

Beaumont Farmington Hills (formerly Botsford Hospital)

# Neuromusculoskeletal Medicine Programs

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## **INTRODUCTION AND ACCREDITATION INFORMATION**

The Botsford Hospital Family Practice Residency Program, Integrated FM/NMM, and Combo FM/ONMM programs provide all the essentials necessary for an outstanding graduate medical education. Training is based at Botsford Hospital, a 336-bed suburban hospital located in Farmington Hills, Michigan, that has full services in internal medicine, surgery, obstetrics/gynecology, emergency medicine, pediatrics, and various subspecialty medical and surgical types. Botsford Hospital, a member of the Beaumont Health Care System, has played a significant role in the training of osteopathic physicians since 1946. It currently has 20 approved residency training programs in place with a house staff of 167. Botsford offers the opportunity to gain experience at a progressive multi-disciplined community hospital that has the latest technology and is strategically positioned, both medically and educationally, among leading medical centers.

Selected outpatient placements in the community play a major component in the training program by emphasizing “real world” office-based longitudinal care of patients and their families. Faculty are selected on their commitment to teaching and training and are all board-certified family practitioners.

Residency training in family practice reflects the concepts and philosophy of the discipline. Osteopathic family physicians best express this philosophy by assuming responsibility for continuing and comprehensive care of individuals and families, with appropriate consideration of the social, psychological, physiological, biological, economic, and cultural dimensions of health. Fundamental to the philosophy of osteopathic family practice is a caring attitude that facilitates the total coordination of the patients’ and families’ health care needs.

The purpose of the Family Practice Residency Program is to provide residents with a properly organized, progressive experience for primary responsibility in the care of patients in a family environment through continuity of didactic and clinical experience.

This experience is accomplished in several ways. Residents receive clinical supervision from teaching faculty in all aspects of patient management and are given maximum responsibility in accordance with their levels of experience. Throughout their residencies, residents see patients three half-days per week at the residency clinic for their continuity-of-care experience. Faculty trainers provide assistance, supervision, and management of these cases with the goal of independent and autonomous functioning. Journal Club and residency-sponsored conferences are held regularly in the residency clinic to discuss ongoing issues related to family practice. In addition, behavioral medicine and practice management conferences are provided to teach interpersonal communication skills for both doctor-patient and office staff relationships.

The mission of the Botsford Hospital NMM/OMM residency programs is to develop highly trained physicians in NMM/OMM. Residents will have opportunities for developing their clinical, diagnostic, and treatment skills in NMM/OMM through inpatient care and outpatient clinics. Botsford Hospital is a regional trauma center that provides residents with experience in all aspects of patient care, from critically ill patients

to young children. This breadth of patients allows our residents to learn to integrate osteopathic principles and NMM/OMM into many types and levels of patient care.

Our NMM/OMM residency programs also excel in training future teachers. Many graduates of our Integrated FP/NMM Residency Program and our Plus One Residency Program have gone on to teaching careers at hospitals and osteopathic medical schools across the nation. Through our extensive didactics, and through the many lectures that residents give at the hospital, our residents learn the many skills needed to become great teachers.

Above all, our residents excel in becoming caring osteopathic physicians who integrate the concepts of osteopathic medicine, both philosophically and via NMM/OMM, into their patient care. Osteopathic principles and practice are integrated into each didactic session, into each lecture, and with each patient, based on the seven core competencies (see attached competency list and rotation guidelines).

Three programs have been designed for implementation at Botsford within the context of the Michigan statewide consortium. Each program has as its goal the expansion of osteopathic education for the participants in the program and for the hospital as a whole.

The first track is the NMM Emphasis Track. This track is designed for the resident interested in developing osteopathic skills without having to do an additional year of training. It allows for Family Practice (FP) certification but not NMM certification.

The second track is the Family Practice/NMM Integrated Program, which is designed for the resident who desires dual certification in NMM and FP. This program also will allow the resident to be eligible for program directorship after completion. *After initial accreditation from the ACGME is achieved, this program will be converted to the Combo FM/ONMM1 Program.*

The third track is the ONMM2/Plus One Program, which is designed to provide additional training in NMM. The Plus One Program provides intensive training in NMM for those individuals who have previously completed training in a postdoctoral program. This program will allow for NMM certification and eligibility for program directorship after completion.

## **ACCREDITATION INFORMATION**

### **Program and Positions Offered**

The Combo FM/NMM Program is 4 years in duration, and fulfills the eligibility for certification examination of the American College of Family Practitioners in Osteopathic Medicine and Surgery and the American Academy of Osteopathy. The ONMM2/Plus One Program fulfills the eligibility for certification examination of the American Academy of Osteopathy.

Twelve positions are currently approved and funded: six in the Combo Program and six in the ONMM2/Plus One Program.

### **Residency Program Accreditation**

The Botsford Hospital Family Practice Residency Program is fully approved by the Committee on Evaluation and Education of the American College of Family Practitioners in Osteopathic Medicine and Surgery and accredited by the American Osteopathic Association. The Integrated FM/NMM and ONMM2/Plus One programs are fully approved by the Postdoctoral Standards and Accreditation Committee of the American Academy of Osteopathy and accredited by the American Osteopathic Association.

### **Affiliations**

Botsford Hospital (part of Beaumont Health System) is affiliated with the Michigan State University College of Osteopathic Medicine and offers training to externs, interns, residents, and fellows from all over the United States. The Family Practice Residency and ONMM programs also participate in the Statewide Campus System of the Michigan State University College of Osteopathic Medicine.

### **Faculty**

The Family Practice/NMM Integrated Program and the ONMM2/Plus One Program are currently composed of a full-time program director/trainer and clinical director/trainer as well as other core faculty. See the Faculty Information section of this manual for further details.

# **BOTSFORD GENERAL HOSPITAL NEUROMUSCULOSKELETAL MEDICINE PROGRAM DESCRIPTIONS**

## **Rationale for Development of Programs**

The NMM Emphasis Track, Family Practice/NMM Integrated Program, and ONMM2/Plus One Program are designed to improve the NMM education of the participant in the program and also to benefit the family practice program and the hospital. The resident will receive additional NMM training from NMM specialists and then will be able to apply this knowledge in lectures, in his or her resident continuity clinic, and in interactions with other residents, interns, and students at the hospital. Increased educational opportunities will be provided for residents and house staff. Increased exposure of osteopathic medicine to the community will occur.

## **NMM Emphasis Track**

The NMM Emphasis Track allows a Year 2 or Year 3 Family Practice resident to obtain additional training in osteopathic treatment and philosophy and in primary-care sports medicine. The resident may elect to take the track for one year or to stay in the track for a total of two years. The resident is eligible to sit for the ACOFP board exams according to the requirements of the ACOFP, but is not eligible to sit for the AOBNMM board exams. Specifically, the track involves one of the weekly family practice clinic half-days spent with a physician specializing in ONMM or in ONMM and sports medicine. This clinical schedule allows the resident to have continuity of training in ONMM for an entire year or two years. It also allows time for the resident to apply principles he or she has learned with the ONMM preceptor into his or her other two half-days in the family practice continuity clinic. The resident in the NMM Emphasis Track is also required to spend at least one month per year doing a rotation in an NMM specialty office. Additional responsibilities for the resident include attending lectures and participating as a table trainer for family practice lectures and other activities within the hospital. The Emphasis Track does not allow the resident to seek NMM certification upon completion.

## **Family Practice/NMM Integrated Program**

The Family Practice/NMM Integrated Program shares the same ideals as the NMM Emphasis Track, and its rationale for development is much the same as the emphasis track. Its goal is to provide additional NMM training to the family practice resident while bolstering OMM education in the residency and within the hospital. The program differs from the NMM Emphasis Track in that it provides an additional year of training beyond the requirements of the ACOFP and it fulfills the requirements of the AOBNMM. The integrated program meets AOA requirements for both FP and NMM certification.

Years 2 and 3 are similar to those in the NMM Emphasis Track, but the presence of Year 4 allows for extensive additional educational experiences. This training includes rotations in sports medicine, orthopedics, neurology, physical medicine and rehabilitation, and NMM. The resident will also rotate among clinics of several OMM specialists. He or she will develop skills as an educator and researcher and will achieve an understanding of how to integrate the multidisciplinary aspects of patient care. The resident will gain an understanding of delivering cost-effective care while maintaining excellent quality of

care. During this year, the resident will continue to provide lectures to the residents and house staff. He or she will be present in the family practice clinic for at least one half-day per week to see patients or assist in preceptorship of residents or students. This presence in the family practice clinic will provide an additional educational resource to those rotating through the clinic. The resident is eligible to sit for the ACOFP boards and the AOBNMM boards during Year 4.

### **Combo FM/ONMM1 Program**

It is our plan to convert the Family Practice/NMM Integrated Program to the ACGME Combo model after we have achieved ACGME initial accreditation for the FP and ONMM residency programs. For additional details, please refer to the Combo program curriculum schedule.

### **ONMM2/Plus One Program**

The ONMM2/Plus One Program also shares the same ideals as the NMM Emphasis Track. Its goal is to provide additional training in NMM for those residents who have previously completed their postdoctoral training in an AOA-approved specialty. The ONMM2/Plus One Program meets AOA requirements for NMM certification. The program enables residents to become competent and proficient in OMM and neuromusculoskeletal medicine, and it prepares them to be lifelong learners and future teachers in NMM/OMM.

This program is similar to the Family Practice/NMM Integrated Program in that it includes rotations in sports medicine, orthopedics, neurology, physical medicine and rehabilitation, and NMM. It also provides rotations among clinics of OMM specialists. Because residents in the ONMM2/Plus One Program must have previously completed training in an accredited AOA specialty, the curriculum is designed to provide yearlong intensive training in topics in NMM. Residents become proficient in diagnosis and treatment in both inpatient and outpatient settings.

As in the Family Practice/NMM Integrated Program, the resident will develop skills as an educator and researcher, achieve an understanding of how to integrate the multidisciplinary aspects of patient care, and gain an understanding of administering cost-effective, excellent-quality care. During the residency, the resident will provide lectures to other residents and house staff. At the end of the program, the resident will be eligible to sit for the AOBNMM board exams.

## **RESIDENCY REQUIREMENTS**

### **Hospital Care**

Inpatient care is to be incorporated into these residency programs through inpatient consultations. Each consult will be given under the supervision of a physician who is board-certified in NMM/OMM. Further description of hospital-care goals and objectives can be found on page 28.

## **Michigan State University Statewide Campus System**

Both residency programs participate in the NMM/OMM Consortium of the MSU Statewide Campus System. One to two didactic sessions will be offered each month on the campus of MSUCOM or at Botsford Hospital. Responsibilities of resident participation are included in the following program objectives. FP SCS normally meets on the first Wednesday of each month and the OMM SCS on the third Friday of each month. To receive an SCS diploma, the resident must attend 80% of *both* conferences. Leaving early constitutes an absence. If there is a problem, notify Dr. Nelson or Dr. Goldman. The resident is *required* to be there. If 80% attendance is not met, the resident will not receive his or her residency diploma!

## **CONFERENCE/COURSE REQUIREMENTS**

### **FP/NMM Integrated Residents and Combo Residents**

These residents are required to attend the annual Convocation of the American Academy of Osteopathy twice between OGME 2, 3, and 4. They are also required to take the annual resident in-service examination either at Convocation or at the hospital each year during OGME 2, 3, and 4. Additionally, residents are required to complete a basic course in Cranial OMM during OGME 2. This requirement will be waived with permission from the program director if the resident has completed the course prior to beginning the residency program, and the resident may substitute a more advanced course in Cranial OMM. ACOFP is mandatory at least once during residency. All other conferences must be approved by the program directors.

### **ONMM2/Plus One Residents**

These residents are required to attend the annual Convocation of the American Academy of Osteopathy and take the resident in-service examination. They are also required to complete a course in Cranial OMM during the residency program. This requirement will be waived with permission from the program director if the resident has completed the course prior to beginning the residency program.

## **RESIDENCY PROJECT REQUIREMENTS**

### **FP/NMM Integrated Residents and Combo Residents**

These residents are required to submit two finished projects by the end of the residency: one on a topic in NMM and one on a topic in primary care. Topics must be submitted to the NMM and FP program directors for approval. The requirement for two projects will continue when the Integrated Program becomes the Combo Program.

### **ONMM2/Plus One Residents**

These residents are required to submit a finished project on a topic in NMM by the end of their residency year. Topics must be approved by the program director.

## **RESPONSIBILITIES OF PROGRAM DIRECTOR AND RESIDENTS**

To complete residency paperwork and ensure the ability to become board certified, residents must complete the following requirements to Medical Education that will be sent to the AOA.

### **Program director's responsibility:**

- Quarterly evaluations
- Program Director's Annual Report
- AOA Competency Evaluation
- ACOFP Final Report
- AAO Final Residency Reports

### **Residents' responsibility:**

- Procedure logs
  - For FP: Keep a log of inpatient pediatric patients and IM patients for inspections
  - For OMM: Keep a log of all OMM clinic patients, inpatient consults, and patients seen during outside OMM rotations
- Lecture schedules for FP and OMM
- Scientific project FP paper/project due by March of OGME 3 for review by the FP program director. OMM paper/project due by January of OGME 4 for review by the OMM program director.
  - Resident must forward the paper/project to ACOFP. The project remains in the resident's file.
- Out-rotation forms (filed at beginning of each year)
- Elective rotation forms (filed at beginning of each year)
- Work hour logs
- Complete rotation evaluations
- Portfolio development
- CV development

Only residents who meet AOA requirements are selected for the residency programs. Applications are reviewed through ERAS, and interviews are granted based on board scores, transcripts, references, and rotation evaluations, if applicable. Interviews include input from the program director, faculty, and residents. Students are ranked and put through the Match. (To be ranked, students must pass COMLEX Levels 1 and 2 prior to the Match.)

## **YEARLY ROTATION SCHEDULE**

If any changes need to be made to a resident's rotation schedule, the request must be submitted to the Program Coordinator in the Department of Medical Education so it can be approved by Dr. Nelson and Dr. Goldman.

Electives must be scheduled by the resident but must also be approved by Dr. Nelson (for FP) or Dr. Goldman (for OMM).

All out-rotations must have paperwork completed at least one month prior to the beginning of the rotation, otherwise the resident may not be allowed to go on that rotation.

Second-year rotations may be discussed at any time prior to May. If you have any particular requests, let Dr. Nelson or Dr. Goldman know.

The resident should call his or her service one or two months prior to the beginning of the service to potentially arrange clinic days. If residents need any days off, they must change their clinic days or add days. Days off during the week are *not appropriate* unless first discussed with Dr. Nelson and Dr. Goldman.

### **Orientation**

Orientation occurs during July and August of each year. It includes distribution of each resident's portfolio, which is to be individually maintained during the residency program.

### **Lectures**

- FP: Wednesday evening 4:00–7:00 p.m.
- OMM: Thursday morning 6:30–8:00 a.m.
- Family Practice Department meeting on the second Tuesday quarterly

A schedule of all lectures will be available the month prior.

### **Vacations**

Residents receive 4 weeks of PTO per year. Vacations must be authorized by Dr. Nelson and Medical Education. Residents must also complete a time-off form.

### **Moonlighting**

Moonlighting is allowed and advised, providing certain requirements are met. It must not interfere with any rotation, clinic day, lecture, or call schedule. No resident on probation can moonlight. The hospital is not responsible for residents' malpractice; residents should make sure they are covered. Moonlighting must also fit into the new on-call guidelines. The hospital must have proof of each resident's malpractice coverage. *All* paperwork must be on file in Medical Education.

### **Outside Rotations and Electives**

Forms for outside rotation and elective requests are available in Medical Education. They must be completed and submitted to Medical Education at least two months in advance of the requested rotation.

### **Logs**

Competency-based evaluation forms will be distributed at the beginning of the residency. It is the resident's responsibility to see they are completed. Residents can also use the disc at the FP clinic to access lost evaluation forms. OMM logs can be obtained through

the clinic EMR system. Eventually, all OMM logs will be kept through the ACGME system.

Procedure logs must be completed monthly, and reviewed and signed by the FP or NMM program director.

Time sheets, aka Duty Hours, must be completed in New Innovations by the end of each quarter.

## **TEACHING FACULTY**

### **FP CONTINUITY CLINICS**

Farmington Village Family Practice West  
32754 Grand River Ave.  
Farmington, MI 48336  
(248) 476-3280

Farmington Village Family Practice East  
28100 Grand River Ave. Ste. 313  
Farmington Hills, MI 48336  
(248) 615-7150

### **NMM CONTINUITY CLINIC**

Novi Center for Manipulative and Sports Medicine  
23995 Novi Rd. Ste. C102  
Novi, MI 48375  
(248) 380-1900

### **PROGRAM DIRECTORS**

FP: Carolyn Nelson, DO  
(248) 615-7150  
NMM: Stephen I. Goldman, DO, FAAO, FAOASM  
(248) 380-1900

### **NMM PROGRAM ACTIVE FACULTY**

Barbara Zajdel, DO  
T. Reid Kavieff, DO

# **NEUROMUSCULAR MEDICINE PROGRAM OBJECTIVES**

## **PROGRAM OBJECTIVES**

A neuromuscular medicine (NMM) program director will be appointed to ensure that program objectives are accomplished. Residents in the Family Practice/NMM Integrated Program and the NMM Emphasis Track shall fulfill all criteria specified in the Botsford Hospital Family Practice Residency Handbook and the additions and changes listed in this handbook. The Family Practice/NMM Integrated Program shall meet all requirements for FP through the AOA and ACOFP and for NMM certification through the AOBNMM. In addition, the Combo FM/ONMM1 Program shall meet all requirements for FM through the AOA, ACOFP, AAFP, and AAO. The ONMM2/Plus One Program shall meet all requirements for NMM certification through the AOBNMM.

## **HOSPITAL RESPONSIBILITIES**

- Residents shall adhere to hospital policies regarding patient logs, resident papers, and acute and consultation care under supervision in the hospital setting.
- Residents shall attend all educational programs and courses as required by the FP and NMM programs.
- Residents shall attend all conferences and lectures as required by the FP program.
- Residents shall attend weekly NMM didactic sessions.
- Residents shall attend 80% of all required meetings and educational programs to which they are assigned, including SCS meetings.
- Each resident's NMM procedure log shall be submitted to the NMM program director on a quarterly basis.
- Residents shall attend hospital OPP Committee meetings.

## **REQUIRED READINGS**

*Foundations for Osteopathic Medicine*, ed. Ward

Pain Series, Calliet

*Orthopaedic Neurology*, Hoppenfeld

*AAO Journal*, *The Journal of the American Osteopathic Association*, and *The Journal of Sports Medicine and Physical Fitness*

Position papers of the American College of Sports Medicine

*Greenman's Principles of Manual Medicine*

*Osteopathic Considerations in Systemic Dysfunction*, Kuchera

*Autobiography of Andrew T. Still*, Still

Other journals, texts, and articles as assigned by the NMM program director

## **NEUROMUSCULAR MEDICINE EMPHASIS TRACK**

### **Eligibility Requirements**

- Acceptance to the Botsford Hospital Family Practice Residency Program
- Acceptance to the NMM Emphasis Track
- Adherence to all requirements of the FP program
- Good standing in the R2 or R3 years

### **Responsibilities of Participants during R-2 or R-3**

- All requirements within the FP program as listed in the FP Residency Manual
- One of the FP continuity clinic half-days spent in continuity care at an NMM clinic
- Presentation of 6 lectures per year on NMM. Target audiences include FP residents, hospital lecture attendees, MSU, and community groups.
- Monthly participation in NMM lectures as assistants and table trainers
- Monthly journal club on NMM with the NMM program participants (Note: This is in addition to journal clubs within the FP program.)
- Optional attendance to NMM lecture series one half-day per month in lieu of one half-day NMM clinic
- Weekly NMM didactics with NMM program participants
- Required one-month rotation in NMM (See schedule for details.)

## **FAMILY PRACTICE/NMM INTEGRATED PROGRAM**

### **Eligibility Requirements**

- Acceptance to the Family Practice/NMM Integrated Program

### **Responsibilities of Participants**

Residents shall attend at least two annual meetings of the AAO during their participation in the residency program. During OGME 2–4, each resident shall complete a total of 312 clinic half-days for FP and 156 half-days for NMM. Residents shall see a minimum of 120 individual patients and have a minimum of 360 patient encounters in the NMM clinic. In addition, R-1s shall see at least 150 patients during the first year in the clinic setting. By the end of the residency, each resident shall have seen a total of 1650 patients.

In addition, residents shall evaluate and provide OMT to a minimum of

- 100 patients with a variety of medical diagnoses,
- 100 patients with a variety of surgical diagnoses,
- 100 patients with a variety of pediatric diagnoses,
- 100 patients with a variety of OB/GYN diagnoses, and
- 100 patients in the inpatient setting.

All of these encounters shall be under the supervision of an NMM certified physician.

During OGME 2, residents shall also complete one basic or advanced course on osteopathy in the cranial field.

Specific yearly responsibilities are as follows:

### **Year 1**

- Half-days spent at the FP continuity clinic and one month spent in the NMM continuity clinic
- Monthly participation in NMM lectures as assistants and table trainers, as permitted by the OGME 1 schedule
- Monthly journal club on NMM with the NMM program participants (Note: This is in addition to journal clubs within the FP program.)
- Monthly attendance at didactic sessions of the Statewide Campus System of MSU College of Osteopathic Medicine for FP and NMM when permitted by the OGME 1 schedule
- Weekly NMM and FP didactics
- 12 months of rotations of the FP curriculum. The elective month will be spent in the NMM continuity clinic.

### **Year 2**

- 2 half-days at the FP continuity clinic, 1 half-day in continuity care at the NMM continuity clinic, and one monthlong rotation at the FP continuity clinic
- Presentation of 3 lectures per year on topics in NMM. Target audiences include FP residents, hospital lecture attendees, MSU, and community groups.
- Monthly participation in NMM lectures as assistants and table trainers
- Monthly attendance at didactic sessions of the Statewide Campus System of MSU College of Osteopathic Medicine for FP and NMM
- Required 4 months of rotation in NMM (see schedule for details). 2 of the 12 total NMM rotation months may be spent in a dedicated inpatient OMM rotation. 3 NMM selective rotations shall be completed during the residency program in the identified specialty areas of neurology, rheumatology, orthopedics, and physical medicine and rehabilitation.
- 8 months of rotation of the FP curriculum
- Weekly NMM and FP didactics
- Attendance of hospital OPP Committee meetings
- Participation in educational activities and continuity care clinics even while doing base-site electives or local non-NMM and OMM rotations

### **Year 3**

- 2 half-days at the FP continuity clinic, 1 half-day in continuity care at the NMM continuity clinic, and one monthlong rotation at the FP continuity clinic
- Presentation of 3 lectures per year on topics in NMM. Target audiences include FP residents, hospital lecture attendees, MSU, and community groups.
- Monthly participation in NMM lectures as assistants and table trainers
- Monthly attendance at didactic sessions of the Statewide Campus System of MSU College of Osteopathic Medicine for FP and NMM

- Required 4 months of rotation in NMM (see schedule for details). 2 of the 12 total NMM rotation months may be spent in a dedicated inpatient OMM rotation. 3 NMM selective rotations shall be completed during the residency program in the identified specialty areas of neurology, rheumatology, orthopedics, and physical medicine and rehabilitation.
- 8 months of rotation of the FP curriculum
- Weekly NMM and FP didactics
- Attendance of hospital OPP Committee meetings
- By the end of OGME 3, satisfactory completion of the FP project on a subject mutually agreed upon by the resident and the FP program director
- Participation in educational activities and continuity care clinics even while doing base-site electives or local non-NMM and OMM rotations

#### **Year 4**

- 2 half-days at the FP continuity clinic, 1 half-day in continuity care at the NMM continuity clinic, and one monthlong rotation at the FP continuity clinic
- Presentation of 3 lectures per year on topics in NMM. Target audiences include FP residents, hospital lecture attendees, MSU, and community groups.
- Monthly participation in NMM lectures as assistants and table trainers
- Monthly attendance at didactic sessions of the Statewide Campus System of MSU College of Osteopathic Medicine for FP and NMM
- Required 4 months of rotation in NMM (see schedule for details). 2 of the 12 total NMM rotation months may be spent in a dedicated inpatient OMM rotation. 3 NMM selective rotations shall be completed during the residency program in the identified specialty areas of neurology, rheumatology, orthopedics, and physical medicine and rehabilitation.
- 8 months of rotation of the FP curriculum
- Weekly NMM and FP didactics
- Attendance of hospital OPP Committee meetings
- Satisfactory completion of the FP project on a subject mutually agreed upon by the resident and the FP program director
- By the end of January, satisfactory completion of NMM paper on a subject mutually agreed upon by the resident and the NMM program director
- Completion of eligibility requirements for AOBNMM and AOFB boards
- Participation in educational activities and continuity care clinics even while doing base-site electives or local non-NMM and OMM rotations

### **ONMM2/PLUS ONE PROGRAM**

#### **Eligibility Requirements**

- Acceptance to the ONMM2/Plus One Program
- Adherence to all requirements of the ONMM2/Plus One Program
- Completion of previous postdoctoral education, training, or certification(s) demonstrating board eligibility and/or board certification through an accredited AOA specialty

### **Patient Care—ONMM**

Through longitudinal, clinical, or hospital care, residents shall evaluate and provide OMT to a minimum of

- 35 patients with a variety of surgical diagnoses,
- 35 patients with a variety of pediatric diagnoses,
- 35 patients with a variety of OB/GYN diagnoses, and
- 35 patients in the inpatient setting.

All of these encounters shall be under the supervision of an NMM certified specialist.

### **Continuity of Care Clinic—ONMM**

Residents shall see a minimum of 175 patients with at least 2 encounters, and shall have a minimum of 700 total patient encounters. All of these shall be under the supervision of an NMM certified specialist.

Additional yearly responsibilities are as follows:

- Presentation of 6 lectures per year on topics in NMM. Target audiences include FP residents, hospital lecture attendees, MSU, and community groups
- Monthly participation in NMM lectures as assistants and table trainers
- Monthly journal club on NMM with the NMM program participants
- Monthly attendance at didactic sessions of the NMM/OMM Consortium of the Statewide Campus System of MSU College of Osteopathic Medicine
- Required 4 months of rotation in NMM (see schedule for details)
- Completion of all required and elective rotations (see schedule for details)
- Weekly NMM didactics with NMM program participants
- Satisfactory completion of the NMM paper on a subject mutually agreed upon by the resident and the NMM program director
- Completion of eligibility requirements for AOBNMM boards
- Attendance of hospital OPP Committee meetings

## **COMBO FM/ONMM1 PROGRAM**

### **Eligibility Requirements**

Acceptance to the Botsford Hospital Family Practice Residency Program

Acceptance to the ONMM1 Program

### **Responsibilities of Participants**

Residents shall attend the annual meeting of the AAO during 3 of the 4 years of participation in the Combo residency program. During years 1–3, residents shall participate at the FP continuity care clinic 3 half-days per week. Residents shall participate at the NMM continuity care clinic one half-day per month in Year 1, one half-day per week in Years 2 and 3, and three half-days per week in Year 4.

### **Patient Care—ONMM**

Through longitudinal, clinical, or hospital care, residents shall evaluate and provide OMT to a minimum of

- 50 patients with a variety of surgical diagnoses,
- 50 patients with a variety of pediatric diagnoses,
- 50 patients with a variety of OB/GYN diagnoses, and
- 50 patients in the inpatient setting.

All of these encounters shall be under the supervision of an NMM specialist.

### **Continuity of Care Clinic—ONMM**

Residents shall see a minimum of 250 patients with at least 2 encounters, and shall have a minimum of 1,000 total patient encounters. All of these encounters shall be under the supervision of an NMM certified specialist.

Specific yearly responsibilities are as follows. For additional information, see the rotation schedule.

#### **R-1**

- 1 half-day per week spent at the FP continuity clinic, 1 half-day per month spent in NMM continuity clinic, and one month rotation spent in the NMM continuity clinic
- Monthly participation in NMM lectures as assistants and table trainers, as permitted by the OGME 1 schedule
- Monthly journal club on NMM with the NMM program participants (Note: This is in addition to journal clubs within the FP program.)
- Monthly attendance at didactic sessions of the Statewide Campus System of MSU College of Osteopathic Medicine for FP and NMM when permitted by the OGME 1 schedule
- Weekly NMM and FP didactics
- 12 months of rotations of the FP curriculum. The elective month will be spent in the NMM continuity clinic.

#### **R-2**

- 2 half-days at the FP continuity clinic, and 1 half-day in continuity care at the NMM continuity clinic, and one monthlong rotation at the FP continuity clinic
- Presentation of 3 lectures per year on topics in NMM. Target audiences include FP residents, hospital lecture attendees, MSU, and community groups
- Monthly participation in NMM lectures as assistants and table trainers
- Monthly attendance at didactic sessions of the Statewide Campus System of MSU College of Osteopathic Medicine for FP and NMM
- Required 3 months of rotation in NMM (see schedule for details). 1 month of NMM shall be in outpatient clinic, 1 month shall be in inpatient rotation, and 1 month shall be in an NMM elective.
- 9 months of rotation of the FP curriculum
- Weekly NMM and FP didactics
- Attendance of hospital OPP Committee meetings
- Participation in educational activities and continuity care clinics even while doing base-site electives or local non-NMM and OMM rotations

**R-3**

- 2 half-days at the FP continuity clinic, 1 half-day in continuity care at the NMM continuity clinic, and one monthlong rotation at the FP continuity clinic
- Presentation of 3 lectures per year on topics in NMM. Target audiences include FP residents, hospital lecture attendees, MSU, and community groups.
- Monthly participation in NMM lectures as assistants and table trainers
- Monthly attendance at didactic sessions of the Statewide Campus System of MSU College of Osteopathic Medicine for FP and NMM
- Required 3 months of rotation in NMM (see schedule for details). 1 month of NMM shall be in outpatient clinic, 1 month shall be in inpatient rotation, and 1 month shall be in an NMM elective.
- 9 months of rotation of the FP curriculum
- Weekly NMM and FP didactics
- Attendance of hospital OPP Committee meetings
- Participation in educational activities and continuity care clinics even while doing base-site electives or local non-NMM and OMM rotations
- Completion of eligibility requirements for AOFP boards

**R-4**

- 3 half-days at the NMM continuity clinic
- Presentation of 3 lectures per year on topics in NMM. Target audiences include FP residents, hospital lecture attendees, MSU, and community groups.
- Monthly participation in NMM lectures as assistants and table trainers
- Monthly attendance at didactic sessions of the Statewide Campus System of MSU College of Osteopathic Medicine for FP and NMM
- Required 6 months of rotation in NMM (see schedule for details). 4 months shall be in an outpatient setting and 2 months in an inpatient setting.
- 6 months of NMM electives (see schedule for details)
- Weekly NMM didactics
- By the end of January, satisfactory completion of the NMM paper on a subject mutually agreed upon by the resident and the NMM program director
- Completion of eligibility requirements for AOBNMM boards
- Attendance of hospital OPP Committee meetings
- Participation in educational activities and continuity care clinics even while doing base-site electives or local non-NMM and OMM rotations

## EDUCATIONAL OBJECTIVES

- A) Residents shall become proficient in all educational objectives as outlined in the Family Practice Residency Manual.
- B) Residents shall become proficient in obtaining an accurate history and arriving at the correct diagnosis of diseases and injuries to the systems listed under Section C.
- C) Residents shall become proficient in treating the following outpatient conditions using the principles and practices of NMM:
  - 1) Upper extremity
    - a) shoulder
      - 1) impingement syndrome
      - 2) supraspinatus and biceps tendinitis
      - 3) labrum tears
      - 4) assessment of instability
      - 5) neuromuscular imbalance
    - b) elbow
      - 1) lateral epicondylitis
      - 2) medial epicondylitis
      - 3) neurological impingements
    - c) wrist/hand
      - 1) sprains
      - 2) fractures/instabilities
      - 3) tendinitis
  - 2) Lower extremity
    - a) hip
      - 1) iliotibial band syndrome
      - 2) greater trochanteric bursitis
      - 3) capsulitis
      - 4) degenerative joint disease
      - 5) other
    - b) knee
      - 1) meniscal injuries
      - 2) collateral ligament injuries
      - 3) cruciate ligament injuries
      - 4) patellofemoral injuries
    - c) foot and ankle
      - 1) sprains
      - 2) tendinitis
      - 3) plantar fasciitis
      - 4) toe problems/injuries
      - 5) neurological impingements
  - 3) Thoracic and Lumbar Spine
    - a) degenerative disk disease
    - b) spondylolisthesis
    - c) scoliosis
    - d) spinal stenosis

- e) radiculopathy
- f) muscle imbalance and somatic dysfunction
- 4) Cervical Spine
  - a) degenerative disk disease
  - b) radiculopathy
  - c) cord compression
  - d) fractures
  - e) sports-related injuries
- 5) Cranial
  - a) cephalgia
    - 1) TMJ syndrome and malocclusion
    - 2) migraine cephalgia
    - 3) tension cephalgia
  - b) strain patterns
- \*D) Residents shall become proficient in NMM evaluation and management of these common inpatient conditions:
  - 1) Inpatient NMM Examination
  - 2) COPD/Asthma
  - 3) Postoperative Ileus
  - 4) Pneumonia
  - 5) Low-Back Pain
  - 6) Upper GI Complaints
  - 7) Musculoskeletal Headaches
  - 8) Chest Pain
  - 9) Congestive Heart Failure/Edema
- E) Residents shall become proficient in diagnosing neuromuscular imbalance patterns.
- F) Residents shall become proficient in diagnosing common entrapment neuropathies.
- \*G) Residents shall become proficient in managing common medical problems that occur in athletes.
- \*H) Residents shall achieve proficiency in preparticipation physical examinations for participants in sports and recreational activities.
- \*I) Residents shall become proficient in properly ordering laboratory tests and diagnostic imaging.
- J) Residents shall become proficient in caring for athletes at a local high school or sports team.
- K) Residents shall become adept at presenting appropriate educational material to coaches and athletes.
- L) Residents shall develop and coordinate physical therapy/rehabilitation programs for neuromusculoskeletal and athletic injuries.
- \*M) Residents shall understand the indications and contraindications of various treatment modalities and exercise programs.
- \*N) Residents shall participate in care of referral patients with sports- and neuromusculoskeletal-related problems.
- O) Residents shall perform OMM in conjunction with rehabilitation for sports and neuromusculoskeletal injuries.
- \*P) Residents shall become proficient in taping and bracing techniques.

Q) Residents shall become proficient in NMM evaluation and management of common office medical conditions.

R) Residents shall be trained in trigger-point/tender-point injections, peripheral nerve blocks, and joint aspiration/injection.

**\*Requirements specific to the Family Practice/NMM Integrated Program**

## **OSTEOPATHIC PRINCIPLES AND PRACTICES**

- A) Principles
  - 1) Understanding of basic osteopathic tenets
    - a) The body is a unit with mind, body, and spirit interrelations.
    - b) The body has self-regulating, self-healing mechanisms.
    - c) The body has structure-function interrelations.
  - 2) Understanding of the definition of somatic dysfunction
- B) Familiarity with the following types of treatment:
  - 1) Cranial strain patterns
  - 2) Lift therapy
  - 3) Appropriate prescription of PT/rehabilitation
  - 4) Visceral manipulation
  - 5) Exercise prescriptions
- C) Proficiency in the following types of treatment as well as awareness of when such techniques are best applied:
  - 1) Myofascial release
  - 2) Muscle energy
  - 3) High-velocity low-amplitude
  - 4) Articular and Still's Techniques
  - 5) Indirect/functional technique
  - \*6) Basic cranial diagnosis and technique
  - 7) Inhibition
  - 8) Kneading and stretching
- D) Familiarity with office management and practice
  - 1) Residents shall rotate among clinics of OMM specialists.
  - 2) Residents shall develop skills as educators and researchers and shall achieve understanding of how to integrate the multidisciplinary aspects of patient care.
  - 3) Residents shall gain understanding of delivering cost-effective care while maintaining excellent quality of care.

**\*Requirements specific to the Family Practice/NMM Integrated Program**

# CURRICULUM/ROTATION SCHEDULES

## NMM EMPHASIS TRACK

### **R-2**

- 1 Month: Family Practice (in continuity clinic)
- 1 Month: Internal Medicine (inpatient rounder)
- 2 Months: Internal Medicine (subspecialty)
  - Suggest: (1 month each)
  - 1) Pulmonary
  - 2) Cardiology
  - 3) GI
- 2 Weeks: Surgery Elective
- 2 Weeks: Radiology
- 1 Month: ENT
- 1 Month: Orthopedics
- 1 Month: OB/GYN
- 2 Months: Pediatrics (1 month hospital/ER and 1 month outpatient)
- 1 Month: Emergency Medicine
- 1 Month: OMM

Family Practice Office: 2 half-days per week

OMT Office: 1 half-day per week

### **R-3**

- 1 Month: Internal Medicine (inpatient rounder)
- 1 Month/2 Weeks Each: Internal Medicine Electives
  - 1) Dermatology
  - 2) Endocrine
  - 3) Rheumatology
- 1 Month: Neurology
- 1 Month: Geriatrics
- 1 Month: Pediatrics
- 1 Month: OB/GYN
- 2 Weeks Each/1 Month Total: Surgery Subspecialty Selectives
  - Suggest:
  - 1) Urology
  - 2) Ophthalmology
- 1 Month: Sports Medicine
- 1 Month: Occupational Medicine
- 1 Month: OMM
- 2–3 Months: Electives depending on selectives chosen (includes 2 weeks community service if not done previously)

Family Practice Office: 2 half-days per week

OMT Office: 1 half-day per week

## **COMBO FM/ONMM1 PROGRAM**

Note: For additional information on FP rotations, please refer to the FP Residency Manual.

### **Year 1**

1 Month: Pediatrics (inpatient and newborn)  
1 Month: OB Labor and Delivery  
1 Month: Emergency Medicine  
1 Month: General Surgery  
1 Month: ICU  
1 Month: Surgery Elective  
2 Months: General Internal Medicine (hospital rounder)  
1 Month: NMM Rotation in Continuity Clinic  
1 Month: Elective (medicine)  
2 Weeks: Podiatry  
1-1/2 Months and 1 half-day per week (except during ICU months): Family Medicine Continuity Clinic weekly  
1 half-day per month: NMM Continuity Clinic

### **Year 2**

1 Month: Internal Medicine (FP and NMM inpatient rounder)\*  
2 Months: Internal Medicine Subspecialty; 2 choosings for 1 month each (cardiology, pulmonary, or GI suggested)  
1 Month: Family Medicine (in continuity clinic)  
1 Month: ENT  
1 Month: OB/Prenatal  
2 Months: Pediatrics; 1 month inpatient at Beaumont and 1 month pediatrics at Botsford (ambulate and newborn)  
2 Months: NMM; 1 month outpatient and 1 month inpatient  
1 Month: FP Elective  
1 Month: NMM Elective; choose either sports medicine or orthopedics  
2 half-days per week for entire year: Family Medicine Continuity Clinic  
1 half-day per week for entire year: NMM Continuity Clinic

### **Year 3**

1 Month: Pediatrics  
1 Month: Geriatrics  
1 Month: OB/GYN Ambulatory  
1 Month: Surgery Elective  
1 Month: Internal Medicine (FP and NMM inpatient rounder)\*  
1 Month: Neurology  
1 Month: Orthopedics/sports medicine/occupational medicine  
2 Months: NMM; 1 month outpatient and 1 month inpatient  
1 Month: FP Elective  
1 Month: NMM Elective; choose either sports medicine or orthopedics, whichever was not done in Year 2  
1 Month: Emergency Medicine

2 half-days per week for entire year: Family Medicine Continuity Clinic  
1 half-day per week for entire year: NMM Continuity Clinic

\*One month in Year 2 and one month in Year 3 will be spent in inpatient NMM consult service and Internal Medicine inpatient rounder at Beaumont Hospital, Farmington Hills.

**\*\*FM Electives:**

- Need to have 1 month in a surgery elective and 3 of the months in a medicine elective
- **Need 2 weeks in a radiology and surgery elective during Year 2 or 3**
- Surgery suggestions: urology, ophthalmology, or podiatry (2-week rotations are acceptable).
- Medicine recommendations: dermatology, rheumatology, endocrine (2 week–1 month rotations)
- **Note that FM electives may be used to satisfy NMM electives if they are included in the NMM elective list.**

\*\*\*Community Service: Homeless shelter, working at schools, free clinics, Guatemala, health screenings, or Brighton AA

\*\*\*\*Health Systems Management: 1 month or 100 hours. Hours met through lectures, SCS, committee assignments, clinic meetings, department meetings, or rotations

\*\*\*\*\*All FP residency core curriculum requirements must be completed by the end of Year 3

**Year 4**

4 Months: NMM Outpatient

2 Months: NMM Inpatient

6 Months: NMM Electives\*

3 half-days per week: NMM Continuity Clinic

1 half-day per week FP Preceptor

**\*NMM Electives:**

- With input from the program director, residents will schedule the 6 NMM elective months in Year 4 based on their prior rotations to strengthen knowledge in specific subjects as needed.
- If an NMM elective has already been completed during Years 1–3, it does not need to be repeated unless the program director feels that the resident needs to strengthen knowledge in rotation(s) that he or she has previously completed.
- Residents may also choose to repeat required NMM electives that have been already completed in Years 1–3 to gain additional knowledge in those subject areas, or residents may choose rotations they did not complete during Years 1–3.
- **Note that NMM electives may be used to satisfy FP electives if they are included in the FP Elective list.**

NMM electives must be chosen from the following options:

- Residents must complete **one month in at least two** of the following rotations in an ambulatory setting: neurological surgery, occupational medicine, orthopedics, podiatric medicine, or sports medicine.
- Residents must complete **one month in at least two** of the following rotations in an ambulatory setting: neurology, PMR, or rheumatology.
- Residents must complete **one month in at least two** of the following rotations in an ambulatory setting: diagnostic radiology, musculoskeletal radiology, or pain management.

Patient Care:

Through longitudinal, clinical, or hospital care, residents shall evaluate and provide OMT to a minimum of

- 50 patients with a variety of surgical diagnoses,
- 50 patients with a variety of pediatric diagnoses,
- 50 patients with a variety of OB/GYN diagnoses, and
- 50 patients in the inpatient setting.

All of these encounters shall be under the supervision of an NMM certified specialist.

Continuity of Care Clinic:

Upon completion of the program, residents shall see a minimum of 250 patients with at least 2 encounters, and shall have a minimum of 1,000 total patient encounters.

## **ONMM2/PLUS ONE PROGRAM**

4 Months: Outpatient NMM

2 Months: Inpatient NMM

1 Month of at least two of the following: sports medicine, orthopedic surgery, neurosurgery, podiatric medicine, occupational medicine, or neurological surgery

1 Month of at least two of the following: rheumatology, neurology, or PMR

1 Month of at least one of the following: pain management, or musculoskeletal or diagnostic radiology

1 Month: Elective

3 half-days per week: OMT Office to achieve 175 designated patients and 700 total patient encounters

Total patient contacts (outpatient and/or inpatient):

- 35 surgical diagnoses
- 35 pediatric diagnoses
- 35 OB/GYN diagnoses

## **Elective Rotations**

These must be approved by the program director. They include but are not limited to:

1 Month: Behavioral Medicine/Chronic Pain

1 Month: Geriatrics

- 1 Month: Gynecology
- 1 Month: Family Practice
- 1 Month: Inpatient Pediatrics
- 1 Month: Orthopedics
- 1 Month: Sports Medicine
- 1 Month: Musculoskeletal Radiology

## **NMM INPATIENT SERVICE OBJECTIVES**

### **HOSPITAL CARE**

(Adapted from “Basic Standards for “Plus-One” Residency Training in NMM and OMM, 2012”)

The goals of this consultation service is for the resident to understand the role of NMM in the work-up and treatment of hospitalized patients with a broad diversity of illnesses and severity, and to develop the knowledge base to design osteopathic manipulative treatment plans to produce a physiological change in the hospitalized patient while refining palpatory and diagnostic skills to contribute to the work-up and care of the hospitalized patient.

Residents will participate at the level of Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine Specialist Consultant. Follow-up hospital care must be given to those patients on whom consultations are performed. Inpatient osteopathic care must be given under the supervision of a physician who is board certified in neuromusculoskeletal medicine and osteopathic manipulative medicine or its predecessor, the American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine (AOBSPOMM). The osteopathic manipulative treatment provided must be designed to produce a physiological change in the patient that will impact the course of the illness. It is insufficient to treat only the musculoskeletal complaints in hospitalized patients. The resident must participate in all phases of the consultation, including patient evaluation, management (including the delivery of osteopathic manipulative treatment), and writing of the consultation and follow-up notes. By the end of the program, the resident should have developed the skills necessary to practice as an osteopathic neuromusculoskeletal consultant in a hospital service.

This requirement may be met by a minimum of 2 dedicated months in an NMM inpatient consultation service or by participating in a minimum of 100 NMM consults on medical, surgical, pediatrics, or OB/GYN patients.

Additional information for NMM/OMM hospital rotations and consultation services can be found in the Inpatient FP/NMM-OMM Rotation Goals and Competencies.

### **General Responsibilities for Residents**

Before beginning inpatient service, the resident is responsible for notifying the rounding physician that the resident is on the rounding service. Each night *before* 9 p.m., the resident must check the hospital computer system for the following day’s inpatient service and must contact the rounding physician to coordinate a.m. inpatient rounds. Inpatient rounds will start no later than 6:30 a.m. in order to allow the resident sufficient time to perform consultations and follow-up visits. The rounding service will not hold the resident past 8:30 a.m. so the resident can still tend to his or her clinic/rotation duties. On rare occasions, the resident may be asked to return to the hospital after clinic/rotation duty hours in order to complete inpatient rounds.

At the beginning of the service, the resident must notify the rounding physician of any vacation time or days off. If the resident takes time off, it is his or her responsibility to arrange for another resident to cover his or her inpatient service. Residents do *not* need to find someone to cover for them if they are missing shifts in order to attend didactic programs for the residency program such as SCS, FP lectures, or NMM lectures. Every attempt will be made to avoid morning conflicts between the resident rotation service and the OMM inpatient rounding service. If a conflict arises, it is the resident's responsibility to notify the rounding physician *before* the service begins so that such conflicts can be resolved.

### **Yearly Goals and Competencies**

#### **R-1**

The resident will participate in the inpatient service during his or her OMM month. By the end of the month, the resident will be able to complete the following tasks:

- Evaluate hospitalized patients for somatic dysfunction and document his or her findings
- Identify areas of tissue texture abnormality, asymmetry, restricted range of motion, and tenderness
- Identify viscerosomatic tissue texture changes
- Complete the write-up of the consultation and form an OMM assessment for the patient
- Assist in the follow-up of patients on the service and write OMM-specific progress notes for patients
- Perform OMM on inpatients in the supine position in hospital beds

#### **R-2**

The resident will continue to build upon the PGY-1 skills. By the end of the PGY-2 year, the resident will be able to complete the following tasks:

- Appropriately identify specific mechanical diagnoses (i.e. FRS/ERS of the spine and sacral and rib dysfunctions)
- Appropriately distinguish between acute and chronic viscerosomatic reflexes
- Identify contraindications to treatment techniques
- Discuss musculoskeletal findings and their relations to patients' disease processes
- Appropriately apply OMM techniques on hospitalized patients

#### **R-3**

The resident will continue to build upon the skills learned in prior years. The resident will be able to complete the following tasks:

- Discuss indications and contraindications of cranial OMM on hospitalized patients
- Apply cranial OMM, and discuss the cranial somatic dysfunctions identified and how they relate to patients' disease processes
- Develop an osteopathic treatment plan for patients
- Work more independently

**R-4**

The resident will continue to build upon the skills learned in prior years. The resident will be expected to complete the following tasks:

- Independently assess and formulate osteopathic treatment plans for hospitalized patients based on the patients' medical diagnoses and within the consult parameters requested
- Identify and determine the intensity of service and frequency of OMM to be applied
- Discuss the necessary components of consult/chart documentation for the billing and coding of OMT in the hospital setting

## **ROTATION GOALS AND OBJECTIVES: CORE COMPETENCIES**

The osteopathic education committees have delineated areas of evaluation for residents. The goal is to mold a well-rounded physician who is competent in the care of the patient and can function proficiently in today's health care arena. During each rotation, education is geared toward the seven competencies that are outlined by the osteopathic profession and listed below. Residents will be evaluated in these areas to ensure growth during their training period.

### **1. OSTEOPATHIC PHILOSOPHY PRINCIPLES AND MANIPULATIVE TREATMENT**

The resident should be able to correlate osteopathic philosophy into disease entities. He or she should be able to demonstrate knowledge of the relationship of structure and function in both health and disease and demonstrate a mastery of appropriate use of osteopathic manipulative techniques. He or she should understand the philosophy of the neuromuscular basis of homeostasis.

### **2. MEDICAL KNOWLEDGE AND ITS APPLICATION INTO OSTEOPATHIC MEDICAL PRACTICE**

The resident should demonstrate knowledge of current biomedical and social sciences and apply that knowledge effectively to patient care. He or she should also have an understanding of clinical epidemiology as related to disease.

### **3. OSTEOPATHIC PATIENT CARE**

The resident should be able to provide compassionate care that is effective for health promotion, wellness, disease treatment, and end-of-life care. The resident should be able to perform interviews and physical exams on patients. He or she should be continually respectful of the patient and remember to treat each patient with dignity.

### **4. INTERPERSONAL AND COMMUNICATION SKILLS IN OSTEOPATHIC MEDICAL PRACTICE**

The resident needs to develop skills that result in effective information exchange between patients, families, and other members of the health care team. The resident should be able to educate patients and health-care peers. He or she should be able to interact and communicate well with these people. Documentation should be comprehensive, timely, and legible.

### **5. PROFESSIONALISM IN OSTEOPATHIC MEDICAL PRACTICE**

The resident should demonstrate commitment to professional development and ethical principles. He or she should show sensitivity toward patients, family members, and peers. He or she should be respectful of diversity of those around them. Honesty and integrity should be important to the resident. He or she should accept responsibility when errors occur. He or she should consider the needs of patients and colleagues and be willing to be a member of the medical team.

## **6. OSTEOPATHIC MEDICAL PRACTICE-BASED LEARNING AND IMPROVEMENT**

The resident must be able to understand evidence-based medicine and how it applies to the care of the patient. He or she must apply sound principles of practice to patient care. He or she should accept feedback and incorporate it into improvement activities. He or she should use technology to improve patient care.

## **7. SYSTEM-BASED OSTEOPATHIC MEDICAL PRACTICE**

The resident needs to develop awareness of the overall health-care system and demonstrate the ability to improve and optimize the system. A knowledge of cost-effective health care is essential. This physician should assist patients in dealing with the complexities of the health-care system.

**ROTATION DESCRIPTIONS,  
GOALS, OBJECTIVES,  
AND EVALUATIONS**

# **OSTEOPATHIC MANIPULATIVE MEDICINE/ONMM**

## **DESCRIPTION**

One monthlong rotation must be done with an NMM-certified specialist. It can be done in Years 1, 2, 3, or 4. In Years 2 and 3, one or two months of outpatient OMT can be scheduled. In Year 4, four months of outpatient OMT can be scheduled.

## **RESIDENT RESPONSIBILITIES**

Residents will see patients in an outpatient setting under the supervision of an NMM board-certified physician.

1. A thorough history and physical will be performed on all patients including accurate and comprehensive documentation in EHR.
2. All patients will be discussed with the attending physician.
3. The resident will derive clear assessments and perform OMM treatments on patients.

## **FACULTY RESPONSIBILITIES**

The attending will review all findings with the resident and discuss cases. All cases are to be reviewed. All consultations will be supervised by a specialist board certified in NMM or its equivalent. Evaluation should be complete and discussed with the resident at the end of service.

## **RECOMMENDED READINGS**

*Foundations for Osteopathic Medicine*, ed. Ward

*Greenman's Principles of Manual Medicine*

*The Still Technique Manual*, 2<sup>nd</sup> ed., Van Buskirk

*Counterstrain and Exercise*, Rennie, et al.

*Movement, Stability & Lumbopelvic Pain*, 3<sup>rd</sup> ed., Vleeming

**OMM ROTATION GOALS AND OBJECTIVES**

**Competencies**

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism  
**Resident Level:** 1,2,3

**Rotational Goal**

To obtain knowledge and confidence in Osteopathic Principals, Osteopathic Exam, and Treatment of a Patient.

**Objectives (Note that numbers listed on top rows are FM Milestones and numbers listed on bottom rows are ONMM Milestones.)**

OP P	MK	PC	PB L	ICS	SB P	P	EPAs (Observable Activities)	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<b>2</b>	<b>1</b>	<b>1,3</b>		<b>1,2, 4</b>		<b>1,2, 3</b>	1. Acquire an accurate and relevant patient history focused on the patient's central concerns.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>1,3, 4</b>		<b>1,2</b>		<b>1,2</b>					
<b>1</b>							2. Perform a full musculoskeletal structural exam.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>1,3</b>		<b>1,2</b>							
<b>1</b>							3. Document the full exam including osteopathic musculoskeletal findings and which areas will be treated with which modality.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>1,3, 4</b>		<b>2</b>	<b>2</b>						
<b>1</b>							4. Define somatic dysfunction and Fryette's laws.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>	<b>1,3</b>									
<b>1</b>				<b>3</b>			5. Communicate the structural findings and the steps or course of treatment to the patients and preceptors.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>	<b>1</b>		<b>1,2</b>		<b>1,2</b>					

2		1,2, 4		2,4		3	6. Communicate clearly and effectively with patients and family members, minimizing unfamiliar terms and using effective listening, narrative, and non-verbal skills to elicit and provide information.		<u>X</u>	<u>X</u>	<u>X</u>
		4		1,2	1	1,2					
1				3			7. Identify where the patient's tissue-texture abnormalities and somatic dysfunctions are located.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	1,2	1,3				1,2					
1		5					8. Diagnose and treat somatic dysfunction of the sacrum and pelvis using at least two different modalities of treatment.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	1,2	1,3				1,2					
1		5					9. Diagnose and treat somatic dysfunction of the ribs, cervical, thoracic, and lumbar spines using at least two different modalities of treatment.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	1,2	1,3				1,2					
1		5					10. Diagnose and treat the somatic dysfunction of the upper and lower extremities using at least two different modalities of treatment.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	1,2	1,3				1,2					
1		5					11. Explain and demonstrate the steps of Still technique and/or Functional techniques.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	1,2	1,3				1,2					
1		5					12. Explain and demonstrate the steps of osteopathic cranial technique.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	1,2	1,3				1,2					

							13. Explain and demonstrate the steps of articular/joint-play techniques.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	<b>1,2</b>	<b>1,3</b>				<b>1,2</b>					
<b>1</b>		<b>5</b>					14. Explain and demonstrate the steps of myofascial release and muscle energy techniques.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	<b>1,2</b>	<b>1,3</b>				<b>1,2</b>					
<b>1</b>		<b>5</b>					15. Explain and demonstrate the steps of High Velocity and know the contraindications specific to HVLA.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	<b>1,2</b>	<b>1,3</b>				<b>1,2</b>					
	<b>1,2</b>	<b>1</b>			<b>4</b>	<b>1</b>	16. Teach physical findings to junior members of the health-care team.		<u>X</u>	<u>X</u>	<u>X</u>
		<b>1,3</b>				<b>1,2</b>					
<b>1</b>						<b>1</b>	17. Use the concepts of OPP, holistic approach, and professionalism in all patient care.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	<b>1</b>	<b>1,3</b>				<b>1,2</b>					
<b>1</b>							18. Explain and demonstrate the use of Chapman's points and note their locations.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	<b>1,2</b>	<b>1,3</b>				<b>1,2</b>					
<b>1</b>							19. Explain the difference between trigger and tender points and demonstrate their treatment with counterstrain technique.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	<b>1,2</b>	<b>1,3</b>				<b>1,2</b>					
<b>1</b>							20. Appropriately recheck the patient's landmarks for possible resolution of somatic dysfunctions.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	<b>1,2</b>	<b>1,3</b>				<b>1,2</b>					
<b>1</b>	<b>2</b>						21. Modify OMT treatment when other modalities are not successful.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>

2	2	4					22. Differentiate when OMT is not going to fix the problem at hand and that the patient may need further work-up, such as labs or diagnostic imaging.		X	X	X
	2	1,3				1,2					
1							23. Explain the contraindications for the use of OMT in a patient.		X	X	X
	2	1,3		1,2							
1		4			4		24. Describe when to use adjunct treatment with OMT such as physical therapy, acupuncture, or massage.		X	X	X
	1			1,2							
1		1,5	2		2,4	4	25. Recognize the scope of his or her abilities and ask for supervision and assistance when appropriate.	X	X	X	X
			1	1,2		3					
							26. Describe diagnosis and demonstrate treatment plans for upper- and lower-body neuromuscular imbalance.	X	X	X	X
	1	1,3									
							27. Describe and understand current research on neuromuscular imbalance and implement treatment plans based on this research.	X	X	X	X
	1	1,3	2								
							28. Develop understanding and treatment skills for neuromusculoskeletal problems in OB patients.	X	X	X	X
	1,2	1,3,4									
							29. Develop understanding and treatment skills for neuromusculoskeletal problems in pediatric patients.	X	X	X	X
	1,2	1,3,4									

	1,2	1,3,4				30. Develop understanding and treatment skills for neuromusculoskeletal problems in surgical patients.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	1,2	4				31. Recognize limits of OMT and when to seek referrals from other specialties.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
1		2		3,4	2	32. Maintain timely, efficient, and accurate documentation, including charting, coding, and billing in an EMR system.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
				2	2					
	1,2	1,3			1	33. Recognize “red flags”/absolute and relative contraindications to OMT.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
		4				34. Design appropriate exercise, PT, and OT prescriptions.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>

## OMM End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance <b>(1)</b>	Resident can be trusted to perform skill with <b>direct supervision</b> <b>(2)</b>	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident) <b>(3)</b>	Resident can be trusted to perform skill independently ( <b>at attending level</b> ) <b>(4)</b>	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level <b>(5)</b>	Skill <b>not observed</b> on this rotation  <b>(produces no score)</b>
1. Acquire an accurate and relevant patient history focused on the patient's central concerns.						
2. Perform a full musculoskeletal structural exam.						
3. Document the full exam including osteopathic musculoskeletal findings and which areas will be treated with which modality.						
4. Define somatic dysfunction and Fryette's laws.						
5. Communicate the structural findings and the steps or course of treatment to the patients and preceptors.						
6. Communicate clearly and effectively with patients and family members, minimizing unfamiliar terms and using effective listening, narrative, and non-verbal skills to elicit and provide information.						

7. Identify where the patient's tissue-texture abnormalities and somatic dysfunctions are located.						
8. Diagnose and treat somatic dysfunction of the sacrum and pelvis using at least two different modalities of treatment.						
9. Diagnose and treat somatic dysfunction of the ribs, cervical, thoracic, and lumbar spines using at least two different modalities of treatment.						
10. Diagnose and treat the somatic dysfunction of the upper and lower extremities using at least two different modalities of treatment.						
11. Explain and demonstrate the steps of Still technique and/or Functional techniques.						
12. Explain and demonstrate the steps of osteopathic cranial technique.						
13. Explain and demonstrate the steps of articular/joint-play techniques.						
14. Explain and demonstrate the steps of myofascial release and muscle energy techniques.						
15. Explain and demonstrate the steps of High Velocity and know the contraindications specific to HVLA.						
16. Teach physical findings to junior members of the health-care team.						

17. Use the concepts of OPP, holistic approach, and professionalism in all patient care.						
18. Explain and demonstrate the use of Chapman's points and note their locations.						
19. Explain the difference between trigger and tender points and demonstrate their treatment with counterstrain technique.						
20. Appropriately recheck the patient's landmarks for possible resolution of somatic dysfunctions.						
21. Modify OMT treatment when other modalities are not successful.						
22. Differentiate when OMT is not going to fix the problem at hand and that the patient may need further work-up, such as labs or diagnostic imaging.						
23. Explain the contraindications for the use of OMT in a patient.						
24. Describe when to use adjunct treatment with OMT such as physical therapy, acupuncture, or massage.						
25. Recognize the scope of his or her abilities and ask for supervision and assistance when appropriate.						

26. Describe diagnosis and demonstrate treatment plans for upper- and lower-body neuromuscular imbalance.						
27. Describe and understand current research on neuromuscular imbalance and implement treatment plans based on this research.						
28. Develop understanding and treatment skills for neuromusculoskeletal problems in OB patients.						
29. Develop understanding and treatment skills for neuromusculoskeletal problems in pediatric patients.						
30. Develop understanding and treatment skills for neuromusculoskeletal problems in surgical patients.						
31. Recognize limits of OMT and when to seek referrals from other specialties.						
32. Maintain timely, efficient, and accurate documentation, including charting, coding, and billing in an EMR system.						
33. Recognize “red flags”/absolute and relative contraindications to OMT.						
34. Design appropriate exercise, PT, and OT prescriptions.						

# **INPATIENT OMM**

## **DESCRIPTION**

For the Combo FM/ONMM1 Program, a total of 4 months of Inpatient ONMM will be done during Resident Level 2, 3, and 4. For the ONMM2/Plus One Program, 2–4 months of Inpatient ONMM will be done during that year. For the ONMM1 Program, 4 months of Inpatient NMM are required.

## **RESIDENT RESPONSIBILITIES**

Residents will see patients in-hospital under the supervision of an NMM board-certified physician.

1. A thorough history and physical will be performed on all patients including accurate and comprehensive documentation in EHR.
2. All patients will be discussed with the attending physician.
3. The resident will derive clear assessments and perform ONMM treatments on patients.

## **FACULTY RESPONSIBILITIES**

The attending will review all findings with the resident and discuss cases. All cases are to be reviewed. All consultations will be supervised by a specialist board certified in NMM or its equivalent. Evaluation should be complete and discussed with the resident at the end of service.

## **RECOMMENDED READINGS**

Please refer to the most recent edition. This is accurate as of January 2015.

*Osteopathic Considerations in Systemic Dysfunction*, Kuchera

## INPATIENT OMM GOALS & OBJECTIVES

### Competencies

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism  
**Resident Level: 1,2,3,4**

**Rotational Goal:** Residents will develop knowledge, skills, and attitudes to identify and manage common sports-medicine problems.

### Objectives

MK	PC	PBL	ICS	SBP	P	EPAs (Observable Activities)	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<b>1,2</b>	<b>1,3</b>					1. Accurately evaluate and document findings of somatic dysfunction.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3</b>					2. Correctly identify areas of tissue-texture abnormality, asymmetry, restricted range of motion, and tenderness.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3</b>					3. Correctly identify viscerosomatic tissue-texture changes.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3,4</b>			<b>2</b>	<b>1</b>	4. Complete documentation of the consultation and form an OMT assessment for the patient.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3,4</b>		<b>1,2</b>	<b>2</b>	<b>1,2,3</b>	5. Assist in the follow-up of patients on the ONMM consultation service and write ONMM-specific progress notes.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3,4</b>	<b>3,4</b>	<b>1,2</b>		<b>1,2,3</b>	6. Perform OMT on inpatients in the supine position in hospital beds.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3</b>					7. Appropriately identify specific mechanical diagnoses (i.e. FRS, ERS of the spine, and sacral and rib dysfunctions).		<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3</b>					8. Appropriately distinguish between acute and chronic viscerosomatic reflexes.		<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3</b>					9. Identify contraindications to OMT treatment techniques.		<u>X</u>	<u>X</u>	<u>X</u>
<b>1,2</b>	<b>1,3</b>					10. Discuss musculoskeletal findings and their relationship to patients' disease processes.		<u>X</u>	<u>X</u>	<u>X</u>

1,2	1,3		1,2		1,2	11. Appropriately apply OMT techniques on hospitalized patients.		<u>X</u>	<u>X</u>	<u>X</u>
1,2	1,3					12. Discuss indications and contraindications of cranial OMT on hospitalized patients.			<u>X</u>	<u>X</u>
1,2	1,3		1,2			13. Apply cranial OMT and discuss the cranial somatic dysfunctions identified and how they relate to patients' disease processes.			<u>X</u>	<u>X</u>
1,2	1,3	1,2			1,2,3	14. Develop an osteopathic treatment plan for patients.			<u>X</u>	<u>X</u>
1,2	1,3	1,2	1,2	1,2	1,2,3	15. Independently assess and formulate osteopathic treatment plans for hospitalized patients based on the patients' medical diagnoses and within the requested consult parameters.				<u>X</u>
1,2	1,3	1,2	1,2	1,2	1,2,3	16. Identify and determine the intensity of service and frequency of OMT to be applied.				<u>X</u>
1,2	1,3	1,2	1,2	1,2		17. Discuss the necessary components of consult/chart documentation for the billing and coding of OMT in the hospital setting.				<u>X</u>
	1,2	1,3				18. Appropriately identify specific mechanical diagnoses (i.e. FRS, ERS of the spine, and sacral and rib dysfunctions) on patients restricted to the supine position.			<u>X</u>	<u>X</u>

## Inpatient OMM End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance <b>(1)</b>	Resident can be trusted to perform skill with <b>direct supervision</b> <b>(2)</b>	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident) <b>(3)</b>	Resident can be trusted to perform skill independently ( <b>at attending level</b> ) <b>(4)</b>	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level <b>(5)</b>	Skill <b>not observed</b> on this rotation  <b>(produces no score)</b>
1. Accurately evaluate and document findings of somatic dysfunction.						
2. Correctly identify areas of tissue-texture abnormality, asymmetry, restricted range of motion, and tenderness.						
3. Correctly identify viscerosomatic tissue-texture changes.						
4. Complete documentation of the consultation and form an OMT assessment for the patient.						
5. Assist in the follow-up of patients on the ONMM consultation service and write ONMM-specific progress notes.						
6. Perform OMT on inpatients in the supine position in hospital beds.						
7. Appropriately identify specific mechanical diagnoses (i.e. FRS, ERS of the spine, and sacral and rib dysfunctions).						

8. Appropriately distinguish between acute and chronic viscerosomatic reflexes.						
9. Identify contraindications to OMT treatment techniques.						
10. Discuss musculoskeletal findings and their relationship to patients' disease processes.						
11. Appropriately apply OMT techniques on hospitalized patients.						
12. Discuss indications and contraindications of cranial OMT on hospitalized patients.						
13. Apply cranial OMT and discuss the cranial somatic dysfunctions identified and how they relate to patients' disease processes.						
14. Develop an osteopathic treatment plan for patients.						
15. Independently assess and formulate osteopathic treatment plans for hospitalized patients based on the patients' medical diagnoses and within the requested consult parameters.						
16. Identify and determine the intensity of service and frequency of OMT to be applied.						
17. Discuss the necessary components of consult/chart documentation for the billing and coding of OMT in the hospital setting.						

18. Appropriately identify specific mechanical diagnoses (i.e. FRS, ERS of the spine, and sacral and rib dysfunctions) on patients restricted to the supine position.						
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# NEUROLOGY

## **DESCRIPTION**

At least one month may be chosen in the R-2, R-3, or R-4 years. Rotation may encompass both outpatient services and inpatient services. Neurology may also be chosen as a rotation for the ONMM1 and ONMM2 programs.

## **RESIDENT RESPONSIBILITIES**

Residents will see patients under the supervision of a board-certified physician. Residents will achieve an understanding of the role of neurology for treatment of inpatient and outpatient medical conditions. During the rotation, each resident will be required to prepare a 10–15 minute presentation on a topic chosen from the below list. Presentations should be ready to present during the third week of the rotation. Residents are also responsible for attending Internal Medicine morning report, noon lectures, and monthly neurology-department didactics.

## **FACULTY RESPONSIBILITIES**

The attending will review all findings with the resident and discuss cases.

## **RECOMMENDED READINGS**

*Merritt's Textbook of Neurology*, ed. Rowland (library or online access)

*Adams and Victor's Principles of Neurology* (library or online access)

*Bradley's Neurology in Clinical Practice* (library or online access)

UpToDate.com (available on the desktops in the hospital)

*Functional Neuroanatomy* (available in the neurology office)

## NEUROLOGY ROTATION GOALS & OBJECTIVES

### Competencies

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism

**Resident Level: 2,3,4**

### Rotational Goals

1. Learn basic neuroanatomy of the body and neurological examination.
2. Learn to read testing such as CT, MRI, and EMG, which are commonly ordered in the neurology setting.
3. Learn which studies are indicated in emergent, urgent, or routine patient care (i.e. EMG, MRI, and CT scans and when to contrast them).
4. Understand when these studies are contraindicated for patients.
5. Learn diagnosis and treatment of common inpatient and outpatient neurological conditions.

**Objectives (Note that numbers listed on top rows are FM Milestones and numbers listed on bottom rows are ONMM Milestones.)**

OP P	MK	PC	PB L	IC S	SB P	P	EPAs (Observable Activities)	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
	<b>1</b>		<b>1</b>			<b>1</b>	1. Demonstrate knowledge of neurological examination: upper vs. lower motor neuron findings (including CN VII palsies), and unconscious examination findings (including significance of cranial nerve reflexes).		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>						2. Understand stroke vascular territories and expected neurological sequelae, large- vs. small-vessel stroke, stroke risk factors, and acute management of strokes.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>						3. Understand the indications and exclusions for the use of tPA and NIHSS.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>				<b>1,2</b>		4. Order appropriate imaging studies in the evaluation of patients with neurological conditions.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>						5. Understand intracranial hemorrhages: IPH (including causes), SDH vs. EDH (radiologic findings, exam findings, and treatment), SAH (traumatic vs. aneurysmal, and management).		<b>X</b>	<b>X</b>	<b>X</b>

	1,2					6. Understand seizures: classification, semiology, acute management, epileptic vs. non-epileptic (including common causes of symptomatic seizures), and AEDs (including side-effects and indications).		X	X	X
	2		1,2			7. Assess, apply, and assimilate investigative knowledge to improve patient care.		X	X	X
				1	1	8. Utilize terminology specific to neurology and how to use it in verbal and written communication with patients.		X	X	X
	1,2					9. Understand status epilepticus (definition, clinical findings, and treatment).		X	X	X
	1,2	3		1	1	10. Understand concussions, including classification and recent management guidelines.		X	X	X
	1,2	3		1	1	11. Understand headaches, including types and abortive vs. preventative treatment.		X	X	X
	1,2	3		1	1	12. Understand the diagnosis and treatment of brachial plexopathies, such as thoracic outlet syndrome and Parsonage-Turner Syndrome.		X	X	X
	1,2	3		1	1	13. Understand the diagnosis and treatment of common entrapment neuropathies, such as carpal tunnel syndrome.		X	X	X
	1,2	1,3		1	1	14. Understand the diagnosis and treatment of cervical, thoracic, and lumbar radiculopathies.		X	X	X
		1,3			1	15. Understand the anatomical and physiological considerations of the nervous system and the relationship of the central nervous system and peripheral nervous system to the body as a whole.		X	X	X

		<b>1,3</b>	<b>1</b>			<b>1</b>	16. Understand the role of structural and reflex changes in neurological dysfunction.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>2</b>	<b>3,4</b>		<b>2</b>	<b>1</b>	<b>1,2</b>	17. Understand the role of the neurological specialist in the care of patients and how to develop appropriate referral patterns.		<b>X</b>	<b>X</b>	<b>X</b>

## Neurology End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance  (1)	Resident can be trusted to perform skill with <b>direct supervision</b>  (2)	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident)  (3)	Resident can be trusted to perform skill independently ( <b>at attending level</b> )  (4)	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level  (5)	Skill <b>not observed</b> on this rotation  ( <b>produces no score</b> )
1. Demonstrate knowledge of neurological examination: upper vs. lower motor neuron findings (including CN VII palsies), and unconscious examination findings (including significance of cranial nerve reflexes).						
2. Understand stroke vascular territories and expected neurological sequelae, large- vs. small-vessel stroke, stroke risk factors, and acute management of strokes.						
3. Understand the indications and exclusions for use of tPA and NIHSS.						
4. Order appropriate imaging studies in the evaluation of patients with neurological conditions.						
5. Understand intracranial hemorrhages: IPH (including causes), SDH vs. EDH (radiologic findings, exam findings, and treatment), SAH (traumatic vs. aneurysmal, and management).						

6. Understand seizures: classification, semiology, acute management, epileptic vs. non-epileptic (including common causes of symptomatic seizures), and AEDs (including side-effects and indications).						
7. Assess, apply, and assimilate investigative knowledge to improve patient care.						
8. Utilize terminology specific to neurology and how to use it in verbal and written communication with patients.						
9. Understand status epilepticus (definition, clinical findings, and treatment).						
10. Understand concussions, including classification and recent management guidelines.						
11. Understand headaches, including types and abortive vs. preventative treatment.						
12. Understand the diagnosis and treatment of brachial plexopathies, such as thoracic outlet syndrome and Parsonage-Turner Syndrome.						
13. Understand the diagnosis and treatment of common entrapment neuropathies, such as carpal tunnel syndrome.						
14. Understand the diagnosis and treatment of cervical, thoracic, and lumbar radiculopathies.						

15. Understand the anatomical and physiological considerations of the nervous system and the relationship of the central nervous system and peripheral nervous system to the body as a whole.						
16. Understand the role of structural and reflex changes in neurological dysfunction.						
17. Understand the role of the neurological specialist in the care of patients and how to develop appropriate referral patterns.						

# ORTHOPEDECS

## **DESCRIPTION**

A minimum of one month will be spent on the service. Residents will spend time primarily in the outpatient setting and also in the emergency room (with an ortho resident) and in the surgery suite (as an assistant). Residents in the Combo program will spend at least one month with a board-certified orthopedic surgeon during Year R-2, R-3, or R-4, one month during the ONMM2 year, or one month during either year of the ONMM1 program.

## **RESIDENT RESPONSIBILITIES**

1. In the office, the resident will see patients and document a concise orthopedic history and physical.
2. Cases and radiologic studies will be reviewed and discussed.
3. When called to the ER, the resident will assist the orthopedic resident in seeing patients and casting/splinting.
4. The resident will see patients in the office M–F except during FM and NMM clinic times.

## **FACULTY RESPONSIBILITIES**

The attending will review all cases and radiologic studies with the resident, evaluate the resident at the end of his or her service, and hold daily morning report with residents.

## **RECOMMENDED READINGS**

Please refer to the most recent editions. These are accurate as of January 2015.

*Handbook of Fractures: Fourth Edition*, Egol, Koval, and Zuckerman  
*Physical Examination of the Spine and Extremities*, Hoppenfeld  
*Sports Medicine: Prevention, Assessment, Management & Rehabilitation of Athletic Injuries, 2nd Edition*, Irvin  
*Osteopathic Clinical Joint Exam*, Stockard

A recommended reference for orthopedic exam videos:

<https://sites.google.com/a/umich.edu/fammed-modules/musculoskeletal-examinations>

## ORTHOPEDIC SURGERY ROTATION GOALS & OBJECTIVES

### Competencies

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism

**Resident Level: 1,2,3,4**

### Rotational Goals

Recognize and treat common orthopedic conditions. Understand the orthopedic surgeries or procedures that patients may undergo. Be able to stabilize and refer orthopedic problems that are beyond the scope of primary-care physicians.

**Objectives (Note that numbers listed on top rows are FM Milestones and numbers listed on bottom rows are ONMM Milestones.)**

OP P	MK	PC	P B L	ICS	SB P	P	EPAs (Observable Activities)	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<b>2</b>	<b>1</b>	<b>1,3</b>		<b>1,2,4</b>		<b>1,2,3</b>	1. Acquire an accurate and relevant patient history focused on the patient's central concerns.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>3</b>				<b>1,2,3</b>					
<b>1</b>	<b>1,2</b>	<b>1,2</b>		<b>2</b>		<b>1,2</b>	2. Perform and document an accurate, appropriate, and relevant physical examination.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>3</b>				<b>1,2,3</b>					
				<b>1,2,3</b>		<b>1,2</b>	3. Demonstrate professional dress and appearance, and use professional introductions with patients, families, and staff.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
						<b>1,2,3</b>					
<b>2</b>		<b>1,2,4</b>		<b>2,4</b>		<b>3</b>	4. Communicate clearly and effectively with patients and family members, minimizing unfamiliar terms and using effective listening, narrative, and non-verbal skills.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>					<b>1,2,</b>					

						<b>3</b>					
<b>2</b>		<b>2,4</b>		<b>1,2</b>		<b>3</b>	5. Display compassion, empathy, and respect for patients and their families.	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>2</b></u>
	<b>1,2</b>					<b>1,2,3</b>					
<b>2</b>		<b>2,4</b>		<b>1,2</b>	<b>1,2</b>	<b>3</b>	6. Engage patients in shared decision-making for diagnostic and therapeutic scenarios, focusing on patient safety and cost-conscious medical care.	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>2</b></u>
	<b>1,2</b>	<b>3</b>			<b>1,2</b>	<b>1,2,3</b>					
<b>1</b>	<b>1,2</b>		<b>1,2</b>	<b>4</b>	<b>2</b>	<b>1,4</b>	7. Demonstrate effectiveness in using a variety of resources, including technology, to research evidence-based materials for self-learning and growth.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>2</b></u>
	<b>1,2</b>		<b>1,2</b>			<b>1,2,3</b>					
<b>1</b>	<b>1,2</b>	<b>2</b>	<b>1,2</b>				8. Apply and explain clinical evidence-based decision-making with regard to patient diagnoses and treatment plans.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>2</b></u>
	<b>1,2</b>	<b>3</b>	<b>1,2</b>								
		<b>1,3</b>		<b>3</b>	<b>2,4</b>	<b>1,2,4</b>	9. Work effectively as part of an interdisciplinary health-care team.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>2</b></u>
		<b>4</b>			<b>1,2</b>	<b>1,2,3</b>					
	<b>1,2</b>	<b>1,4</b>	<b>3</b>		<b>1</b>		10. Choose the appropriate diagnostic tests and imaging to support the differential diagnosis and treatment plan, considering efficacy and cost-		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>2</b></u>

	1,2		1,2			effectiveness.					
2		2,4		2		3	11. Perform bedside presentations that engage the patient and focus on the patient's central concerns.	X	X	X	X
	1,2	4									
1		2		3,4		2	12. Maintain timely, efficient, and accurate documentation, including charting, coding, and billing in an EMR system.	X	X	X	X
					2						
	2	1,5		3	2,4	2,4	13. Stabilize patients with urgent or emergent medical conditions and transfer to a higher level of care when necessary.		X	X	X
	2										
1,2	1				4	1	14. Teach physical findings to junior members of the health-care team.				X
	1,2					1,2,3					
	1,2			3			15. Demonstrate the ability to accurately describe fractures.		X	X	X
	1										
	1,2	1					16. Explain and demonstrate the principles for the initial immobilization of fractures, including the use of upper- and lower-extremity splints.		X	X	X
	1										
	1,2	1			4		17. Demonstrate proper management of fractures, and differentiate which fractures are appropriate to be managed by the primary-care physician.		X	X	X
	1										
	1,2	1					18. Describe common soft-tissue orthopedic injuries and conditions,		X	X	X

							including immobilization, diagnosis, and treatment of such.				
	<b>1</b>										
	<b>2</b>	<b>1,2,4</b>		<b>3</b>	<b>4</b>		19. Choose the appropriate consultative services.	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>
	<b>1</b>	<b>4</b>									
		<b>5</b>					20. Assist in orthopedic surgical procedures as a primary-care physician, including total hip and knee arthroplasty.	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>
	<b>1</b>										
	<b>2</b>	<b>5</b>					21. Properly apply a short arm cast.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>
	<b>1</b>										
	<b>2</b>	<b>5</b>					22. Properly apply a short leg cast.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>
	<b>1</b>										
							23. Understand the role of pharmacologic management in the acute- and chronic-pain patient.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>
	<b>1</b>										
							24. Explain the need for and perform joint aspirations/injections.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>
	<b>1</b>	<b>2</b>									

## Orthopedics End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance  (1)	Resident can be trusted to perform skill with <b>direct supervision</b>  (2)	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident)  (3)	Resident can be trusted to perform skill independently ( <b>at attending level</b> )  (4)	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level  (5)	Skill <b>not observed</b> on this rotation  (produces no score)
1. Acquire an accurate and relevant patient history focused on the patient's central concerns.						
2. Perform and document an accurate, appropriate, and relevant physical examination.						
3. Demonstrate professional dress and appearance, and use professional introductions with patients, families, and staff.						
4. Communicate clearly and effectively with patients and family members, minimizing unfamiliar terms and using effective listening, narrative, and non-verbal skills.						
5. Display compassion, empathy, and respect for patients and their families.						
6. Engage patients in shared decision-making for diagnostic and therapeutic scenarios, focusing on patient safety and cost-conscious medical care.						

7. Demonstrate effectiveness in using a variety of resources, including technology, to research evidence-based materials for self-learning and growth.						
8. Apply and explain clinical evidence-based decision-making with regard to patient diagnoses and treatment plans.						
9. Work effectively as part of an interdisciplinary health-care team.						
10. Choose the appropriate diagnostic tests and imaging to support the differential diagnosis and treatment plan, considering efficacy and cost-effectiveness.						
11. Perform bedside presentations that engage the patient and focus on the patient's central concerns.						
12. Maintain timely, efficient, and accurate documentation, including charting, coding, and billing in an EMR system.						
13. Stabilize patients with urgent or emergent medical conditions and transfer to a higher level of care when necessary.						
14. Teach physical findings to junior members of the health-care team.						
15. Demonstrate the ability to accurately describe fractures.						

16. Explain and demonstrate the principles for the initial immobilization of fractures, including the use of upper- and lower-extremity splints.						
17. Demonstrate proper management of fractures, and differentiate which fractures are appropriate to be managed by the primary-care physician.						
18. Describe common soft-tissue orthopedic injuries and conditions, including immobilization, diagnosis, and treatment of such.						
19. Choose the appropriate consultative services.						
20. Assist in orthopedic surgical procedures as a primary-care physician, including total hip and knee arthroplasty.						
21. Properly apply a short arm cast.						
22. Properly apply a short leg cast.						
23. Understand the role of pharmacologic management in the acute- and chronic-pain patient.						
24. Explain the need for and perform joint aspirations/injections.						

**ORTHOPEDIC TOPICS: SELF-STUDY LEARNING METHOD**

**P:** Patient, **L:** Lecture, **R:** Read

TOPIC	P	L	R
<p>I. Accurately diagnose, order appropriate imaging, provide initial care (splints, casts, and braces), and arrange for referrals to sports-medicine/orthopedic surgeons or PTs for problems including but not limited to</p> <ul style="list-style-type: none"> <li>a. rib and clavicle fractures</li> <li>b. upper-extremity fractures and dislocations/subluxations</li> <li>c. scaphoid fractures</li> <li>d. pelvic fractures</li> <li>e. femur fractures</li> <li>f. lower-extremity fractures and dislocations/subluxations</li> <li>g. phalangeal fractures and dislocations/subluxations</li> <li>h. vertebral fractures</li> <li>i. rotator cuff tears</li> <li>j. labral tears (shoulder)</li> <li>k. labral tears (hip)</li> <li>l. hip impingement</li> <li>m. avascular necrosis</li> <li>n. ACL tears</li> <li>o. meniscus tears</li> <li>p. LCL and MCL sprains</li> <li>q. syndesmotic ankle sprains</li> <li>r. grade 1–3 ankle sprains</li> <li>s. achilles tendon rupture</li> <li>t. quadriceps tendon rupture</li> </ul>			
<p>II. Demonstrate accurate physical exam of</p> <ul style="list-style-type: none"> <li>a. shoulder</li> <li>b. low back</li> <li>c. hip</li> <li>d. knee</li> <li>e. ankle</li> <li>f. wrist/hand</li> <li>g. elbow</li> </ul>			
<p>III. Recognize and manage common muscle, tendon, and nerve injuries including</p> <ul style="list-style-type: none"> <li>a. hamstring strain</li> <li>b. gastrocnemius strain</li> <li>c. biceps/quad strain</li> <li>d. carpal tunnel syndrome</li> <li>e. tarsal tunnel syndrome</li> <li>f. ulnar neuropathy</li> <li>g. peroneal neuropathy</li> </ul>			

<p>IV. Accurately diagnose and treat common foot disorders including</p> <ol style="list-style-type: none"> <li>a. plantar fasciitis</li> <li>b. hallux valgus (bunion)</li> <li>c. Morton’s neuroma</li> <li>d. osteoarthritis</li> </ol>			
<p>V. Recognize and properly manage the signs, symptoms, and physical findings associated with</p> <ol style="list-style-type: none"> <li>a. compartment syndrome</li> <li>b. osteomyelitis</li> <li>c. herniated vertebral disks</li> <li>d. spinal-cord compression</li> <li>e. septic joint</li> </ol>			
<p>VI. Demonstrate knowledge and management of routine vs. complicated post-operative management of</p> <ol style="list-style-type: none"> <li>a. joint replacements</li> <li>b. surgical fracture fixation</li> </ol>			
<p>VII. Demonstrate knowledge and conservative management of osteoarthritis</p> <ol style="list-style-type: none"> <li>a. Accurately perform intra-articular aspirations and injections of <ol style="list-style-type: none"> <li>1. knee</li> <li>2. shoulder</li> </ol> </li> </ol>			
<p>VIII. Demonstrate knowledge of common pediatric orthopedic disorders, appropriate imaging, and proper referral (if warranted) for</p> <ol style="list-style-type: none"> <li>a. congenital hip dysplasia</li> <li>b. Salter-Harris fractures</li> <li>c. SCFE</li> <li>d. osteochondrosis syndromes <ol style="list-style-type: none"> <li>1. Legg-Calve-Perthes Disease</li> <li>2. Osgood-Schlatter Disease</li> <li>3. Sinding-Larsen-Johansson Syndrome</li> <li>4. Sever’s Disease</li> </ol> </li> </ol>			
<p>IX. Adequately perform a pre-participation sports physical exam and demonstrate knowledge of abnormal findings that warrant further work-up vs. findings that disqualify an athlete from competition.</p>			
<p>X. Demonstrate knowledge of current guidelines for concussion diagnosis and management, including graduated return to play.</p>			

XI. Demonstrate knowledge of proper c-spine stabilization.			
XII. Accurately order physical therapy/occupational therapy.			
XIII. Attend SCS Splinting & Joint Injections workshops.			

# **PAIN MANAGEMENT**

## **DESCRIPTION**

At least one month may be chosen for the NMM program components. Residents in the Combo program will spend at least one month with a board-certified pain-management physician during Year R-2, R-3, or R-4, one month during the ONMM2 year, or one month during either year of the ONMM1 program.

## **RESIDENT RESPONSIBILITIES**

Residents will see patients in the pain-management office under the supervision of a board-certified physician. Residents will develop an understanding of the many treatment modalities and medications that are available for the treatment of pain conditions and will learn the use of appropriate referrals to pain-management specialists.

## **FACULTY RESPONSIBILITIES**

The attending will review all findings with the resident and discuss cases.

**PAIN-MANAGEMENT ROTATION GOALS & OBJECTIVES FOR INTEGRATED FM/NMM RESIDENTS**

**Competencies**

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism  
**Resident Level: 1,2,3,4**

**Rotational Goals**

1. Learn basic anatomy of the body and its appearance on imaging studies.
2. Learn to read plain films that are commonly ordered in the outpatient setting.
3. Learn which studies are indicated in emergent, urgent, or routine patient care (ultrasound, MRI, and CT scans and when to use contrast).
4. Understand which studies are contraindicated for patients.

**Objectives (Note that numbers listed on top rows are FM Milestones and numbers listed on bottom rows are ONMM Milestones.)**

OP P	MK	PC	PB L	IC S	SB P	P	EPAs (Observable Activities)	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
		<b>1,3</b>					1. Demonstrate knowledge of human anatomy by recognizing key structures on various imaging modalities in each of the subspecialty content areas.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>3,4</b>		<b>2</b>	<b>2</b>	<b>2</b>	2. Understand the role of the pain specialist in the care of patients undergoing imaging and/or image-guided procedures and how to develop appropriate referral patterns.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>						3. Recognize changes seen on follow-up studies and utilize knowledge in the care of patients.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>			<b>2</b>	<b>1</b>		4. Order appropriate imaging studies to evaluate patients with pain conditions.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>	<b>2</b>		<b>2</b>		<b>3</b>	5. Demonstrate knowledge of indications or contraindications of certain studies based on patients' conditions.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>2</b>		<b>1</b>	<b>1</b>		<b>3</b>	6. Gain skills in use of pharmacologic agents in management of acute and chronic pain.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>2</b>		<b>1,2</b>				7. Assess, apply, and assimilate investigative knowledge to improve patient care.		<b>X</b>	<b>X</b>	<b>X</b>

				<b>1</b>		<b>1</b>	8. Utilize terminology specific to pain management and how to use it in verbal and written communication with patients.		<b>X</b>	<b>X</b>	<b>X</b>
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## Pain Management End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance <b>(1)</b>	Resident can be trusted to perform skill with <b>direct supervision</b> <b>(2)</b>	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident) <b>(3)</b>	Resident can be trusted to perform skill independently ( <b>at attending level</b> ) <b>(4)</b>	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level <b>(5)</b>	Skill <b>not observed</b> on this rotation  <b>(produces no score)</b>
1. Demonstrate knowledge of human anatomy by recognizing key structures on various imaging modalities in each of the subspecialty content areas.						
2. Understand the role of the pain specialist in the care of patients undergoing imaging and/or image-guided procedures and how to develop appropriate referral patterns.						
3. Recognize changes seen on follow-up studies and utilize knowledge in the care of patients.						
4. Order appropriate imaging studies to evaluate patients with pain conditions.						
5. Demonstrate knowledge of indications or contraindications of certain studies based on patients' conditions.						
6. Gain skills in use of pharmacologic agents in management of acute and chronic pain.						

7. Assess, apply, and assimilate investigative knowledge to improve patient care.						
8. Utilize terminology specific to pain management and how to use it in verbal and written communication with patients.						

# **PHYSICAL MEDICINE/REHABILITATION**

## **DESCRIPTION**

Residents in the Combo program will spend at least one month with a board-certified rehabilitation physician during Year R-2, R-3, or R-4, one month during the ONMM2 year, or one month during either year of the ONMM1 program. Rotation may encompass both outpatient services and inpatient services on the Rehabilitation Unit.

## **RESIDENT RESPONSIBILITIES**

Residents will see patients in the PM&R office under the supervision of a board-certified physician. Residents will achieve an understanding of the role of PM&R for treatment of inpatient and outpatient medical conditions and the role of NMM in rehabilitation medicine. The resident will also focus on developing an understanding of the roles of exercise prescription, physical therapy, and occupational therapy in treating patients with neuromusculoskeletal conditions and how to prescribe physical and occupational therapy.

## **FACULTY RESPONSIBILITIES**

The attending will review all findings with the resident and discuss cases.

**PHYSICAL MEDICINE/REHABILITATION ROTATION GOALS & OBJECTIVES**

**Competencies**

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism  
**Resident Level: 2,3,4**

**Rotational Goals**

1. Learn basic anatomy of the body and its appearance on imaging studies.
2. Learn to read plain films that are commonly ordered in the outpatient setting.
3. Learn which studies are indicated in emergent, urgent, or routine patient care (ultrasound, MRI, and CT scans and when to use contrast).
4. Understand which studies are contraindicated for patients.

**Objectives (Note that numbers listed on top rows are FM Milestones and numbers listed on bottom rows are ONMM Milestones.)**

OP P	MK	PC	PB L	IC S	SB P	P	EPAs (Observable Activities)	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
	<b>1</b>	<b>1,3</b>					1. Demonstrate knowledge of human anatomy by recognizing key structures on various imaging modalities in each of the subspecialty content areas.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>2</b>	<b>3,4</b>		<b>2</b>	<b>1</b>	<b>2</b>	2. Understand the role of the rehabilitation specialist in the care of patients and how to develop appropriate referral patterns.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>	<b>4</b>			<b>2</b>	<b>1,3</b>	3. Understand the role of physical and occupational therapy in the rehabilitation of the patient with neuromuscular disease.		<b>X</b>	<b>X</b>	<b>X</b>
					<b>1</b>		4. Order appropriate imaging studies to evaluate patients with pain/rehabilitation conditions.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>	<b>4</b>			<b>2</b>		5. Learn the various modalities and treatments available through PT and OT and their uses and indications in the rehabilitation process.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>2</b>		<b>1</b>		<b>1</b>		6. Gain skills in use of pharmacologic agents in management of acute and chronic pain.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>2</b>		<b>1,2</b>				7. Assess, apply, and assimilate investigative knowledge to improve patient care.		<b>X</b>	<b>X</b>	<b>X</b>
				<b>1</b>		<b>1</b>	8. Utilize terminology specific to rehabilitation management and how to use it in verbal and written communication with patients.		<b>X</b>	<b>X</b>	<b>X</b>

		<b>4</b>					9. Design appropriate exercise, PT, and OT prescriptions.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>
		<b>4</b>					10. Understand the role of orthotic and prosthetic devices and how to prescribe them.		<u><b>X</b></u>	<u><b>X</b></u>	<u><b>X</b></u>

## Physical Medicine/Rehabilitation End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance  (1)	Resident can be trusted to perform skill with <b>direct supervision</b>  (2)	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident)  (3)	Resident can be trusted to perform skill independently ( <b>at attending level</b> )  (4)	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level  (5)	Skill <b>not observed</b> on this rotation  ( <b>produces no score</b> )
1. Demonstrate knowledge of human anatomy by recognizing key structures on various imaging modalities in each of the subspecialty content areas.						
2. Understand the role of the rehabilitation specialist in the care of patients and how to develop appropriate referral patterns.						
3. Understand the role of physical and occupational therapy in the rehabilitation of the patient with neuromuscular disease.						
4. Order appropriate imaging studies to evaluate patients with pain/rehabilitation conditions.						
5. Learn the various modalities and treatments available through PT and OT and their uses and indications in the rehabilitation process.						
6. Gain skills in use of pharmacologic agents in management of acute and chronic pain.						

7. Assess, apply, and assimilate investigative knowledge to improve patient care.						
8. Utilize terminology specific to rehabilitation management and how to use it in verbal and written communication with patients.						
9. Design appropriate exercise, PT, and OT prescriptions.						

# **RADIOLOGY/MUSCULOSKELETAL RADIOLOGY**

## **DESCRIPTION**

FM residents will spend 2 weeks on the radiology service. NMM residents may also spend 1 month on the service.

## **RESIDENT RESPONSIBILITIES**

Residents will see patients and review imaging studies in the radiology department under the supervision of a board-certified physician.

## **FACULTY RESPONSIBILITIES**

The attending will review all findings with the resident and discuss cases.

**RADIOLOGY/MUSCULOSKELETAL RADIOLOGY ROTATION GOALS & OBJECTIVES**

**Competencies**

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism  
**Resident Level: 1,2,3,4**

**Rotational Goals**

1. Learn basic anatomy of the body and its appearance on imaging studies.
2. Learn to read plain films that are commonly ordered in the outpatient setting.
3. Learn which studies are indicated in emergent, urgent, or routine patient care (ultrasound, MRI, and CT scans and when to use contrast).
4. Understand which studies are contraindicated for patients.

**Objectives (Note that numbers listed on top rows are FM Milestones and numbers listed on bottom rows are ONMM Milestones.)**

OP P	MK	PC	PB L	IC S	SB P	P	EPAs (Observable Activities)	1	2	3	4
	2 1						1. Demonstrate knowledge of human anatomy by recognizing key structures on various imaging modalities in each of the radiology subspecialty content areas.		X	X	X
	2 2	1,2 3,4	1,3		1,4 1	2	2. Understand the role of the radiologist in the care of patients undergoing imaging and/or image-guided procedures.		X	X	X
	2 1	1,2					3. Recognize changes seen on follow-up studies and utilize knowledge in the care of the patient.		X	X	X
	2 1	1,2			1 1		4. Order appropriate imaging studies in emergent, urgent, and routine patient care.		X	X	X
	1	1,2 2		2		3	5. Demonstrate knowledge of indications or contraindications of certain studies based on patients' conditions.		X	X	X
	2	1,2	1,3 1		1 2		6. Demonstrate knowledge of the socioeconomic impact of radiologic studies to patients and evidence-based medicine regarding the usefulness of the studies.		X	X	X
	2 2		2 1,2				7. Assess, apply, and assimilate investigative knowledge to improve patient care.		X	X	X
	2			2 1		1	8. Utilize terminology specific to radiology and how to use it in verbal and written communication with patients.		X	X	X

## Radiology/Musculoskeletal Radiology End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance  (1)	Resident can be trusted to perform skill with <b>direct supervision</b>  (2)	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident)  (3)	Resident can be trusted to perform skill independently ( <b>at attending level</b> )  (4)	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level  (5)	Skill <b>not observed</b> on this rotation  ( <b>produces no score</b> )
1. Demonstrate knowledge of human anatomy by recognizing key structures on various imaging modalities in each of the radiology subspecialty content areas.						
2. Understand the role of the radiologist in the care of patients undergoing imaging and/or image-guided procedures.						
3. Recognize changes seen on follow-up studies and utilize knowledge in the care of the patient.						
4. Order appropriate imaging studies in emergent, urgent, and routine patient care.						
5. Demonstrate knowledge of indications or contraindications of certain studies based on patients' conditions.						
6. Demonstrate knowledge of the socioeconomic impact of radiologic studies to patients and evidence-based medicine regarding the usefulness of the studies.						

7. Assess, apply, and assimilate investigative knowledge to improve patient care.						
8. Utilize terminology specific to radiology and how to use it in verbal and written communication with patients.						

# **RHEUMATOLOGY**

## **DESCRIPTION**

Residents in the Combo program will spend at least one month with a board-certified rheumatologist during Year R-2, R-3, or R-4, one month during the ONMM2 year, or one month during either year of the ONMM1 program.

## **RESIDENT RESPONSIBILITIES**

Residents will see patients in the rheumatology office under the supervision of a board-certified physician.

1. A thorough history and physical will be performed on all patients including accurate and comprehensive documentation in EHR.
2. All patients will be discussed with the attending physician.
3. The resident will derive clear assessments and order appropriate testing on patients.

## **FACULTY RESPONSIBILITIES**

The attending will review all findings with the resident and discuss cases. All orders are to be reviewed. Evaluation should be complete and discussed with the resident at the end of service.

## **RECOMMENDED READINGS**

MKSAP Rheumatology

American College of Rheumatology Subcommittee on Rheumatoid Arthritis Guidelines. "Guidelines for the management of rheumatoid arthritis: 2002 Update." *Arthritis & Rheumatism* 46, no. 2 (2002): 328–346.

Koopman WJ, DW Boulware, GR Heudebert, eds. *Clinical Primer of Rheumatology*. Philadelphia: Lippincott Williams & Wilkins, 2003.

Harris, E. D., Jr., R. C. Budd, G. S. Firestein et al., eds. *Kelley's Textbook of Rheumatology*. 7th ed. Vols. 1 and 2. Philadelphia: Elsevier Saunders, 2004.

**RHEUMATOLOGY ROTATION GOALS & OBJECTIVES FOR FP/NMM INTEGRATED RESIDENTS**

**Competencies**

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism  
**Resident Level: 2,3,4**

**Rotational Goals**

The rheumatology rotation is a four-week clinical experience offered during Year 2, 3, or 4. The rotation is primarily an outpatient, consultative, office-based experience. Residents will gain knowledge in evaluating and managing patients with the following conditions:

1. Chronic, noninflammatory, regional, and generalized pain syndromes and peripheral joints
2. Osteoarthritis
3. Acute monoarthritis
4. The autoimmune rheumatic disease syndromes
5. Spondyloarthropathies
6. Systemic vasculitis syndromes
7. Osteoporosis
8. Polymyalgia rheumatica
9. Gouty arthritis

**Objectives (Note that numbers listed on top rows are FM Milestones and numbers listed on bottom rows are ONMM Milestones.)**

OP P	M K	PC	P B L	ICS	SB P	P	EPAs (Observable Activities)	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<b>1</b>	<b>1,2</b>  <b>1</b>	<b>2</b>  <b>4</b>	<b>1,2</b>  <b>1,2</b>				1. Apply and explain clinical evidence-based decision-making with regard to patient diagnoses and treatment plans.		<b>X</b>	<b>X</b>	<b>X</b>
<b>1</b>	<b>1,2</b>  <b>1</b>	<b>1</b>  <b>3</b>					2. Assemble, document, and explain prioritized differential diagnoses based on history and physical evaluation.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>2</b>  <b>1</b>	<b>2</b>  <b>3</b>					3. Modify the differential diagnosis and care plan based on clinical observations and response.		<b>X</b>	<b>X</b>	<b>X</b>
<b>1</b>	<b>1,2</b>		<b>1,2</b>	<b>4</b>	<b>2</b>	<b>1,4</b>	4. Demonstrate effectiveness in using a variety of resources, including technology, to research evidence-based		<b>X</b>	<b>X</b>	<b>X</b>

	1		1, 2	2		1	materials for self-learning and growth.					
	1,2	1,4	3			1	5. Choose the appropriate diagnostic tests and imaging to support the differential diagnosis and treatment plan, considering efficacy and cost-effectiveness.		<u>X</u>	<u>X</u>	<u>X</u>	
	1	4				1						
1		2		3,4		2	6. Maintain timely, efficient, and accurate documentation, including charting, coding, and billing in an EMR system.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	
				2		2						
2	2	2,3		1,2		3	7. Customize care plans in the context of the patient's preferences, focusing on disease prevention and health promotion.		<u>X</u>	<u>X</u>	<u>X</u>	
	1	3,4		1,2		2,3						
1		1,5	2			2,4	4	8. Recognize the scope of his or her abilities and ask for supervision and assistance when appropriate.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
		4										
		3		1,2		3	3	9. Demonstrate sensitivity to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disability, and sexual orientation.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	1	3		1,2			2,3					
2		1,2, 4		2,4		3	3	10. Communicate clearly and effectively with patients and family members, minimizing unfamiliar terms and using effective listening, narrative, and non-verbal skills.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
				1,2			2,3					
1	2	1,2		2			1,2	11. Perform and document an accurate, appropriate, and relevant physical examination.	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
	2	3		3			1					

		5 2					12. Perform an arthrocentesis of the knee, shoulder, and other joints as needed under the direct supervision of the supervising physician.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2	2	2				13. Appropriately identify key anatomic findings when examining patients with rheumatologic conditions.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2	3					13. Appropriately identify key anatomic findings when examining patients with rheumatologic conditions.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2		1		1		14. Identify autoimmune disorders and how to appropriately diagnose and manage them along with their associated complications.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2	3,4	1		1		14. Identify autoimmune disorders and how to appropriately diagnose and manage them along with their associated complications.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2		1,2		1		15. Identify PE stigmata for rheumatoid arthritis and initiate appropriate work-up and treatment.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2	3	1		1		15. Identify PE stigmata for rheumatoid arthritis and initiate appropriate work-up and treatment.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2		1,2		1		16. Identify symptoms of vasculitic syndromes and how to initiate work-up and treatment.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2	3	1		1		16. Identify symptoms of vasculitic syndromes and how to initiate work-up and treatment.		<u>X</u>	<u>X</u>	<u>2</u>
	1,2	1,3					17. Understand the role of the lymphatic system in immune function and the resolution of the inflammatory process.		<u>X</u>	<u>X</u>	<u>2</u>
	2	1,3					18. Design an overall treatment program that incorporates the use of osteopathic manipulative treatment in the rheumatological patient.		<u>X</u>	<u>X</u>	<u>2</u>

## Rheumatology End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance <b>(1)</b>	Resident can be trusted to perform skill with <b>direct supervision</b> <b>(2)</b>	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident) <b>(3)</b>	Resident can be trusted to perform skill independently ( <b>at attending level</b> ) <b>(4)</b>	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level <b>(5)</b>	Skill <b>not observed</b> on this rotation  <b>(produces no score)</b>
1. Apply and explain clinical evidence-based decision-making with regard to patient diagnoses and treatment plans.						
2. Assemble, document, and explain prioritized differential diagnoses based on history and physical evaluation.						
3. Modify the differential diagnosis and care plan based on clinical observations and response.						
4. Demonstrate effectiveness in using a variety of resources, including technology, to research evidence-based materials for self-learning and growth.						
5. Choose the appropriate diagnostic tests and imaging to support the differential diagnosis and treatment plan, considering efficacy and cost-effectiveness.						
6. Maintain timely, efficient, and accurate documentation, including charting, coding,						

and billing in an EMR system.						
7. Customize care plans in the context of the patient's preferences, focusing on disease prevention and health promotion.						
8. Recognize the scope of his or her abilities and ask for supervision and assistance when appropriate.						
9. Demonstrate sensitivity to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disability, and sexual orientation.						
10. Communicate clearly and effectively with patients and family members, minimizing unfamiliar terms and using effective listening, narrative, and non-verbal skills.						
11. Perform and document an accurate, appropriate, and relevant physical examination.						
12. Perform an arthrocentesis of the knee, shoulder, and other joints as needed under the direct supervision of the supervising physician.						
13. Appropriately identify key anatomic findings when examining patients with rheumatologic conditions.						
14. Identify autoimmune disorders and how to appropriately diagnose and manage them along with their associated complications.						
15. Identify PE stigmata for rheumatoid arthritis and						

initiate appropriate work-up and treatment.						
16. Identify symptoms of vasculitic syndromes and how to initiate work-up and treatment.						
17. Understand the role of the lymphatic system in immune function and the resolution of the inflammatory process.						
18. Design an overall treatment program that incorporates the use of osteopathic manipulative treatment in the rheumatological patient.						

## **RHEUMATOLOGY TOPICS: SELF-STUDY LEARNING METHOD**

**P:** Patient, **L:** Lecture, **R:** Read

TOPIC	P	L	R
<p>I. Differentially diagnose, order appropriate testing, and arrange appropriate management plans or referral for patients with rheumatologic diseases including, but not limited to:</p> <ul style="list-style-type: none"> <li>a. rheumatoid arthritis</li> <li>b. fibromyalgia</li> <li>c. seronegative spondyloarthropathies (ankylosing spondylitis, reactive arthritis, enteropathic arthritis, psoriatic arthritis)</li> <li>d. mixed connective tissue disease</li> <li>e. systemic lupus erythematosus</li> <li>f. progressive systemic sclerosis</li> <li>g. Sjogren’s syndrome</li> <li>h. gout</li> <li>i. pseudogout</li> <li>j. infectious arthritis</li> <li>k. polymyositis</li> <li>l. dermatomyositis</li> <li>m. giant cell arteritis</li> <li>n. polymyalgia rheumatica</li> <li>o. polyarteritis nodosa</li> <li>p. Wegener’s granulomatosis</li> <li>q. sarcoidosis</li> <li>r. metabolic rheumatologic states</li> <li>s. neoplasms presenting as inflammatory diseases</li> <li>t. neuropathic disorders</li> <li>u. articular cartilage disorders</li> </ul>			
<p>II. Demonstrate knowledge of the indications for diagnostic and therapeutic arthrocentesis and joint injections (tendon sheath, bursal, and trigger-point injections).</p>			
<p>III. Safely and adequately perform the following treatments:</p> <ul style="list-style-type: none"> <li>a. arthrocentesis</li> <li>b. steroid joint injection</li> <li>c. viscosupplementation injection</li> <li>d. tendon sheath injection</li> <li>e. bursal injection</li> <li>f. trigger-point injection</li> </ul>			
<p>IV. Interpret appropriate rheumatologic lab tests, including but not limited to:</p> <ul style="list-style-type: none"> <li>a. ESR</li> <li>b. CRP</li> </ul>			

<ul style="list-style-type: none"> <li>c. complement (C3 &amp; C4) levels</li> <li>d. ANA (anti-nuclear antibody)</li> <li>e. anti-dsDNA</li> <li>f. anti-smith</li> <li>g. anti-Scl-70</li> <li>h. anticentromere</li> <li>i. anti-RNP</li> <li>j. anti-SSA and anti-SSB</li> <li>k. ANCA, c-ANCA, p-ANCA</li> </ul>			
<p>V. Demonstrate knowledge of the role of OMT and various physical-therapy modalities in treating rheumatologic diseases, including PT/OT, nerve and muscle stimulators, ultrasounds, and TENS devices.</p>			

# **SPORTS MEDICINE**

## **DESCRIPTION**

Residents in the Combo program will spend at least one month with a board-certified sports-medicine physician during Year R-2, R-3, or R-4, one month during the ONMM2 year, or one month during either year of the ONMM1 program.

## **RESIDENT RESPONSIBILITIES**

Residents will see patients in the sports-medicine office under the supervision of a board-certified physician.

1. A thorough history and physical will be performed on all patients including accurate and comprehensive documentation in EHR.
2. All patients will be discussed with the attending physician.
3. The resident will derive clear assessments and order appropriate testing and treatment on patients.

## **FACULTY RESPONSIBILITIES**

The attending will review all findings with the resident and discuss cases. All orders are to be reviewed. Evaluation should be complete and discussed with the resident at the end of service.

## **RECOMMENDED READINGS**

Please refer to the most recent editions. These are accurate as of January 2015.

*Handbook of Fractures: Fourth Edition*, Egol, Koval, and Zuckerman  
*Physical Examination of the Spine and Extremities*, Hoppenfeld  
*Sports Medicine: Prevention, Assessment, Management & Rehabilitation of Athletic Injuries, 2nd Edition*, Irvin  
*Orthopaedic Neurology*, Hoppenfeld  
*Principles of Manual Sports Medicine*, ed. Karageanes  
*Osteopathic Clinical Joint Exam*, Stockard  
*ACSM's Primary Care Sports Medicine*, ed. McKeag and Moeller

A recommended reference for orthopedic exam videos:

<https://sites.google.com/a/umich.edu/fammed-modules/musculoskeletal-examinations>

**SPORTS MEDICINE ROTATION GOALS & OBJECTIVES FOR FM/NMM RESIDENTS**

**Competencies**

**MK:** Medical Knowledge, **PC:** Patient Care, **PBL:** Problem-Based Learning, **ICS:** Interpersonal Communication Skills, **SBP:** Systems-Based Practice, **P:** Professionalism  
**Resident Level: 2,3,4**

**Rotational Goal**

Residents will develop knowledge, skills, and attitudes to identify and manage common sports-medicine problems.

**Objectives (Note that numbers listed on top rows are FM Milestones and numbers listed on bottom rows are ONMM Milestones.)**

OPP	MK	PC	PBL	ICS	SBP	P	EPAs (Observable Activities)	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<b>2</b>	<b>1</b>	<b>1,3</b>		<b>1,2,4</b>		<b>1,2,3</b>	1. Accurately evaluate and treat common injuries related to sport activities encountered in the office setting and on the field.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>1,3</b>		<b>1</b>		<b>1,2,3</b>					
<b>1</b>	<b>2</b>	<b>1,2</b>		<b>2</b>		<b>1,2</b>	2. Correctly perform age- and sport-appropriate pre-participation exams, including history and physical exam.	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>3</b>		<b>1</b>		<b>1,2</b>					
	<b>2</b>	<b>1</b>			<b>4</b>		3. Evaluate and treat sports-related head injuries and concussions and recognize the need for specialty referrals such as to neurology.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>	<b>1,4</b>			<b>2</b>						
	<b>2</b>	<b>1</b>			<b>4</b>		4. Appropriately manage fractures and other musculoskeletal injuries via casting, splinting, and other methods.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>4</b>									
	<b>2</b>	<b>1,5</b>		<b>3</b>	<b>2,4</b>	<b>2,4</b>	5. Stabilize injured patients with urgent or emergent conditions and transfer to higher-level care if needed.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>	<b>4</b>		<b>1</b>	<b>2</b>	<b>2</b>					
				<b>2,3</b>	<b>3,4</b>	<b>2</b>	6. Define the role of the physician as part of the team for organized sports.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1</b>	<b>3</b>		<b>1</b>	<b>2</b>	<b>1,2</b>					
	<b>2</b>	<b>1,2,3</b>		<b>2</b>			7. Describe the atypical athlete (the female athlete, the geriatric athlete, the handicapped athlete, and others) and his or her associated concerns.		<b>X</b>	<b>X</b>	<b>X</b>
	<b>1,2</b>	<b>3,4</b>		<b>1</b>							

			1,2				8. Find and apply relevant clinical guidelines and evidence-based medicine (EBM) at the point of patient care.	X	X	X	X
			1,2		1	3					
	2			2,3			9. Explain and incorporate orthopedic guidelines into management of patients.		X	X	X
	1,2										
	2	1,2,3		2			10. Discuss with athletes the age-appropriate risks involved with sports.		X	X	X
	2	3									
				2,3		3	11. Discuss treatment options in detail with athletic patients while minimizing unfamiliar terms.		X	X	X
	1	3,4		1		2					
	2	2,3		2,3			12. Educate players about exercise and nutrition.		X	X	X
	1,2	3		1							
	1					3,4	13. Recognize and discuss the psychosocial and economic impact that musculoskeletal disease and injury have on the individual patient and family.		X	X	X
	1,2	3,4		1		1,2					
	2	1		3	1		14. Demonstrate interaction between the type of care provided and the various health-care delivery systems, including ancillary services such as physical therapy and medication.		X	X	X
	2	4		1,2	1,2						
1,2	2	1,2				2	15. Demonstrate and understand how the use of OMT integrates into the overall care of the athlete.		X	X	X
	1,2	1,3				1					
							16. Understand how musculoskeletal ultrasounds and ultrasound-guided injections are used.		X	X	X
	1	2,4		2							
	1	2					17. Understand how tendinitis and tendinosis differ in terms of diagnosis and treatment.		X	X	X
	1	4		2			18. Understand the role PT and OT play in the treatment of sports injuries, and understand PT/OT modalities.		X	X	X
	1	2,4		2			19. Understand the indications that proliferative medicine techniques, such as PRP and prolotherapy, are needed to treat injuries.		X	X	X

## Sports Medicine End-of-Rotation Evaluation

Please complete the following evaluation using entrustment as your frame of reference. Based on your observation of the resident, at what level do you TRUST him or her to perform the specific skill?

	Resident <b>cannot perform skill</b> even with assistance <b>(1)</b>	Resident can be trusted to perform skill with <b>direct supervision</b> <b>(2)</b>	Resident can be trusted to perform skill with <b>indirect supervision</b> of an attending (does not need direct supervision of senior resident) <b>(3)</b>	Resident can be trusted to perform skill independently ( <b>at attending level</b> ) <b>(4)</b>	Resident can <b>act as instructor</b> or supervisor for this skill and is performing at aspirational level <b>(5)</b>	Skill <b>not observed</b> on this rotation  <b>(produces no score)</b>
1. Accurately evaluate and treat common injuries related to sport activities encountered in the office setting and on the field.						
2. Correctly perform age- and sport- appropriate pre-participation exams, including history and physical exam.						
3. Evaluate and treat sports-related head injuries and concussions and recognize the need for specialty referrals such as to neurology.						
4. Appropriately manage fractures and other musculoskeletal injuries via casting, splinting, and other methods.						
5. Stabilize injured patients with urgent or emergent conditions and transfer to higher-level care if needed.						
6. Define the role of the physician as part of the team for organized sports.						

7. Describe the atypical athlete (the female athlete, the geriatric athlete, the handicapped athlete, and others) and his or her associated concerns.						
8. Find and apply relevant clinical guidelines and evidence-based medicine (EBM) at the point of patient care.						
9. Explain and incorporate orthopedic guidelines into management of patients.						
10. Discuss with athletes the age-appropriate risks involved with sports.						
11. Discuss treatment options in detail with athletic patients while minimizing unfamiliar terms.						
12. Educate players about exercise and nutrition.						
13. Recognize and discuss the psychosocial and economic impact that musculoskeletal disease and injury have on the individual patient and family.						
14. Demonstrate interaction between the type of care provided and the various health-care delivery systems, including ancillary services such as physical therapy and medication.						
15. Demonstrate and understand how the use of OMT integrates into the overall care of the athlete.						
16. Understand how musculoskeletal ultrasounds and ultrasound-guided injections are used.						

17. Understand how tendinitis and tendinosis differ in terms of diagnosis and treatment.						
18. Understand the role PT and OT play in the treatment of sports injuries, and understand PT/OT modalities.						
19. Understand the indications that proliferative medicine techniques, such as PRP and prolotherapy, are needed to treat injuries.						

## SPORTS MEDICINE TOPICS: SELF-STUDY LEARNING METHOD

**P:** Patient, **L:** Lecture, **R:** Read

TOPIC	P	L	R
<p>I. Accurately diagnose, order appropriate imaging, provide initial care (splints, casts, and braces), and arrange for referrals to sports-medicine/orthopedic surgeons or PTs for problems including but not limited to</p> <ul style="list-style-type: none"> <li>a. rib and clavicle fractures</li> <li>b. upper-extremity fractures and dislocations/subluxations</li> <li>c. scaphoid fractures</li> <li>d. pelvic fractures</li> <li>e. femur fractures</li> <li>f. lower-extremity fractures and dislocations/subluxations</li> <li>g. phalangeal fractures and dislocations/subluxations</li> <li>h. vertebral fractures</li> <li>i. rotator cuff tears</li> <li>j. labral tears (shoulder)</li> <li>k. labral tears (hip)</li> <li>l. hip impingement</li> <li>m. avascular necrosis</li> <li>n. ACL tears</li> <li>o. meniscus tears</li> <li>p. LCL and MCL sprains</li> <li>q. syndesmotic ankle sprains</li> <li>r. grade 1–3 ankle sprains</li> <li>s. achilles tendon rupture</li> <li>t. quadriceps tendon rupture</li> </ul>			
<p>II. Demonstrate accurate physical exam of</p> <ul style="list-style-type: none"> <li>a. shoulder</li> <li>b. low back</li> <li>c. hip</li> <li>d. knee</li> <li>e. ankle</li> <li>f. wrist/hand</li> <li>g. elbow</li> </ul>			
<p>III. Recognize and manage common muscle, tendon, and nerve injuries including</p> <ul style="list-style-type: none"> <li>a. hamstring strain</li> <li>b. gastrocnemius strain</li> <li>c. biceps/quad strain</li> <li>d. carpal tunnel syndrome</li> <li>e. tarsal tunnel syndrome</li> <li>f. ulnar neuropathy</li> <li>g. peroneal neuropathy</li> </ul>			

<p>IV. Accurately diagnose and treat common foot disorders including</p> <ol style="list-style-type: none"> <li>a. plantar fasciitis</li> <li>b. hallux valgus (bunion)</li> <li>c. Morton’s neuroma</li> <li>d. osteoarthritis</li> </ol>			
<p>V. Recognize and properly manage the signs, symptoms, and physical findings associated with</p> <ol style="list-style-type: none"> <li>a. compartment syndrome</li> <li>b. osteomyelitis</li> <li>c. herniated vertebral disks</li> <li>d. spinal-cord compression</li> <li>e. septic joint</li> </ol>			
<p>VI. Demonstrate knowledge and management of routine vs. complicated post-operative management of</p> <ol style="list-style-type: none"> <li>a. joint replacements</li> <li>b. surgical fracture fixation</li> </ol>			
<p>VII. Demonstrate knowledge and conservative management of osteoarthritis</p> <ol style="list-style-type: none"> <li>a. Accurately perform intra-articular aspirations and injections of <ol style="list-style-type: none"> <li>1. knee</li> <li>2. shoulder</li> </ol> </li> </ol>			
<p>VIII. Demonstrate knowledge of common pediatric orthopedic disorders, appropriate imaging, and proper referral (if warranted) for</p> <ol style="list-style-type: none"> <li>a. congenital hip dysplasia</li> <li>b. Salter-Harris fractures</li> <li>c. SCFE</li> <li>d. osteochondrosis syndromes <ol style="list-style-type: none"> <li>1. Legg-Calve-Perthes Disease</li> <li>2. Osgood-Schlatter Disease</li> <li>3. Sinding-Larsen-Johansson Syndrome</li> <li>4. Sever’s Disease</li> </ol> </li> </ol>			
<p>IX. Adequately perform a pre-participation sports physical exam and demonstrate knowledge of abnormal findings that warrant further work-up vs. findings that disqualify an athlete from competition.</p>			
<p>X. Demonstrate knowledge of current guidelines for concussion diagnosis and management, including graduated return to play.</p>			

XI. Demonstrate knowledge of proper c-spine stabilization.			
XII. Accurately order physical therapy/occupational therapy.			
XIII. Attend SCS Splinting & Joint Injections workshops.			

**OSTEOPATHIC MANIPULATIVE  
MEDICINE**

**LECTURE TOPICS/YEARLY SCHEDULES**

- **Residency Didactics**
  - **Monthly Lectures to Housestaff**
  - **Family Medicine Dept. Lectures**

## OMM LECTURE RESIDENCY DIDACTIC SCHEDULE YEARLY CURRICULUM GRID

DATE	TIME	LOCATION	AUDIENCE	TOPIC	
<b>AUGUST</b>					
WEEK 1	6:30 AM	OFFICE	OMM RES:DIDACTIC	TEXTBOOK	
WEEK 1	12:00 PM	COMM RM	HOUSESTAFF	Inpt OMM	
WEEK 2	6:30 AM	OFFICE	OMM RES:DIDACTIC	TEXTBOOK, JOURNAL CLUB	
WEEK 3	3:30 PM	COMM RM	HOUSESTAFF	SACRUM/PELVIS	
WEEK 3	5:30 PM	FARM VILL E	FP RESIDENTS	SEE FP CURRIC SCHED	
WEEK 3	6:30 AM	OFFICE	OMM RES:DIDACTIC	TEXTBOOK, TECHNIQUE REV	
WEEK 3	12:00 PM	MSU	MSU DIDACTIC	SEE MSU CURRIC SCHED	
WEEK 4	6:30 AM	OFFICE	OMM RES:DIDACTIC	VISCERAL, CASE STUDY	
TBD	7:00 AM	TBD	OMM RES:ANAT	TBD	
<b>SEPTEMBER</b>					
WEEK 1	6:30 AM	OFFICE	OMM RES:DIDACTIC	TEXTBOOK	
WEEK 1	12:00 PM	COMM RM	COMM RM	COPD/ASTHMA	
WEEK 2	6:30 AM	OFFICE	OMM RES:DIDACTIC	TEXTBOOK, JOURNAL CLUB	
WEEK 3	3:30 PM	COMM RM	HOUSESTAFF	LUMBAR SPINE	
WEEK 3	5:30 PM	FARM VILL E	FP RESIDENTS	SEE FP CURRIC SCHED	
WEEK 3	6:30 AM	OFFICE	OMM RES:DIDACTIC	TEXTBOOK, TECHNIQUE REV	
WEEK 3	12:00 PM	MSU	MSU DIDACTIC	SEE MSU CURRIC SCHED	
WEEK 4	6:30 AM	OFFICE	OMM RES:DIDACTIC	VISCERAL, CASE STUDY	
TBD	7:00 AM	TBD	OMM RES:ANAT	TBD	
<b>OCTOBER</b>					
WEEK 1	6:30 AM	OFFICE	OMM RES:DIDACTIC	TEXTBOOK	
WEEK 1	12:00 PM	COMM RM	HOUSESTAFF	POSTOP ILEUS	
WEEK 2	6:30 AM	OFFICE	OMM RES:DIDACTIC	TEXTBOOK, JOURNAL CLUB	
WEEK 3	3:30 PM	COMM RM	HOUSESTAFF	THORACIC SPINE	

<b>WEEK 3</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	
<b>WEEK 3</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, TECHNIQUE REV	
<b>WEEK 3</b>	<b>12:00 PM</b>	<b>MSU</b>	<b>MSU DIDACTIC</b>	SEE MSU CURRIC SCHED	
<b>WEEK 4</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES:ANAT</b>	TBD	
<b>NOVEMBER</b>					
<b>WEEK 1</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK	
<b>WEEK 1</b>	<b>12:00 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	PNEUMONIA	
<b>WEEK 2</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, JOURNAL CLUB	
<b>WEEK 3</b>	<b>3:30 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	COSTAL CAGE	
<b>WEEK 3</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	
<b>WEEK 3</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>WEEK 3</b>	<b>12:00 PM</b>	<b>MSU</b>	<b>MSU DIDACTIC</b>	SEE MSU CURRIC SCHED	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES:ANAT</b>	TBD	
<b>DECEMBER</b>					
<b>WEEK 1</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK	
<b>WEEK 1</b>	<b>12:00 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	LOW BACK PAIN	
<b>WEEK 2</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	COSTAL CAGE	
<b>WEEK 3</b>	<b>3:30 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	CERVICAL SPINE	
<b>WEEK 3</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	
<b>WEEK 3</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>WEEK 3</b>	<b>12:00 PM</b>	<b>MSU</b>	<b>MSU DIDACTIC</b>	SEE MSU CURRIC SCHED	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES:ANAT</b>	TBD	
<b>JANUARY</b>					
<b>WEEK 1</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, BOARD REVIEW	
<b>WEEK 1</b>	<b>12:00 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	UPPER GI	
<b>WEEK 2</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, JOURNAL CLUB	
<b>WEEK 3</b>	<b>3:30 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	SACRUM/PELVIS	
<b>WEEK 3</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	

<b>WEEK 3</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, TECHNIQUE REV	
<b>WEEK 3</b>	<b>12:00 PM</b>	<b>MSU</b>	<b>MSU DIDACTIC</b>	SEE MSU CURRIC SCHED	
<b>WEEK 4</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES:ANAT</b>	TBD	
<b>FEBRUARY</b>					
<b>WEEK 1</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, BOARD REVIEW	
<b>WEEK 1</b>	<b>12:00 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	MSKEL HEADACHES	
<b>WEEK 2</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, JOURNAL CLUB	
<b>WEEK 3</b>	<b>3:30 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	LUMBAR SPINE	
<b>WEEK 3</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	
<b>WEEK 3</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, TECHNIQUE REV	
<b>WEEK 3</b>	<b>12:00 PM</b>	<b>MSU</b>	<b>MSU DIDACTIC</b>	SEE MSU CURRIC SCHED	
<b>WEEK 4</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES:ANAT</b>	TBD	
<b>MARCH</b>					
<b>WEEK 1</b>	<b>7:00 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, BOARD REVIEW	
<b>WEEK 1</b>	<b>12:00 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	CHEST PAIN	
<b>WEEK 2</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, JOURNAL CLUB	
<b>WEEK 3</b>	<b>3:30 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	THORACIC SPINE	
<b>WEEK 3</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, TECHNIQUE REV	
<b>WEEK 3</b>	<b>AAO CONVO</b>				
<b>WEEK 4</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	
<b>WEEK 4</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES:ANAT</b>	TBD	
<b>APRIL</b>					
<b>WEEK 1</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, BOARD REVIEW	
<b>WEEK 1</b>	<b>12:00 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	CHF/EDEMA	
<b>WEEK 2</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:DIDACTIC</b>	TEXTBOOK, JOURNAL CLUB	
<b>WEEK 3</b>	<b>3:30 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	COSTAL CAGE	

<b>WEEK 3</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	
<b>WEEK 3</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES: DIDACTIC</b>	TEXTBOOK, TECHNIQUE REV	
<b>WEEK 3</b>	<b>12:00 PM</b>	<b>MSU</b>	<b>MSU DIDACTIC</b>	SEE MSU CURRIC SCHED	
<b>WEEK 4</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES: DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES: ANAT</b>	TBD	
<b>MAY</b>					
<b>WEEK 1</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES: DIDACTIC</b>	TEXTBOOK, BOARD REVIEW	
<b>WEEK 1</b>	<b>12:00 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	REVIEW	
<b>WEEK 2</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES: DIDACTIC</b>	TEXTBOOK, JOURNAL CLUB	
<b>WEEK 3</b>	<b>3:30 PM</b>	<b>COMM RM</b>	<b>HOUSESTAFF</b>	CERVICAL SPINE	
<b>WEEK 3</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	
<b>WEEK 3</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES: DIDACTIC</b>	TEXTBOOK, TECHNIQUE REV	
<b>WEEK 3</b>	<b>12:00 PM</b>	<b>MSU</b>	<b>MSU DIDACTIC</b>	SEE MSU CURRIC SCHED	
<b>WEEK 4</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES: DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES: ANAT</b>	TBD	
<b>JUNE</b>					
<b>WEEK 1</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES:</b>	TEXTBOOK, BOARD REVIEW	
<b>WEEK 1</b>	<b>12:00 PM</b>	<b>MSU</b>	<b>MSU DIDACTIC</b>	SEE MSU CURRIC SCHED	
<b>WEEK 2</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES: DIDACTIC</b>	TEXTBOOK, JOURNAL CLUB	
<b>WEEK 3</b>	<b>5:30 PM</b>	<b>FARM VILL E</b>	<b>FP RESIDENTS</b>	SEE FP CURRIC SCHED	
<b>WEEK 3</b>	<b>6:30 AM</b>	<b>CLASSRM A</b>	<b>OMM RES: DIDACTIC</b>	TEXTBOOK, TECHNIQUE REV	
<b>WEEK 4</b>	<b>6:30 AM</b>	<b>OFFICE</b>	<b>OMM RES: DIDACTIC</b>	VISCERAL, CASE STUDY	
<b>TBD</b>	<b>7:00 AM</b>	<b>TBD</b>	<b>OMM RES: ANAT</b>	TBD	

## NOTES

<b>MSU DIDACTIC</b>
<b>FP RESIDENTS</b>
<b>HOUSESTAFF</b>

SEE ATTACHED  
YEARLY CURRIC.  
SCHEDULE

SEE ATTACHED FP  
3-YEAR CURRIC.  
SCHEDULE

THIS SCHEDULE  
REPEATS YEARLY

**ONMM2/Plus  
One**

Will follow one year  
of this curriculum  
cycle

**Integrated/  
Combo**

Will follow four  
years of this  
curriculum cycle

## OMM COMPETENCY LECTURE DATES/TOPICS

August	Sacrum/Pelvis
September	Lumbar Spine
October	Thoracic Spine
November	Costal Cage
December	Cervical Spine
January	Sacrum/Pelvis
February	Lumbar Spine
March	Thoracic Spine
April	Costal Cage
May	Cervical Spine

## OMM NOON LECTURES

August	Inpatient Exam
September	COPD/Asthma
October	Postop Ileus
November	Pneumonia
December	Low-Back Pain
January	Upper GI
February	Headaches
March	Chest Pain
April	CHF/Edema
May	Review

**FP OMM CURRICULUM  
THREE-YEAR CURRICULUM CYCLE**

<b>MONTH</b>	<b>YEAR 1</b>	<b>YEAR 2</b>	<b>YEAR 3</b>
<b>AUG</b>	<b>SACRAL DX/TX</b>	<b>SACRAL DX/TX</b>	<b>SACRAL DX/TX</b>
<b>SEP</b>	<b>PELVIS DX/TX</b>	<b>PELVIS DX/TX</b>	<b>PELVIS DX/TX</b>
<b>OCT</b>	<b>LUMBAR DX/TX</b>	<b>LUMBAR DX/TX</b>	<b>LUMBAR DX/TX</b>
<b>NOV</b>	<b>THORACIC DX/TX</b>	<b>THORACIC DX/TX</b>	<b>THORACIC DX/TX</b>
<b>DEC</b>	<b>COSTAL CAGE DX/TX</b>	<b>COSTAL CAGE DX/TX</b>	<b>COSTAL CAGE DX/TX</b>
<b>JAN</b>	<b>CERVICAL DX/TX</b>	<b>CERVICAL DX/TX</b>	<b>CERVICAL DX/TX</b>
<b>FEB</b>	<b>PREPARTICIPA- TION EXAM</b>	<b>OB PT TX</b>	<b>FEMALE ATHLETE TRIAD</b>
<b>MAR</b>	<b>KNEE EXAM/TX</b>	<b>SHOULDER EXAM/TX</b>	<b>FUNCTIONAL NEUROLOGY</b>
<b>APR</b>	<b>FOOT/ANKLE DX/TX</b>	<b>UPPER-EXTREM. EXAM/TX</b>	<b>ADOLESCENT SPORTS MED.</b>
<b>MAY</b>	<b>COPD/ PNEUMONIA</b>	<b>SIDELINE INJURY TX</b>	<b>HA/URI TX</b>
<b>JUN</b>	<b>PHYS. THERAPY RX</b>	<b>OMM BILLING/CODING</b>	<b>SPORTS NUTRITION</b>

# **HOSPITAL POLICIES**

The following policies regarding resident training must be reviewed by all residents in the FP/NMM Integrated Program, the ONMM2/Plus One Program, and the NMM Emphasis Track and will be discussed in a formal presentation setting at the beginning of each academic year.

**Note to residents in the FP/NMM Integrated Program:** More specific policies for working with FP patients are contained in the FP Residency Manual.

# **BOTSFORD**

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HOSPITAL  
**POLICY**

PAGE 1 of 4

TITLE: TRAINEE SUPERVISION POLICY

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EFFECTIVE: APRIL 2015

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REPLACES: TRAINEE SUPERVISION POLICY; September 2014

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## **PURPOSE**

It is recognized that the lack of trainee supervision can lead to errors in judgment and clinical decision-making. Trainee supervision can greatly decrease the amount of errors made that affect patient safety. The degree to which each trainee physician requires supervision is dependent on the level of training and judgment made by the supervising physician. The training institution, Residency Program Director and Designated Institutional Official (DIO) must effectively define each trainee's supervision level and continuously monitor to ensure that each trainee is at the appropriate level of supervision for patient safety.

## **DEFINITIONS**

Supervision: The level of patient care oversight accessible to a trainee physician usually determined by the supervising physician.

Supervising Physician: Any individuals who have received a formal assignment to teach trainees and oversee trainee patient care.

Trainee: Any physician in an accredited graduate medical education program, including interns, residents, and fellows.

## POLICY

### Trainee Supervision

1. In the clinical learning environment, each patient has an identifiable, appropriately credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
  - a) This information is available to trainees, faculty members, and patients.
  - b) Trainees and faculty members should inform patients of their respective roles in each patient's care.
  
2. The program must demonstrate that the appropriate level of supervision is in place for all trainees who care for patients.
  - a) Trainees participating in patient care must be supervised by faculty physicians, or by other physicians who have been designated by the Program Director as being qualified to provide appropriate supervision, at all times. Supervising physicians shall have clinical privileges for the procedures for which they supervise trainees. The Program Director has primary responsibility for ensuring, directing, and documenting adequate supervision of trainees. Schedules for faculty physicians must be structured to ensure that supervision is readily available to the trainee on duty, including weekend and night call schedules.
  - b) Supervision may be exercised through a variety of methods. Some activities require the physician presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced trainee. Other portions of care provided by the trainee can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of trainee-delivered care with feedback as to the appropriateness of that care.
  
3. Trainee supervision on NMM rotations and inpatient consultations must be done by a specialist in osteopathic neuromusculoskeletal medicine.
  
4. In addition, trainee supervision of patients to meet specific basic standards goals for number of patients seen for NMM evaluation and treatment for categories of medicine, pediatrics, surgery and OB/Gyn must be done by a specialist in osteopathic neuromusculoskeletal medicine.

### Levels of Supervision

To ensure oversight of trainee supervision and graded authority and responsibility, the program must use the following classification of supervision:

- a) **Direct Supervision:** the supervising physician is physically present with the trainee and patient.

- b) **Indirect Supervision with direct supervision immediately available:** the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- c) **Indirect Supervision with direct supervision available:** the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- d) **Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

### **Progressive Responsibility**

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each trainee must be assigned by the program director and faculty members.

- a) The program director must evaluate each trainee's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
- b) Faculty members functioning as supervising physicians should delegate portions of care to trainees, based on the needs of the patient and the skills of the trainee.
- c) Senior trainees should serve in a supervisory role of junior trainees in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual trainee.

### **Communication**

- a) The trainee job description and list of supervision guidelines by trainee post graduate level shall be provided to appropriate medical, nursing, and clinical staff in the settings where the trainee physicians are involved in the provision of patient care. Any restrictions or limitations on a trainee's participation in patient care shall be communicated in writing to the trainee, to the supervising teaching staff, to nursing administration, and to other appropriate parties prior to the assignment of the trainee to a clinical rotation or as otherwise deemed appropriate by the Program Director.
- b) Programs must set guidelines for circumstances and events in which trainees must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
  - i. Each trainee must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
    - In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.
  - ii. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each trainee and delegate to him/her the appropriate level of patient care authority and responsibility.
- c) The hospital shall provide trainees with appropriate systems for communication with supervisors, e.g., paging systems.

**Clinical Responsibilities**

The clinical responsibilities for each trainee must be based on PGY-level, patient safety, trainee education, severity and complexity of patient illness/condition and available support services.

**Supervision on Outside Rotations**

Supervision of trainees on clinical rotations outside of Botsford Hospital must be documented.

**Review and Evaluation of Trainee Supervision**

Program Directors shall provide an annual report to the Graduate Medical Education Committee on trainee supervision procedures and issues for their program.

The DIO shall include a report on trainee supervision issues in the annual medical education report to the Graduate Medical Education Committee.



## **POLICY**

PAGE 1 of 4

TITLE: RESIDENT DUTY HOURS/FATIGUE MANAGEMENT

EFFECTIVE: APRIL 2015

REPLACES: RESIDENT DUTY HOURS/FATIGUE MANAGEMENT; SEPTEMBER 2014

### **PURPOSE**

It is recognized that excessive hours worked by residents can lead to errors in judgment and clinical decision-making. These can impact patient safety through medical errors, as well as the safety of the residents through increased motor vehicle accidents, stress, depression and illness related complications. The training institution, Residency Program Director and Designated Institutional Official (DIO) must maintain a high degree of sensitivity to the physical and mental well-being of the residents and make every attempt to avoid scheduling excessive work hours leading to sleep deprivation, fatigue, or inability to conduct personal activities.

### **DEFINITIONS**

Faculty: Any individuals who have received a formal assignment to teach residents.

Fatigue Management: Recognition [by fellow resident, peer or supervisor] of a level of fatigue that may adversely affect patient safety and enactment of a solution to mitigate the fatigue.

Fitness for Duty: Mentally and physically able to effectively perform the required duties and promote patient safety.

Resident: Any physician in an accredited graduate medical education program, including interns, residents, and fellows.

Scheduled Duty Periods: Assigned duty within the institution encompassing hours, and may be within the normal work day, beyond the normal work day, or a combination of both.

## POLICY

The institution, DIO, and Program Directors must make every attempt to avoid scheduling excessive work hours leading to sleep deprivation, fatigue or inability to conduct personal activities. The following are the 'Duty Hour' rules. No exceptions to this policy shall be permitted.

1. Duty Hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting (VI.G.1).
2. Duty periods of PGY-1 residents must not exceed 16 hours in duration (VI.G.4.a).
3. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital (VI.G.4.b).
  - a. In unusual circumstances, residents, on their own initiative may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family (VI.G.4.b)(4).
4. Residents shall not assume responsibility for a new patient or any new clinical activity after working 24 hours.
5. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days (VI.G.3).
6. PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods (VI.G.5.a).
7. Intermediate-level residents (as defined by the Review Committee) should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty (VI.G.5.b).
8. Residents in the final years of education (as defined by the Review Committee) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods (VI.G.5.c).
  - a. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards (VI.G.5.c)(1).
9. Residents must not be scheduled for more than six consecutive nights of night float (VI.G.6).
10. PGY-2 residents and above must be schedule for in-house call no more frequently than every-third-night (when averaged over a four-week period) (VI.G.7).

11. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty (VI.G.8.a).
  - a. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident (VI.G.8.a)(1).
  - b. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period” (VI.G.8.b).
  
12. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program (VI.G.2.a).
  - a. Time spent by residents in Internal and External Moonlighting must be counted towards the 80-hour Maximum Weekly Hour Limit (VI.G.2.b).
  - b. PGY-1 residents are not permitted to Moonlight (VI.G.2.c).
  
13. At the resident’s request, the training institution must provide comfortable sleep facilities to residents who are too fatigued at shift conclusion to safely drive.
  
14. Residents must log all hours worked, including any violations of these rules, in the New Innovations software and a valid rationale for the additional time worked must be provided.
  
15. All duty hour violations will be reviewed by the Program Director, the DIO and the Graduate Medical Education Committee for monitoring of individual residents and residency programs.
  
16. Residents can report without reprisal, inconsistencies, violations, or disregard for published work hour policies to the Graduate Medical Education Department.

## **FATIGUE MANAGEMENT POLICY**

Botsford Hospital supports high quality education along with safe and effective patient care. The institution is committed to meeting the requirements of patient safety and resident well-being. Excessive sleep loss, fatigue and stress are serious matters. Appropriate backup support will be provided when patient care responsibilities are especially difficult and prolonged, and if unexpected needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.

The resident must be able to:

1. Recognize the signs of fatigue and sleep deprivation.
2. Implement alertness management and fatigue mitigation processes.
3. Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

## **PROCEDURE**

All attending physicians and residents are instructed to closely observe each other for any signs of undue stress and/or fatigue, which may make them unfit for duty. Faculty and other residents are to report such concerns of sleepiness, tardiness, resident absences, inattentiveness, or other indicators of possible fatigue and/or excessive stress to the supervising Attending, Program Director or DIO. The resident will be relieved of his/her duties until the effects of fatigue and/or stress are no longer present. In order to mitigate the effect of fatigue and to ensure safety, the institution recommends/provides the following:

1. Residents are encouraged to set aside time, utilizing the call rooms, for strategic napping. A 15-20 minute nap will allow the resident to feel refreshed.
2. If after a call shift, the resident feels that it is unsafe to drive home, a taxi service may be used. The resident must submit the receipt (with the time and date) on the approved expense reimbursement form to their Program Coordinator to receive reimbursement for the taxi service.
3. Every resident has the responsibility to remain compliant with this policy.

**RESOURCES:** Accreditation Council for Graduate Medical Education Guidelines

# **BOTSFORD**

HOSPITAL

## **POLICY**

PAGE 1 of 2

TITLE: RESIDENT/FELLOW BENEFITS

EFFECTIVE: APRIL 2015

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REPLACES: POLICY FOR SELECTION OF INTERNS AND RESIDENTS

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### **PURPOSE**

Botsford Hospital offers a comprehensive and competitive benefits program to all eligible participants. The program affords participants the opportunity to personalize their benefits selection based upon individual need at reasonable costs. In addition to a comprehensive benefits program, Botsford offers benefits at reasonable cost with low out of pocket expense for co-payments and annual deductibles. This summary outline represents a brief overview of the benefits features and does not constitute a legally binding document. Furthermore, the benefits offered may be modified at any time in the sole discretion of the Employer. Refer to the benefit plan descriptions for more information about the specific plan provisions. These descriptions are available in the Human Resources Department.

### **BENEFIT SUMMARY**

**Medical Plan Options** – Effective Date of Hire.

- Community Blue PPO
- Blue Care Network HMO
- No Coverage if a medical plan is not selected

**Dental Plan Options** – Effective Date of Hire.

- Met Life Dental (Preferred Provider Program)
- No Coverage if a dental plan is not selected

**Vision Plan Options** – Effective Date of Hire.

- Basic Plan
- Premium Plan
- No Coverage if a vision plan is not selected

**Life and Accidental Death and Dismemberment Insurance** – Effective Date of Hire.

There are additional 'buy up' options at group rates via payroll deductions for two, three and four times base annual salary.

***Dependent Life Insurance*** – *Effective Date of Hire.*

*There are options to purchase dependent life at group rates via payroll deduction.*

**Family Accidental Death and Dismemberment Coverage** – Effective Date of Hire.

There are options to purchase Family Accidental Death and Dismemberment at group rates via payroll deduction.

**Short Term Disability** – Effective Date of Hire.

**Long Term Disability** – Effective Date of Hire.

**Health Care and Dependent Care Accounts (Optional)**

Health Care and/or Dependent Care Reimbursement Accounts will allow participants to deposit pre-taxed dollars into separate accounts to be used for eligible uncovered medical, dental, vision care or certain child care/dependent care expenses. While each of these programs provides certain tax advantages, there are important IRS regulatory provisions, participation requirements and consequences that should be understood by each participant.

**Voluntary Benefits**

To supplement the benefits program, Botsford offers a selection of voluntary benefits. Voluntary benefits may include Universal Life and Long Term Care Coverage, Accident Indemnity, Sickness Indemnity, Hospital Protection, Hyatt Legal Plan, Home and Auto Insurance and Pet Insurance Coverage. These options are available at certain times during the calendar year.

# **BOTSFORD**

HOSPITAL

## **POLICY**

PAGE 1 of 2

TITLE: EVALUATION, PROMOTION, DISCIPLINE, & DISMISSAL OF RESIDENTS/FELLOWS

EFFECTIVE: MARCH 2015

REPLACES: NONE

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### **PURPOSE**

Each Residency & Fellowship program must develop formal written criteria and processes for the evaluation, promotion, discipline, and dismissal of Residents/Fellows – in accordance with these guidelines.

#### **1. EVALUATION**

Residents must be evaluated in writing by an attending physician at the conclusion of each rotation. Formal written criteria shall be established for these evaluations and incorporated into pertinent Evaluation Forms, which are formatted according to the 6 ACGME Competencies or CPME requirements. Residents have access to these evaluations through the online database system, New Innovations. Residents must be provided formal, individualized feedback based upon these written evaluations at least every six months by the Program Director or his/her designee. Documentation of these semiannual reviews shall be maintained in the individual resident files.

Additionally, each program is encouraged to promote sit-down, verbal feedback sessions with each Resident/Fellow at approximately the midpoint and again at the end of each rotation.

#### **2. PROMOTION**

Promotion of residents shall be based upon satisfactory performance as measured by the formal written evaluation criteria. Residents who may not be advanced or who may not be offered a contract for the next year are identified and so informed as early as possible. The Resident/Fellow should be alerted to this possibility no later than the sixth month of the contract year (if practicable under the circumstances), with appropriate notification and documentation to the Director of Graduate Medical Education (GME). If the event that threatens timely promotion occurs after the 6-month mark, the Resident/Fellow will be informed as soon as possible.

### **3. DISCIPLINE**

Unsatisfactory resident performance or misconduct may result in the need for remediation or disciplinary actions. If such an action is considered by the program Director, the Director of GME should be informed immediately of the details of the situation. The Program Director and the Director of GME will jointly determine the need for and extent of the remedial or disciplinary action. The resident will be notified in writing of the planned action, its justification, the length of action, and the conditions of performance or conduct by which the action will be terminated, extended, or result in a consideration for dismissal from the program. In the event of an emergency situation necessitating temporary Suspension, the Chief Medical Officer or his/her designee may act upon the recommendation of the Director of GME or Program Director.

### **4. DISMISSAL**

If the Program Director plans denial of reappointment or advancement, the Resident/Fellow should be notified as early in the year as practical to allow remedial action or counseling to be undertaken. The Resident/Fellow should be alerted to this possibility no later than the sixth month of the contract year with appropriate notification and documentation to the Director of Graduate Medical Education. If at the end of the eighth month of the contract year there is no significant improvement, the Program Director must make the final determination. In the event that remedial action or counseling is unsuccessful, and temporary Suspension or Termination is deemed appropriate, the Resident/Fellow and the Director of Graduate Medical Education must be apprised of the circumstances in writing.

Due Process is assured according to the current version of Graduate Medical Education's "Discipline, Hearing, and Review Process Policy."

# **BOTSFORD**

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HOSPITAL  
**POLICY**

PAGE 1 of 3

TITLE: TRANSITIONS OF CARE POLICY

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EFFECTIVE: DECEMBER 2014

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## **PURPOSE**

To establish protocol and standards within Botsford Hospital residency and fellowship programs to ensure the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances. Transitions of care are necessary in the hospital setting for various reasons. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

- Change in level of patient care, including inpatient admission from an outpatient procedure or diagnostic area or ER and transfer to or from a critical care unit.
- Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas.
- Discharge, including discharge to home or another facility such as skilled nursing care.
- Change in provider or service change, including change of shift for nurses, resident sign-out, and rotation changes for residents.

## **DEFINITIONS**

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

## **TRANSITIONS OF CARE POLICY**

Individual programs must design schedules and clinical assignments to maximize the learning experience for residents as well as to ensure quality care and patient safety, and adhere to general institutional policies concerning transitions of patient care.

## **TRANSITIONS OF CARE PROCEDURE**

1. The transition/hand-off process should involve face to face interaction with both verbal and written/computerized communication\*, with opportunity for the receiver of the information to ask questions or clarify specific issues. The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:
  - Identification of patient, including name, medical record number, and age
  - Identification of admitting/primary/supervising physician and contact information
  - Diagnosis and current status/condition (level of acuity) of patient
  - Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
  - Outstanding tasks—what needs to be completed in immediate future
  - Outstanding laboratories/studies—what needs follow up during shift
  - Changes in patient condition that may occur requiring interventions or contingency plans

\*Hand-offs can be conducted over the phone as long as both parties have access to an electronic or hard copy version of the sign-out sheet. Additionally, all attempts to preserve patient confidentiality are observed.

2. Each residency program must develop components ancillary to the institutional transition of care policy that integrate specifics from their specialty field. Programs are required to develop scheduling and transition/hand-off procedures to ensure that:
  - Residents comply with specialty/institutional duty hour requirements
  - Faculty are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents
  - Patients are not inconvenienced or endangered in any way by frequent transitions in their care
  - All parties directly involved in the patient's care before, during, and after the transition have opportunity for communication, consultation, and clarification of information
  - Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency

- Programs should provide an opportunity for residents to both give and receive feedback from each other or faculty physicians about their handoff skills
3. Each program must include the transitions of care process in its curriculum.
  4. Residents must demonstrate competency in performance of this task. There are numerous mechanisms through which a program might elect to determine the competency of trainees in handoff skills and communication. These include:
    - Direct observation of a handoff session by a licensed independent practitioner-level clinician familiar with the patient(s)
    - Direct observation of a handoff session by a licensed independent practitioner-level clinician unfamiliar with the patient(s)
    - Either of the previous, by a peer or by a more senior trainee
    - Evaluation of written handoff materials by a licensed independent practitioner-level clinician familiar with the patient(s)
    - Evaluation of written handoff materials by a licensed independent practitioner-level clinician unfamiliar with the patient(s)
    - Either of the previous, by a peer or by a more senior trainee
    - Didactic sessions on communication skills including in-person lectures, web-based training, review of curricular materials and/or knowledge assessment
    - Assessment of handoff quality in terms of ability to predict overnight events
    - Assessment of adverse events and relationship to sign-out quality through:
      - Survey
      - Reporting hotline
      - Chart review
  5. Programs must develop and utilize a method of monitoring the transition of care process and update as necessary. Monitoring of handoffs by the program to ensure:
    - There is a standardized process in place that is routinely followed
    - There are consistent opportunities for questions
    - The necessary materials are available to support the handoff (including, for instance, written sign-out materials, access to electronic clinical information)
    - A quiet setting free of interruptions is consistently available, for handoff processes that include face-to-face communication
    - Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines

# **BOTSFORD**

HOSPITAL

## **POLICY**

PAGE 1 of 2

TITLE: DISASTER POLICY: CONTINUATION OF GME RESOURCE, FINANCIAL, & ADMINISTRATIVE SUPPORT

EFFECTIVE: APRIL 2015

REPLACES: \_\_\_\_\_

### **PURPOSE**

Botsford Hospital strives to provide a stable educational and employment environment for all residents/fellows. If an event or set of events causes significant alteration to the Residency/Fellowship experience in one or more programs, the Program Directors' first point of contact for answers to questions regarding a local extreme emergent situation is the Director of GME/Designated Institutional Officer (DIO).

### **DEFINITIONS**

Disaster: An event or set of events (natural or man-made, external or internal) causing significant alteration to the Residency/Fellowship experience in one or more programs. Within Botsford, a formal declaration of "Disaster" will be made only in accordance with Botsford's "Emergency Management Plan Manual."

### **DISASTER PROCEDURE**

The Department of GME and/or the Graduate Medical Education Committee (GMEC) will take the following steps:

1. As soon as possible, the Department of GME will:
  - a. Gather data and information from training programs regarding the extent of damage and the impact of the disaster on the short-term (days/weeks) and long-term (weeks/months) function of individual programs and/or training sites.
  - b. Work directly with Medical and Hospital Administration to determine the short-term and long-term impact on clinical operations caused by the disaster.
2. The GMEC will hold an emergency meeting as soon as possible during or following the disaster to review the available information regarding the impact of the disaster on clinical operations and training programs.

3. The Director of GME/DIO will notify the Executive Director of the ACGME's Institutional Review Committee if an extreme emergent situation causes, or is anticipated to cause, serious extended disruption to resident assignments, educational infrastructure, or clinical operations that might affect the programs' ability to conduct resident/fellow education in substantial compliance with all ACGME requirements. He/She will also respond to any ACGME request for a written description of current, ongoing, and anticipated disruptions. Finally, he/she will notify the Executive Director of the Institutional Review Committee when the extreme emergent situation has been resolved.
4. Program Directors are expected to follow Beaumont Health policies and procedures regarding communication and service during disasters. Additionally, they may contact the Executive Director of their Review Committee if necessary to discuss any program-specific concerns.
5. The GMEC will meet regularly, as necessary, to continue its assessment of the situation and to make decisions regarding the training programs.
6. The Department of GME will continue to provide administrative support to all affected programs during this period.
7. Issues to be reviewed, assessed, or acted upon by the Department of GME and/or GMEC include:
  - a. Safety of residents/fellows, teaching physicians, and staff
  - b. Inventory of available teaching physicians and residents for clinical and educational duties
  - c. Changes in the volume of patient activity in the short-term and long-term
  - d. Extent/impact of damage to the physical plant and facilities
  - e. Extent/impact of damage to communication technology and clinical information systems
8. If the Department of GME and/or GMEC determine that a program and the institution cannot provide an adequate educational experience for residents because of the disaster, then the program(s) and the institution will work to temporarily relocate a resident/fellow to a training site within the institution or to a local affiliated training site.
9. If it becomes necessary to transfer residents temporarily to another institution, Botsford will work with that institution and within the rules of CMS (Center for Medicare and Medicaid Services) GME funding policies and procedures to assure maintenance of resident salaries and benefits and to allow the other institution to claim and collect the CMS GME funds during the residents temporary duty assignment.
10. The Department of GME and Botsford Hospital will make every effort to restore clinical services and educational resources to the normal pre-disaster condition in order to reinstitute resident training at Botsford as soon as possible.
11. If desired by affected residents/fellows, the Program Director and Department of GME will assist in the permanent transfer to another program or institution.

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## **POLICY**

PAGE 1 of 2

TITLE: PROFESSIONAL LIABILITY COVERAGE FOR RESIDENTS/FELLOWS IN ACCREDITED PROGRAMS POLICY

EFFECTIVE: APRIL 2015

REPLACES: \_\_\_\_\_

### **PURPOSE**

The policy serves as the explanation for Residents/Fellows of their professional liability coverage. The policy identifies the different key points of the policy and assigns responsibility to the sponsoring institution in carrying the coverage for the Residents/Fellows.

### **DEFINITIONS**

Professional Liability: The legal obligation of health care professionals or their insurers to compensate patients for injury or suffering caused by acts of omission or commission by the professionals.

### **POLICY**

All accredited Residents and Fellows employed by Botsford Hospital are provided the following liability insurance coverage:

#### **Scope**

Residents/Fellows are covered for Medical Professional Liability and General Liability claims. This coverage includes the related defense costs that arise out of the rendering or failure to render medical professional services while performing duties within the scope of the Residency/Fellowship program for which they are employed by Botsford.

#### **Limits**

Botsford Hospital is self-insured for this exposure and limits are not expressly stated. The coverage and the limits provided are the same for all Botsford employed physicians, including Residents/Fellows.

**Type**

Coverage is provided to Residents/Fellows in occurrence form. Occurrence form of coverage provides protection of patient care action that occurs during the policy period no matter when a claim or suit is filed. With occurrence coverage, there is not extended reporting period coverage required. In other words, Residents/Fellows are covered no matter how long after their employment a claim or suit is filed.

**Term**

The coverage period begins on the employment date as a Resident/Fellow and ends on the day that employment with Botsford Hospital ends.

**Restrictions**

Liability coverage is **not** provided to any Resident/Fellow during the following instances:

- a) While on an educational rotation or other patient care activity in a foreign country (including Canada)
- b) When moonlighting as a physician outside of Botsford Hospital
- c) Performing non-program-related volunteer medical services outside of Botsford Hospital