Pain Medicine Fellowship Orientation

JULY 2018

Dr. Rana
Pain Fellowship Director

Dr. Simopoulos
Director of Pain Medicine

KEEP CALM AND WELCOME TO THE TEAM

Pain Fellowship Team
Dr. Thomas Simopoulos – Division Director Pain Medicine

Chronic Pain Service Director

Fellowship Program Coordinator: Kim Brown

Fellowship Program Coordinator Pain Fellowship: Renetta Johnson

Pain Fellowship: Goals and Objectives
Patient Care and Procedural Skills

Neurology

eliciting a directed neurological history;

performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in fifteen patients; and, 

Neuroimaging

identifying significant findings of basic neuro-imaging.

Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computed tomography (CT) of the spine and brain on a minimum of 15 CT and/or MRI studies.

Neuro-imaging studies must be drawn from the following areas: brain, cervical, thoracic, and lumbar spine.

Physical Medicine and Rehabilitation

must demonstrate the following competencies in physical medicine and rehabilitation.

performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both acute and chronic pain processes.

Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of at least 10 patients.

Developing rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue conditions, and:

Fellows must demonstrate proficiency in the clinical evaluation and rehabilitation plan development of at least two patients, integrating therapeutic exercises and surgical intervention in the treatment algorithms.
Psychiatry

carrying out a complete psychiatric history with special attention to psychiatric and pain
comorbidities; (b) conducting a complete mental status examination and (c) A complete mental status
examination must be conducted on a minimum of 15 patients. Each fellow must demonstrate this
ability in five patients to a faculty observer and (d) explaining psychosocial therapy to a patient
and making a referral when indicated.

Medical Knowledge

anatomy, physiology and pharmacology of pain
transmission and modulation; (a) natural history of various musculoskeletal pain
disorders; (b) general principles of pain evaluation and management including neuroradiological
exams, musculoskeletal exams, psychological assessment; (c) indicators and interpretation of electro-diagnostic
studies: X-rays, MRI, CT, and clinical nerve function studies; (d) pain measurement in humans, both experimental
and clinical; (e) psychological aspects of pain, including cultural and cross-cultural considerations; (f) taxonomy of pain syndromes;

pain of spinal origin, including radicular pain, zygapophysial joint disease, and discogenic pain;
myofascial pain; (a) neuropathic pain; (b) headache and orofacial pain; (c) rheumatological aspects of pain;
complex regional pain syndromes; (d) visceral pain; (e) urogenital pain; (f) cancer pain, including palliative and hospice care;
acute pain; (g)
Treatment of Pain

Drug Treatment I: opioids;
Drug Treatment II: antinociceptive analgesics;
Drug Treatment III: antidepressants, anticonvulsants, and miscellaneous drugs;
psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy;

psychosocial therapies and treatment of psychiatric illness;
prescription drug diversion concepts;
functional and occupational rehabilitation;
surgical approaches;
complementary and alternative treatments in pain management;
treatments that comprise multidisciplinary cancer pain care;
strategies to integrate pain management into the treatment model;

treatment of pain in pediatric patients;

General topics, research, and ethics

epidemiology of pain;
gender issues in pain;
placebo response;
multidisciplinary pain medicine;
organization and management of a pain center;
Continuing Quality Improvement, Utilization Review, and Program Evaluation;
patient and provider safety;
designing, reporting, and interpreting clinical trials of treatment for pain;
ethical standards in pain management and research; and,
animal models of pain, ethics of animal experimentation;
Interventional Pain Treatment

1. Selection criteria for a broad range of interventions and an understanding of the risks and potential advantages of these interventions.
2. Airway management skills.
4. Fluoroscopic imaging and radiation safety.
5. Pharmacology of local anesthetics and other injectable medications, including radiographic contrast agents and spinal preparations.
6. This must include treatment of local anesthetic systemic toxicity.
7. Trigger point injections.
8. Peripheral and cranial nerve blocks and ablation.

Spinal injections including epidural injections; interlaminar, transforaminal, nerve root sheath injections, and zygapophysial joint injections;

Discography and intradiscal/percutaneous disc treatments;

Joint and bursal injections, including sacroiliac, hip, knee, and shoulder joint injections;

Sympathetic ganglion blocks;

Epidural and intrathecal medication management;

Spinal cord stimulation; and;

Intrathecal drug administration systems.

Practice Based Learning and Improvement

1. Identify strengths, deficiencies, and limits in one’s knowledge and expertise.
2. Set learning and improvement goals.
3. Identify and perform appropriate learning activities.
4. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.
5. Incorporate formative evaluation feedback into daily practice.
6. Locate, appraise, and maintain evidence from scientific studies related to their patients’ health problems.
7. Use information technology to optimize learning and share.
8. Participate in the education of patients, families, students, fellows and other health professionals.
Interpersonal and Communication Skills

- Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
- Communicate effectively with physicians, other health professionals, and health-related agencies.
- Work effectively as a member or leader of a health care team or other professional group.
- Act in a consultative role to other physicians and health professionals.
- Maintain comprehensive, timely, and legible medical records, if applicable.

Professionalism

- Compassion, integrity, and respect for others.
- Responsiveness to patient needs that supersedes self-interest.
- Respect for patient privacy and autonomy.
- Accountability to patients, society and the profession.
- Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Systems Based Practice

- Work effectively in various health care delivery settings and systems relevant to their clinical specialty.
- Coordinate patient care within the health care system relevant to their clinical specialty.
- Incorporate considerations of cost awareness and risk/benefit analysis in patient and population-based care as appropriate.
- Advocate for quality patient care and optimal patient care systems.
- Work in interprofessional teams to enhance patient safety and improve patient care quality.
- Participate in identifying system errors and implementing potential system solutions.
3. **Practice Based Learning and Improvement** that involves investigation and evaluation of one's own patient care, appraisal and assimilation of scientific evidence and improvements in patient care.

4. **Interpersonal and Communication Skills** that result in effective information exchange and learning with patients, their families, and other health care professionals.

5. **Professionalism** that demonstrates a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

6. **A.S. (1) (b) (i) (a) (I)**: performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellar examination, and gait in **all patients** (Core).

   - **(II)**: : Performing the examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellar examination, and gait in **all patients** (Core).

7. **A.S. (1) (b) (i) (b) (I)**: Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computed tomography (CT) of the spine and brain on a minimum of **31 CT and/or MRI studies** (Core).

   - **(II)**: Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computed tomography (CT) of the spine and brain on a minimum of **31 CT and/or MRI studies** (Core).

8. **A.S. (1) (b) (ii) (a)**: Fellows must gain significant hands-on experience in the musculoskeletal and neurovascular assessment of **25 patients** (Core).

   - **(II)**: Fellows must gain significant hands-on experience in the musculoskeletal and neurovascular assessment of **25 patients** (Core).

9. **A.S. (1) (b) (ii) (a)**: Fellows must demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of **5 patients** (Core).

   - **(II)**: Fellows must demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of **5 patients** (Core).

10. **A.S. (1) (c) (a) (I)**: A complete mental status examination must be conducted on a minimum of **15 patients** (Core).

    - **(II)**: A complete mental status examination must be conducted on a minimum of **15 patients** (Core).

11. **A.S. (1) (c) (a) (b) (I)**: Each fellow must demonstrate this ability in **five patients** to a faculty observer (Core).

    - **(II)**: Each fellow must demonstrate this ability in **five patients** to a faculty observer (Core).

12. **A.S. (1) (c) (a) (b) (II)**: Intravenous access must be obtained in a minimum of **15 patients** (Core).

13. **A.S. (1) (d) (a) (I)**: This must include a minimum of **mask ventilation in 15 patients** (Core).

14. **A.S. (1) (d) (a) (II)**: Intubation ventilation must be performed on **15 patients** (Core).

15. **A.S. (2) (a) (I)**: Must include direct administration of sedation to a minimum of **15 patients** (Core).

16. **A.S. (2) (a) (II)**: A minimum of **15 thoracic or lumbar epidural injections using an interlaminar technique must be completed** (Core).

17. **A.S. (4) (c) (a) (I)**: The fellow will provide the fellow with supervised experience in the ongoing management of a diverse population of patients with chronic pain, including cancer pain. The experience allows interaction with other specialists in a multidisciplinary approach to chronic pain management. In this role, the pain medicine fellow should attend a supervised outpatient clinic approximately weekly throughout the year (Core).

    - **(II)**: The fellow will provide the fellow with supervised experience in the ongoing management of a diverse population of patients with chronic pain, including cancer pain. The experience allows interaction with other specialists in a multidisciplinary approach to chronic pain management. In this role, the pain medicine fellow should attend a supervised outpatient clinic approximately weekly throughout the year (Core).

18. **A.S. (5) (b) (a)**: This will provide a minimum of **eight months experience (full-time equivalent or at least 40 half days)** (Core).
IV. A. (1) (c) Primary responsibility for Mid-Adult patients followed over at least two months each should be documented. (Detail)

IV. A. (2) (d) Inpatient chronic pain experience should be supervised by a pain team responsible for the assessment and management of inpatients with chronic pain. Patients should be seen through either a consultation-liaison or inpatient pain medicine service. (Detail)

IV. A. (2) (e) To establish this experience, the fellow should document involvement with a minimum of 15 new patients assessed in this setting. (Detail)

IV. A. M. (1) (a) Acute pain inpatient experience should be supervised in the assessment and management of inpatients with acute pain. (Detail)

IV. A. M. (1) (b) To establish this experience, the fellow should document involvement with a minimum of 10 new patients. (Detail)

IV. A. (4) (b) (i) To establish this experience, the fellow must document involvement with a minimum of 60 patients who undergo interventional procedures in the following categories: (Core)

IV. A. (4) (b) (ii) (a) At least 25 image-guided spinal interventions. (Detail)

IV. A. (4) (b) (ii) (b) At least 10 trigger point injections. (Detail)

IV. A. (4) (b) (ii) (c) At least 10 neuroaxial procedures. (Detail)

IV. A. (4) (b) (ii) (d) At least five joint and bursa injections. (Detail)

IV. A. (4) (b) (ii) (e) At least five neurodestructive and analgesic interventions. (Detail)

IV. A. (4) (b) (ii) (f) At least five nerve blocks, including a variety of blocks such as ilioinguinal blocks, bisseptical blocks, perineal blocks, and tarsal forefoot venous blocks. (Detail)

IV. A. (5) (a) Pain care experience should be a supervised, longitudinal experience in an ambulatory or inpatient population that requires care for cancer pain, and may be integrated with continuity of inpatient experience. The experience should include: (Detail)

IV. A. (5) (a) (i) The fellow must document longitudinal involvement with a minimum of 20 patients. (Detail)

IV. A. (5) (b) Palliative Care Experience: and, (Core)

IV. A. (5) (b) (i) Palliative care should be a supervised, longitudinal experience in an ambulatory or inpatient population that requires palliative care. It may be integrated with continuity of inpatient experience. (Detail)

IV. A. (5) (b) (ii) To establish this experience, the fellow must document longitudinal involvement with a minimum of 10 patients who require palliative care. (Core)
Some Important Phone Numbers:

- **AWPMC Main Line** – (617) 278-8000
- **Direct Line to Nurses** – (617) 278 – 8008
- **Renetta Johnson (Fellowship Coordinator)** – (617) 278 – 8037
- **Menrika Louis (Operations Director)** – (617) 278 – 8018
- **Nate Beyer (Practice Manager)** – (617) 278 – 8007

**Cell Phone:**

- **Dr. Rana** – (732) 236 – 8154

[https://portal.bidmc.org/Education/GradMedEd/Housestaff-Resources.aspx - GME House Staff Resources]
Some Helpful Tips:

Shields MRI Access:
https://id.shields.com/WSShieldsAuth/Registration/SEL/index.html

CDI Access
http://www.myedi.com/massachusetts/

Longwood MRI
http://www.longwoodmri.com/

Get a Harvard ID!

http://www.campusservicecenter.harvard.edu/services/id-cards/locations

- Countway Library
  - Furman, Atlas of Imaged Guided Pain Procedures
  - Jacobson, Fundamentals of MSK U/S
Educational Funds:

- Can be utilized for board exams, textbooks, conferences including airfare, taxi, food, and registration fees, MA full medical license
- Can not be used for purchase of electronics
- Any request for reimbursement must be submitted within 30 days with receipt
- Total Awarded: $2250.00
- Further information and forms to obtain reimbursement are located on the Anesthesia Intranet. Any questions regarding this please contact Renetta Johnson.

I-PAD

I-pads are the property of BIDMC, please do not lend this device to others or sell it.
At the conclusion of the Academic Year, your I-pad will be turned into the Anesthesia Education Office where it will be wiped of any patient related or BIDMC proprietary information and then returned back to you.
TRANSPORTATION:
At the parking office on the east campus, you can get a Link pass that grants unlimited bus and T trips for about $40/month.

Also at that office you can get a parking pass which will allow you park on night and weekends for a more reasonable rate 5-10dollars. This is helpful on the weekends when you’re covering CPS as the T comes less frequently.

Lastly, BIDMC offers a discount for Hubway memberships. The annual cost, usually $85, is discounted to about $38 if you identify yourself as a BIDMC employee when signing up. The password is WvKzLz7.

TRANSPORTATION TO NEEDHAM OR NEBH:
It is the expectation that if you own a vehicle that you will drive to these off site location, parking is free! ☺

Otherwise please plan on taking taxi or Uber/Lyft, max reimbursement is 50 dollars round trip. Submit your request for reimbursement within 5 business days of the date of transport.

Zip car, car rentals will not be reimbursed!!

Duty Hours
- Trainees must not be scheduled for more than 80 hours clinical work per week, averaged over 4 weeks.
- Trainees must have one (1) day in seven (7) without clinical responsibility. This may be averaged over 4 weeks.
- There must be a minimum 8 hour rest period between clinical assignments (10 hours preferred). In the unusual event that a trainee finishes late and will not be able to return to the hospital in time for the next day's assignment, arrangements will be made by the clinical service.
- Several services require trainees to take call from home – i.e. beeper call. For instance the acute pain service, transplant and cardiac services are home call assignments. It is only the hours actually spent in the hospital that count towards the duty hours, and these may not exceed 50 hours per week or a 24 hours period (with a 4 hour sign out possible). However there must be one (1) day in seven (7) free, and at least an 8-hour rest period must be provided between clinical duties (10 hours preferred, as described above).
- Duty hour reports will be collected semi-annually and reviewed by the program director for the trainees.
In accordance with ACGME regulations, you will be asked to log duty hours for 2-3 months during the academic year. 100% compliance is expected.

FATIGUE

https://portal.bidmc.org/Education/GradMedEd/Housestaff/Resources/~/media/872CAE8F3611444A99C950062776D283.ashx

Fatigued residents typically have difficulty with:
- Appreciating a complex situation while avoiding distraction
- Keeping track of the current situation and updating strategies
- Planning and analyzing
- Assessing risk and/or anticipating consequences
- Maintaining interest in outcome
- Coordinating mental and avoiding inappropriate behavior

More specifically, signs of fatigue include:
- Involuntary nodding off
- Inability to awaken
- Problems focusing
- Lethargy
- Instability
- Mood lability
- Slurred speech
- Difficulty with short-term recall
- Tiredness or absence at work

High risk times for fatigue-related symptoms are:
- Midnight to 4:00 AM
- Shifts that involve the shift right after a break
- Change of service
- First 2 to 3 hours of a shift or end of shift
- Shifts in residence or when new to night call

Countermeasures:
1. Increased Sleep
2. Naps
3. Caffeine
4. Modafinil
5. Multiple human control layers
6. Multiple non human control layers ie error tracking and warning systems
Daily Schedule

- Tentative monthly schedule will be emailed to you ahead of time.
- However, a daily updated schedule will be sent to you the previous work day.
  - Multiple iterations

<table>
<thead>
<tr>
<th>AM</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient</td>
<td>Patient</td>
<td>Patient</td>
<td>Patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PM</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check out:
- 11:00
- 11:30
Rooms?? And Locations

- **Procedure Rooms:**
  - Rooms 1,2,4,5
  - WPC – West Procedural Center

- **Evaluation Rooms:**
  - Rooms 3,7,6 and SR (Swing Room)
  - Suite 406 – 3 evaluation rooms (primarily headache practice)
  - 6th Floor – 6 Evaluation Rooms
  - Spine Center – 330 Brookline Ave BIDMC East Campus Shapiro 2

- **Operating Rooms:**
  - OR – OR East Campus Feldberg or Shapiro 3rd floor
  - ORN – OR Needham
Rooms?? And Locations

- Off Site Locations
  - MIL – Milton
  - BIDN – Needham
  - Chelsea
  - OR-A – OR Anesthesia
  - LEX – Lexington

- CPS, Vacation, Meeting, outside rotations including BCH, Palliative Care, PM&R, Neuro, Psych will also be noted on the daily schedule

Expectations??

- You will know which rooms and attending you are assigned to the night prior.
- Please familiarize yourself with your patient panel for the next working day.
- Review relevant imaging for your procedure patients. Familiarize yourself with the expected imaging, type of drug to be administered and risks and benefits of the proposed procedure. Discuss with your attending if it is the first time you are performing a particular procedure.

“Before anything else, preparation is the key to success.” [Anonymous]
When assigned to OR cases, please contact your attending the night before to discuss the cases.

Familiarize yourself with patient’s history and imaging.

Discuss with your attending:
1. System to be implanted
2. Post Operative Pain Medications
3. Antibiotic prophylaxis
   etc.

Daily Schedule

If you are sick please email Dr. Rana, Renetta Johnson, Menrika Louis, and your assigned attending before 0700. Also please call the nursing desk @ 617-278-8008. A sick day is counted towards your 20 day allotment for the year.

If you are sick, and are offsite at Children’s contact prior as above, as well as, the contact person at your site.

BCH – Marybeth.Sweeney@childrens.harvard.edu
Administrative Time

All fellows will receive administrative time to complete documentation and pursue scholarly activity. **You will be expected to be physically present in clinic during that time and maybe asked to take on clinical responsibility if there is a need.**

If you plan to have offsite meetings, for example with CARE for research, during that time please inform us.

Administrative time **will not** be granted to allow for early release for flights (vacation, conference, industry sponsored events or cadaver labs), sick time, or to extend long weekends or time off...please do not make these requests.

Thank you!

VACATION TIME

ACGME allows for 3 weeks (15 days of vacation time) and 1 week (5 days of sick time/personal days), and 1 week (5 meeting days which can be applied only if you are presenting)

All fellows should have submitted requests for three weeks of vacation at this time, Mon – Fri of a single week.

The remaining four days are flex and likely be utilized for interviews. Please provide as much lead time as possible for these days and make your interviewers aware that you may need some flexibility in your dates. Ideally you will give us at least two weeks prior notice.

One day of vacation is applied to the day after Thanksgiving, when the clinic is closed.
How do I ask for vacation time?

Vacation time should be formally requested by email. Please email Renetta Johnson who will confer with leadership for approval. Please be aware this may take several days!

Vacation time, early release or late arrival to clinic **CANNOT** be approved by anyone other than Dr. Rana alternatively I am offsite or unavailable this approval will come from Renetta Johnson.

---

**200. ABSENCE FROM TRAINING**

The total of any and all absences during a subspecialty fellowship may not exceed the equivalent of 20 working days (3 weeks) per year, attendance at scientific meetings, not to exceed five working days during the year and not to exceed nine working days during the year. Any absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence.

Training in an anesthesiology subspecialty must not be interrupted by frequent or prolonged periods of absence. When there is an absence for a period in excess of six months, the Credentialing Committee of the ABA shall determine the number of months of training subsequent to resumption of the program that are necessary to satisfy the training requirement for admission to the ABA subspecialty examination system.

---

---A few notes

Travel time to airport from the AWPMC typically ranges from 45 minutes to 90 minutes depending on traffic if driving. By public transport around 45 minutes to 1 hour.

Please keep this in mind when booking flights.

Your clinical day does not end until the last patient is evaluated this can be between 5 - 5:30 PM.

You will not reach the airport until 6:30 - 7 PM.

You will require approximately 60-90 minutes to get through security.

This means that your flight should not take off before 8:30 PM.
Board Exams:
Three days are given without penalty for board exams. One for written boards, one travel day and one day for oral boards. You will be expected to be working in the clinic the day following your oral exams.

No more than five non allocated days can be carried over the last quarter from April 1st to June 30th.

Vacation time will not be granted during the last week of June.

End of the Year!

The last day of the academic year is Sunday June 30th 2019.
The last working day for the majority of trainees will be Friday June 28th 2019.

Please do not book travel plans that would interfere with your ability to complete a full clinic day on Friday June 28th (ie plan to finish clinic around 5 – 5:30 PM) trainees are not guaranteed early release.

The CPS fellow who is covering the last week of June will be expected to cover both Saturday June 29th and Sunday June 30th, coverage will then transfer to the Attending on Sunday June 30th when they feel that it is appropriate.
No more than three fellows will be permitted to be “off site” from the clinic on any given day. This includes CPS, outside rotations, meeting time and vacations. Please be mindful of this when requesting days off.

A Special Note**

During your CPS week you may discuss with your Attending taking some time for appointments or other obligations, and while this is not out of the question, please inform Renetta Johnson and Dr. Rana. The CPS fellow is preferentially pulled back to the clinic to provide support in case of a call out etc and if this occurs be aware, you may not be able to keep that commitment.

Cadaver Courses:

Many of you will be participating in various cadaver courses for SCS, kypho etc during the year which is an excellent learning opportunity. This however is not covered by your meeting time.

You will not be released early from clinic to travel to these courses, please plan to take flights which are concordant with your normal clinic schedule. This same rule applies for travel for vacation or meetings.

Meeting time can only be utilized if you are presenting or are a part of a governing committee, otherwise if you are attending a meeting as simply an “attendee” this time is taken from your allotted vacation days.

Special reference to NANS which is conducted in conjunction with a Medtronic Cadaver Course, selection to the cadaver course is random and this will assigned as vacation time.

Conferences

Attendance will generally be limited to one non local major meeting per year (ie. AAPM, ASIPP, NANS, ASRA etc), exceptions may be made for those with committee involvement or presenting original research.

In order for any non major local meeting to be approved trainees must plan on submitting their presentation for publication and participate in local presentation opportunities.

Program leadership must be informed one month prior to the posted submission deadline.

Abstract acceptance does not guarantee attendance, if attendance at a particular meeting is limited priority is given to original research.

Only one author per abstract will receive departmental support.
Travel Reimbursement

In order to qualify for travel reimbursement presented case reports must also be submitted for publication.

Policy for meeting days is the presentation day plus one travel day on either side. Workshops and other fees will be deducted from your education funds. Reimbursement must be submitted w/in 30d of your meeting attendance.

International Meetings

2. International Conferences: A trainee wishing to attend a scientific conference outside of the United States must have approval of their training program director, the department chair and identify a faculty mentor prior to abstract submission.

   i. Trainees wishing to submit/present at meetings outside of the United States may use their existing educational funds to defray expenses. Departmental support is not available for international meetings.

Clinic Procedures

- Patient phone calls
  - Weekdays incoming patient phone calls are triaged by the triage nurse
  - All emergency calls are answered by the triage nurse, however, fellows will be expected to assist with other calls.
  - Patient phone calls should be addressed on the same day and a phone note should be entered into OMR
  - Fellows maybe asked to call patients that were seen by them during their most recent visit.
Clinic Procedures

- If the primary attending is away, a covering physician has typically been identified and the case should be discussed with that individual.
- Fellows working in OR are responsible for calling those patients the day after the procedure and updating the Attending.
- Fellows will check in with the nursing staff to assist with phone calls or "pink sheets" prior to leaving clinic at the end of the day.

Clinic Procedures

On weekends, holidays, and evenings the CPS (chronic pain service) fellows under the supervision of the CPS attending is responsible for ALL TELEPHONE CALLS which should then be appropriately documented in OMR.

Clinic Procedures

- Fellows are expected to remain in the clinic until 5:00 PM
- If your room finishes early please check in with the Resource Nurse to assist with phone calls, other clinics or any pending matters.
- Fellows will take an active role in keeping the rooms running on time. Phone calls, dictations, emails etc will not interfere with patient flow.
Clinical Responsibilities and Work Flow:
- Fellows will be assigned to BIDMC Needham with Drs. Gill and Aner, generally on Wednesdays
  - Kyphoplasty
  - Spinal Cord Stimulator Phase I and Phase II implants
- Parking is free and available onsite
- If you do not have a vehicle you may use Uber and submit receipts for reimbursement

First case starts on Wednesday mornings are typically 9AM, plan arrive at the patient’s bedside by 830AM for preoperative evaluation, consent etc.

Confirm start time with your assigned attending Dr. Aner or Dr. Gill by phone, email or page the night prior to your cases.

Locker Rooms are located on the second floor, scrubs are available. Staff at the front desk will be able to direct you if needed.

Chief Fellow will be a rotating assignment, each fellow will assume this role for a seven to eight week block:
- Responsible for recording attendance at daily didactic sessions
- Shoulder board for any fellowship related issues, which can then be brought to the attention of Dr. Prestero, Anderson or Dr. Rana, such that appropriate steps can be taken to address the situation
- Coordinating the Friday lunch round table discussion per month. The chief fellow will be responsible for selecting a date, speaker (co fellow or resident) and approve a topic of discussion. An email will be sent to the Pua Attendants, Fellows, and Residents to identify the day and topic to facilitate attendance. You will also be given access to a discretionary fund to order lunch for that day.

Friday round tables are typically held the 2nd Friday of the month.
A report of monthly totals should be emailed to Paragi Rana and Renetta Johnson which will be tracked to ensure equity among trainees.

...google doc

Documentation

- All notes or dictations should be complete at the end of each workday. OMR notes will be reviewed, edited and signed daily by Attendings, Fellows, and Residents.

- **Do Not Cut and Paste**

- Fellows must remain in compliance with Beth Israel Medical Records – Ambulatory Completion Requirements (ADM-24-A) which states in part:

  - Ambulatory clinical documentation should be completed as soon as possible after each clinical encounter, but no later than 7 calendar days following the date of service. Under special circumstances, this time period may be extended to accommodate providers who are ill, on vacation, or away on leave. Authentication of documentation may be done by computer key only. Any corrections to documentation must be done as an addendum to the original note. In all cases, the author of the entry is solely responsible for complying with all the requirements in this policy. The full policy is included as part of your fellowship orientation materials. S:\Anesthesia\Pain\Fellows Resources\Hospital Policies\Ambulatory Record Completion Policy.doc
Initial Evaluation

Date: __/__/__

Chief Complaint: 

History of Present Illness:

Past Medical History: 

Medications: 

Allergies: 

Review of Systems: 

Imaging: 

Note the date and location of the exam. A summary of findings should be documented.
Initial Eval is 40 minutes, Routine follow up 20 minutes, Fluoroscopic or Ultrasound guided procedures are 30 minutes, and RF/Cryo are 60 minutes.
Sign up for dragon medical mobile recorder for E&M dictations.

It has several advantages over the legacy dictation system.

Download the app.

Contact Jay Cormier at 617-754-9228 or Elisa Trigilio at 617-754-9235.

They can grant you access on the back end and then walk you through how to set up the app on your phone... (iphone only!)
HIPAA Policy

All patient interactions need to be done in a confidential, respectful and professional manner in accordance with HIPAA and hospital policy (Doors kept closed, curtains drawn in recovery bays).

Radiation Safety

Fellows **MUST** wear their individual radiation safety badge (no sharing of badges is permitted) daily. This badge will be collected and changed at the end of every month to ensure appropriate radiation level monitoring.
Recommendations of Personal Health Care

1. Change your immunization status before working on the project.
2. Avoid direct contact with any object that might be affected by radiation.
3. Wear protective clothing when working on or near a radiation source.
4. Keep the distance from the source as far away as possible.
5. Use proper shielding materials when necessary.
6. Wear radiation protection equipment as required.
7. Keep a record of your exposure.
8. Notify your supervisor if you suspect any unusual radiation levels.
9. Work with a radiation supervisor as directed.
10. Follow the procedures outlined in the Radiation Safety Policy.

Declared Pregnancy Policy

In accordance with the Radiation Safety Office's "Pregnancy Policy," all employees are required to complete a Radiation Safety Orientation and Training. All employees must complete this training before starting their job. The training will cover the following topics:

- Radiation Safety
- Personal Protective Equipment (PPE)
- Radiation Monitoring
- Radiation Protection Measures
- Radiation Monitoring Equipment
- Radiation Exposure

If you are pregnant or plan to become pregnant, you must notify your supervisor immediately. If you are found to be pregnant, you will be removed from the radiation area and placed on a waiting list. You will be evaluated for further testing to determine your radiation exposure levels. The Radiation Safety Office will provide you with a detailed report of your radiation exposure levels.

If you have any questions or concerns, please contact the Radiation Safety Office at (555) 123-4567.
Clinic Etiquette

Patient Communication: Communication with patients, their families and the other staff members is an important part of becoming a good physician. How we listen to, talk with, and instruct patients is an important area of growth expected during training. Learning to explain illness and treatment instruction in simpler terms that are clear to everyone is essential.

Clinic Etiquette

Professionalism: The Pain Management Team at Beth Israel Medical Center values professionalism as being of utmost importance in the career development of fellows. The Pain Management Team seeks to maintain the highest standards of professionalism. The Fellows are expected to adhere to hospital guidelines for attire. If you wear scrubs in the evaluation/follow-up rooms or on the inpatient service, please make sure to wear a white coat over your scrubs. It is expected that all team members will remain polite and professional at all times.

Clinic Etiquette

The use of cell phones for personal use and texts while in patient areas is strictly prohibited.
A comprehensive didactic curriculum is at the core of the Pain Medicine Fellowship program. It is based on the ACGME Requirements for Pain Medicine, as well as, the content outline for the Pain Medicine Subspeciality Board Certification.

- Morning didactics begin at 0700.
- Every first Monday of the month a combined Spine Indications Conference is held on the 4th Floor of the Rosenberg Building West Campus Anesthesia library at 0630.

**Didactic Curriculum**

- Attendance at scheduled lectures is Mandatory. This includes all didactic conferences and weekly Grand Rounds and Mortality and Morbidity Conferences.
- Fellows will be expected to sign the attendance sheet which will be available at each conference.
- If you have NC time or are on certain off site rotations such as CPS, Palliative Care etc. lecture attendance is mandatory.
Per Departmental Guidelines for trainees attendance is required at \textbf{70\% of Grand Round and Morbidity and Mortality Conferences.}

Please ensure that you sign in each Wednesday Morning. There are two sign in sheets one for grand rounds and one for M&M please be sure to sign both.

Your attendance will be monitored and we will report back to you during your 6 month evaluation if you are not on track to complete this requirement.

---

\textbf{Didactic Curriculum}

\textbf{Core Fellowship Didactic Lectures:}
Provided by Pain Medicine Core faculty as well as Multidisciplinary Faculty and guest speakers from, Neurology, Physical Medicine and Rehabilitation, Toxicology and other disciplines. Additional topics in Patient Safety/Quality Improvement methodologies, Epidemiology, basic science research and statistics are included in the core lecture series, as well as areas of Faculty clinical and academic interest.

---

\textbf{Didactic Curriculum}

\textbf{Journal Club:}
Critical evaluation of the medical literature, understanding evidence based approach and current advances in the field of basic and clinical pain research is a key component of the fellowship. Fellows are encouraged to choose meaningful articles with faculty for discussion at journal club and spearhead discussions. Additionally residents rotating to Pain Medicine are also expected to participate and engage fully in journal club presentations.
Didactic Curriculum

**Case Conferences:**
This multidisciplinary conference includes all Pain Medicine faculty/staff, trainees and residents. Selected cases are presented and discussed. In addition to being an educational forum, this conference serves to improve patient care through the open discussion of treatment successes and failures. As such, this conference is an integral part of the Quality Improvement/Patient Safety process. These conferences also provides a structured curriculum to enable fellows to concentrate on psychopathology as well as behavioral interventions targeting patients with acute, chronic and cancer pain.

---

Didactic Curriculum

**Spine Conference:**
1st Monday 6:30 – 7:30 AM Pain Fellows participate in the Interdisciplinary Spine conference conducted with Orthopedic Spine and Neurosurgeons.

---

A didactic schedule is released monthly. It is **your** responsibility to look at the schedule and be prepared for any lecture or journal club for which you have been assigned or to recognize any conflicts.

Separate emails **will not** be sent.

Contact your assigned attending to discuss journal club topics.

You will be asked to present more than once throughout the year.
QA/QI Project

All Fellows are required to complete a QA/QI project over the course of the academic year. This is an ACGME mandated requirement and must be completed to successfully graduate.

At the conclusion of the Academic year your project will be presented to the division.

Scholarly Activity

Fellows are required to pursue at least one scholarly activity/project over the course of the academic year:

- Abstract
- Poster Presentation
- Original Research
- Case Reports
- Review Articles

...etc

Information regarding scholarly work will be collected at regular intervals.

Fellow’s Role in Education of Other Learners

- Typically during any given month between 2-4 junior and senior residents will be rotating through the pain clinic, as well as, outside rotators.

- Residents in most cases are considered "ancillary" meaning they will see fewer patients than their fellow counterparts.

- In procedure suites residents will always be paired with a fellow. Prior to considering allowing a resident to perform a procedure, please confirm with your attending that the procedure and patient is appropriate.
Fellow’s should take an active role in teaching residents in the procedure suite and should *always* be gloved with the resident.

Residents *will not* document for fellows. If a fellow is performing a procedure without the resident gloved and participating the fellow is responsible for generating the procedure note.

**Chronic Pain Service**

- Inpatient assignment, each fellow will typically cover 6-7 weeks over the academic year

- Each assignment will consist of a full week beginning on Monday morning and ending on the following Monday morning or Tuesday if Monday is a holiday.

- The fellow will be available by pager 24hrs/day including evenings, nights, and weekends.

Rarely a clinical situation will arise which will require the fellow to come to hospital in the evening.

However, if this occurs....

......For example, an infected stimulator needs to be explanted and you are in the OR until 0100 and you would therefore not have the requisite 8 hours off between duty shifts where you are physically present in the hospital or actively engaged in patient care the following steps should be taken

1. Discuss with your CPS attending
2. Email PD and Renetta Johnson
3. Appropriate coverage will be provided to allow for 8hrs off between duty shifts either by assignment of another fellow to CPS or solo coverage by the Attending
Any change in the CPS call schedule must be formally requested by email to PD and Renetta Johnson and approved.

If switches are to be made, they are to be for the full 7 or 8 day assignment partial requests will not be accepted.

The CPS fellow will start each clinical day at 0700 with morning didactic session and then proceed to their CPS duties thereafter.

On weekdays rounds with your Attending will typically commence around 1300, your staff will have an outpatient clinic for the morning session.

On weekends rounding will begin at a time decided by the attending on call. Your attending will also be covering the Acute Pain Service on holidays and weekends, this service is covered by the Anesthesia Residents.

**CPS Responsibilities**

- Consulting on various inpatient services
- Rounding on the service, including both pre rounding independently in the AM and rounding with attending in the afternoon
- Fielding after hours calls from clinic patients
- Participating and coordinating CPS procedures ie blocks, epidural blood patches etc
- Occasionally fellows will be pulled back to clinic
Weekly sign outs are to be completed prior to didactics at 0700 on Monday or Tuesday morning (long weekend). Verbal sign outs are required.

Fellows and Attendings are required to be with 30 minutes of the hospital at all time during your CPS week!

**I-PASS**

- **I** = Illness Severity: one word summary of patient acuity
- **P** = Patient Summary: brief summary of the patient’s diagnoses and treatment plan
- **A** = Action List: to-do items to be completed by the clinician receiving sign out
- **S** = Situation Awareness and contingency plans: directions to follow in case of changes in the patient’s status often in an “if – then” format
- **S** = Synthesis by the receiver: an opportunity for the receiver to ask questions and confirm the plan of care
Allows for
- Interactive communication
- Dissemination of up to date and accurate information
- Ensure limited interruptions
- A process for verification
- An opportunity to review any relevant historical data

Situation, Background, Assessment and Recommendation: SBAR

- Effective and efficient way to communicate information, method to standardize communication and allows parties to have common expectation related to what is to be communicated and how the communication is structured
  - S = Situation (a concise statement about the problem)
  - B = Background (pertinent and brief information related to the situation)
  - A = Assessment (analysis and considerations of options – what you found or think)
  - R = Recommendation (action requested/recommended – what you want)

The page ID for CPS is 3-OUCH (36824), following weekly sign out, fellows will switch 3-OUCH’s covered by status to the oncoming fellow.

Do not sign out the pager to a telephone number or to another pager number.
CPS Census:

Fellows will be expected to update the CPS census daily, including changes in medications and patient condition in the team census.
How are consults placed?

- Generally a house officer will page the CPS fellow on call via (3-OUCH) regarding an inpatient referral.
- Clarify the specific question being asked
- Name and pager of the person to be contacted regarding inpatient recommendations
- Level of urgency
  - Inpatient consults are to be done promptly or at least within 24hrs.
- For floor nurses calling a chronic pain consult, discuss that a formal consult will need to be placed by the primary team so that a consult may be executed.

Please be courteous, available and approachable.

CPS is often our only interaction with hospital providers.
Please Do Not Curbside Consults.

CPS fellow will review the relevant notes including pain center if applicable, perform an initial evaluation (H&P), and inform the attending of the consult.

A note which will be initially placed in the Team Census, will be transferred to the Online Medical Record or OMR and forwarded to your attending for co-signature.

All notes are to be time, dated and signed legibly with credentials and pager number.

DO NOT CUT AND PASTE

We provide a consultation service only with treatment recommendations. The final orders are written by the primary team.

Except:

1. Ketamine gtt
2. Intrathecal Pumps
3. Epidural Catheter Trials
Patients will be followed daily until discharged from the service by the CPS attending.

Daily SOAP notes will be documented in OMR, this should include any pertinent changes in clinical condition.

Of particular concern:

VAS
Consumption of opioids over a 24 hr period
List of Analgesics

If considering Injection:
Anticoagulation Status
Infection risk? Blood Cx, Neutropenia, Fever curve
Appropriate imaging available?

Inpt procedures can be performed at AWPMC 5 days a week or WPC on Fridays

Notify the clinic 617-278-8008

Primary team must be in agreement, and they should write for NPO orders if needed, arrange transport, hold heparin if needed, and all other necessary orders.

The CPS fellow must examine the pt the morning of the procedure to ensure the pt is ready for the procedure.

The APS resident may also call the CPS fellow for assistance with complicated patients (ie suboxone, methadone etc)

The CPS fellow will often handle opioid tolerant patients with acute peri operative pain even if the consult is initially routed to APS.

CPS fellow is responsible for all consults related to trauma patients in the ED and ICU on nights and weekends including consults for epidural placement for rib fractures.
**Telephone Calls:**

Weekday evening/nights and weekends fellows may receive phone calls from clinic patients. They may require reassurance, an urgent clinic appointment, or immediate ED evaluation.

All telephone conversations must be documented in OMR. If unable to reach, a note should still be entered ie “returned patient phone, patient unavailable voicemail left with instructions to contact clinic”

**Do Not give a specific appointment time.**

If a patient needs to be seen urgently inform the Attending and Resource Nurse in the AM.

If a patient is being referred to ED call the ED physician and inform them.

---

**Blood Patches:**

CPS fellow will be called for presumed PDPH, typically from the ED or Neurology following LP.

**If patient has had an LP for concern of infection/malignancy etc you must have the results!!**

If the patient is “in house” please evaluate the patient and discuss with the CPS Attending for possible blood patch vs conservative management.

If the patient is an outpatient please triage over the phone, referral to the ED can be made if needed. Otherwise patient’s can be seen urgently in the clinic.

---

**Blood Patch on a Weekend?**

Occasionally patient’s with PDPH in the ED or on the floor could have a blood patch done without fluoroscopy. Every case is different, and this should be discussed with your attending.

In the large majority of cases EBP is done in the clinic under fluoroscopic guidance to minimize risk of inadvertent dural puncture.
Intrathecal Pumps:

IT pumps must be interrogated before and after surgical procedure or MRI studies. Please notify your attending in any of these situations for assistance.

Any IT pump change requires the presence of two clinicians (ie Attending and Fellow) and their signatures.

There are two programmers, one in the West Campus Clinical Center Fishbowl Rosenberg 5 and one in the Pain Clinic.

Palliative Care Conference:

A multi disciplinary palliative care conference is held on the 4th Tuesday of the month. This conference runs from Aug to June of the academic year.

If you are the CPS fellow during the 4th Tuesday of the month you will be expected to prepare a Journal Club or Topic for Review in conjunction with Dr. Aner.

Moonlighting??

Fellows:

Critical Care, Pain Medicine and Adult Cardiothoracic Anesthesia Fellows are not permitted to moonlight per their respective fellowship Program Directors.

NMC anesthesia trainees: we are not permitted to moonlight at external institutions during their employment as a tenure in the Department of Anesthesia, Critical Care and Pain Medicine.

In the event that a trainee moonlights at an outside institution they may be subject to dismissal from the training program.
Beth Israel Deaconess Medical Center
Department of Anesthesia, Critical Care, and Pain Medicine

PhD Rotation

Dr. Josh Wootton and Dr. Josh Smith, Suite 406

- Develop an understanding of the flow of a psychiatric interview, including the following sections:
  - A full psychiatric assessment
    - Presenting patient complaint
    - History of presenting pain complaint
    - Current level of functioning
    - Presenting medical conditions
    - Psychiatric History
    - Substance Abuse History
    - Medical History
    - Developmental and social history

- A mental status examination – formal, informal, and/or psychiatric
- A dynamic formulation of the patient's situation, identifying pertinent psychosocial risk factors
  - Review and discussion – with the patient, where appropriate, of psychometric testing results
- A multidisciplinary treatment plan with appropriate recommendations to the primary pain physician
  - Review with the patient of the patient's questions and self-reported goals for treatment
- Develop knowledge of and confidence toward the psychosocial risk factors, affecting treatment
- Demonstrate mastery of the psychology curriculum
- Proactively fulfill written and in-person requests on a minimal of five patient interviews for the Dell in Medical Record (DMR), co-signed by the pain psychologist

Beth Israel Deaconess Medical Center
Department of Anesthesia, Critical Care, and Pain Medicine
Rotation: Physical Medicine and Rehabilitation

Dr. Anthony Lee BIDMC

- Gain an understanding of the broad history of various musculoskeletal pain disorders and be able to appropriately integrate therapeutic modalities.
- Learn the techniques of a musculoskeletal exam.
- Understand the anatomy and function as it applies to diagnosing acute and chronic pain problems.
- Develop a comprehensive musculoskeletal and appropriate interventional spine and evaluation.
- Develop a comprehensive spine evaluation and chronic pain.
- Evaluate patient pain with quick-box and response at the musculoskeletal and comprehensive movement of 15 joints.
- Develop a multimodal comprehensive approach to include assessment of acute and chronic disability, strength, coordination, and agility for prehabilitation and return to play.
- Develop a comprehensive functional evaluation and rehabilitation plan.
- Develop an understanding of the treatment algorithm.
Beth Israel Deaconess Medical Center
Department of Anesthesia, Critical Care, and Pain Medicine

Rotation: Headache Center
Dr. Sait Ashina BIDMC Headache Center Suite 406

- Learn diagnostic criteria for the most common types of headaches, as well as some more unusual varieties.
- Review a basic neurologic examination, and discuss differentials, indications for imaging and other work-ups and treatment options.
- Decide on best treatment options through discussions of medications and integrative therapies.

Beth Israel Deaconess Medical Center
Department of Anesthesia, Critical Care, and Pain Medicine

Rotation: Pediatric Pain – Boston Children’s Hospital

- Know the recommended guidelines for acute and chronic pain management in the pediatric population.
- Understand the necessity and understanding of the common diagnostic tests and imaging studies used in the evaluation and treatment setting for patients with pain.
- Evaluate the patient for each study ordered and interpret the results in the context of the specific patient.
- Generate a differential diagnosis for a child with acute or chronic pain.
- Demonstrate a commitment to acquiring the basic knowledge needed for the care of children with acute and chronic pain.
- Cognizance of a comprehensive pediatric medical history and physical exam while addressing a complete pain history including Patient’s medical diagnosis, goals of care, psychosocial

Beth Israel Deaconess Medical Center
Department of Anesthesia, Critical Care, and Pain Medicine

Rotation: Palliative Care

- Learn epidemiology, natural history, and treatment options for patients of all ages with common chronic, serious, and life-threatening conditions.
- Perform age-appropriate comprehensive assessments including physical, psychosocial, functional, social, psychological, and spiritual domains using data gathered from history, examination, appropriate laboratory studies, and assessment of suffering and quality of life.
- Understand common co-morbidities and complications in patients with life-threatening illness.
- Understand management team: palliative co-morbidities in patients with life threatening illness.
- Overcome discomfort of being present in the room of an actively dying patient and their family.
- Anticipate common questions from family members.
- Identify physical signs of impending death (respiratory patterns, cardiac output)
- Manage common symptoms: sedatives, delirium, psychosocial/hypoesthesia.
- Address emotional and spiritual concerns of family members (not “other patient”).
New Innovations

Procedure and Case Logs

Fellows must keep their procedure logs current, and it is your responsibility to ensure that your logs are completed in a timely manner.

Your progress is monitored on a quarterly basis.

*If logs are not up to date, you will be required to take a vacation day and be assigned to the Anesthesia Education Office to complete your logs under supervision.*

If logs are not complete by the end of the Academic Year, you will be allowed to walk during graduation however your diploma will be withheld.

DEMONSTRATION
EVALUATIONS...

All fellows are evaluated based on the:

The Pain Medicine Milestone Project

A joint initiative of:
The Accreditation Council for Graduate Medical Education
The American Board of Anesthesiology
The American Board of Physical Medicine and Rehabilitation
The American Board of Psychiatry and Neurology

Level 3: The fellow demonstrates milestones expected of an incoming fellow.

Level 4: The fellow is mastering and demonstrating additional milestones, but is not yet performing at a mid-fellowship level.

Level 5: The fellow continues to advance and demonstrate additional milestones, consistently meeting the majority of milestones expected for fellowship.

Level 6: The fellow has achieved as much as is relevant and demonstrates the milestones targeted for fellowship. This level is designated as the graduate level.

Patient Case – Gather and Synthesize Essential and Essential to Define Key Patient’s Clinical Problem(s).

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Level 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to effectively elicit patient’s medical history</td>
<td>Able to effectively elicit patient’s medical history and provide basic interpretation</td>
<td>Able to effectively elicit patient’s medical history and provide detailed interpretation</td>
<td>Able to effectively elicit patient’s medical history and provide comprehensive interpretation</td>
<td>Able to effectively elicit patient’s medical history and provide detailed interpretation</td>
<td>Able to effectively elicit patient’s medical history and provide comprehensive interpretation</td>
</tr>
<tr>
<td>Able to effectively perform focused physical examination</td>
<td>Able to effectively perform focused physical examination and interpret findings</td>
<td>Able to effectively perform focused physical examination and interpret findings and provide differential diagnosis</td>
<td>Able to effectively perform focused physical examination, interpret findings, and provide comprehensive differential diagnosis</td>
<td>Able to effectively perform focused physical examination, interpret findings, and provide detailed differential diagnosis</td>
<td>Able to effectively perform focused physical examination, interpret findings, and provide comprehensive differential diagnosis</td>
</tr>
<tr>
<td>Able to generate an initial differential diagnosis</td>
<td>Able to generate an initial differential diagnosis and provide basic interpretation</td>
<td>Able to generate an initial differential diagnosis and provide detailed interpretation</td>
<td>Able to generate an initial differential diagnosis and provide comprehensive interpretation</td>
<td>Able to generate an initial differential diagnosis and provide detailed interpretation</td>
<td>Able to generate an initial differential diagnosis and provide comprehensive interpretation</td>
</tr>
<tr>
<td>Able to synthesize and organize data to define the patient’s clinical problem</td>
<td>Able to synthesize and organize data to define the patient’s clinical problem and provide basic interpretation</td>
<td>Able to synthesize and organize data to define the patient’s clinical problem and provide detailed interpretation</td>
<td>Able to synthesize and organize data to define the patient’s clinical problem and provide comprehensive interpretation</td>
<td>Able to synthesize and organize data to define the patient’s clinical problem and provide detailed interpretation</td>
<td>Able to synthesize and organize data to define the patient’s clinical problem and provide comprehensive interpretation</td>
</tr>
</tbody>
</table>

Comments: [ ] [ ] [ ] [ ] [ ] [ ]
### Patient Care - Gather and Synthesize Relevant and Appropriate Information to Define Each Patient’s Clinical Problems

<table>
<thead>
<tr>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 10/24/2018 | - Perform an initial comprehensive head-to-toe exam to gather baseline information.  
  - Identify and prioritize potential clinical problems based on the patient's presentation.  
  - Develop a differential diagnosis list for each potential problem.  
  - Utilize appropriate laboratory and diagnostic tests to confirm or rule out each diagnosis.  
  - Collaborate with other healthcare professionals as needed. |

**Key Points:**
- Accurately identify and triage the patient's chief complaint.  
- Collaborate with other healthcare team members to ensure comprehensive patient care.  
- Prioritize patient care based on the acuity and severity of the patient's condition.  
- Communicate effectively with patients and families to ensure they understand their care plan.  
- Continuously reassess the patient's condition and adjust care plans as necessary.
### Patient Care: Recognition and Integration of Diagnostic and Therapeutic Interventions

<table>
<thead>
<tr>
<th>Category</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patient’s needs</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Communicate effectively with patients</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Collaborate with other healthcare providers</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Manage patient’s medications</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

### Patient Care: Requests and Provide Consultative Care

<table>
<thead>
<tr>
<th>Category</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patient’s needs</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Communicate effectively with patients</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Collaborate with other healthcare providers</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Manage patient’s medications</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

### Material Knowledge: Knowledge of Clinical Knowledge

<table>
<thead>
<tr>
<th>Category</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patient’s needs</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Communicate effectively with patients</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Collaborate with other healthcare providers</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Manage patient’s medications</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
### Systems-based Practice - Recognize System-based Error and Advocates for Systems Improvement

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Does not recognize the potential for system-based errors or feedback about decisions that may harm patient or other healthcare team members.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Recognizes potential for error within the system but does not identify specific errors or advocate for systems improvements.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Identifies specific system-Based errors and advocate for systems improvement.</td>
</tr>
</tbody>
</table>

### Systems-based Practice - Identifies Forces That Impact the Cost of Health Care and Advocates for Cost-effective Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Does not consider cost effects in the provision of care.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Recognizes the impact of cost-effective care and takes actions to reduce cost.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Identifies specific forces that impact the cost of health care and advocates for cost-effective care.</td>
</tr>
</tbody>
</table>

### Systems-based Practice - Transitions Patients (Adults) Within and Across Health Care Settings

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Does not understand or communicate at level of facilitator.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Understands the need to support the needs of ongoing clinical systems.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Identifies and develops effective strategies for transitions of care.</td>
</tr>
</tbody>
</table>

### Systems-based Practice - Identifies Forces That Impact the Cost of Health Care and Advocates for Cost-effective Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Does not consider cost effects in the provision of care.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Recognizes the impact of cost-effective care and takes actions to reduce cost.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Identifies specific forces that impact the cost of health care and advocates for cost-effective care.</td>
</tr>
</tbody>
</table>

### Systems-based Practice - Transitions Patients (Adults) Within and Across Health Care Settings

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Does not understand or communicate at level of facilitator.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Understands the need to support the needs of ongoing clinical systems.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Identifies and develops effective strategies for transitions of care.</td>
</tr>
</tbody>
</table>

Comments: Not yet achieved (check box)
### Practice-Based Learning and Improvement - Altimore Practice with a Line for Improvement

<table>
<thead>
<tr>
<th>Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Practice Based Learning and Improvement - Learn and Improve at the Point of Care

<table>
<thead>
<tr>
<th>Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

1. Identify and report a problem, error, or safety risk.
2. Participate in self-assessment and improvement.
4. Engage in quality improvement activities.

**Community:** Not yet achieved level 3.

### Professionalism - Interpersonal and Communication Skills

<table>
<thead>
<tr>
<th>Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

1. Demonstrates best communication and collaboration through active listening and questioning.
2. Communicates effectively, clearly, and accurately.
3. Cultivates, demonstrates, and maintains a patient-centered approach.
4. Communicates effectively with patients and their families.

**Community:** Not yet achieved level 3.

### Professionalism - Autonomy, Accountability, and Responsibility

<table>
<thead>
<tr>
<th>Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

1. Demonstrates the ability to make independent decisions.
2. Accepts accountability for own actions.
3. Demonstrates a commitment to improving practice.
4. Demonstrates commitment to the improvement of patient safety.

**Community:** Not yet achieved level 3.
### Professionalism - Responds to each Patient's Unique Characteristics and Needs

<table>
<thead>
<tr>
<th>Level</th>
<th>Not met</th>
<th>Partially met</th>
<th>Met</th>
<th>Not met</th>
<th>Partially met</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Comments: Not yet assessed (10/24/2018)

---

### Professionalism - Exhibits Integrity and Ethical Behavior in Professional Conduct

<table>
<thead>
<tr>
<th>Level</th>
<th>Not met</th>
<th>Partially met</th>
<th>Met</th>
<th>Not met</th>
<th>Partially met</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Comments: Not yet assessed (10/24/2018)

---

### Interpersonal and Communication Skills - Communicates Effectively with Patients and Caregivers

<table>
<thead>
<tr>
<th>Level</th>
<th>Not met</th>
<th>Partially met</th>
<th>Met</th>
<th>Not met</th>
<th>Partially met</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Comments: Not yet assessed (10/24/2018)
Please answer the following questions as they pertain to each of the seven Pain Medicine Fellows. Written comments are always appreciated. Each Pain Fellow is listed on a separate page. Thank you.

1. How well does the Fellow respond to requests from the admin staff when questions arise concerning patient scheduling, prior authorizations, dictations and/or billing?

2. What percentage of the time are the Fellow’s OMR Records and referring physician letters completed in a timely fashion?

3. Please rate how well the fellow adheres with the clinic’s cell phone usage and patient confidentiality policies while working in the clinic.

4. How courteous is the Pain Fellow to the administrative and front desk staff?
Respect for professional knowledge and skills of co-workers

Clarity of written orders and records

Compassion to patients and their families

Returning patient phone calls, addressing self requests and answering pages in a timely fashion

Maintaining confidentiality of patients

Accepting responsibility for professional actions

Respecting a patient's culture, gender, disability, sexual orientation, age and religion

As part of our ongoing effort to improve the care delivered at the Arnold Pain Management Center, we want to ask your honest opinion about the doctor you saw today. The doctor is currently a Pain Medicine Fellow in our practice, and we routinely seek feedback from patients about how our fellows are doing.

Evaluation Process:

Fellows will have formal evaluation/feedback meetings with PD and Associate PD at 3 and 6 months followed by a final exit interview.

Fellows are evaluated by the faculty on a quarterly basis, globally bimannually and by patients over a four week period biannually.

Fellows are required to complete rotation evaluation at the conclusion of each rotation. Email with link to evaluation will be sent via New Innovations.

Fellows will evaluate both the program and the faculty anonymously in the Spring, 100% compliance is expected.
Fellows will formally evaluate the program in March-April of the academic year and the faculty shortly after that.

All program and faculty evaluation are 100% confidential. Absolutely no efforts are made to identify who has completed a particular evaluation, results are used in amalgam to continue to improve the educational content and resources of the fellowship program.

Evaluations can be accessed at anytime by request to Susan Kilbride. Formal review of evaluation will occur at 6 month intervals or sooner if needed.

MOONLIGHTING??

**External Moonlighting**

EDOC anesthesiologists are not permitted to moonlight at external institutions during their employment as a trainee in the Department of Anesthesia, Critical Care and Pain Medicine.

In the event that a trainee moonlights at an outside institution they may be subject to dismissal from their training program.

**Internal Moonlighting**

POT3/CA3 residents are eligible to moonlight in the operating rooms and procedural areas at BIDMC on the weekends, subject to approval by the Program Director and the Director of the Clinical Competency Committee.

Follows: Critical Care, Pain Medicine and Adult Cardiac Anesthesia Fellows are not permitted to moonlight per their respective Fellowship Program Directors.
Conferences:

Attendance will be generally limited to no more than 2 major meetings per year (e.g. APSA, APS, ASSP, ASA, IAS, NAASC, SWASS, SCA, SACC, or ASRA). Exceptions will be made on an individual basis for those with a role in a meeting (e.g. convention registrar, site chair, etc.). Exceptions may also be granted for those presenting original research not already presented at another meeting.

In order for any research paper presented in a congress, the abstract must be submitted to the annual meeting for publication as well as participate in either of the following local presentation opportunities: NEAIR, Harvard Anesthesia Night, ISMAR, scientific research day and the Sherman Lecture.

In order to qualify for travel reimbursement, presenters/case reports must also be submitted as a letter or case report to an appropriate journal (e.g., Anesthesiology, Anesthesia Care Reports, Journal of Cardiovascular and Thoracic Anesthesiology, etc.). A letter must be written on hospital letterhead, but sufficient effort should be put into the manuscript to make acceptance a possibility.

The general departmental policy for meeting days is the presentation day plus one travel day on either side. If your plans exceed this, and you are approved for the time off, you can pay the difference from your educational fund.

The department will pay for meeting registration, hotel, meals, and transportation to/from airport, with copies of receipts must be submitted. Workshop and other extra fees may be paid for from your educational fund. As reminder you must submit your reimbursement to the Business office within thirty (30) days of your meeting attendance.

International Conferences: Trainees wishing to attend a scientific conference outside of the United States must have approval of the fellowship program director and identify a faculty mentor prior to abstract submission.

1. Trainees wishing to submit an abstract at meetings outside of the United States may use their existing educational funds to defray expenses. Departmental support is not available for International meetings.

EMAIL, WIFI ETC...
1. To add Exchange account to your iPhone or iPod touch, go to Settings. Tap Mail, Add Account. Tap Add Account. Tap Microsoft Exchange. Now, you can configure the Exchange account on your device.

2. On Exchange setup, enter the following information:
   - Email address: yourname@yourdomain.com
   - Name: Your Name
   - Password: Type your password
   - Description: Any other details you like.

3. Your iPhone or iPod touch will now try to locate your Exchange server using Microsoft Autodiscover service. If the server cannot be located, the screen below is shown. Enter your Exchange server's complete address (mail.ename.cgiurl.com) in the Server field.

   After successfully adding a connection to the Exchange server, you must set a device password to protect your phone incase you lose it/steal it.
A Note about Android Devices:

BIDMC has found it far easier to encrypt Apple products than Google Android products. Google’s Android operating system is implemented differently by each smartphone vendor. For example, some manufacturers have chosen not to offer media card encryption even though it is a function that the Android operating system supports. If part of the device cannot be encrypted then the device does not meet HIPAA “safe harbor” requirements if it is lost or stolen. If there was a theft or loss, BIDMC would be required to report a HIPAA breach, which is a serious and expensive process. From what we have seen thus far, some Android devices cannot meet Federal and State security standards and therefore cannot be used to access the BIDMC network for email or any other activity.