is still dark, then use flash
- After debridement the wound must be measure for length, width and depth. It is easiest to put the measurement in millimeters and include in the name of the picture.
- After Debridement of the wound other photos must be taken of the wound.
- An example of this corrected labeling would be "Right 2nd Toe PIPJ wound 11 x 5 x 2 mm "
- It is expected that the Resident will learn how to offload a wound using various modalities.
- Remember It doesn't matter what medication you put on the wound if you don't offload the wound. Of course, there are other factors that are important, but offloading is the key.
- **When doing a encounter note when putting a patient's age and list problem list in the note make it refreshable. Please use .ageref and .probref Please Use .Ageref only in the subjective line. Wound Care & High-Risk Foot care patients are seen regularly for months, years and sometimes until death. Thus, a Refreshable age and problem list is very helpful.**
- **Please use a minimum font size 11.**

Orthotic Casting & Scanning

- Residents will be expected to become proficient of the Neutral Suspension Casting Technique
- Second Year Residents will learn to cast using Plaster of Paris using the Neutral Suspension Casting Technique.
- Third Year Residents will progress to using a Laser Scanner for Orthotics using the Neutral Suspension Technique.
- Residents will learn how to evaluate their plaster casts and laser scans before writing their writing their prescriptions for the orthotics.

Residents will write orthotic prescriptions addressing the patient's foot pathology

Diabetic Shoes (Extra Depth Shoes) & Custom Inserts Facts

Insurance Coverage - The Durable Medical Equipment Department approves through the patient's insurance and checks for DME coverage. DME approves Diabetic Shoes & Custom Inserts, AFOs, etc.

Diabetic Shoes are Extra Depth Shoes

- Custom inserts are covered by DME (Do not order off the shelf inserts)
- Not all Insurances offer Diabetic Patients DME coverage. So do not guaranteed coverage.
- DME coverage usually is 80% of the Medicare allowed Reimbursement. The patient's co-pay is usually 20% of the balance for the EDS and custom inserts. If the patient has a secondary insurance the 20% co-pay may be covered, and the patient would have no out of pocket cost.

Types of EDS Prescriptions –

Typically RX is for Off the Shelf shoes or Extra Depth Shoes (EDS) and 3 pairs custom inserts. (Pearl – write dispense 3 pairs of custom inserts in your order instructions).

The Custom inserts can be made in two ways.

1) Made by Weight bearing impression on soft foam box. Our local vendors use this technique.

2) Heat molded to a patient's feet. This can be done but is more time consuming.

Shoe Types

OFF the Shelf – Works for almost all of our patients. A digital amputation or even a TMA does **not** require a CUSTOM Extra Depth Shoe. Usually an Off the Shelf Shoe will be fine.

Custom Shoes – A severe Charcot foot deformity may require Custom Extra Depth Shoes but this takes up to 3 months to make. Plus, the co-pay (20% of the cost) is significantly higher to the patient.

Off the Shelf Shoe Variations – You can also order **Extra Extra Depth** Shoes for a patient with severe rigid hammer toes or overlapping toes . Custom Shoes will already be Extra Extra Deep since they are custom. Rocker Bottom shoes can also be ordered.

Custom Insert Coverage –

Custom Inserts – 3 pairs are covered per year. (please put in order instructions dispense 3 pairs)

Custom Insert with Shoe Filler - Our DME office is incorrectly only giving custom one insert with shoe filler for a TMA or digital amp annually. They should get 3 inserts per foot. This problem is being worked out by the Regional Wound Care Committee and the DME Department..

With Custom Shoes (EDS) the patient gets only 2 pairs of custom inserts annually not 3 pairs of custom inserts. I need to double check but I don't think a patient can get a pair of Custom shoes annually. Perhaps every 2-3 years.

Carbon Plates could also be ordered for patients with a hallux amp or TMA to help maintain a semblance of a propulsive gait. This will help offload the distal forefoot and prevent blisters, calluses and wounds.

Some of the above does not make sense but that is what the DME Medicare Coverage Provides.

HOW TO GUIDE

a. ER consult INFECTION

- Receive phone call from ED MD about the patient — listen to their given history:
  - Brief pertinent past medical history (e.g., uncontrolled diabetes, peripheral vascular disease, neuropathy, afib on blood thinners)
  - Brief background about mental status (e.g., developmental delay, altered mental status, severe dementia, combative)
  - Brief history of present illness regarding wound/infection
  - EXAMPLE: it will go something like this...
    - "Hi this is Dr. Blank from the (location) ED. I have a pretty nasty foot wound that I think

      podiatry will need to see. She is a 75-year-old lady, uncontrolled diabetes, who lives alone but takes care of herself. Her vitals are stable here, but she reports not feeling well for the past week and has measured temperatures at home to 101. She was brought in today by her daughter, who took off her shoes and found the foot wound in the picture that I put on Health Connect. I have ordered labs and a foot x-ray, which are not back yet"
- If not provided, ask more pertinent detailed questions about history
  - Ask about constitutional symptoms (fevers, chills, vomiting, diarrhea, malaise?)
  - Ask about vitals (SIRS criteria?)
  - Nature/location/duration/onset of wound
  - Mechanism of wound — puncture, foreign body, neuropathic ulcer, ischemic ulcer?
  - Pulses present?
  - Any pus?
  - Any fluctuance?
  - Did you take a culture?
    - If no photo — ask fora photo be uploaded to the chart.
      - Sometimes they give pushback and ask, "if I put a photo, are you still going to come?", but they haven't been doing that as much lately.
      - I just tell them that it helps us get a sense of what we're dealing with in advance, and I can show it to my attending. No problems there.

- Ask about lab abnormalities (CBC, lactate, ESR, CRP, Chem7)
- Has an x-ray been ordered or completed?
  - Typically, when you are called, it has been ordered but not complete yet
- Discuss with ED MD about your ETA and advice for now
  - Usually they don't care exactly what time you're coming, just that you are coming at some point
  - Things to strongly consider:
    - Verify their call back number
      - Say you'll run it by your attending
      - Ask for labs or XR if not ordered
      - Ask for photo if not uploaded, as discussed above

        - Ask for wound cultures — but in my experience they are hesitant to do it and slow about it (and they just swab the superficial skin flora), so just bring culture tubes with you
- Pack some essential supplies that you can't find in the ED
    - In general, it's best not to deplete clinic supplies that you can find in the ED, so I try to be mindful of that
    - Things to bring in your pocket, however, for efficiency:
        - #15 blade, monofilament to test sensation, cotton tip applicators, disposable curette, a few gauze packets
        - Possibly what wound care product you anticipate, that they wouldn't have in ED, if you want that to be applied right away (e.g., iodosorb, antibiotic ointment, Bactroban)
- Go to the ED
    - Depending on how prepared I feel with what I'll need, I usually go to the ED supply room first
    - Grab some more essential supplies that you'll likely need
        - Culture tubes, bacitracin or betadine paint swabs, gauze pads, ABD, Kerlix, tape, saline irrigation, chucks pad
- Go to the patient's room and begin consult
    - Introduce yourself and determine who is with the patient in the room
        - I usually say, "and who do we have with you?" to clarify their relationship
    - Obtain history
        - Ask about nature, duration, onset, etiology of wound
            - Often the details are fuzzy in neuropathic patients, but I find that family members are very helpful
            - Was there a change in activity or shoe gear?
            - Did you notice any pus or drainage?
        - Ask about constitutional symptoms (fevers, chills, vomiting, diarrhea, fatigue, loss of appetite?)
            - Measured fever to what temperature?
            - How many episodes of vomiting or diarrhea?
        - Ask about social history
            - Current or prior cigarette smoking? Marijuana smoking? How many cigarettes or packs per day, for how many years? When did you quit?
            - Alcohol use? What frequency? How any drinks per week, month, year?
            - Any recreational drug use?
            - Where do you live? Is this normally the hospital you come to for care?
            - Who do you live with at home?
            - What devices do you use for mobility at home?
            - What do you do for work? What did you do before you retired?
        - Somewhere in the history obtaining I am typically already examining the wound simultaneously
        - Check pulses
            - Per Dr. Willson —"if you have to think about if you can feel the pulses, then you can't feel the pulses. Go get a Doppler"
            - Have a low threshold for getting the Doppler — all ED's have them. Find out where they keep it, and you won't have to bother them again about where to get it

- Examine wound
    - On Haiku I usually take a pre-debridement photo of the wound, and a "global" sort of leg photo to show cellulitis or lack thereof
- Then debride wound
    - If you see pus — CULTURE IT
        - In vAi/vAc you need to do three of the white top EZ tubes (for Gram stain, aerobic, anaerobic)
        - I believe in SRO/SRF you only need to do one white top EZ tube for all in one, but I'm not sure about that one
- Irrigate wound
    - I usually use the large white chuck pad tucked under the foot and steer it into a red biohazard bin
    - Stuff a few paper towels in the biohazard bin hinge to keep it open on its own
    - Irrigate as much as you think necessary
- I usually take a post-debridement photo on Haiku
    - Consider taking a regular photo (not on Haiku) to send directly to attending's phone (obviously no part of patient's face visible, or name/MRN)
- Dress wound
- Clean up some of your mess...

- Give the patient a sense of what you're thinking, with the caveat that you'll discuss with your attending, if necessary.
    - 1) "This is very superficial, just needed some debridement, no signs of infection, we'll see you in clinic, +/- oral antibiotics"
    - 2) "I think you'll need to be admitted to the hospital to keep you on IV antibiotics, and we'll continue monitoring the wound and everything else to make sure the infection is under control"
    - 3) "This is a very bad infection, and I think we will need to go to the operating room to help get rid of this infection. Leaving it as is can make you very sick. You will be admitted to the hospital."

- Give yourself a minute to collect your thoughts and formulate your plan.
    - During this minute, I'll order the cultures, x-ray, labs, etc. that might also be helpful.
- Then call your attending and explain the above. I usually do so sitting at a computer so that I can fill in other details if they have questions. *Send* a photo to the attending directly, especially if they are at home and not near a computer.
    - Try to be concise — the art of this can be difficult to achieve, but it just takes some practice and repetition, and we are all still working on it to improve. Additionally, there are nuances with what each attending wants to hear...
    - Do whatever additional things they would advise.
    - Perhaps more debridement, more imaging, more labs
    - Perhaps filling in more details on certain parts of history
    - Talk to ED MD to update plan (they often don't really care, if they know HBS will already be admitting, but sometimes they are curious)
    - If patient needs to be admitted by HBS, talk to admitting HBS MD
        - Sometimes ED MD already did, and if the situation is pretty cut-and-dry, you don't necessarily need to talk to FIBS, since they will read your note
        - But otherwise, I think it is helpful to talk to them if they are already in the ED. Give them a brief presentation and explanation of the plan, particularly if it involves going to OR
    - Go back to patient's room and update them about the plan
    - Go somewhere else and write your consult note
    - If you stay there too long, you will get a sidebar consult about something else

ER consult ANKLE FRACTURE REDUCTION

- Receive phone call from ED MD about the patient — listen to their given history:
  - Brief pertinent past medical history (e.g., uncontrolled diabetes, peripheral vascular disease, neuropathy, afib on blood thinners)
  - Brief background about mental status (e.g., developmental delay, altered mental status, severe dementia, combative)
  - Brief history of present illness regarding injury/fracture
  - EXAMPLE: it will go something like this...
    - "Hi this is Dr. Blank from the (location) ED. I have a young guy who fell off a ladder a few feet and fractured his ankle. (Ideally, they tried to reduce it once, but sometimes they do not feel comfortable with this.) I tried doing a reduction, but it still looks like it needs improvement. If you have a moment to look at the XR..."
- If not provided, ask more pertinent detailed questions about history
  - Ask about constitutional symptoms (fevers, chills, vomiting, diarrhea, malaise?) Overall feeling well? Overall healthy?
  - Nature/location/duration/onset of ankle pain
  - Mechanism of injury
  - Pulses present?
  - Any open wound or skin tenting?
    - If skin is tenting, ask them to reduce the limb before sending to x-ray if possible, even if they don't get the reduction perfect, it's best to reduce the tenting until you get there and before x-rays (if possible), so that by the time you get there it does NOT turn into an open fracture.
- Discuss with ED MD about your ETA and advice for now
  - Verify their call back number
  - Say you'll run it by your attending
  - Say you'll need conscious sedation arranged, if you think you do (especially true for pediatric ankle fracture reductions, or very anxious patients)
  - Say you'll need splint materials and a cast tech to help you with splinting
- Review ankle films with attending
- Bring anticipated injection supplies from clinic to save some time (e.g., chloral prep wand and betadine swab for ankle hematoma block, 10cc syringes x2, 25-gauge needle x2, 18 gauge needle)
  - You can order local to the ED bedside, but this takes ages
  - Sometimes the ED will have it ready for you, but not often unless you specifically ask
  - Typically, there is an ED local anesthetic supply hidden somewhere in rapid care (learn where this is, and remember it)
- Go to the ED
- Go to the patient's room and begin consult
  - Introduce yourself and determine who is with the patient in the room
    - I usually say, "and who do we have with you?" to clarify their relationship
  - obtain history
    - Ask about nature, onset, mechanism of injury
    - Ask if they have overall been feeling well? Constitutional symptoms? Dizziness? Syncopal episode? What led to this fall?
    - Ask about social history
      - Current or prior cigarette smoking? Marijuana smoking? How many cigarettes or packs per day, for how many years? When did you quit?
      - Alcohol use? What frequency? How many drinks *per* week, month, year?
      - Any recreational drug use?
      - Where do you live? Is this normally the hospital you come to for care?
      - Who do you live with at home?
      - What devices do you use for mobility at home?
      - What do you do for work? Is there a modified duty version of your work, where you can sit and keep your leg elevated in your cast/boot?

- Start physical exam
  - Check pulses
    - Per Dr. Willson —"if you have to think about if you can feel the pulses, then you can't feel the pulses. Go get a Doppler"
    - Have a low threshold for getting the Doppler— all ED's have them. Find out where they keep it, and you won't have to bother the m again about where to get it
  - Examine for any breaks in skin/abrasions, pre-ulcerative lesions, skin tenting
  - Check for significance of edema (pitting?)
  - Take a photo on Haiku if any breaks In skin or significant edema
- Discuss XR findings with patient. It is helpful to show them the XR, as usually the ED MD has not. Discuss unstable nature of injury and need to attempt improved alignment of the ankle joint with closed reduction.
- Discuss ankle block to help with pain. Perform an ankle block —typically a common peroneal and ankle hematoma block, +/- saphenous nerve augmentation.
- Order a STATpost-reduction XR, portable OK to bedside. This is helpful *in* getting the ball rolling so XR is aware they need to come after you are done reducing.

- Make sure you have everything and <u>everyone</u> you need for the reduction. Cast techs are there in the ER too and need you to direct them before hand and during the reduction regarding what you want them to do.
  - Cast tech and all splinting supplies (Webril; 5x30 plaster, usually a set of 10 and 15 or something along those lines, for the posterior slab and stirrup; ACE or BIAS)
  - If conscious sedation, it's a much bigger production:
    - ED MD to administer anesthesia/conscious sedation
    - RN who is drawing and recording meds
    - Respiratory therapy at bedside
    - Cast tech
    - Extra set of hands for holding traction while you do reduction
- Position the patient in the way you think will be most successful.
  - For some patients, they can tolerate sitting up at the edge of the bed and dangling their leg down
    - You then can sit in a low stool or kneel on the ground to do the reduction, while the cast tech splints around your hands
    - You do not need as many other people around to help
    - I find this to work better for calmer patients, for which you do not need a ton of distraction or a huge maneuver for the reduction (and don't anticipate passing out on you! Make sure someone is there bracing them and rubbing their shoulders so if they start to get light-headed, they won't collapse over).
  - For the rest, and the EASIEST way, I have them lie flat on their backs on the gurney with their hip flexed at 90 degrees or greater and their knee bent also at 90 degrees (where the extra set of hands holds traction for you)
    - Make sure the bed is at the right height for you to do the reduction
    - Have the rail down so you and the traction person have good access. If you don't have a traction person, keep the rail up, pad it well with a few blankets, then dangle the leg over it
    - I find this to work better for when you need more distraction and a bigger reduction maneuver, as well as for patients who are less relaxed

- Do the closed reduction.
    - Have the cast tech splint around your hands. Make sure there is enough padding over the ankle fracture sites, without moving your hands or losing the reduction too many times.
    - I usually do one more squeeze/check after the layers of the splint are on, which also helps to mold it in.
- Wait for the post-reduction SPUNTTO DRY and keep your fingers crossed while waiting for the xray. You must wait for it to dry or else you will regret the loss of your reduction.
    - Take a screenshot of the portable XR image and send to attending to make sure they approve of your reduction.
- If still needs a reduction, repeat.
- If it's a successful reduction, let the patient know, let the ED MD know, and go write your consult *note.*

b. Write a consult note:

- Go to the patient's inpatient chart (double click *on* them from the Patient List)
- On the left-hand side, click on Notes
- At the top bar click on "New Note"
- Under Type, you will select "Consult Note" if you are doing a consult
    - You will click "H&P" only if you are doing an admission H&P, which we typically would do only for relatively healthy patients without systemic illness that requires HBS management
- Check the box for Cosign Required, and select the attending on call
- In the box, type your dot phrase for your Consult Note template
    - You will figure out along the way what you like to have in your Consult Note template — I cobbled something together from the standard Consult Note template that comes on Health Connect, with things I picked up from coresidents
    - Chief Complaint
    - History of Present Illness
    - Auto populated PMH, surgical history, social history
    - If you obtained a detailed social history from the patient that is not reflected in their chart currently, you should update it
    - On the left-hand side, click History
    - Click Substance &Sexual History— update everything
    - Click Social Documentation — include the date and add a little blurb about their job/marital status/living situation
    - Review of systems
    - Auto populated vital signs, blood glucose and intake & output if applicable
    - Physical exam
    - General profile of patient — e.g. elderly, disheveled, appears stated age, no distress, pleasant, conversant, etc.
    - Mental status — e.g. alert, confused, cooperative, oriented to self/place/time (I usually only ask these for patients with dementia or altered mental status)
    - Focused lower extremity exam
    - Auto populated labs
    - CBC, Chem7, PT/INR, ESR, CRP, albumin, serial lactates
    - Microbiology/cultures
    - Imaging reads
    - Assessment & Plan
    - Type a pertinent assessment of the patient, which includes their pertinent PMH and HPI up until the podiatry consult.

EXAMPLE: "Mr. Blank is a 74-year-old M with pertinent PMH including well controlled DM2 (A1c of 5.6 in 6/2018), PVD s/p R TMA in 2014, afib on lifelong coumadin, s/p kidney transplant in 2011 on

- immunosuppressants, who presented to the (location) ED with L 2nd toe wound, in setting of 4 days of malaise and fevers to 100 at home. Podiatry was consulted on (date) to evaluate L rd toe wound."
  - Type a brief description of the patient's overall picture — including vitals and pertinent labs, how sick appearing they are.
  - Type a brief description of your physical exam findings.
  - I have a list of separate recommendations as follows, in list format:
    - Surgery:
      - Anticipate OR L 2nd toe amputation tomorrow
      - No surgery anticipated by podiatry
    - Wound care:
      - RN to perform blank dressing change as follows
      - RN to leave dressing clean, dry, and intact— reinforce as needed for strikethrough —podiatry to perform AM dressing change
    - Activities:
      - L foot weight bearing as tolerated in post-op shoe
      - PT eval appreciated
    - ID:
      - Antibiotic—on zosyn (8/4-)
    - Dispo:
      - Pending above, improvement in wound/cellulitis/labs, culture results, PT eval
      - OK from podiatry perspective for discharge home today
      - Podiatry outpatient follow-up to be arranged
- At the bottom list which attending you discussed/saw the case with
- Have your name auto filled at the bottom

c. <u>Add on case request for surgery:</u>

***Case Requests are relatively time sensitive, once you find out you need to get a patient to the OR, place the case request first over writing notes!

- Open patient's hospital chart
- Left side tabs click on "Case Request"
- Under "order sets" type in "podiatry" in the search bar and click on the Day of Surgery and Intra-Op Orders Podiatry set
- Click on "Surgical Case Request" and fill out the following boxes:
  - Provider
  - Location (Val vs Vac)
  - Procedure date
  - Procedure (i.e. incision and drainage, closure of wound, midfoot amputation, ankle ORIF, etc.)
  - Laterality
  - Anesthesia: if neuropathic diabetic infection, choose local MAC. If trauma, choose "choice" (this means spinal vs general anesthesia) and type in region (i.e. foot, ankle, etc.)
  - Dx Assoc: you can click on current things already on their problem list that pertains to why they're undergoing surgery or type in a new diagnosis if not already listed
  - What date is the patient first available for surgery? Click on the date the patient is to undergo surgery
  - Case classification: usually for add on's they'll be within 24 hours or within 48 hours
  - Patient complexity: usually for diabetic infection they're "Relatively Complex"
  - Intended Post Op Dispo: If trauma and we don't need to keep them overnight, click discharge. For diabetic infection click "Med/Surg" unless they're going to ICU or need telemetry for a particular reason
  - Add on Case? YES ***this step is very important, it allows it to be placed in the depot and for the charge nurses to see it
  - After this I usually skip the rest until the Comments box. This is the place where you can put special equipment requests

- Infection: TPS (if amputating and need power), #111 blade, 2 bulb syringes for irrigation or cysto tubing, two 3-liter bags of normal saline for irrigation. Paterno and Lee specifically like the Stryker laparoscopic irrigator with the under buttocks drape
- Ankle ORIF: TPS, foot modular set, small frag, large frag on standby with large peri-articular reduction clamp, mini-C arm. Kernbach has a dot phrase. kksxankleorif that you can steal that has all the things he would want.

- If this is a case that is going during lunch or after clinic you can write in the comments the surgeon's availability (i.e. Dr. available after 3pm, etc.)

- Scroll down and click on the rest of the hard stop items
  - Diet, NPO
    - Click on this and click "no" on holding oral meds
  - Pre-Op Antibiotics
    - For diabetic infections, usually they're already on antibiotics and don't need additional dosing
    - For trauma, usually Ancef is good (go by patient's weight) and make sure to check drug allergies
  - I always click "apply sequential compression device" as well, unless it doesn't make sense to (recent angio/PVD pt that recently underwent some vascular procedure, ie, don't want to squeeze the leg when the vascular team spent so much time trying to open up the vessels)
- Click "Make it So!" button

- Consent
  - Column second to the far left with a link labeled "consents"
  - Click "New OR Consent"
  - Fill out the blanks
- Go to the SnapBoard and check to make sure your case request made it to the depot
- Call charge anesthesia first to let them know about the case request
  - Let them know name of patient, surgeon, generally the procedure, if they're an inpatient and anesthesia needs (local MAC vs general vs spinal etc.)
- Call OR charge nurse and let them know about the case request and what time you would like it to go (look at the OR board and check in with attending too to figure out ideal availability/time)

d. <u>Admission of relatively healthy patient from clinic (No HBS)</u>

- Perform your usual history and physical
  - Listen to heart, lungs, abdomen
  - Make sure to get a good review of systems
- Tell the patient about your plan for admission and anticipated length of stay
  - It is very important to ask the patient about CODE STATUS
    - Are they FULL CODE? If during this hospital stay they needed life-saving measures including chest compressions and a tube down their throat to save their life, would they want that?
    - Or are they DNR? And they would NOT want these life-saving measures
  - If they are DNR, is there a POLST documenting this?
    - Click on "Prior" next to Code at the very top of the chart
    - Click on Advance Directives and see if there are any documents filed
    - If there is nothing, ask ED PCC for assistance
- Go through all of their "Prior to Admission (PTA) Meds" in detail
  - Since podiatry will be the primary service, we need to know exactly which medications they are taking, and at what dosages.
  - Click on PTA Meds and update/clean it up accordingly. This will make your Admission Orders much easier!
- There are two pathways from here.
  - 1) See if patient can be admitted directly to floor, as a "direct admit"
    - Send the patient to Admitting.
  - 2) Have the patient go to the ED to get admitted via the ED

- Send the patient to ED.

- To figure out where to send them (and if you have no preference for direct admit versus ED), call the operator to connect you to BED HUB.
    - Discuss that you need to have a patient admitted from clinic— what is the bed situation?
    - They will tell you how feasible it is for a direct admission.
    - If there are no beds available, bed hub will tell you to send the patient to the ED to wait for admission there.
    - If there are beds available, bed hub will tell you to send the patient to Admitting, and from there they will be taken to their room.
- If you want/need to send to ED for admission (possibly to get started immediately with labs, IV fluids, IV antibiotics, any additional imaging), then send the patient to ED.
    - It is polite and prudent to call the operator to connect you to the ED CHARGE MD, so you can give report about a patient that you are sending over.
    - They will want to know patient MRN and name, what you are sending them for, what you want them to do (labs, fluids, antibiotics, imaging), and whether HBS knows (if they need to know).
- In the meantime, while you wait for patient to go to Admitting or to ED for admission, you can start your Admission H&P (obviously you just saw the patient in clinic, so there is no need for you to see them again elsewhere).
    - Under the patient's clinic chart, within the patient navigator, click on "H&P notes" on the left-hand side. In this section, you can write your full admission H&P, using your dot phrase for this.
        - This is different from your consult note or your pre-op H&P, in that podiatry will be the primary and admitting service. This means that you actually will be addressing all of the patient's hospital problems:
    - EXAMPLE for under Assessment & Plan:
        - L ankle fracture
            - Assessment: L displaced bimalleolar ankle fracture, unable to maintain NWB status safely.
            - Plan:
                - OR L ankle fracture anticipated on (date)
                - Maintain NWB in splint, PT eval pending
        - Depression
            - Assessment: Symptoms controlled.
            - Plan:
                - Continue home venlafaxine
                - Monitor symptoms
- Now check to see if the patient's inpatient chart has been created yet
    - At the very top, click Hospital Chart. Search for your patient. If the current admission file has been created, click on it and Accept. Now you are in the patient's inpatient chart for this admission.
- Now you can do their admission orders!
    - On the left-hand side, click on "Direct Admission."
    - If you weren't able to review PTA meds, do that now. Click "Review PTA Meds" and update them accordingly.
    - Click on "Admission Orders."
    - You can choose either of these, depending on where the patient physically is:
        - Patient is in a hospital floor or ICU bed — "Click here your orders will be signed for admission"
        - Patient is not in the hospital yet — "Click here your orders will be signed for admission"
    - Go through the "Reorder PTA Meds" tab
    - This is why the "Review PTA Meds" section is so important — now you can just

order all of the same meds that they normally take

- EXAMPLE:
  - Click on amlodipine.
  - Select the appropriate dose (which should already be listed as "Previous Sig"). Click frequency. Click when you want them to start taking it (e.g., this evening, tomorrow AM, etc).
  - Click Accept.
- Do this for all of their PTA Meds.
- Click Next.
- Now you'll be under the "New Admission Orders."
- Diagnosis—free type "ankle fracture, cellulitis, etc."
- Attending— select podiatry attending (as we are primary service)
- Type of admission — select observation (anticipate <24h), inpatient (>2 midnights), hospital ambulatory surgery (admitting only to PERIOP/PACU for surgery with anticipated discharge)
- Level of care —usually Med/Surg would be where we'd admit, or PERIOP/PACU if just going to surgery
- Service—Podiatry
- Click Accept
- Then in the box for "Additional Transfer Orders and Order Sets," this is where you can pull up a prepopulated order set to help you with the admission orders
- Then do their admission orders—there are a few options for the admission orders order set
- FIBS Standard Admission OrderSet
  - +Insulin Sliding Scale Order Set (if a diabetic patient— however this would typically be done by HBS if they are diabetic, i.e., ASA CLASS III or higher. In cases where the pt is a diabetic, please always consult with the HBS doctor. They really should be doing the admitting as they manage their meds/fluids in more detail. Remember, to also discuss any medicine orders that YOU specifically placed for whatever reason with not only FIBS admitting them but also your on-call attending as it is their license on the line).
  - ALWAYS talk to the attending as to what pain-control management they want for the pt. Don't assume to know. DISCUSS THIS!
  - This is my go-to admission order set, as it includes everything most patients would need,
- ERAS Admission Order Set
  - This is a helpful orderset for patients that will be going to surgery while admitted, and you want some good options auto populated for post-operative pain control and therapy
  - Avoid glucose preop *beverage* in any pt. that has had gastric bypass surgery
- Ortho Extremity Order Set
  - This is another helpful order set for patients that are admitted post-op, although it does not have all the features of the ERAS post-op pain protocol
  - It includes details like "apply drain to suction," "measure drain output," "initiate PT eval on day of surgery"

- If there are any additional orders to do that were NOT in the admission order set (sometimes you'll want something extra, for example typically you do have to do a separate diet order), you can also free type these orders separately in the same box.
  - EXAMPLE: Diabetic diet, no concentrated sweets; NPO after midnight; NPO now except meds
  - EXAMPLE: Patient activity — bedrest with bathroom privileges

        - EXAMPLE: Nursing wound care order— write specific wound care orders
    - Then click Next or "Review and Sign & Hold"
        - Then click Sign & Hold your orders
    - Now you're all done with admission orders!
    - All that's left is to finish writing your Admission H&P.
    - (Don't forget to log it on Podiatry Residency Resource.)

Admission of relatively healthy patient from ED (No HBS)

After seeing your consult in the ED and doing a full admission H&P (please review workflows for how to see a consult in ED) ...

- Tell the ED MD that you will be admitting the patient under podiatry as primary service and that you will be doing the admission orders
- Tell the patient about your plan for admission and anticipated length of stay
- It is very important to ask the patient about CODE STATUS
    - Are they FULL CODE? If during this hospital stay they needed life-saving measures including chest compressions and a tube down their throat to save their life, would they want that?
    - Or are they DNR? And they would NOT want these life-saving measures
- If they are DNR, is there a POLST documenting this?
    - Click on "Prior" next to Code at the very top of the chart
    - Click on Advance Directives and see if there are any documents filed
    - If there is nothing, ask ED PCC for assistance
- Click on "ED Consult/Admission"
- Click on "Review PTA Meds" in the left-hand navigator under My ED Documentation
- Since podiatry will be the primary service, we need to know exactly which medications they are taking, and at what dosages.
- Update/clean it up accordingly. This will make your Admission Orders much easier!
- Along the top bar click "Floor/ICU Orders" — this is where you will do all of your admission orders
- Now you can do their admission orders!
- Go through the "Reorder PTA Meds" tab
    - This is why the "Review PTA Meds" section is so important — now you can just order all of the same meds that they normally take
    - EXAMPLE:
        - Click on amlodipine.
        - Select the appropriate dose (which should already be listed as "Previous Sig"). Click frequency. Click when you want them to start taking it (e.g., this evening, tomorrow AM, etc.).
        - Click Accept.
    - Do this for all of their PTA Meds.
    - Click Next.
- Now you'll be under the "New Admission Orders."
    - Diagnosis —free type "ankle fracture, cellulitis, etc."
    - Attending — select podiatry attending (as we are primary service)
    - Type of admission — select observation (anticipate <24h), inpatient (>2 midnights), hospital ambulatory surgery (admitting only to PERIOP/PACU for surgery with anticipated discharge)
    - Level of care —usually Med/Surg would be where we'd admit, or PERIOP/PACU if just going to surgery
    - Service—Podiatry
    - Click Accept
    - Then in the box for "Additional Transfer Orders and Order Sets," this is where you can pull up a prepopulated order set to help you with the admission orders
- Then do their admission orders — there are a few options for the admission orders order set
    - HBS Standard Admission Order Set

- +Insulin Sliding Scale Order Set (if a diabetic patient — however this would typically be done by HBS if they are diabetic, i.e., ASA CLASS III or higher. In cases where the pt. is a diabetic, please always consult with the HBS doctor. They really should be doing the admitting as they manage their meds/fluids in more detail. Remember, to also discuss any medicine orders that YOU specifically placed for whatever reason with not only HBS admitting them but also your on-call attending as it is their license on the line).
- ALWAYS talk to the attending as to what pain-control management they want for the pt. Don't assume to know. DISCUSS THIS!
- This is my go-to admission order set, as it includes everything most patients would need

- ERAS Admission Order Set
  - This is a helpful orderset for patients that will be going to surgery while admitted, and you want some good options auto populated for post-operative pain control and therapy
  - No preop glucose beverage for gastric bypass patients
- Ortho Extremity Order Set
  - This is another helpful order set for patients that are admitted post-op, although it does not have all the features of the ERAS post-op pain protocol
  - It includes details like "apply drain to suction," "measure drain output," "initiate PT eval on day of surgery"

- If there are any additional orders to do that were NOT in the admission order set (sometimes you'll want something extra, for example typically you do have to do a separate diet order), you can also free type these orders separately in the same box.
  - EXAMPLE: Diabetic diet, no concentrated sweets; NPO after midnight; NPO now except meds
  - EXAMPLE: Patient activity — bedrest with bathroom privileges
  - EXAMPLE: Nursing wound care order—write specific wound care orders
- Then click Next or "Review and Sign & Hold"
  - Then click Sign & Hold your orders
- Now you're all done with their admission orders from the ED

- Now click on "ED Consult/H&P"
- This is where you will write your Admission H&P, using your dot phrase for this
  - This is different from your consult note or your pre-op H&P, in that podiatry will be the primary and admitting service. This means that you will be addressing all of the patient's hospital problems:
- EXAMPLE for under Assessment & Plan:
  - L ankle fracture
    - Assessment: L displaced bimalleolar ankle fracture, unable to maintain NWB status safely.
    - Plan:
      OR L ankle fracture anticipated on (date)
      Maintain NWB in splint, PT eval pending
  - Depression
    - Assessment: Symptoms controlled.
    - Plan:
      Continue home venlafaxine
      Monitor symptoms
- (Don't forget to log it on Podiatry Residency Resource.)

Admission of a relatively unhealthy patient to hospital FROM ED (HBS NEEDED)

- Podiatry is only the primary service for patients that are relatively healthy(anyone with ASA III or above is out of our jurisdiction — so essentially any diabetic is not appropriate for us to be primary service).
  - So, you will NOT be doing a full admission H&P, since you will not be doing the full

admission orders.
    - If you want to, for learning purposes, you still can do a full H&P (minus the admission orders).
    - Or you can do the admission orders and have FIBS check all of them for you. I have done this sometimes as a learning exercise or as a courtesy if HBS is slammed, and the patient is not too difficult to handle.
- After seeing your consult in the ED (please review workflows for how to see a consult in ED)...
- Tell the ED MD you think the patient needs HBS admission
    - A lot of the time, the ED MD will have already talked to HBS — but if not, let them know and they will often page HBS
- Page, call, or talk to HBS in person (they are often floating around ED somewhere)
    - Tell them what the general plan is, antibiotic recommendations, weight bearing restrictions
- ...and that's it. It's a lot easier when HBS does the admission orders.
- Go off somewhere and write your Consult Note (please review how to write a consult note), before you get another sidebar consult.

e. Rounding Workflow
- Pre-round (check vitals, cultures, pathology, overnight events, labs). Sometimes pending your progress notes ahead of time can help with pre-rounding
- Round w/ or w/o attending (bring supplies you wouldn't be able to get on the floor like 15 blades, tissue nippers, 4x4 woven gauze, etc.)
- Sometimes an attending may ask that you already take the pt's dressing down and they will meet you at the room. They will let you know.
- Place orders that were decided on during rounding (XR, NIVS, patient activity status, nursing dressing changes, cultures, etc.)
- Touch base with primary care team on your plan for the patient (esp if patient is going to OR or needs to be NPO after midnight)
- Write your progress note (aim to have this in ~10am)

f. Inpatient chart review
- Click on Patient List 3 Print out the list
- Double click on the patient's inpatient chart
- Check and write down vital signs
    - Check on tmax (temperature max over 24 hours) and write down
- Click on labs
    - Check on CBC, Chem7
    - Check on any pertinent updates like HbA1c, albumin
    - Click the ID/MICRO checkbox
        - Review any new culture results and sensitivities
    - Write these down
- Type "Micro" in the search box
    - This is how I look at what antibiotics they are on now, and what they were on previously
    - Do these make sense for what bacteria are growing?
- Check on any new imaging if you ordered any
- Click on Notes
    - Read most recent notes since last progress note — any interval events over night? Any changes in plan per HBS notes?

g. **Discharge from Hospital Workflow (when podiatry is not primary service)**
- Discuss your plan with HBS — that patient is OK from podiatry perspective for discharge
- As needed, discuss certain discharge issues with PCC (that might affect placement):
    - Wound care:
        - Patient needs daily wound care — typically has to go to a SNF
        - Patient needs3x weekly wound care — might be able to be covered by Home Health Nursing or at a Board & Care

        - Discuss needs such as a freedom home wound VAC for home
    - Physical therapy:
        - Daily physical therapy —SNF
        - Intermittent physical therapy — home health physical therapy
    - Kaiser member?
        - If not, the patient can typically have one outpatient specialty follow up visit
        - Discuss with PCC your requests for timing of outpatient follow up (such as at the county hospital, or at the VA)

- Make sure patient has outpatient follow-up (either arranged for staff has been messaged to make follow-up)
    - Double check the correct location they would want to follow up in

- Now write some podiatry-specific discharge instructions
    - Click on "Discharge" on the left-hand menu
    - Click on "Write Discharge Instructions"
    - Use your dot phrase for podiatry discharge instructions
        - Steph's is. smdci
        - Megan's is. mhayswoundcare
    - Just some basic instructions about wound care, weight bearing status, elevation/icing, rest, taking antibiotic as prescribed, monitoring for signs of infection
    - Include the smart phrase for future appointments refreshable (.futureapptrf)
    - Include the smart phrase for clinic phone numbers (.rjclinichours, or Megan's is kaiser hours)

Discharge from Hospital Workflow (when podiatry is the primary service)

- If you need any assistance with anything, call the PCC for help
- You will still need to do a full physical on their day of discharge
    - I usually do a regular Progress Note, just for simplicity (rather than trying to cram a physical exam Into the discharge summary note)
- Then you can start their discharge paperwork—so click on "Discharge" on the left-hand side
- Click on "Reconcile Orders"
    - Click on "Click Here" beneath "Reconcile and Write Discharge Orders"
        - This is where you will go through all of their medications that they should be discharged with
        - If they will need refills or new orders on anything, you will reorder them here
        - For pain medications, this has to be done by an attending
        - Make sure to send to the discharge pharmacy
        - These orders will be signed and held pending discharge
    - Then click on "Write Disch Instr"
        - Instead of the short blurb version of podiatry-specific instructions, you have to do the full template of discharge instructions (.dci)
            - Tab through the discharge instructions and fill out everything
            - Under "topics to discuss with my doctor," I usually format it the way that a patient (layperson) would frame it
                - "My pain," "my mobility," "my surgery recovery"

- Under "activities and lifestyle," I actually delete this and replace it with my usually podiatry-specific blurb of discharge instructions — or if it is a post-op trauma type patient, I sometimes use the standard post-operative instructions as if it had been an ambulatory surgery

o Then click on "Discharge Summary"
- Use the dot phrase ". dcsumm" to get the template
- Click on "Standard Discharge Summary"
- Tab through it and fill it out
- Under "Issues to be addressed at follow-up"
  - # Ankle fracture s/p ORIF (DOS 8/6/18, Dr. Blank)
    - oIn splint, non-weight bearing
    - oOutpatient podiatry f/u arranged for 2 weeks
  - # Anxiety
    - o Continued on home meds as inpatient
    - o Defer to PCP for further management
    - o Under "Hospital Course and Significant Findings"
  - I use another dot phrase ". smdcsumm" — this is just a very brief summary of the patient's hospital course for people to be able to read easily later on, to get a sense of what was done during their hospital stay
- Under "Reason for Hospital Admission" — type. admitdx
  - o Then click "Order to Discharge"
- Select Discharge Disposition — Home, SNF, Home Health
- If there is anything CONDITIONAL about the discharge (meaning you are
- waiting for a consult first, or something that needs to happen first), then click on Conditional DC Usually for our purposes, it is just waiting for a Physical Therapy eval
- Click Accept
- Click Order to Discharge

h. <u>Elective OR Day Workflow</u>

Day Before Checklist
- POM Pre-Op H&P
- Consent
- Read over office visits/pod pre-op appts
- Check if they have followed up (if not, staff message for a f/u appt or make one yourself in CIPS)
- <u>Day of Surgery</u>
- IF YOU ARE ROUNDING PRIOR TO STARTING OR GOING INTO THE OR, **<u>YOU MUST CHANGE YOUR SCRUBS!</u>** (would you want someone to operate on your bunion who just changed a gas-gangrene pt's dressings? NOPE!)
- Check in the patient (usually get there around 7:15am or so)
- Introduce yourself to the patient, ask if they've had anything to eat/drink since midnight,
- confirm side and procedure
- Listen to their heart, lungs and examine the foot that is to be operated on
- Can discuss general things to expect postoperatively, let them know the attending will be by to
- sign their foot
- Write your interval note (get this in by/before 7:30am)
- Go to Snapboard, double click on their case
- Far left column click on "Notes"3Add new note-)under note type, type in "interval H&P"
- .interval for dot phrase and F3 through the blanks

- You should be clicking yes for reviewing labs/data/imaging etc.
- When it comes to physical exam I usually click on "General Appearance, Mental Status,
- Chest, Lungs, Extremities"
- For extremities I type in exam findings that are pertinent to their surgery
- Set up OR
- X-rays (cid.kp.org)->click on "NCALRadiology..." link->Vallejo—>sign in->type in
- patient's MRN (usually needs one "0 [zero]" beforehand)
- Pull up pertinent images
- Bump, tourniquet, gloves/gowns
-

i. Clinic Surgery Workflow

Before

- Create consent and print out
- MA's should set up the room, but you can help out
- If it's a hardware removal, make sure you have the proper equipment to remove the hardware! (may
- have to call SPD to get special equipment)
- Draw up local
- Go over consent w/patient and have them sign (MA witnesses' consent)
- Usually attending is okay for you to do local block beforehand and putting on tourniquet but can check with them beforehand
    - Usually you can gown/glove first, so you can drape the patient/help attending gown and glove After
    - Patient instructions

14. **After Graduation** (Board Certification and Pass Rate Reporting)

Board pass rates are an important metric that we use to monitor the effectiveness of the residency training we provide; results are reported yearly in the Annual Program Evaluation. Residents typically take ABFAS board part 1 (qualification exams) during the 3rd year of training and are notified of their results in the spring.

The following URL will link you to the necessary information from ABFAS. Pathway to Certification | ABFAS

Please plan to notify us of your results as you take these exams and eventually become board certified. Send score results to the Program Coordinator. Your training qualifies you to pursue certification in both Foot and Reconstructive Rearfoot and Ankle surgery so make sure to review the website for the details of the process.

Appendices

APPENDIX A: Curriculum

APPENDIX B: Block Schedule

APPENDIX C: Appeals Process

APPENDIX A: Curriculum

Anesthesia Curriculum

This is a two-week rotation designed to expose the 1' year residents to the medical care of the patient during their surgery experience. The following document provides a framework for pursuing the learning experiences available in both the operating room and perioperative care areas. At the end of the rotation, the resident should have a deeper understanding of the total care experience including managing medical risks for the wide variety of patients undergoing various types of surgery and anesthesia.

Knowledge and Skills

1. Understand and perform a History and Physical exam specific to the **pre-anesthetic assessment.**
2. Understand and assign the correct **ASA status.**
3. Understand the risks, benefits and appropriate uses of various **anesthesia options.**
4. **Understand** the proper use and selection of **pre-anesthesia medications.**
5. Understand and recognize **anesthesia complications** and their management, including Bronchospasin, Laryngospasm, Difficult Airways, Difficult Intubatiuns, Allergic Reactions and Altered States of Perfusion.
6. Understand the techniques and options for evaluating and **maintaining an airway.**
7. Understand and participate in intubation, including use of a **glide scope.**
   S. Properly manage an airway using Mask **Ventilation.**
9. Understand the proper techniques of **patient positioning** for surgery and anesthesia.

Attitudes

- Develop and exhibit professionalism with respect to timeliness, collegiality and fully engaging in the learning process.

Experiences

- Assist and observe preop anesthesia H&P's using the anesthesia specific preop H&P forms. (ACS H&P)
- Shadow and participate in patient evaluation and care with the Charge/Late anesthesiologist.
- Spend a half day participating **in** various regional anesthetic nerve blocks, including popliteal blocks.
- Learn and practice mask ventilation techniques.
- Engage the anesthesia provider during cases and ask questions about medications used, familiarize with the setup and monitoring of various machines and monitors, anesthesia complications and review the monitoring of specific vital signs involved.

Reading and Resources

- ACS H&P template.
- Additional Issues to Consider in this document:
  More about specific pharmacology of induction agents, muscle relaxants, toxic doses of local anesthetics, ERAS protocols, pain management, RSD blocks, evaluation and management of cardiac risk

Competency Fulfillment 6.1 A. 4. & B.7.; 6.4

KAISER PERMANENTE VALLEJO FOOT AND ANKLE RESIDENCY PROGRAM

Behavioral Medicine Curriculum

This is a two-week rotation based in the Chemical Dependency Recovery Program department arid affords rt year residents a look inside the world of psychological and psychiatric disorders and treatment. By the end of the rotation, the resident will have a greater appreciation for and recognition of patients with this subset of disease.

Knowledge and Skills

1. Understand and identify the effects of medications used in the treatment of common mental disorders.
2. Understand the effective use of **narcotic analgesics** and the factors which lead to dependence and/or abuse.
3. Understand the factors involved in managing patients with **chronic pain.**
4. Understand how to establish a **therapeutic relationship** and **motivate change** in patients, including those suffering from common mental disorders, including **Chemical Dependency, Eating Disorders, Common Mental Disorders**
5. Understand how to effectively communicate with patients who may have deficits in literacy and verbal communication.
6. Understand behavioral and communication differences amongst diverse patient populations.
7. Demonstrate awareness of psychological factors that may affect clinical and surgical decision making.

Attitudes

- Demonstrate professionalism with respect to timeliness, demeanor and engaging in the learning experience.

Experiences

- The resident is exposed to the necessary learning experiences by participating in psychosocial treatment sessions (including group and educiltion sessions), clinical team meetings, initial addiction medicine and addiction psychiatry assessments as well as follow up visits. Through these experiences the resident should look for opportunities to gain the understanding listed above, not only through participation in the experiences, but also by asking questions of the providers who lead the training experiences.

Reading and Resources

- "Mastering the Addicted Brain" Walter Ling, MD; "Responsible Opioid Prescribing" - Scott Fishman; "Feeling Good: The New Mood Therapy" - David Burns, MD; "Addiction" HBO Series DVD 2012

Competency Fulfillment

- 6.1 B. 10.; E.1-2; 6.4 c.

Dermatology Curriculum

This is a two-week rotation for 1'-year residents based at the Fairfield outpatient clinic and led by Dr. Fromer. A fuller understanding of the morphological basis of skin disease identification, categorization, and treatment will be developed by the resident. Essential diagnostic methods and effective treatment protocols will be a key part of the experience allowing residents to develop competence in treating the full variety of skin conditions encountered in the lower extremity.

Knowledge and Skills

1. Understand and describe the **classification of skin diseases based on morphological structure** with categories including papulosquamous, inflammatory, eczematous and granulomatous disease.
2. Understand and describe the essential microscopic and gross features differentiating between benign and malignant melanocytic skin lesions.
3. Understand and describe the **staging of malignant skin lesions.**
4. Understand and describe essential workup, diagnostic features, and appropriate treatment plans for **mycologic skin and nail disease.**
5. Understand and describe essential workup, diagnostic features, and appropriate treatment plans for **papulosquamous skin disease.**
6. Understand and describe essential workup, diagnostic features, and appropriate treatment plans for **hypersensitivity dermatoses.**
7. Understand and describe essential workup, diagnostic features, and appropriate treatment plans for **infectious skin disease.**
8. Exhibit sufficient knowledge of common dermatological conditions and be able to provide an appropriate **differential diagnosis.**
9. Understand indications and proper techniques to perform a **shave, punch, and excisional biopsies.**
10. Understand and describe the use of **topical steroids,** their classification by potency, and prescribe the proper drug, potency, and dosage amount.
11. Understand indications for and properly performs **cryotherapy.**

Attitudes

- Accept criticism constructively.
- Demonstrate responsible, reliable, and punctual behavior and engages fully in the clinical learning process.
- Maintain a professional appearance and demeanor appropriate to a clinical setting.

Experiences

- By seeing outpatient clinic patients in the dermatology clinic under direct supervision by staff dermatologists, the resident will gain the knowledge and skills outlined above. This experience will allow the resident to expand and develop their understanding in the recognition and treatment of the variety of dermatological conditions and how they manifest in the lower extremity.

- Key learning goals include skin cancer management, fungal disease management, and topical steroid class and usage.
- Pursue additional procedural/biopsy experiences and exposure to KOH prep by discussing with Dr. Fromer and consider pursuing these experiences with other faculty as available.
- 3-clinic Days, remote lunch sessions for gaps in clinical coverage

Reading and Resources

- American Academy of Dermatology website:
  Basic Dermatology Curriculum **nups://www.aaa.orgjeaucationhasic-aerm-curriculum** — review 1 week ahead. Review and discussion of the modules with Dr. Fromer during the rotation especially: Adult Fungal Infections, Bacterial Skin Infections, Melanoma and Non-Melanoma Skin Cancer, Warts, The Red Leg.
- Principles of Dermatology by Lookingbill and Marks (Clinical Library and by loan)
- Lynch's Dermatology for House Officer (by loan)
- Fitzpatrick's Dermatology Color Atlas (by loan

Competency Fulfillment

- 6.1:A 1, 4 & 6.4:f

KAISER PERMANENTE VALLEJO FOOT AND ANKLE RESIDENCY PROGRAM

Emergency Medicine Curriculum

This is a one-month rotation at Kaiser Permanente Medical Center in Vacaville, CA — a Level 2 Trauma Center. The rotation is coordinated by Dr. Taya Roberts. Anjanet David is the administrative contact. Dr. Holder needs to review the annual schedule to insure we aren't overlapping with the FM Residents.

Knowledge and Skills

1. Understands and performs a **Comprehensive History and Physical Exam** appropriate to an emergency presentation and documents the appropriate level of detail using logical organization.
   Performs and documents a **Trauma Evaluation** with appropriate level of detail.
3. Recognizes and gets help with **Medically Unstable Patients** accurately assessing the essential clinical exam, vital signs, EKG, and laboratory findings.
4. Develops skill in **Verbal Patient Presentations** using good communication skills and logical organization.
5. Understands appropriate use of **Laboratory and Imaging Studies** for the assessment of the emergency department patient.
6. Understands principles of **BLS and ACLS** in relation to the emergency room patient.
7. Understands the role of medical and surgical specialties with **Appropriate Consultation** in emergency room setting.
8. Performs **Emergency Room Procedures** including, but not limited to:
   Laceration Repair, Subcutaneous Abscess Drainage, Reduction of Extremity Fractures and Dislocations, Intravenous Access and Line Placement, Intubation.
9. Demonstrates increased knowledge and skill in the use of ultrasound for medical evaluation in the Emergency Room setting.
10. Demonstrates appropriate level of knowledge and skill in the administration of **Procedural Sedation** including medications and proper patient monitoring.

1 1 Understands the effect of **Socioeconomic Issues** on medical decision making.

12 Understands medical decision making with respect to **Admission and Discharge Criteria.**

13 Understands how to **Prioritize the Differential Diagnosis** to clear a patient for discharge.

Attitudes

- Pursues learning opportunities wherever possible.
- Accepts criticism constructively.
- Respects and adapts to cultural differences.
- Establishes trust and rapport with patients and peers.
- Functions appropriately in a multidisciplinary setting using good communication skills.
- Demonstrates responsible, reliable, punctual, cooperative behavior and maintains records in a timely manner.

Experiences and Expectations

- You will see patients independently. Therefore, if you see that a patient has unstable vitals, notify the supervising physician before seeing the patient. If a patient looks, acts, or otherwise seems altered, notify the supervising physician immediately.
- Be reliable. Follow through on all tasks that you have committed to with the care team.
- Be relentlessly proactive to learn as much as possible.
    - You will be assigned to one attending for each shift, but you can branch out and gain experiences from the other attendings.
    - introduce yourself to all faculty on both sides of the ED (and even In rapid/urgent care); let them know that you would like to be notified of interesting cases or procedures.
- You will *see* both podiatry and non-podiatry patients; you will help expedite the work up of foot and ankle cases and understand how they flow through the ER setting. However, do speak up as needed so you don't miss out on all the other interesting cases and procedures.
- Whenever possible plan to follow at least one patient. Following multiple patients can help you work on juggling multiple tasks and prioritizing specific duties but too many patients can do more harm than good.
- Observe full trauma activations whenever possible and participate in medical code (blue) activations performing CPR, placing lines, and assessing vasculature.
- Complete and Log as many Comprehensive H&Ps as you can on this rotation. This is a critical part of your 1St year Competency Fulfillment. Make *sure* to log the supervising ER doctor. A comprehensive H&P must include medical and social history, ROS, and a multiple organ system exam.

Things you'll learn

- Develop an ED mindset:
    - What must be ruled out first and what diagnoses/conditions require admission?
    - What needs to be done at this moment to expedite the workup/admission/discharge?
    - Will this patient be stable for discharge, or will they have to be admitted?

  Learn to organize your thoughts and assessments in an "organ system-based approach".
  Learn both focal and general trauma assessment; focus on identifying occult trauma as many patients may not be communicative for a variety of reasons.
  Pursue ER procedures including US guided nerve blocks, procedural sedation, abscess I&Ds, laceration repair, IV and line placement, cast and splint application.
  Gain knowledge and experience in the management of trauma, lacerations, and acute skin and soft tissue infections.

Competency Fulfillment

- 6.1.B.5.&8., 6.1.E., 6.4.j.

Medicine — HBS Curriculum

This is a 4 - 6 week rotation for 1' year residents working alongside Family Medicine Residents on the **Family** Medicine HBS team. You will be 1' call on inpatient medical issues and manage hospitalized patients, learn to admit them, round/present on patients, place orders, document in chart, participate in proper patient hand-offs, learn to discharge patients, participate in nursing/family meetings and provide short presentations on various assigned topics. The goal is to provide the resident with the knowledge and skills to directly participate in the medical evaluation and management of internal medicine patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status.

Knowledge and Skills

1. Perform and accurately document the findings of a **comprehensive medical history and physical** examination with the appropriate level of detail.
2. Formulate and articulate an appropriate **differential diagnosis** of the patient's general medical problem(s).
3. Recognize the need for and order **diagnostic studies** when indicated including EKG, Medical Imaging, and Laboratory studies.
4. Exhibit sufficient knowledge of common inpatient medical conditions, including the diagnosis and management of Cardiac disease, Cerebrovascular disease, Pulmonary disease and Pneumonia, Infectious disease and Sepsis, Kidney Failure and AKI, and Metabolic and Endocrine disorders.
5. Demonstrate competency in utilizing information obtained from the history and physical examination and ancillary studies to arrive at an **appropriate diagnosis and treatment plan.**
6. Demonstrate appropriate knowledge of **fluid and electrolyte management.**
7. Demonstrate competent knowledge of **renal function.**
8. Understands basic diagnosis and treatment of cardiovascular function including chest pain, CAD, acute MI, and Heart Failure
9. Display **physical exam skills** including chest, heart, lungs, and abdomen.
10. Display **stethoscope skills** including accurate identification and description of heart and lung sounds.
11. Proper understanding of the medical **management of diabetes,** including Oral Hypoglycemics, DKA, Sliding Scale Insulin Coverage and general medical management
12. Demonstrate understanding of **end-of-life care** including DNR/DNI, DPAHC, Hospice, and Comfort Care.
13. Exhibit **communication skills,** including Team Communication, Transitions of Care and handoffs, establishing effective therapeutic relationships with patients, discussion of resuscitation and code status, listening skills and non-verbal communication.
14. Participate fully in **didactic activities** including preparation of topical presentations to the group.

Attitudes

- Exhibit timeliness, professionalism and interact appropriately with staff.
- Show a desire to learn and participate actively in the vast learning opportunities provided.
- Treat patients with respect and use good communication skills.

Experiences

- This is an intense two-month rotation (6 days per week). Podiatry residents take care of hospitalized patients along with the Family Medicine Resident team. They are assigned 2-4 patients at a time and remain first call on all issues for those patients.
- Do admission H&Ps (5.6 per week). Log them all in PRR.
- Participate with team on a.m. rounds presenting your patients. Primary supervision is by RI. who also writes a note on the patients after rounds.
- You will do discharges, including SNF discharges when necessary.
- Participate in nursing/PCC/family meetings.
- You will do mini-talks in didactic *sessions* on various assigned topics once a week (both pod and non-pod).
- Make sure to expand your learning and seek opportunities to learn all you can in the evaluation and management of the following conditions:
- Anticoagulation and DVT prophylaxis and treatment, Cerebrovascular disease, Altered mental status, Pulmonary disease COPD, Infectious disease (including the diagnosis and treatment of sepsis and medical management with antibiotics), Cardiac Disease including Chest pain, Cardiac arrest and CAD, Heart Failure, Abdominal Processes including GI bleeds, Metabolic and Endocrine disorders. Pain Management, Fluids MI, Hospital and general medications.
- A major emphasis is placed on learning about medically critical communication including: Team communication, Transitions of Care and Handoffs, establishing effective therapeutic relationships with patients, discussion of resuscitation and code status, listening skills and non-verbal communication.

Reading and Resources

- Agile MD phone App, UCSF Hospitalists Handbook

Competency Fulfillment

- 6.1: B-G, 6.4

Infectious Disease Curriculum

This is a two-week rotation is to provide 1"t year residents with knowledge and skills in the prevention, diagnosis and management of infectious disease. Dr. Amanda Thornton is the Rotation Director.

Knowledge and Skills

1. Recognize and diagnose infections with common **gram-negative and gram-positive organisms** and the **classification of bacteria.**
2. Understand **appropriate antimicrobial therapy** including selection, dosing and duration of therapy.
3. Interpret **laboratory data** including CBC, markers of inflammation, blood cultures, gram stains, microbiological data including gram stain and culture, serologic interpretation, and laboratory data associated with antibiotic monitoring.
4. Understand diagnosis and treatment of **local and systemic infections.**
5. Understand the need for **wound evaluation** and its effect on the management of infection.
6. Understand the use of **culture and sensitivity** on the diagnosis and management of various types of infection.
7. Understand **renal dosing** including which antibiotics require adjustment.
8. Perform an appropriate workup of patients with infectious diseases including: Histories and Physicals, Lab Work, X-Rays and advanced diagnostic imaging.
9. Suggest and/or order appropriate antimicrobial therapy.
10. Develop competence in the diagnosis and treatment of soft tissue and bone infections.

Attitudes

- Demonstrate responsible, reliable, punctual, and cooperative behavior.
- Maintain records in a timely manner.

Experiences

- Stewardship Rounds: Includes case reviews focused on drug, dosing and duration as well as evaluation and management of sepsis and the critically ill patient.
- Learn about renal dosing and other routes of administration.
- Learn about osteomyelitis, joint infections and priorities in Culture and Sensitivity.
- Consults: the resident will participate in ID consults of various types and may write notes for later review.
- Selected learning experiences may be completed via online meetings to maintain social distancing.

Reading and Resources

- IDSA Guidelines on 1) Diabetic Foot & 2) Prosthetic Joint Infection.
- Online courses as assigned including but not limited to Rabies post exposure, isolation guidelines, & cutaneous manifestations of HIV.

Competency Fulfillment

- 6.1.B.9, 6.4.d.

Orthopedic Surgery Curriculum — R1

This is a one-month rotation for 1st year residents to develop knowledge and skills in the management of orthopedic surgery at both Kaiser Vallejo and Vacaville - a Level 2 trauma center. Residents will seek learning opportunities in the longitudinal management of patients from workup in the emergency room-tooperative management and, when possible, follow up with inpatient rounding. By working with a variety of surgery types within orthopedics, the podiatric surgery resident will gain a broader understanding of surgical management of orthopedic problems.

Knowledge and Skills

1. Demonstrate increased knowledge and skill in the performance of Comprehensive History and Physical Exam
2. Demonstrate increased knowledge in risk assessment and surgical decision making.
3. Demonstrate understanding of preoperative planning and OR setup.
4. Demonstrate appropriate level of knowledge in management of skeletal trauma including a working knowledge of AO principles.
5. Demonstrate increased understanding of internal fixation including temporary and final fixation with screws, plates, and locking fixation techniques.
6. Demonstrate increased knowledge of the management of soft tissue trauma including tendon and ligament repair.
7. Demonstrate appropriate level of knowledge and skill in surgical assisting techniques including dissection, atraumatic technique and wound closure.
8. Demonstrate increased knowledge and skill in arthroscopic surgery technique and utility.
9. Demonstrate increased understanding of the uses of intraoperative fluoroscopy.
10. Demonstrate knowledge and skill in splint and bandage application techniques.
11. Demonstrate increased knowledge of tissue healing principles of Bone, Ligament and Tendon and the effect on postoperative management

Attitudes

- Demonstrate professionalism, including timeliness and respect for the staff and team.
- Demonstrate good communication skills and engage fully in the learning environment.
- Accept criticism constructively.

Experiences

General rotation structure: The weekly schedule will be Monday through Thursday in Hand/Sports Medicine at Vallejo with Fridays in Vacaville with Trauma.

- For Vallejo observe some arthroscopy, but more hands-on scrubbing cases with the Hand Surgeons as these correlates better with Foot and Ankle.
- At Vacaville, the day will begin in the Breakfast Lounge at 7:30. You will round with the PA or on-call orthopedist then scrub trauma cases.

- During rounding pursue knowledge and experience in acute trauma care issues including anti-coagulation, DYT prophylaxis, pain management and general medical assessment and stability and the effect of total health on recovery and outcome.
- When opportunities for ER workup and Comprehensive H&Ps present themselves, discuss supervision of the documentation with the supervising orthopedist.
- Experience with closed reduction of displaced fractures should be pursued.

in all experiences, pursue increased Knowledge and Skill in the items listed above as these align with the evaluation document. Focus on developing the ability to integrate the injury with the tissue type damaged, soft tissue factors and medical complexity of each patient. Understand how surgical decision making is affected by the patient's needs and the expected level of functional outcome.

Competency Fulfillment

- 6.1:A4, 6.4.h.

Podiatric Medicine & Surgery — R3 Curriculum

The podiatric Medicine and Surgery Curriculum is designed to guide the resident in the achievement of competency in all areas of podiatric practice. To that end this document provides a thorough listing of the **Knowledge, Skills and Attitudes** you will need to acquire as a second-year resident, and which make up your formal evaluations. The listing is categorized by training in various settings including outpatient clinic, the operating room, the inpatient setting and taking call. The **Experiences** section that follows provides additional information and training priorities. This document is intended to be a practical guide to your training as a foot and ankle surgeon and should be reviewed routinely.

Knowledge and Skills

Outpatient Clinical Experience

1. Perform and document a thorough **PROBLEM FOCUSED H&P** of **lower** extremity complaints with the appropriate level of detail and proper organization.
2. Access **ATTENDING SUPERVISION** appropriately based on level of training.
3. Diagnose and manage **COMMON PODIATRY PROBLEMS** including skin and nail disorders, tendinitis, heel pain, soft tissue masses, arthritides, forefoot pain, etc.
4. Perform and interpret complete **BIOMECHANICAL EXAMS** and formulate appropriate treatment plans for mechanical foot pain.
5. Effectively manage patients with **NON-SURGICAL TRAUMA** based on tissue healing principles and adapt treatment to patient needs.
6. Effectively **MANAGE POSTOPERATIVE PATIENTS** including wound management, analgesics, immobilization, weight bearing and rehabilitation, communication of expectations arid management of complications.
7. Work up patients for **ELECTIVE OUTPATIENT SURGERY** including appropriate patient and procedure selection, informed consent and management of co-morbidities.
8. Effectively diagnose and manage **NEUROPATHIC AND DYSVASCULAR WOUNDS** in the outpatient setting with appropriate debridement, wound care modalities, medical management and offloading
9. Demonstrate knowledge and skill in **the safe and effective MEDICAL MANAGEMENT** of common podiatry problems.
10. Utilize diagnostic tools such as **LAB, XRAY & ADVANCED IMAGING** in an appropriate and cost-effective manner.
11. Effectively perform **IN-OFFICE CLINICAL PROCEDURES** including appropriate procedure selection, informed consent, skillful execution, and appropriate aftercare.
    Includes injection therapies, excisions and biopsies, nail procedures, and minor procedures.

Foot & Ankle Surgery/O.R. Experience

12. Execute patient flow-through in the OR setting.
13. Prepare for surgery ahead of time and demonstrate understanding of **PREOPERATIVE PLANNING** and the importance of both **PATIENT AND PROCEDURE SELECTION.**
14. Maintain focus on **PATIENT SAFETY** in the OR setting (timeout, consent, and patient identification).
15. Demonstrate skill in **SOFT TISSUE HANDLING** including dissection, retraction, soft tissue repair and wound closure.

16. Demonstrate knowledge and skill in the use of **POWER INSTRUMENTS** and application of **INTERNAL FIXATION**
17. Demonstrate skill in the execution and intra-operative evaluation of **DEFORMITY CORRECTION.**
18. Demonstrate skill in the recognition and management of **INTRAOPERATIVE COMPLICATIONS** including damage to neighboring tissues, failure of fixation, under and over correction of deformities.
19. Demonstrate competency in **FIRST RAY SURGERY and RECONSTRUCTIVE REARFOOT & ANKLE SURGERY.**
20. Demonstrate competency in **FOOT & ANKLE TRAUMA SURGERY.**
21. Complete accurate and timely **CHART DOCUMENTATION.**

Inpatient & On-Call Experience

22. Respond to calls with excellent **COMMUNICATION** maintaining a cooperative **TEAMWORK** attitude.
23. Communicate with attendings on-call at the point of patient care giving timely, accurate and essential information during patient presentations (SBAR).
24. Skillfully execute transitions of care and patient hand-offs maintaining a focus on **PATIENT SAFETY.**
25. Demonstrate knowledge and skill in **MEDICAL DECISION MAKING** in the hospital and ER setting including involvement of the patient and addressing their needs, admission and discharge criteria, transitions of care and when to seek additional consultations.
26. Demonstrate knowledge of safe and effective **MEDICAL MANAGEMENT** including antibiotics, narcotic analgesics, sedative/hypnotics, anticoagulants, fluid and electrolyte management, diabetes management and corticosteroids.
27. Demonstrate knowledge and skill in the **DIAGNOSIS AND MANAGEMENT OF INFECTIONS** of both soft tissue and bone.
28. Demonstrate knowledge and skill in the **DIAGNOSIS AND MANAGEMENT OF PERIPHERAL VASCULAR DISEASE** including timing and need for wound debridement, level of amputation and recognition of limb threatening vascular compromise.
29. Demonstrate knowledge and skill in the **DIAGNOSIS AND MANAGEMENT OF DIABETES COMPLICATIONS** in the inpatient setting including blood glucose management, renal disease and peripheral neuropathy.
30. Recognize the signs and symptoms and understand the proper management of the critically ill and medically unstable patient with regard to sepsis, diabetic ketoacidosis, and life-threatening infections.
31. Demonstrate knowledge of the timing and appropriateness of operative management for injuries, wounds and infections.
32. Understand and execute debridement of necrotic and non-viable tissue in the management of wounds and infections
33. Demonstrate skill in the closed reduction of displaced fractures.
34. Understand, identify, and manage **NEUROVASCULAR COMPROMISE** in the injured patient.
35. Comply with hospital protocols with focus on **HAND HYGIENE and INFECTION CONTROL** measures.

Attitudes

- Pursues all learning opportunities with an independent desire to learn and grow.
- Exhibit coachability and accept constructive criticism.
- Function well within a team using excellent communication.

Experiences

- As a 2" year resident, you have made more progress in your training than you think. You are familiar with the general flow of communication, documenting and executing patient care functions in KPHC, have a general feel for the health care delivery system, the various personnel involved in the various areas of care, and some basic understanding of where you stand with your own skills and abilities. You have gained a great deal of general medical knowledge and experience and have a much clearer understanding of the full picture of patient care from your non-podiatry rotations.
- The focus of your 2" year of training is to strengthen your knowledge and skills in all areas of practice. This happens by seeing as many patients as reasonable while maintaining curiosity and focusing your learning on the things you see day in and day out.
- As you will now begin rotating between multiple medical centers, you will have to adapt to the different way that things are done at each location. This may be frustrating at times, but it will provide you with a broad base of experience with different populations, different faculty and different ways of approaching patients. Whether you resonate with a particular approach or not, keep an open mind and you will learn a lot about your own skills and abilities. By analyzing your own personality, strengths and weaknesses, you will be able to focus your training and ultimately maximize your ability to take excellent care of patients.
- You will run your own **Outpatient Clinic** as a 2" year resident at Santa Rosa and San Rafael. Never hesitate to get help when you are out of your comfort zone. Autonomy is good but has a risk that something will be missed. Never compromise excellent patient care while you are learning.
- Develop your diagnostic skill and treatment approach to **Biomechanical Foot Pain.**
- Work on **Doctor-Patient Communication.** Practice speaking clearly and avoiding medical jargon. Listen well and stay focused on the individual patient's needs. Look for opportunities to take care of every area of the patient's experience. Pay special attention to the way faculty members talk with their patients. Print instructions for patients as often as possible.
- Refine your **Surgical Skills** in dissection, suturing, tissue handling, use of saws and power instruments and effectively applying internal fixation.
- Become competent in **Bunion Surgery.** Make an effort to follow the patients you operate on so you can see the outcomes and get comfortable with the range of patient responses to the recovery process.

Competency Fulfillment

- 6.1 A. 4, 5

Podiatric Medicine & Surgery — R2 Curriculum

The podiatric Medicine and Surgery Curriculum is designed to guide the resident in the achievement of competency in all areas of podiatric practice. To that end this document provides a thorough listing of the **Knowledge, Skills and Attitudes** you will need to acquire as a second-year resident, and which make up your formal evaluations. The listing is categorized by training in various settings including outpatient clinic, the operating room, the inpatient setting and taking call. The **Experiences** section that follows provides additional information and training priorities. This document is intended to be a practical guide to your training as a foot and ankle surgeon and should he reviewed routinely.

Knowledge and Skills

Outpatient Clinical Experience

1. Perform and document a thorough **PROBLEM FOCUSED H&P** of lower extremity complaints with the appropriate level of detail and proper organization.
2. Access **ATTENDING SUPERVISION** appropriately based on level of training.
3. Diagnose and manage **COMMON PODIATRY PROBLEMS** including skin and nail disorders, tendinitis, heel pain, soft tissue masses, arthritides, forefoot pain, etc.
4. Perform and interpret complete **BIOMECHANICAL EXAMS** and formulate appropriate treatment plans for mechanical foot pain.
5. Effectively manage patients with **NON-SURGICAL TRAUMA** based on tissue healing principles and adapt treatment to patient needs.
6. Effectively **MANAGE POSTOPERATIVE PATIENTS** including wound management, analgesics, immobilization, weight bearing and rehabilitation, communication of expectations and management of complications.
7. Work up patients for **ELECTIVE OUTPATIENT SURGERY** including appropriate patient and procedure selection, informed consent and management of co-morbidities.
8. Effectively diagnose and manage **NEUROPATHIC AND DYSVASCULAR WOUNDS** in the outpatient setting with appropriate debridement, wound care modalities, medical management and offloading
9. Demonstrate knowledge and skill in the safe and effective **MEDICAL MANAGEMENT** of common podiatry problems.
10. Utilize diagnostic tools such as **LAB, XRAY & ADVANCED IMAGING** in an appropriate and cost-effective manner.
11. Effectively perform **IN-OFFICE CLINICAL PROCEDURES** including appropriate procedure selection, informed consent, skillful execution, and appropriate aftercare.
    includes injection therapies, excisions and biopsies, nail procedures, and minor procedures.

Foot €I Ankle Surgery/O.R. **Experience**

12. Execute patient flow-through in the OR setting.
13. Prepare for surgery ahead of time and demonstrate understanding of **PREOPERATIVE PLANNING** and the importance of both **PATIENT AND PROCEDURE SELECTION.**
14. Maintain focus on **PATIENT SAFETY** in the OR setting (timeout, consent, and patient identification).
15. Demonstrate skill in **SOFT TISSUE HANDLING** including dissection, retraction, soft tissue repair and wound closure.

16. Demonstrate knowledge and skill in the use of **POWER INSTRUMENTS** and application of **INTERNAL FIXATION**
17. Demonstrate skill in the execution and intra-operative evaluation of **DEFORMITY CORRECTION.**
18. Demonstrate skill in the recognition and management of **INTRAOPERATIVE COMPLICATIONS** including damage to neighboring tissues, failure of fixation, under and over correction of deformities.
19. Demonstrate competency in **FIRST RAY SURGERY and RECONSTRUCTIVE REARFOOT & ANKLE SURGERY.**
20. Demonstrate competency in **FOOT & ANKLE TRAUMA SURGERY.**
21. Complete accurate and timely **CHART DOCUMENTATION.**

Inpatient & On-Call Experience

22. Respond to calls with excellent **COMMUNICATION** maintaining a cooperative **TEAMWORK** attitude.
23. Communicate with attendings on-call at the point of patient care giving timely, accurate and essential information during patient presentations (SBAR).
24. Skillfully execute transitions of care and patient hand-offs maintaining a focus on **PATIENT SAFETY.**
25. Demonstrate knowledge and skill in **MEDICAL DECISION MAKING** in the hospital arid FR setting including involvement of the patient and addressing their needs, admission and discharge criteria, transitions of care and when to seek additional consultations.
26. Demonstrate knowledge of safe and effective **MEDICAL MANAGEMENT** including antibiotics, narcotic analgesics, sedative/hypnotics, anticoagulants, fluid and electrolyte management, diabetes management and corticosteroids.
27. Demonstrate knowledge and skill in the **DIAGNOSIS AND MANAGEMENT OF INFECTIONS** of both soft tissue and bone.
28. Demonstrate knowledge and skill in the **DIAGNOSIS AND MANAGEMENT OF PERIPHERAL VASCULAR DISEASE** including timing and need for wound debridement, level of amputation and recognition of limb threatening vascular compromise.
29. Demonstrate knowledge and skill in the **DIAGNOSIS AND MANAGEMENT OF DIABETES COMPLICATIONS** in the inpatient setting including blood glucose management, renal disease and peripheral neuropathy.
30. Recognize the signs and symptoms and understand the proper management of the critically ill and medically unstable patient with regard to sepsis, diabetic ketoacidosis, and life-threatening infections.
31. Demonstrate knowledge of the timing and appropriateness of operative management for injuries, wounds and infections.
32. Understand and execute debridement of necrotic and non-viable tissue in the management of wounds and infections
33. Demonstrate skill in the closed reduction of displaced fractures.
34. Understand, identify, and manage **NEUROVASCULAR COMPROMISE** in the injured patient.
35. Comply with hospital protocols with focus on **HAND HYGIENE and INFECTION CONTROL** measures.

Attitudes

- Pursues all learning opportunities with an independent desire to learn and grow.
- Exhibit coachability and accept constructive criticism.
- Function well within a team using excellent communication.

Experiences

- As a 2" year resident, you have made more progress in your training than you think. You are familiar with the general flow of communication, documenting and executing patient care functions in KPHC, have a general feel for the health care delivery system, the various personnel involved in the various areas of care, and some basic understanding of where you stand with your own skills and abilities. You have gained a great deal of general medical knowledge and experience and have a much clearer understanding of the full picture of patient care from your non-podiatry rotations.
- The focus of your 2" year of training is to strengthen your knowledge and skills in all areas of practice. This happens by seeing as many patients as reasonable while maintaining curiosity and focusing your learning on the things you see day in and day out.
- As you will now begin rotating between multiple medical centers, you will have to adapt to the different way that things are done at each location. This may be frustrating at times, but it will provide you with a broad base of experience with different populations, different faculty and different ways of approaching patients. Whether you resonate with a particular approach or not, keep an open mind and you will learn a lot about your own skills and abilities. By analyzing your own personality, strengths and weaknesses, you will be able to focus your training and ultimately maximize your ability to take excellent care of patients.
- You will run your own **Outpatient Clinic** as a 2[1]1([1] year resident at Santa Rosa and San Rafael. Never hesitate to get help when you are out of your comfort zone. Autonomy is good but has a risk that something will be missed. Never compromise excellent patient care while you are learning.
- Develop your diagnostic skill and treatment approach to **Biomechanical Foot Pain.**
- Work on **Doctor-Patient Communication.** Practice speaking clearly and avoiding medical jargon. Listen well and stay focused on the individual patient's needs. Look for opportunities to take care of every area of the patient's experience. Pay special attention to the way faculty members talk with their patients. Print instructions for patients as often as possible.
- Refine your **Surgical Skills** in dissection, suturing, tissue handling, use of saws and power instruments and effectively applying internal fixation.
- Become competent in **Bunion Surgery.** Make an effort to follow the patients you operate on so you can see the outcomes and get comfortable with the range of patient responses to the recovery process.

Competency Fulfillment

- 6.1 A. 4, 5

Val/Vac Podiatric Medicine & Surgery
R1 Curriculum

The podiatric Medicine and Surgery Curriculum is designed to guide the resident in the achievement of competency in all areas of podiatric practice. To that end this document provides a listing of the **Knowledge, Skills and Attitudes** you will need to acquire as a first-year resident. You will note that the listing is organized by training in various settings including outpatient clinic, the operating room, and the inpatient setting and call experiences. **By** aligning the educational goals and objectives with the evaluation forms, this document is intended as a practical guide to your training as a foot and ankle surgeon and should be reviewed routinely. The **Experiences** section that follows is designed to provide practical guidance for your learning in each area of practice.

Knowledge and Skills

Outpatient Clinic

1. Demonstrate Knowledge and Skill in completion of Problem Focused History and Physical exams documenting the appropriate level of detail with proper organization.
2. Access attending supervision appropriately based on level of training.
3. Work up patients for outpatient elective surgery including patient and procedure selection, informed consent and management of comorbidities.
4. Perform and interpret complete biomechanical exams and formulate appropriate treatment plans for mechanical foot pain.
5. Effectively manage patients with non-surgical trauma based on tissue healing principles and adapting the treatment to each patient's needs.
6. Effectively perform in-office clinical procedures including appropriate procedure selection, informed consent, skillful execution, and appropriate aftercare.
7. Effectively manage wounds from a variety of sources addressing underlying etiologies including Diabetic Neuropathy and Peripheral Arterial Disease; perform proper wound care.
8. Effectively manage postoperative patients including wound management, immobilization, rehabilitation, communication of expectations and management of complications.
9. Demonstrate knowledge and skill in the use of medications to treat outpatient podiatric problems.

Foot & Ankle Surgery/O.R.

10. Execute patient flow-through in the OR setting understanding the contributions of all the personnel involved in patient care.
11. Prepare for elective OR cases ahead of time demonstrating understanding of preoperative planning and the importance of both patient and procedure selection.
12. Execute safe and effective local anesthetic blocks.
13. Demonstrate skill in soft tissue handling including dissection, retraction, soft tissue repair and wound closure
14. Exhibit knowledge and surgical skill in the use of power instruments and application of internal fixation.
15. Exhibit skill in the execution and intraoperative evaluation of deformity correction.
16. Exhibit skill including bandaging and casting.
17. Complete accurate arid timely chart documentation.

Inpatient Management & Call Duties

18. Respond to calls with clear communication maintaining a collaborative teamwork attitude.
19. Communicate with un-call attendings at the point of care giving timely, accurate and essential information during patient presentations (SEAR).
20. Perform and document Comprehensive History and Physical Exams with the appropriate level of detail and proper organization.
21. Complete accurate and timely chart documentation for inpatient rounding with the appropriate level of detail to communicate clearly with the team.
22. Demonstrate knowledge and skill in the safe and effective use of medications to treat patients admitted for podiatric problems.
23. Demonstrate knowledge of the full array of laboratory values encountered in inpatient and outpatient medical management.
24. Take appropriate responsibility for inpatient management.

Attitudes

- Pursue all learning opportunities with an independent desire to learn and grow.
- coachability and accept constructive criticism.
- Function well within it team using excellent communication.

Experiences

- Outpatient Clinic — Due to scheduling realities, first year residents at Vallejo and Vacaville can end up with relatively limited outpatient clinical exposure. It is very important for the resident to pursue shadowing experiences on their own. On days that you are not scheduled to be in the OR, finish rounding and write your notes then check in first with the attending on call to see what is on their clinic schedule. From there check in with other residents and attendings and pursue the most educational options available. Resist the temptation to complete less urgent administrative tasks (like checking email) when clinics are in session. Take advantage of the flexible time to engage in patient care whenever possible.

  Establish good habits of reviewing patients before seeing them — never see a patient without first reviewing their chart.

  Get really good at taking effective histories and doing thorough physical exams. Practice listening.

  Focus on Clinical Decision Making — use the available resources to make accurate, efficient diagnoses and determine treatment and procedure options.

  Figure out how to write clear, readable notes that focus on the pertinent positives and negatives.

  - Learn how to communicate effectively with patients at their level educating and motivating them to comply with treatment.
  - Document the conversation of treatment options and risks.

- Operating Room - Performing surgery requires the integration of a great deal of learning and experience. Not only are there many different surgeries to learn but each attending surgeon you work with will do things differently. To further increase the challenge, the operating room environment includes a large, dynamic team each with their own demands and priorities. Therefore, the learner will have to pay attention to a large number of factors that contribute to the care of the patient; this is a necessary part of becoming an effective surgeon. Review the Knowledge and Skills listed above as these are intended to guide you in various areas of learning and will be the components of your formative and summary evaluations. The following are some general recommendations for effectively moving through this part of your education:

- Focus on the attending and more senior residents for direction and cues for what, when and how to do various tasks.
- Pay close attention to the process leading up to the incision and surgery itself.
  Understand that there is a natural progression from close observation and assisting to more and more autonomy to complete all aspects of a particular surgery. Although we avoid a hierarchical model, some cases are better suited for a first-year resident and others are more appropriate for a more experienced resident.

c) Pay special attention to the unique ways that the attending surgeon does things as these are often areas of special interest and excellent learning opportunities.

- Inpatient Management — due to the higher acuity of patient care in the hospital, this is a critical and often intense area of learning and responsibility. There is a unique care team in the hospital, and you must understand the requirements for communication and documentation in this area of patient care.
  - Establish good habits of reviewing patients before seeing them; understand the big picture of their medical and personal reality always keeping the overall plan in mind including need for surgery, additional diagnostic options, discharge disposition and follow-up needs.
  - Be able to communicate the ongoing management issues of each patient with attendings and other residents efficiently and accurately; when there are multiple patients on the list, this can be quite challenging so develop a system to keep track of all inpatients all the time.
    Learn which patients to worry about.
  - Pay attention to the particular events or interventions that change the hospital course for better or worse.

- Call Experiences — communication is of utmost importance in this area as you will be the conduit of communication of patient care needs between the ER and podiatry.
  - You will need to learn to ask callers the appropriate questions and ask for interim workup so you can present properly to the supervising attending.
  - You will need to know when to go in after hours so patient care is never compromised.
  - If you find yourself in some level of conflict with a caller, ALWAYS ask the supervising attending for their help as you are their proxy.
  - You should not make care decisions independently.

Reading and Resources AO Surgery Reference App for trauma care

KAISER PERMANENTE VALLEJO FOOT AND ANKLE RESIDENCY PROGRAM

Medical Imaging Curriculum

The is a two--week rotation based in Vallejo and Vacaville intended to improve knowledge and skills in a variety of diagnostic imaging areas to achieve competence in this important and heavily used resource. The Rotation Director is Dr. Michael Fox, who will help you assemble a schedule ahead of time. See below under 'Experiences' for the key faculty who need to be present during the scheduled week. If key faculty are not available, schedule adjustments will be made to maximize the training experience.

Knowledge and Skills

1. Understand indications and contraindications for ordering CT's and MRI's.
2. Understand tissue enhancement with different MR studies including:
   T2 Weighted, T1 Weighted, and STIR Images
3. Recognize and describe the normal and abnormal findings on CT and MRI exams. **4-**
   : Understand radiation dosing for CT
5. Participate and increase knowledge in the use of ultrasound imaging.
6. Understand radiation safety and shielding
7. Participate and increase knowledge in intraoperative fluoroscopic examinations (see below).

Attitudes

- Accept constructive criticism.
- Conduct yourself in a respectful, collegial manner using good communication skills.
- Demonstrate professionalism through responsible, reliable, cooperative behavior, and engaging in the educational experience.

Experiences

- **Musculoskeletal CT and MRI:** Spend a full day with a musculoskeletal radiologist — Drs. Toni Whang and Michael Nguyen - to get detailed teaching on reading CT and MRI specific to musculoskeletal issues. Review the Knowledge and Skills section above to make sure to cover the essential areas you will be evaluated on.
- **Ultrasound:** Get US experience with an ultrasound trained orthopedist in order to appreciate the musculoskeletal applications such as joint effusions and abscess identification. Email Dr. Crystal Hnatko 1 to 2 weeks ahead of time to check her availability.
- **Radiation Safety:** Review radiation exposure with one of the radiologists including risks from fluoroscopy to plain film to abdominal CT to understand "time, shielding and distance". Understand how diagnostic radiology accounts for 2% of all malignancies in the U.S. and that an abdominal/pelvis CT carries the same risk of death as smoking 100 packs of cigarettes.

- **Intraoperative Fluoroscopy:** Make sure to schedule a half day for this activity: review the OR schedule for a time to observe trauma cases with the techs using the large c-arm in the OR. Learn the nomenclature for intraoperative positioning of the tube.

Pathoanatomy List:

- **MRI:** Complex Anatomy, GCT, Osteomyelitis, Marrow Edema, Peroneal Split Tears and false positives.
- **CT:** Calcaneal Fracture, Peroneal Subluxation, Non-union Identification.
- **Plain film:** Benign Bone Tumors (Fegnomashic -Clyde Helms), Malignant Bone Tumors, Osteomyelitis, Fracture Healing

Opportunities for suture improvement:

- **Develop a list of teaching cases:** 20 x-rays, 5 or more MRIs and 5 CTs to review and learn specific disease processes and diagnoses. Include a posttest emphasizing specific aspects — see TPMG training modules below. (note new outline format that follows)
    - **MRI:** PT Tendinitis, Ganglion Cyst and other benign tumors, tendon rupture, Spring ligament complex anatomy, GCT, osteomyelitis, marrow edema, peroneal split tears and false positives.
    - **CT:** calcaneal fracture, peroneal subluxation, non-union identification.
    - **() Plain film:** Benign bone tumors (fegnomashic -Clyde Helms), malignant bone tumors, osteomyelitis, fracture healing

Reading and Resources

- TPMG training modules (8) including posttests with CME for Radiography Health and Safety: Fluoroscopy and Digital Systems: nttps://cirn.kp.orgdokcincaiiciin/continuing eaucationitraining/radiologyinuoroscopyivlaeosimaex.ntml
- "Fundamentals of Skeletal Radiology" - Clyde Helms *(classic description of benign bone tumors)*

Competency Fulfillment

- 6.1 A-3, 6.1 B-3, 6.4

Rheumatology Curriculum

This is a two-week rotation for 1" year residents based on outpatient clinical experiences at Kaiser Vallejo. It provides the resident with the knowledge and skills to directly participate in the medical evaluation and management of Rheumatology patients. Dr. Rim is the Rotation Director.

Knowledge and Skills

1. Formulate a **differential diagnosis** of common rheurnatological problems from the history and physical exam
2. Understand the essential elements of the workup including proper lab ordering when **referring patients** to rheumatology.
3. Demonstrate an appropriate understanding of **rheumatoid arthritis,** including lab and physical exam characteristics, x-ray changes, and drugs used in medical management.
4. Understand and discuss the diagnosis and management of **gout** in both the acute and chronic settings including medication management and laboratory monitoring.
5. Identify and discuss the common **rheumatology medications** and their adjustment in the perioperative setting.
6. Demonstrate an appropriate understanding of the diagnosis and management of various rheumatologic conditions, including **lupus, scleroderma and seronegative arthropathies.**
7. Demonstrate understanding and execution of intra-articular **steroid injections** including drugs, dosages and risks.
8. Demonstrate an appropriate level of knowledge and skill in progress note writing and **chart documentation.**

Attitudes

- Actively engages in patient care experiences, interactions with teaching physicians and the clinical learning process.
- Demonstrate timeliness and professionalism with good communication skills.

Experiences

- After a day of observation, the resident will see patients under direct supervision and write progress notes in KPHC with an expectation that the resident will proactively engage in seeing patients.
- Therapeutic interventions will be pursued, including intra-articular steroid injections with the understanding of dosing, drugs and complications.

Reading and Resources

- "Primer on Rheumatic Diseases"
- "Rheumatology Secrets" Sterling G. West, MD.

Competency Fulfillment

- 6.1.B.5., 6.4.f.

KAISER PERMANENTE VALLEJO FOOT AND ANKLE RESIDENCY PROGRAM

Vascular Surgery Curriculum

This is a one-month rotation for 1" year residents to provide resident with critical knowledge and skills in Vascular Surgery as it applies to podiatric medicine and surgery. Dr. Wolford is the Rotation Director.

Knowledge and Skills

1. Incorporate an understanding of the full **complexity of the vascular workup** with respect to diagnosis and treatment for an individual patient and the contribution of various **comorbid conditions.**
2. Understand the general criteria that must be considered for healing and how it relates to decision for continued wound care vs. partial foot amputation vs. below or above knee amputation.
3. Appreciate additional **factors effecting wound healing beyond blood flow** including infection, osteomyelitis, soft tissue covering of bone, social factors, smoking, weightbearing status, kidney risk and general health and nutrition.
4. Accurately interpret and describe **invasive and noninvasive diagnostic studies** and demonstrate an appropriate understanding of the anatomy of the arterial tree.
5. Understand the diagnosis and clinical significance of **claudication, rest pain, and tissue loss.**
6. Gain an appropriate understanding of the factors involved in procedure selection for **open vs endovascular revascularization.**
7. Understand anti-coagulation with respect to coagulation issues, surgical timing and true risk of bleeding.
8. Understand **anticoagulation assessment** and lab values and assist in surgical techniques for maintaining hemostasis in patients with various levels of anticoagulation.
9. Understand **dialysis access** issues including advantages and disadvantages of fistula and graft options.
10. Understand the diagnostic criteria for chronic venous insufficiency and how fluid issues effect healing and treatment decisions.
11. Understand the diagnosis and medical management of **deep vein thrombosis and pulmonary embolism.**
12. Understand and practice appropriate **radiation safety** in the operating room and endovascular suite.
13. Perform and document a thorough **vascular examination** including all essential elements.
14. Demonstrate effective and accurate **oral presentation of patients** with a focus on pertinent positives and negatives and the appropriate assessment and plan of management.

Attitudes

- Demonstrate timeliness, engagement in the learning process and good communication skills.

Experiences

- Scrub cases with the vascular surgeons.
- Observe in Vascular Lab.
- Observe and assist in the IR Suite.

- Participate in the workup *and* treatment of lower extremity wounds with the understanding of treatment pathway, including: Conservative, Endovascular, Operative Revascularization ultimately determining amputation level

Reading and Resources

- 2011 ACCF/AHA Focused Update of the Guideline for the Management of Patients with Peripheral Artery Disease

Competency Fulfillment

- 6.4.h.

APPENDIX C: Full Year Academic Calendar

2025-2026

KAISER PERMANENTE thrive

Kaiser Permanente Vallejo Podiatric Medicine & Surgery Residency

[redacted]		SAN RAFAEL	VALLEJO/VAC	SANTA ROSA	
Summer 2025					
July/Aug/Sep/Oct	R2	Vishnupriya Bodempudi	Yvette Arca	Tia Furness	
6/30-11/02	R3	Alexander Byrd	Jake Loitz (Ortho Trauma)	Jessicaa Sibal	
Winter 2025/2026					
Nov/Dec/Jan/Feb	R2	Tia Furness	Vishnupriya Bodempudi	Yvette Arca	
11/3-3/1	R3	Jake Loitz	Jessica Sibal(Ortho Trauma)	Alexander Byrd	
Spring 2026					
Mar/April/May/June	R2	Yvette Arca	Tia Furness	Vishnupriya Bodempudi	
3/2 - 6/30	R3	Jessica Sibal	Alexander Byrd(Ortho Trauma)	Jake Loitz	

Note: Class of 2027 (incoming 1st years) will now be completing their 2 week ID rotation when they are 2nd years.

* Specialty Rotations Include: Medical Imaging (Med Im), Dermatology, Rheumatology, Anesthesiology, Behavioral Medicine (BM), Infectious Disease

	6/30 - 11/02 (18 wks)				11/3 - Mar 1 (17 wks)				3/2 - 6/28 (17 wks)			
	July	Aug	Sep	Oct	Nov	Dec	Jan-26	Feb	Mar	Apr	May	June
Autum Cao	ED(4Wks) Jun 30 - Jul 25	1 week VACAY Jul 28-Aug 3 Med Img (2wks) Aug 4 - Aug 15	ANES(2wks) Sep 15- Sep 26	Vascular(4wks) Oct 6 - Oct 31	POD Surgical (17 wks) Nov 3, 2024 - Feb 27, 2025 (Flex 5 PTO days this block)				Rheum (2wks) Mar 2- Mar 13	Beh Med (2wks) Mar 30 - Apr 10	HBS (6 Wks) May 11 - June 28 1 week VACAY Jun 8- Jun 12	
ID rotation in 2nd Yr		Ortho(4Wks) Aug 18 - Sep 12	1 week VACAY Sep 29 - Oct 3						Derm(2wks) Mar 16 - Mar 27	POD (4 wks) Apr 13 - May 8		

	July	Aug	Sep	Oct	Nov	Dec	Jan-26	Feb	Mar	Apr	May	June
Sonia Chuang	Vascular (4wks) Jun 30 - Jul 25	Rheum(2wks) Jul 28 - Aug 8	1 week VACAY Aug 25-Aug 29	POD (4wks) Sep 29 - Oct 24	Ortho (4wks) Nov 3-Nov 28	ED (4wks) Dec1- Dec 26 1 week VACAY Dec 29 - Jan 2, 2026	HBS(6wks) Jan 5 - Feb 13	Med Img (2 wks) Feb 16 -Feb 27	POD Surgical (17wks) Mar 2 - Jun 28 (Flex 5 PTO days this block)			
ID rotation in 2nd Yr		Anes (2wks) Aug 11 - Aug 22	Beh Med (2wks) Sep 2 - Sep 12 Derm(2 wks) Sep 15 - Sept 26	1 week VACAY Oct 27-Oct 31								

	Jul-24	Aug	Sep	Oct	Nov	Dec	Jan-26	Feb	Mar	Apr	May	June
Mohammad Shigri	POD Surgical (18 wks) Jun 30 - Oct 31 (Flex 5 PTO days this block)				ED (4wks) Nov 3 - Nov 28	Anes(2 wks) Dec 1 - Dec 12	POD (4 wks) Jan 5 - Jan 30	Vasc (4wks) Feb 2- Feb 27	HBS (6 wks) Mar 2 - Apr 10	Ortho (3weeks) Apr 13 - May 1	Derm (2 wks) May 4 -May 15	2 Weeks VACAY Jun 1- Jun 12
ID rotation in 2nd Yr						1 Week VACAY Dec 15 - Dec 19 Beh Med (2 wks) Dec 22 - Jan 2					Rheum (2 wks) May 18- May 29	Med Img (2 wks) June 15- 28

PGY 1 rotations occur both in Vallejo and Vacaville

APPENDIX D: Appeals Process

May 2021

Regional Graduate Medical Education

Institutional Resident Academic & Professional Appeal Policy and Procedures

Appendix A

PURPOSE

The purpose of this policy is to facilitate the fair and timely resolution of issues concerning a Resident's academic or professional performance. This policy, as of its effective date, and thereafter as from time to time amended, sets out the exclusive internal administrative procedures by which a Resident may obtain review of a decision which directly concerns his or her academic or professional performance. This policy shall supersede any prior policies, bylaws, rules or regulations addressing Residents' academic and professional appeals processes, including the Professional Staff Bylaws.

SCOPE

Informal Review (Section IV) is the process available to a Resident to appeal all Decisions that do not fall under the definition of an Adverse Decision.

A Resident subject to an Adverse Decision has a right to request a hearing under the Formal Appeal and Hearing Procedure (Section V below).

Residents do not have a right to the Informal Review or the Formal Appeal and Hearing Procedure for actions taken against Residents acting in any other capacity, *e.g.* in his/her capacity as a "moonlighter."

DEFINITION

Capitalized terms are defined in Exhibit A, or in the text of this policy.

INFORMAL REVIEW

Scope:
Informal Review is the process available to the Resident to appeal Decisions other than Adverse Decisions. Decisions subject to Informal Review include, for example, routine assessments of the Resident's performance or progress, letters of warning, letters of remediation, suspensions for medical record delinquencies pending completion of the records where the period(s) of suspension total less than thirty (30) calendar days in a twelve (12) month period, and Administrative Suspensions or Dismissals, *e.g.*, for failure to obtain a California physician's license in the requisite time period, or restrictions imposed on a California physician's license.

Process:
When the Resident disagrees with a Decision, the Resident has the right and the responsibility to address the disputed matter with their Program Director within 30 calendar days of the Decision. The Program Director shall meet with the Resident to discuss their concerns and provide the Resident with a written response within ten (10) business days of the meeting. All written documentation about the disputed matter shall be made part of the Resident's Residency Program file ("File"). If the Resident fails to discuss a Decision with their Program Director within thirty (30) calendar days, they waive any right to Informal Review of the Decision.

If the Resident is dissatisfied with the outcome of the Program Director's review of the matter, the Resident may submit a written statement to the facility Director of Graduate Medical Education ("DGME"), or the Regional DGME, if the DGME is the Resident's Program Director. The written statement must describe the Resident's concern(s), the

reasons why the Resident believes the matter remains unresolved, and the resolution the Resident is seeking. The DGME shall meet with the Resident to their concerns and provide a written response within ten (10) business days of the meeting. All written documentation shall be made part of the Resident's File. The Resident has no further right to review the matter.

FORMAL APPEAL AND HEARING PROCEDURE

Scope:
This Formal Appeal and Hearing Procedure is the process available to a Resident to appeal an Adverse Decision.

Procedure:

Notice of Adverse Decision and Right to Request Hearing: A Resident who is subject to an Adverse Decision shall be notified in writing mailed or delivered within ten (10) business days of the Adverse Decision. The written notice shall advise the Resident of their right to request a hearing before an Ad Hoc Review Panel and the time limit for requesting the hearing. The written notice shall be hand-delivered to the affected Resident or sent by certified or registered mail, return receipt requested to the Resident's last known address on file in the Office of Graduate Medical Education. It is the Resident's responsibility to keep the Office informed of their current mailing address. Failure to do so may be deemed a waiver of the Resident's right to a hearing and acceptance of the Adverse Decision. The written notice shall be deemed received the sooner of the documented date of actual delivery to the Resident or three (3) calendar days after the date it is mailed.

Time to Request Hearing/Notice of Attorney Representation: To obtain a hearing, the Resident must submit a written request to the Regional Director of Graduate Medical Education (DGME) within thirty (30) calendar days of receipt of the written notice to the Resident of the Adverse Decision. If the Resident intends to be represented by an attorney in the hearing (as further described at Section VB4), their request for a hearing must so state and must provide the name and address of the attorney.

Parties: The parties to the hearing shall be the Resident, and the Program Director (or a designee) acting on behalf of the Residency Program.

Representation: The Resident shall be entitled to be represented by an attorney or an advisor, at their expense. In addition to notifying of intent to be represented by an attorney when submitting their request for a hearing, the Resident must promptly notify the DGME, the Hearing Officer, and the Program Director in writing, and in any case no later than fifteen (15) calendar days before the date set for commencement of the hearing, of any change in representation or any decision to proceed without representation. If the Resident timely notifies the DGME, Hearing Officer, and Program Director of their decision not to be represented by an attorney, an attorney shall not represent the Residency Program at the hearing. If the Resident fails to timely notify of a decision not to be represented by an attorney, the Residency Program may proceed with attorney representation in the hearing, even if the Resident is not represented by an attorney in the hearing, which shall be decided by the DGME. Whether or not either party is represented by an attorney during the hearing, each party shall be entitled to receive assistance of an attorney (including communications between the attorneys and the Hearing Officer) with respect to pre-hearing matters, preparation for the hearing, and preparation of any written statements.

Failure to Timely Request a Hearing—Effect: The Resident's failure to submit a timely written request for the hearing shall constitute waiver of their right to a hearing and acceptance by the Resident of the Adverse Decision.

Hearing Arrangements; Appointment of Ad Hoc Review Committee and Hearing Officer; Role and Authority of Hearing Officer:
Within ten (10) business days of receipt of the Resident's written request for a hearing, the DGME shall arrange for the hearing. This responsibility includes such matters as scheduling a hearing date, appointing the Ad Hoc Review Panel, appointing a Hearing Officer, and notifying the parties of the names of the Ad Hoc Review Panel members and the Hearing Officer and the date, time, and place of the hearing. The hearing shall be scheduled to begin within no less

than thirty (30) and no more than sixty (60) calendar days of receipt of the Resident's request.

The Ad Hoc Review Panel membership shall consist of:

- Two faculty members, one of whom shall act as Chairperson ("Chair").
- One resident.

The Ad Hoc Review Panel members must not have acted as accusers, fact finders, or initial decision- makers in, or previously taken an active part in, the matter contested. One Panel member must be in the same specialty as the affected Resident. Where feasible, the other members shall be from a different department than the Resident requesting the hearing. The Resident shall be afforded a reasonable opportunity to question the Ad Hoc Review Panel members, and to challenge the impartiality of any member, as further described at Section VB7a below.

A Hearing Officer shall be appointed to preside at the hearing:

The Hearing Officer may participate in the deliberations and act as a legal advisor to the Ad Hoc Review Panel, but they shall not be entitled to vote. They shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. They shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing, and to set reasonable schedules for timing and/or completion of all matters related to the hearing.

They shall have the authority and discretion, in accordance with this Policy, to grant continuances, to rule on disputed discovery requests, to decide when evidence may or may not be introduced, to rule on witness issues, including disputes regarding expert witnesses, to rule on challenges to Ad Hoc Review Panel members, to rule on challenges to themselves serving as a Hearing Officer, and to rule on questions which are raised prior to or during the hearing pertaining to matters of law, procedure, or the admissibility of evidence.

If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross- examination and setting fair and reasonable time limits on either side's presentation of the case. Under extraordinary circumstances, the Hearing Officer's discretionary action includes, to the extent permitted by law and subject to concurrence of the Ad Hoc Review Panel, termination of the hearing. If the termination order is against the AD Hoc Review Panel, the charges against the resident will be deemed to have been dropped. If, instead, the order is against the resident, the resident will be deemed to have waived their right to a hearing. The party against whom termination sanctions have been ordered may appeal the matter to the DGME.

In all matters, the Hearing Officer shall act reasonably under the circumstances and in compliance with applicable legal principles and this Policy. In making rulings, the Hearing Officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in this Policy. When no attorney is accompanying any party to the proceedings, the Hearing Officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

Pre-Hearing Procedures:

As soon as possible after appointment of the Hearing Officer and the members of the Ad Hoc Review Panel, the Hearing Officer shall arrange a reasonable process to enable the Resident to pose reasonable and relevant questions and receive answers from the Hearing Officer and each of the Ad Hoc Review Panel members as to possible bias. This may, in the discretion of the Hearing Officer, be conducted in writing, by telephonic meeting, or in person. All challenges must be raised prior to the start of the hearing, unless the challenging party did not know, and could not have known with reasonable diligence, the information upon which the challenge is based prior to the start of the hearing. All challenges shall be ruled upon by the Hearing Officer.

Within ten (10) business days after receipt of the Resident's written request for a hearing, the Program Director shall prepare a brief written statement setting forth the Adverse Decision and the reasons for the Adverse Decision, including the acts or omissions with which the Resident is charged. A copy of the statement shall be hand-delivered or sent to the Resident by certified or registered mail, return receipt requested, at his or her last known address on file in the Office of Graduate Medical Education, with a copy to the DGME.

As soon as reasonably practicable after receipt of the request for a hearing, each party shall have the right to inspect and copy, at the requesting party's expense, relevant documents of the other party, subject to applicable privileges. The right of inspection and copying does not extend to confidential information referring solely to individually identifiable practitioners other than the affected Resident. The Hearing Officer shall consider and rule on any request for access to information and may impose any safeguards that the protection of the hearing process, patient confidentiality, and justice require.

Upon request, either party may request, and within ten (10) business days of such request, the other party shall provide a list of witnesses (including name, title, and address) expected to testify on behalf of that party at the hearing.

Additionally, whether previously requested, at least ten (10) business days before the scheduled hearing date, each party shall distribute the following items to the other party and to the Hearing Officer:

- A list and copies of the documents which the party intends to introduce.
- A list of the party's witnesses with a summary of the subject matter about which each witness will be testifying and the relevance of that witness' testimony to the matters at issue in the hearing.

Failure, without good cause, to provide copies of documents and/or information about intended witnesses and testimony shall be grounds for the Hearing Officer to exclude the proffered documents and/or testimony. The Hearing Officer may provide for prior distribution of documents to the Ad Hoc Review Panel once each party has had a reasonable opportunity to review and pose any objections to the proffered evidence.

The Hearing Officer shall address any other pre-hearing procedural disputes. Objections to any pre- hearing decision or ruling should be posed to the Hearing Officer and ruled upon as promptly as possible prior to the hearing and may be succinctly reasserted at the hearing.

Rights of the Parties at the Hearing: During the hearing, both parties shall have the following rights:

- To be provided with all information made available to the Ad Hoc Review Panel;
- To call, examine, and cross-examine witnesses;
- To present and rebut evidence determined to be relevant by the Hearing Officer;
- To submit a written statement at the close of the hearing;
- To be accompanied at the hearing by an advisor and/or an attorney, as further described at Section VB4.

Resident's Failure to Personally Appear and Proceed—Effect: The Resident's failure to personally appear and proceed at the hearing without good cause shall constitute a waiver of the right to a hearing and acceptance by the Resident of the Adverse Decision.

Presence of Ad Hoc Review Panel: All members of the Ad Hoc Review Panel are expected to be present throughout the hearing. However, if an Ad Hoc Review Panel is unavoidably absent from any part of the proceedings, the absent Panel member may review the recording or transcript of the missed hearing (or portion thereof), and thereafter may participate in deliberations and the final decision.

Procedure at the Hearing

The Hearing Officer shall preside at the hearing and assure that all parties are heard and given an adequate opportunity to present relevant evidence and arguments.

Order of presentation:

- Each party may make an opening statement.
- After each party has made or waived its opening statement, the Program Director shall present, including any witness(es) they intend to call.
- The Resident shall present second, including any witness(es) the Resident intends to call.
- The Resident may be called as a witness and is expected to testify in response to questions posed by the Program Director.
- The Ad Hoc Review Panel or Hearing Officer may pose questions to any witness, including the Resident.

Continuances may be granted by the Hearing Officer upon timely request and a showing of good cause. The Hearing Officer should consider the schedules and availability of the Ad Hoc Review Panel members in ruling on any requested continuances and shall afford priority to expeditious completion of the hearing.

The hearing shall be closed and informal. Rules of evidence or judicial procedure need not be followed. Testimony, however, shall be under oath.

On conclusion of the presentation of evidence and arguments, the Hearing Officer shall declare the hearing closed.

Thereafter, the Ad Hoc Review Panel shall deliberate privately and reach a decision based on the evidence presented at the hearing, including oral testimony, written statements, and other documents, including medical record information, introduced at the hearing. The Chair shall preside over the deliberations, with the assistance of the Hearing Officer who shall be present at and may participate in these deliberations for the purpose of assuring that all relevant issues are addressed, and that appropriate legal standards and procedural rights are observed but shall not vote. The Hearing Officer shall also be responsible to prepare the written report of the Ad Hoc Review Panel's decision.

Within thirty (30) calendar days of the close of the hearing, the Ad Hoc Review Panel shall issue its report and decision in writing to the Hospital Administrator and the DGME. The report shall include findings of fact and a conclusion stating the connection between the evidence produced at the hearing and the decision reached. The report, which shall constitute the final decision of the Ad Hoc Review Panel, shall make findings as to whether the Adverse Decision was or was not reasonable and warranted; but the Ad Hoc Review Panel shall not have authority to modify or impose an alternative Adverse Decision. The Hearing Officer shall have a copy of the report sent to the Resident by personal delivery or registered or certified mail, with a copy to the Program Director.

The decision of the Ad Hoc Review Panel is final, and neither party has any further right to review of the matter.

The report and decision of the Ad Hoc Review Panel shall be made part of the Resident's File.

Other Hearing Issues:

Burden of Going Forward and Burden of Persuasion: The Program Director or other decision-making body which made the Adverse Decision shall initially come forward with evidence in support of the decision concerning the Resident. Thereafter the burden will shift to the Resident to come forward with evidence to establish the decision was improper. The Ad Hoc Review Panel will evaluate the evidence presented. The decision of the Program Director or other decision-making body will be upheld unless the Ad Hoc Review Panel finds upon review of the evidence presented that by clear and convincing proof the disputed action was arbitrary or capricious.

Fees and Costs: Each party shall bear its own legal fees and other costs.

Recording the Proceeding: The Hearing Officer shall arrange to have the hearing recorded by a court reporter, at the expense of the Residency Program. A party shall not be permitted to independently audio or videotape or otherwise record the proceedings. The Hearing Officer shall provide a copy of the transcript to a requesting party upon payment of the cost therefore, as follows: The cost of a transcription of the matters reported by the court reporter

shall be borne by the party requesting the transcription. A party requesting a copy of a transcription shall pay the cost of the copy. The Office of Graduate Medical Education shall retain the original transcripts.

Glossary:

Adverse Decision means an action or proposed action which directly concerns the Resident's academic or professional performance and involves the Resident's proposed dismissal or dismissal (other than Administrative Dismissals) from the Residency Program, or otherwise threatens a Resident's intended career development. An Adverse Decision includes, but is not limited to:

- Notice of intent to suspend or suspension (except Administrative Suspensions or suspensions which total no more than thirty (30) calendar days in any twelve-month period, *e.g.*, for medical records delinquency pending completion of the records);
- Notice of intent to dismiss or dismissal (except Administrative Dismissal);
- requiring the resident to repeat a residency training year
- Nonrenewal of the Resident's contract;
- Any action for which a report is required to a government agency, *e.g.*, a report to the Medical Board of California for a medical disciplinary cause or reason under California Business and Professions Code section 805.

Administrative Suspension or Dismissal means an automatic suspension or dismissal, such as a dismissal for failure to obtain a California physician's license in the requisite time period.

Decision means an action or proposed action which directly concerns the Resident's academic and professional performance.

Resident means a post-graduate medical or podiatric trainee, including a training fellow, who is enrolled in an approved medical or podiatric residency program sponsored by a Kaiser Foundation Hospital.