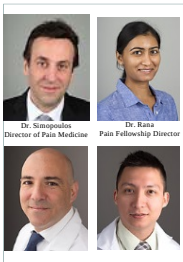
Pain Medicine Fellowship Orientation

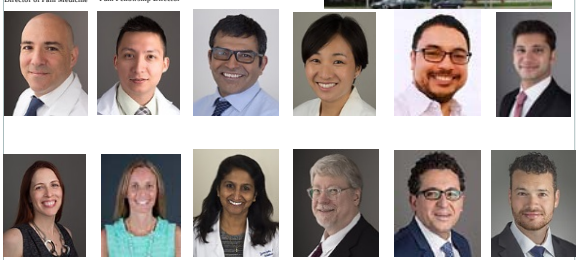
JULY 2018

Beth Israel Deaconess Medical Center

KEEP CALM AND WELCOME TO THE TEAM

Beth Israel Deaconess Medical Center





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

Accreditation Council for Graduate Medical Education

THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.

Patient Care and Procedural Skills

Neurology

eliciting a directed neurological history; (Outcome)

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

Neuroimaging

identifying significant findings of basic neuro-imaging. (Outcome)

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

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

Physical Medicine and Rehabilitation

must demonstrate the following competencies in physical medicine and rehabilitation: (Outcome)

performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain problems; (Outcome)

Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of 15 patients. (Core)

developing rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; and, (Outcome)

Fellows must demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of five patients. (Core)

integrating therapeutic modalities and surgical intervention in the treatment algorithm. (Outcome)

Psychiatry

carrying out a complete psychiatric history with special attention to psychiatric and pain comorbidities; (Outcome)

conducting a complete mental status examination; and, (Outcome)

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

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

explaining psychosocial therapy to a patient and making a referral when indicated. (Outcome)

Medical Knowledge

anatomy, physiology and pharmacology of pain transmission and modulation; (Outcome)

natural history of various musculoskeletal pain disorders; (Outcome)

general principles of pain evaluation and management including neurological exam, musculoskeletal exam, psychological assessment; (Outcome)

indicators and interpretation of electro-diagnostic studies: X-Rays, MRI, CT, and clinical nerve function studies; (Outcome)

pain measurement in humans, both experimental and clinical; (Outcome)

psychosocial aspects of pain, including cultural and cross-cultural considerations; (Outcome)

taxonomy of pain syndromes; (Outcome)

pain of spinal origin, including radicular pain, zygapophysial joint disease, and discogenic pain; (Outcome)

myofascial pain; (Outcome)

neuropathic pain; (Outcome)

headache and orofacial pain; (Outcome)

rheumatological aspects of pain; (Outcome)

complex regional pain syndromes; (Outcome)

visceral pain; (Outcome)

urogenital pain; (Outcome)

cancer pain, including palliative and hospice care; (Outcome)

acute pain; (Outcome)

frequent psychiatric and pain co-morbidities, which include substance-related mood, anxiety, somatoform, factitious, and personality disorders; (Outcome)

the effects of pain medications on mental status; (Outcome)

assessment of pain in special populations, including patients with ongoing substance abuse, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired; and, (Outcome)

functional and disability assessment. (Outcome)

Treatment of Pain

Drug Treatment I: opioids; (Outcome)

Drug Treatment II: antipyretic analgesics; (Outcome)

Drug Treatment III: antidepressants, anticonvulsants, and miscellaneous drugs; (Outcome)

psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy,

psychosocial therapies and treatment of psychiatric illness; (Outcome)

prescription drug detoxification concepts; (Outcome)

functional and vocational rehabilitation; (Outcome)

surgical approaches; (Outcome)

complementary and alternative treatments in pain management; (Outcome)

treatments that comprise multidisciplinary cancer pain care; (Outcome)

strategies to integrate pain management into the treatment model; (Outcome)

hospice and multidimensional treatments that comprise palliative care; and, (Outcome)

treatment of pain in pediatric patients. (Outcome)

General topics, research, and ethics

epidemiology of pain; (Outcome)

gender issues in pain; (Outcome)

placebo response; (Outcome)

multidisciplinary pain medicine; (Outcome)

organization and management of a pain center; (Outcome)

Continuing Quality Improvement, Utilization Review, and Program Evaluation; (Outcome)

patient and provider safety; (Outcome)

designing, reporting, and interpreting clinical trials of treatment for pain; (Outcome)

ethical standards in pain management and research; and, (Outcome)

animal models of pain, ethics of animal experimentation. (Outcome)

Interventional Pain Treatment

selection criteria for a broad range of interventions and an understanding of the risks and potential advantages of these interventions; (Outcome)

airway management skills; (Outcome)

sedation/analgesia; (Outcome)

fluoroscopic imaging and radiation safety; (Outcome)

pharmacology of local anesthetics and other injectable medications, including radiographic contrast agents and steroid preparations; (Outcome)

This must include treatment of local anesthetic systemic toxicity. (Outcome)

trigger point injections; (Outcome)

peripheral and cranial nerve blocks and ablation; (Outcome)

spinal injections including epidural injections: interlaminar, transforaminal, nerve root sheath injections, and zygapophysial joint injections; (Outcome)

discography and intradiscal/percutaneous disc treatments; (Outcome)

joint and bursal injections, including sacroiliac, hip, knee, and shoulder joint injections; (Outcome)

sympathetic ganglion blocks; (Outcome)

epidural and intrathecal medication management; (Outcome)

spinal cord stimulation; and, (Outcome)

intrathecal drug administration systems. (Outcome)

Practice Based Learning and Improvement

identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

set learning and improvement goals; (Outcome)

identify and perform appropriate learning activities; (Outcome)

systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)

incorporate formative evaluation feedback into daily practice; (Outcome)

locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (Outcome)

use information technology to optimize learning; and, (Outcome)

participate in the education of patients, families, students, fellows and other health professionals. (Outcome)

Interpersonal and Communication Skills

communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)

communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

work effectively as a member or leader of a health care team or other professional group; (Outcome)

act in a consultative role to other physicians and health professionals; and, (Outcome)

maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

Professionalism

compassion, integrity, and respect for others; (Outcome)

responsiveness to patient needs that supersedes self-interest; (Outcome)

respect for patient privacy and autonomy; (Outcome)

accountability to patients, society and the profession; and, (Outcome)

sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

Systems Based Practice

work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

advocate for quality patient care and optimal patient care systems; (Outcome)

work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)

participate in identifying system errors and implementing potential systems solutions. (Outcome)

3. **Practice Based Learning and Improvement** that involves investigation and evaluation of their 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.

IV.A.5.a).(1).(a).(ii) performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in **fifteen patients**; and, (Outcome)

IV.A.5.a).(1).(a).(ii).(a) Faculty members must verify this experience in a minimum of **five observed patient examinations.** (Core)

IV.A.5.a).(1).(a).(iii).(a) Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computerized tomography (CT) of the spine and brain on a minimum of **15 CT and/or MRI studies**. (Core)

IV.A.5.a).(1).(b).(i).(a) Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of **15 patients**. (Core)

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

IV.A.5.a).(1).(c).(ii).(a) A complete mental status examination must be conducted on a minimum **of 15 patients.** (Core)

IV.A.5.a).(1).(c).(ii).(b) Each fellow must demonstrate this ability in **five patients** to a faculty observer. (Core)

IV.A.5.a).(2).(a).(i).(a) Intravenous access must be obtained in a **minimum of 15 patients** (Core)

IV.A.5.a).(2).(a).(ii).(a) This must include a **minimum of mask ventilation in 15 patients**; (Core)

IV.A.5.a).(2).(a).(iii).(a) Endotracheal intubation **must be performed on 15 patients**. (Core)

IV.A.5.a).(2).(a).(v).(a) This must include direct administration of sedation to **a minimum of 15 patients**. (Core)

IV.A.5.a).(2).(a).(vi).(a) A minimum of **15 thoracic or lumbar epidural injections using an interlaminar technique must be completed.** (Core)

IV.A.6.b).(1).(a) Continuity experience 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 model of chronic pain management. To this end, **the pain medicine fellow should attend a supervised outpatient clinic, approximately weekly, throughout the year of the program**. Fellows may be absent from continuity clinic experience only if the rotation site is more than one hour from the core institution. The maximum allowable time away may be no more than four months. **This will provide a minimum of eight months experience (full-time equivalent of at least 60 half-days).** (Detail)

IV.A.6.b).(1).(b) **Primary responsibility for 50 different patients followed over at least two months each should be documented. (Detail)**

IV.A.6.b).(2).(a) Inpatient chronic pain experience should be supervised on a pain team responsible for the assessment and management of inpatients with chronic pain including cancer pain. Patients should be seen through either a consultation team or while on a designated inpatient pain medicine service. (Detail)

IV.A.6.b).(2).(b) **To establish this experience, the fellow should document involvement with a minimum of 15 new patients assessed in this setting**. (Detail)

IV.A.6.b).(3).(a) Acute pain inpatient experience should be supervised in the assessment and management of inpatients with acute pain. (Detail)

IV.A.6.b).(3).(b) **To establish this experience, the fellow should document involvement with a minimum of 50 new patients**. (Detail)

IV.A.6.b).(4).(b) 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.6.b).(4).(b).(i) at least 25 image-guided spinal intervention; (Detail)

IV.A.6.b).(4).(b).(ii) at least 10 trigger point injection; (Detail)

IV.A.6.b).(4).(b).(iii) at least 10 neuroablative procedures; (Detail)

IV.A.6.b).(4).(b).(iv) at least five joint and bursa injections; (Detail)

IV.A.6.b).(4).(b).(v) at least five neuromodulation; and, (Detail)

IV.A.6.b).(4).(b).(vi) at least five nerve blocks, including a variety of blocks such as intercostal blocks, ilioinguinal blocks, genitofemoral blocks, and lateral femoral cutaneous blocks. (Detail)

IV.A.6.b).(5).(a) Cancer pain 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 or inpatient experiences. The objectives should include: (Detail)

IV.A.6.b).(5).(a).(i) **The fellow must document longitudinal involvement with a minimum of 20 patients. (Detail)**

IV.A.6.b).(6) Palliative Care Experience; and, (Core)

IV.A.6.b).(6).(a) Palliative care should be a supervised longitudinal experience in an ambulatory or inpatient population that requires palliative care. It may be integrated with continuity experience or inpatient experience. (Detail)

IV.A.6.b).(6).(b) **To establish this experience, the fellow must document longitudinal involvement with a minimum of 10 patients who require palliative care.** (Core)

http://www.theaba.org/Exams/Pain-Medicine-Certification/Pain-Medicine-Certification _ Content Outline

PAIN MEDICINE EXAMINATION

CONTENT OUTLINE

SUBSPECIALTY CERTIFICATION

Policy Book

At the time of initial subspecialty certification by the ABA, the candidate must:

A. Be a diplomate of the ABA.

B. Fulfill the licensure requirement for certification as follows: Hold an unexpired license to practice medicine or osteopathy in at least one state or jurisdiction of the United States or province of Canada that is permanent, unconditional and unrestricted. Further, every United States and Canadian medical license the registrant holds must be free of restrictions.

ABA diplomates have the affirmative obligation to advise the ABA of any and all restrictions placed on any of their medical licenses, and to provide the ABA with complete information concerning such restrictions within 60 days after their imposition or notice, **whichever first occurs**. Such information shall include, but not be limited to, the identity of the State Medical Board imposing the restriction as well as the restriction's duration, basis, and specific terms and conditions. Candidates and diplomates discovered **not** to have made disclosure may be subject to sanctions on their candidate or diplomate status.

C. Have fulfilled the subspecialty training requirement as defined by the ABA.

D. Have satisfied the subspecialty examination requirement as defined by ABA.

E. Have a professional standing satisfactory to the ABA (see Section 4.06).

F. Be capable of performing independently the entire scope of subspecialty practice without accommodation or with reasonable accommodation.

G. For initial subspecialty certification, diplomates must be meeting the ABA's Maintenance of Certification in Anesthesiology Program® (MOCA®) requirements. (Please see the MOCA Policy Book.)

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

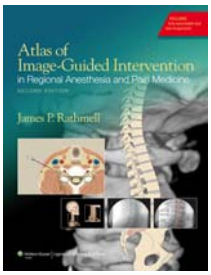
CDI Access
http://www.mycdi.com/massachusetts/

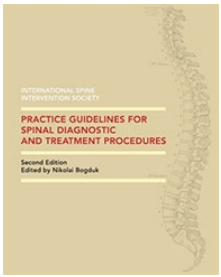
Longwood MRI
http://www.longwoodmri.com/

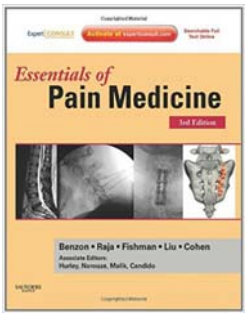
Get a Harvard ID!

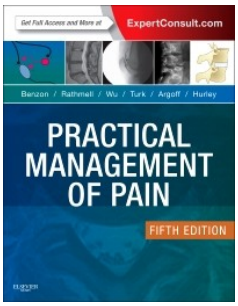
http://www.campusservicecenter.harvard.edu/services/id-cards/locations

- Countway Library
  - Furman, Atlas of Imaged Guided Pain Procedures
  - Jacobson, Fundamentals of MSK U/S
  - Narouze, Atlas of USG procedures in Interventional Pain Management









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 30days 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 WvKtZLn7.

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 80 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
- Thinking laterally and being innovative
- Assessing risk and/or anticipating consequences
- Maintaining interest in outcome
- Controlling mood and avoiding inappropriate behavior

More specifically, signs of fatigue include:

- Involuntary nodding off
- Waves of sleepiness
- Problems focusing
- Lethargy
- Irritability
- Mood lability
- Poor coordination
- Difficulty with short-term recall
- Tardiness or absences at work

High risk times for fatigue-related symptoms are:

- Midnight to 6:00 AM
- Early hours of day shifts
- First night shift or call night after a break
- Change of service
- First 2 to 3 hours of a shift or end of shift
- Early in residency 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

AM					
	Pod 1	**Pod 2**	**Pod 3**	**Pod 406**	
Attending	Dr. Aner	Dr. Peeters-Asdourian	Dr. Nagda	Dr. Pettinato/ Cara	
Fellow	Dr. Chaudary	Drs. Barker & Hoang & Martin	Dr. Syed		
Resident	Drs. Tryjankowski & Dr. Urits		Dr. Buell		
MA	Ana	Amanda	Manny	Mary	
Rooms	6/7	2/4	1/3	Suite 406	
PM					
	Pod 1	**Pod 2**	**Pod 3**	**Pod 4**	**Pod 406**
Attending	Dr. Aner	Dr. Peeters-Asdourian	Dr. Nagda	Dr. Rana	Dr. Pettinato/ Cara
Fellow	Dr. Barker	Drs. Hoang & Syed	Dr. Chaudary & Dr. Syed	Dr. Martin	
Resident	Dr. Buell	Dr. Urits		Drs. Tryjankowski	
MA	Manny	Amanda	Amanda	Manny	Mary
Rooms	6/7	1/3	2/4	SR/5	Suite 406

Check out:

9a-11:30a	Tiffany
2p-4p	Nate

Attending	Aner	Gill	Jang	Lee	Mahmood	Moran	Nagda	Peeters-Asdourian	Pettinato	Rana	Simopoulos	Wootton	Yazdi
AM	MEET	Resrch	BIDN	V	SPINE	AWPC	MEET	CHLSA	AWPC	MIL	AWPC	AWPC	Admin
PM	MEET	CPS	BIDN	V	SPINE	AWPC	MEET	CHLSA	AWPC	MIL	ADMIN	AWPC	NC

Fellow/Resident	Barker	Cai	Chaudary	Kinnaird	Hoang	Rubens	Syed	Belanie (CA2)	Vakassi (CA1)	Highfill (CA1)
AM	AWPC	AWPC	CPS	LOA	AWPC	PM&R	PC	ADMIN	APS	AWPC
PM	AWPC	ADMIN	CPS	LOA	AWPC	PM&R	PC	AWPC	APS	AWPC

AM			
	Pod 1	Pod 2	Pod 406
Attending	Dr. Moran	Dr. Simopoulos	Dr. Pettinato
Fellow	Dr. Cai & Dr. Hoang	Dr. Barker	
Resident		Dr. Highfill	
MA	Ana	Manny	Mary
Room	1/3	2/4	Suite 406
PM			
	Pod 1	Pod 406	
Attending	Dr. Moran	Dr. Pettinato	
Fellow	Dr. Barker & Dr. Hoang		
Resident	Dr. Belanie & Dr. Highfill		
MA	Ana	Mary	
Room	2/4	Suite 406	

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

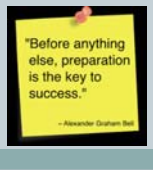
- Off Site Locations
  - MIL – Milton
  - BIDN – Needham
  - Chelsea
  - OR-A – OR Anesthesia
  - LEX – Lexington
- CPS, Vacation, Meeting, outside rotations including BCH, Palliative Care, PM&R, Neuro, Psych will also be noted on the daily schedule

Visit Types:

- Botox (20 min)
- New (40 minutes)
- Procedure Cervical
- Procedure non-fluoroscopy (20 & 40 min)
- Procedure RF (Radiofrequency)
- Procedure with Fluoro & Sedation (30 or 60 min)
- Procedure with Fluoro (30 or 60 min)
- Return (20 & 40 min)
- Special Procedure - includes discography, spinal cord stimulator trial in clinic (User defined time)
- Synvisc (20 min)

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.



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
2. 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 20day 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.Sweeny@childrens.harvard.edu

Administrative Time

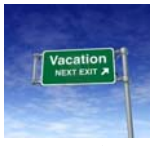
All fellows will receive administrative time to complete documentation and pursue scholarly activity. **You will be expected to be physically present in clinic during that time and maybe asked to take on clinical responsibility if there is a need.**

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 will 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 **CAN NOT** be approved by anyone other than Dr. Rana alternatively I am offsite or unavailable this approval will come from Renetta Johnson.

2.04 ABSENCE FROM TRAINING

The total of any and all absences during a subspecialty fellowship may not exceed the equivalent of 20 working days (four weeks) per year. Attendance at scientific meetings, not to exceed five working days during the year of training, shall be considered part of the training program. 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 two months, the Credentials 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 45mintues to 90 minutes depending on traffic if driving. By public transport around 45min 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 – 530 PM.

You will not reach the airport until 630 – 7 PM.

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

This means that your flight should not take off before **830 PM**.

10. 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 if you have available funds.

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 – 530 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 20 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 appropriated documented in OMR.

Clinic Procedures

- Fellows are expected to remain in the clinic until **5:00PM**
- 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.

BIDMC – Needham

- 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
- Sounding board for any fellowship related issues, which can then be brought to the attention of Dr. Peeters-Asdourian or Dr. Rana, such that appropriate steps can be taken to address the situation.
- Coordinating one Friday lunch round table discussion per month. The chief fellow will be responsible for identifying a date, speaker (co fellow or resident) and approve a topic of discussion. An email will be sent to the Pain Attendings, 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.

- Track and record the number of advanced interventional procedures performed by each fellow on a monthly basis including
  - Spinal Cord Stimulation Phase I
  - Spinal Cord Stimulation Phase II
  - Spinal Cord Stimulator System Explant
  - Kyphoplasty
  - Discography Cervical
  - Discography Lumbar

A report of monthly totals should be emailed to Paragi Rana and Renetta Johnson which will be tracked to ensure equity among trainees.

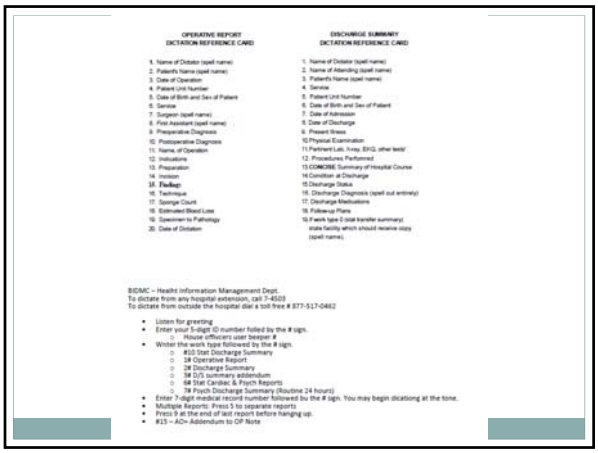
....google doc

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:

Documentation

- "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\Pain1\Fellows Resources\Hospital Policies\Ambulatory Record Completion Policy.doc



OPERATIVE REPORT
DICTATION REFERENCE CARD

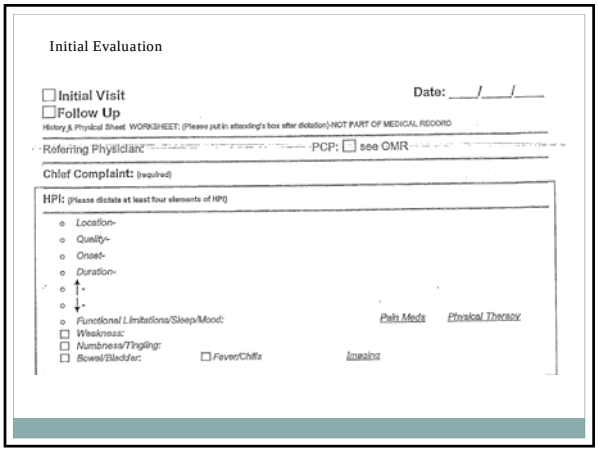
1. Name of Dictator (spell name)
2. Patient's Name (spell name)
3. Date of Operation
4. Patient Unit Number
5. Date of Birth and Sex of Patient
6. Service
7. Surgeon (spell name)
8. First Assistant (spell name)
9. Preoperative Diagnosis
10. Postoperative Diagnosis
11. Name of Operation
12. Indications
13. Preparation
14. Incision
15. Findings
16. Technique
17. Sponge Count
18. Estimated Blood Loss
19. Specimen to Pathology
20. Date of Dictation

DISCHARGE SUMMARY
DICTATION REFERENCE CARD

1. Name of Dictator (spell name)
2. Name of Attending (spell name)
3. Patient's Name (spell name)
4. Service
5. Patient Unit Number
6. Date of Birth and Sex of Patient
7. Date of Admission
8. Date of Discharge
9. Present Illness
10. Physical Examination
11. Pertinent Lab, X-ray, EKG, other tests
12. Procedures Performed
13. CONCISE Summary of Hospital Course
14. Condition at Discharge
15. Discharge Status
16. Discharge Diagnosis (spell out entirely)
17. Discharge Medications
18. Follow-up Plans
19. If work type 2 (dat transfer summary) state facility which should receive copy (spell name).

BIDMC – Health Information Management Dept.
To dictate from any hospital extension, call 7-4503
To dictate from outside the hospital dial a toll free # 877-517-0462

- Listen for greeting
- Enter your 5-digit ID number followed by the # sign.
  - House officers user beeper #
- Enter the work type followed by the # sign.
  - #10 Stat Discharge Summary
  - 1# Operative Report
  - 2# Discharge Summary
  - 3# D/S summary addendum
  - 6# Stat Cardiac & Psych Reports
  - 7# Psych Discharge Summary (Routine 24 hours)
- Enter 7-digit medical record number followed by the # sign. You may begin dictating at the tone.
- Multiple Reports: Press 5 to separate reports
- Press 9 at the end of last report before hanging up.
- #13 – AO= Addendum to OP Note



Initial Evaluation

☐ Initial Visit
☐ Follow Up

Date: ____/____/____

History & Physical Sheet WORKSHEET: (Please put in attending's box after dictation)-NOT PART OF MEDICAL RECORD

Referring Physician: PCP: ☐ see OMR

Chief Complaint: (required)

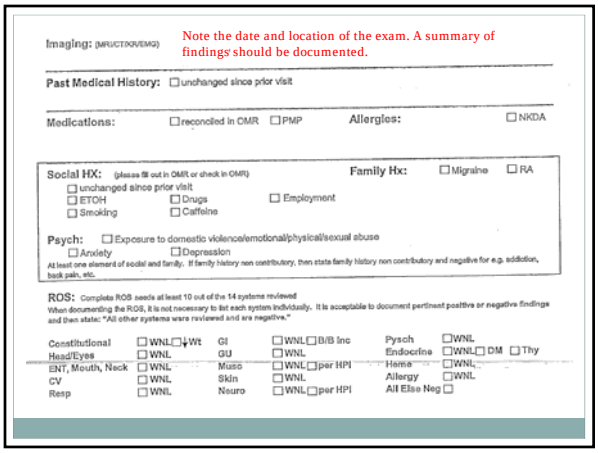
HPI: (Please dictate at least four elements of HPI)

- Location-
- Quality-
- Onset-
- Duration-
- ↑-
- ↓-
- Functional Limitations/Sleep/Mood:

Pain Meds Physical Therapy

☐ Weakness:
☐ Numbness/Tingling:
☐ Bowel/Bladder: ☐ Fever/Chills

Imaging



Imaging: (MRI/CT/XR/EMG)

Note the date and location of the exam. A summary of findings should be documented.

Past Medical History: ☐ unchanged since prior visit

Medications: ☐ reconciled in OMR ☐ PMP Allergies: ☐ NKDA

Social HX: (please fill out in OMR or check in OMR)
☐ unchanged since prior visit
☐ ETOH ☐ Drugs ☐ Employment
☐ Smoking ☐ Caffeine

Family Hx: ☐ Migraine ☐ RA

Psych: ☐ Exposure to domestic violence/emotional/physical/sexual abuse
☐ Anxiety ☐ Depression
At least one element of social and family. If family history non contributory, then state family history non contributory and negative for e.g. addiction, back pain, etc.

ROS: Complete ROS needs at least 10 out of the 14 systems reviewed
When documenting the ROS, it is not necessary to list each system individually. It is acceptable to document pertinent positive or negative findings and then state: "All other systems were reviewed and are negative."

Constitutional	☐ WNL ☐ ↓Wt	GI	☐ WNL ☐ B/B Inc	Psych	☐ WNL
Head/Eyes	☐ WNL	GU	☐ WNL	Endocrine	☐ WNL ☐ DM ☐ Thy
ENT, Mouth, Neck	☐ WNL	Musc	☐ WNL ☐ per HPI	Heme	☐ WNL
CV	☐ WNL	Skin	☐ WNL	Allergy	☐ WNL
Resp	☐ WNL	Neuro	☐ WNL ☐ per HPI	All Else Neg ☐	

PE: Comprehensive examination requires general multisystem exam or complete examination of the affected system. The 1995 guidelines leave the extent of exam upon the judgment of the physician. General Multisystem exam requires documentation of findings of 8 out of the 12 systems. Abnormal findings and relevant negative findings for affected system to be documented. Abnormal findings in the non affected system should be documented. Notation stating normal or negative is sufficient to document negative findings of unaffected system.

Age:	Ht:	Wt:	Temp:	Pain:
HR:	BP:	RR:	O2 sat:	

Constitutional: ☐AAOx3 ☐NAD ☐Obese **Insight & Judgment** ☐WNL
Psychiatric: ☐WNL ☐Anxious ☐Flattened ☐Tearful

Eyes: ☐EOMI ☐Anicteric **ENT/Mouth:** ☐NC/AT ☐MMM
CV: ☐Edema ☐No Cyanosis
Respiratory: ☐Non-labored breathing pattern ☐No resp distress

Skin: ☐Color Change: ☐Allodynia ☐Hyperalgesia

GI: (for abdominal/pelvic pain) ☐NT/ND ☐No Masses ☐Obese Abdomen
GU: (for abdominal/pelvic pain) ☐CVA tenderness ☐Back Tenderness ☐Hernia

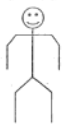
Neurologic: (for spine pain, headache, fibromyalgia and all MSK & Neuro dis)
☐ CN II-XII Intact; Fundus not examined (mostly for headache patients and neurologic d/s)

Strength (for all spine, MSK, Neuro, Fibromyalgia patients)

	Right	Left
Deltoid (C5)	___/5	___/5
Biceps (C5)	___/5	___/5
Wrist Ext (C6)	___/5	___/5
Triceps (C7)	___/5	___/5
Finger flext (C8)	___/5	___/5
Finger Abduction/Interossei (T1)	___/5	___/5
Hip Flex (L2)	___/5	___/5
Knee Ext/Quad (L3)	___/5	___/5
Ankle dorsi/Tib Ant (L4/5)	___/5	___/5
EHL (l%)	___/5	___/5
Gastroc/Plantarflexion (S1)	___/5	___/5

☐ NL Heel Walk ☐ NL Toe Walk

DTRs (for all spine, MSK, Neuro, Fibromyalgia patients)
Biceps (C6), Brachiorad (C6), Triceps (C7), Patella (L4), Achilles (S1)



☐ Babinski downgoing
(perform Babinski for all disc herniation, spinal stenosis)

Sensation: ☐Intact to light touch UE/LE ☐sharp/pinprick ☐Diminished:

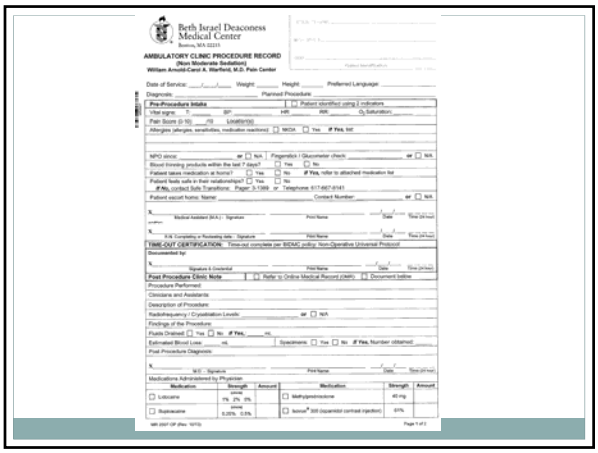
Musculoskeletal: (for all spine, MSK, Neuro, Fibromyalgia patients)
Head (for headache patients) ☐ Temporal TTP ☐GON TTP
Neck ROM: ☐Limited ☐WNL
Pain With: ☐Lat Rotation ☐Flexion ☐Ext ☐Tilt
☐Spurling's ☐Hoffman's ☐Lhermitte's
Trigger points: ☐Traps ☐Rhomboids ☐Paraspinals: Cervical/Thoracic/Lumbar
Back: ROM: Thoracolumbar Flexion ☐WNL ☐Limited ___°
Thoracolumbar Ext ☐WNL ☐Limited ___°
☐SLR L: ___° R: ___°
☐Facet Loading: L / R
☐Paraspinal muscle/facet TTP

SIJ ☐TTP ☐Patrick's ☐Gaenslen's ☐Post Thrust
Hip ☐Pain with manipulation ☐Unstable ☐GTB TTP
Gait ☐WNL ☐Antalgic

Diagnosis:

Treatment Plan: ☐RTC in ___ for ☐F/U ☐Procedure:
Counseling: ☐Weight Loss ☐Tobacco cessation

Attending Note:



Beth Israel Deaconess Medical Center
Boston, MA 02215

AMBULATORY CLINIC PROCEDURE RECORD
(Non Moderate Sedation)
William Arnold-Carol A. Warfield, M.D. Pain Center

Date of Service: ____/____/____ Weight: _____ Height: _____ Preferred Language: _____
Diagnosis: _____ Planned Procedure: _____

Pre-Procedure Intake ☐ Patient identified using 2 indicators

Vital signs: T: _____ BP: _____ HR: _____ RR: _____ O_2 Saturation: _____
Pain Score (0-10): ____ /10 Location(s): _____
Allergies (allergies, sensitivities, medication reactions): ☐ NKDA ☐ Yes **If Yes, list:** _____

NPO since: _____ or ☐ N/A | Fingerstick / Glucometer check: _____ or ☐ N/A
Blood thinning products within the last 7 days? ☐ Yes ☐ No
Patient takes medication at home? ☐ Yes ☐ No **If Yes,** refer to attached medication list
Patient feels safe in their relationships? ☐ Yes ☐ No
If No, contact Safe Transitions: Pager: 5-1369 or Telephone: 617-667-8181
Patient escort home: Name: _____ Contact Number: _____ or ☐ N/A

X_____ _____ _____ ____/____/____ _____
Medical Assistant (M.A.) - Signature Print Name Date Time (24 hour)

X_____ _____ _____ ____/____/____ _____
R.N. Completing or Reviewing data - Signature Print Name Date Time (24 hour)

TIME-OUT CERTIFICATION: Time-out complete per BIDMC policy: Non-Operative Universal Protocol
Documented by:
X_____ _____ _____ ____/____/____ _____
Signature & Credential Print Name Date Time (24 hour)

Post Procedure Clinic Note ☐ Refer to Online Medical Record (OMR) ☐ Document below

Procedure Performed:
Clinicians and Assistants:
Description of Procedure:
Radiofrequency / Cryoablation Levels: _____ or ☐ N/A
Findings of the Procedure:
Fluids Drained: ☐ Yes ☐ No **If Yes,** _____ mL
Estimated Blood Loss: _____ mL Specimens: ☐ Yes ☐ No **If Yes,** Number obtained: _____
Post-Procedure Diagnosis:

X_____ _____ _____ ____/____/____ _____
M.D. - Signature Print Name Date Time (24 hour)

Medications Administered by Physician

Medication	Strength	Amount	Medication	Strength	Amount
☐ Lidocaine	1% 2% 5%		☐ Methylprednisolone	40 mg	
☐ Bupivacaine	0.25% 0.5%		☐ Isovue® 300 (iopamidol contrast injection)	61%	

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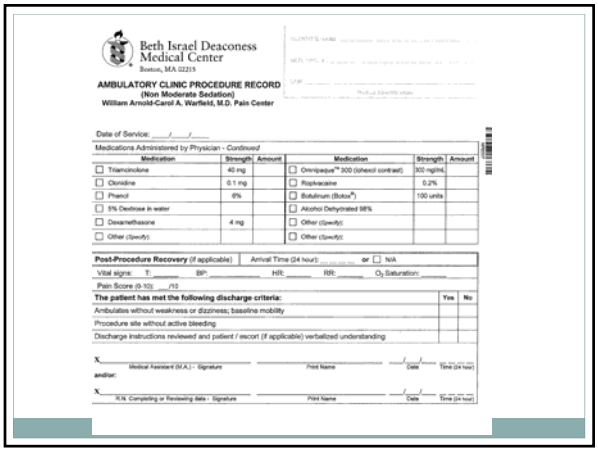


Beth Israel Deaconess Medical Center
Boston, MA 02215

AMBULATORY CLINIC PROCEDURE RECORD
(Non Moderate Sedation)
William Arnold-Carol A. Warfield, M.D. Pain Center

Date of Service: ____/____/____

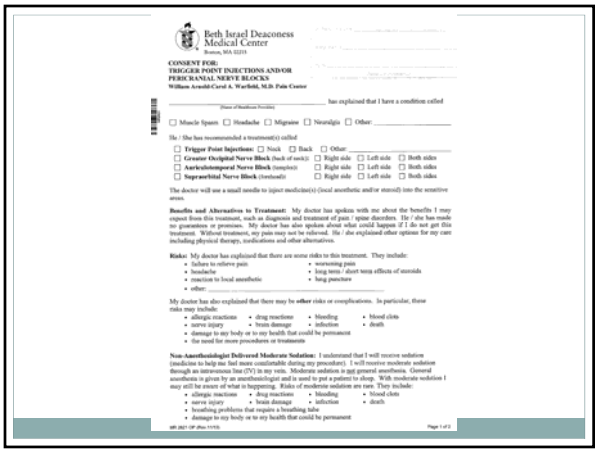
Medications Administered by Physician - *Continued*

Medication	Strength	Amount	Medication	Strength	Amount
☐ Triamcinolone	40 mg		☐ Omnipaque™ 300 (iohexol contrast)	300 mg/mL	
☐ Clonidine	0.1 mg		☐ Ropivacaine	0.2%	
☐ Phenol	6%		☐ Botulinum (Botox®)	100 units	
☐ 5% Dextrose in water			☐ Alcohol Dehydrated 98%		
☐ Dexamethasone	4 mg		☐ Other (*Specify*):		
☐ Other (*Specify*):			☐ Other (*Specify*):		

Post-Procedure Recovery (if applicable) Arrival Time (24 hour): _____ or ☐ N/A
Vital signs: T: _____ BP: _____ HR: _____ RR: _____ O_2 Saturation: _____
Pain Score (0-10): ____ /10

The patient has met the following discharge criteria:	Yes	No
Ambulates without weakness or dizziness; baseline mobility		
Procedure site without active bleeding		
Discharge instructions reviewed and patient / escort (if applicable) verbalized understanding		

X_____ _____ _____ ____/____/____ _____
Medical Assistant (M.A.) - Signature Print Name Date Time (24 hour)
and/or:
X_____ _____ _____ ____/____/____ _____
R.N. Completing or Reviewing data - Signature Print Name Date Time (24 hour)



Beth Israel Deaconess Medical Center
Boston, MA 02215

CONSENT FOR:
TRIGGER POINT INJECTIONS AND/OR
PERICRANIAL NERVE BLOCKS
William Arnold-Carol A. Warfield, M.D. Pain Center

_____ has explained that I have a condition called
(Name of Healthcare Provider)

☐ Muscle Spasm ☐ Headache ☐ Migraine ☐ Neuralgia ☐ Other: _____

He / She has recommended a treatment(s) called

☐ **Trigger Point Injections:** ☐ Neck ☐ Back ☐ Other: _____
☐ **Greater Occipital Nerve Block** (back of neck): ☐ Right side ☐ Left side ☐ Both sides
☐ **Auriculotemporal Nerve Block** (temples): ☐ Right side ☐ Left side ☐ Both sides
☐ **Supraorbital Nerve Block** (forehead): ☐ Right side ☐ Left side ☐ Both sides

The doctor will use a small needle to inject medicine(s) (local anesthetic and/or steroid) into the sensitive areas.

Benefits and Alternatives to Treatment: My doctor has spoken with me about the benefits I may expect from this treatment, such as diagnosis and treatment of pain / spine disorders. He / she has made no guarantees or promises. My doctor has also spoken about what could happen if I do not get this treatment. Without treatment, my pain may not be relieved. He / she explained other options for my care including physical therapy, medications and other alternatives.

Risks: My doctor has explained that there are some risks to this treatment. They include:
- failure to relieve pain
- headache
- reaction to local anesthetic
- other: _____
- worsening pain
- long term / short term effects of steroids
- lung puncture

My doctor has also explained that there may be **other** risks or complications. In particular, these risks may include:
- allergic reactions
- nerve injury
- damage to my body or to my health that could be permanent
- the need for more procedures or treatments
- drug reactions
- brain damage
- bleeding
- infection
- blood clots
- death

Non-Anesthesiologist Delivered Moderate Sedation: I understand that I will receive sedation (medicine to help me feel more comfortable during my procedure). I will receive moderate sedation through an intravenous line (IV) in my vein. Moderate sedation is not general anesthesia. General anesthesia is given by an anesthesiologist and is used to put a patient to sleep. With moderate sedation I may still be aware of what is happening. Risks of moderate sedation are rare. They include:
- allergic reactions
- nerve injury
- breathing problems that require a breathing tube
- damage to my body or to my health that could be permanent
- drug reactions
- brain damage
- bleeding
- infection
- blood clots
- death

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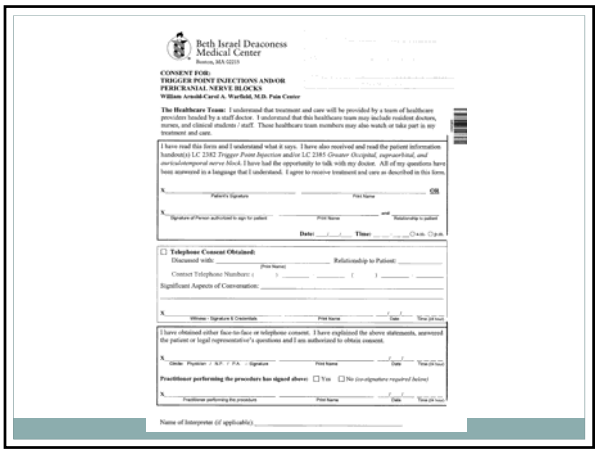


Beth Israel Deaconess Medical Center
Boston, MA 02215

CONSENT FOR:
TRIGGER POINT INJECTIONS AND/OR
PERICRANIAL NERVE BLOCKS
William Arnold-Carol A. Warfield, M.D. Pain Center

The Healthcare Team: I understand that treatment and care will be provided by a team of healthcare providers headed by a staff doctor. I understand that this healthcare team may include resident doctors, nurses, and clinical students / staff. Those healthcare team members may also watch or take part in my treatment and care.

I have read this form and I understand what it says. I have also received and read the patient information handout(s) LC 2382 *Trigger Point Injection* and/or LC 2385 *Greater Occipital, supraorbital, and auriculotemporal nerve block*. I have had the opportunity to talk with my doctor. All of my questions have been answered in a language that I understand. I agree to receive treatment and care as described in this form.

X_____ _____ OR
Patient's Signature Print Name

X_____ _____ and _____
Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: __/__/__ Time: __:__ ○a.m. ○p.m.

☐ **Telephone Consent Obtained:**
Discussed with: _____ Relationship to Patient: _____
(Print Name)
Contact Telephone Number: ( ) _____ ( ) _____
Significant Aspects of Conversation: _____

X_____ _____ __/__/__
Witness - Signature & Credentials Print Name Date Time (24 hour)

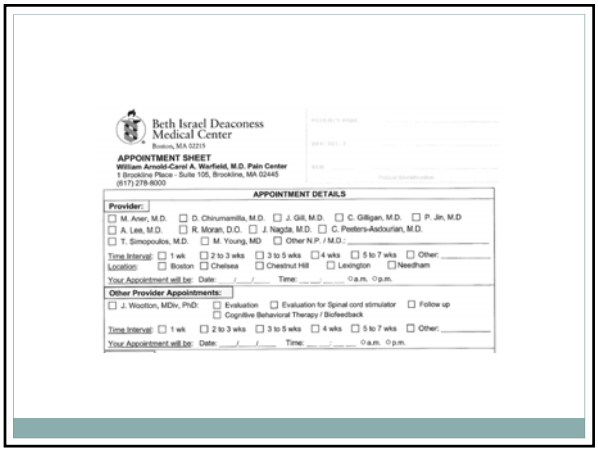
I have obtained either face-to-face or telephone consent. I have explained the above statements, answered the patient or legal representative's questions and I am authorized to obtain consent.

X_____ _____ __/__/__ _____
Circle: Physician / N.P. / P.A. - Signature Print Name Date Time (24 hour)

Practitioner performing the procedure has signed above: ☐ Yes ☐ No *(co-signature required below)*

X_____ _____ __/__/__ _____
Practitioner performing the procedure Print Name Date Time (24 hour)

Name of Interpreter (if applicable): _____



Beth Israel Deaconess Medical Center
Boston, MA 02215

APPOINTMENT SHEET
William Arnold-Carol A. Warfield, M.D. Pain Center
1 Brookline Place - Suite 105, Brookline, MA 02445
(617) 278-8000

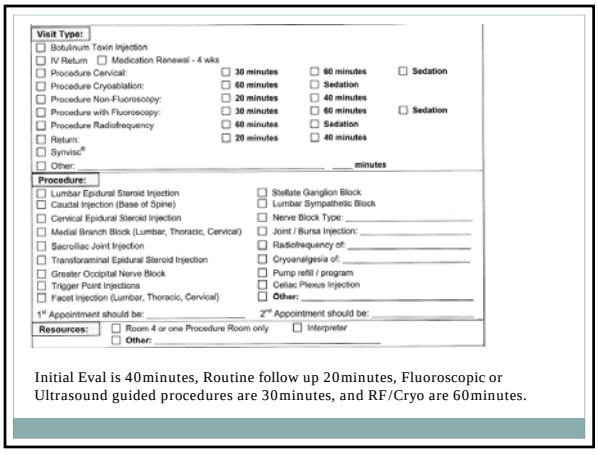
APPOINTMENT DETAILS

Provider:
☐ M. Aner, M.D. ☐ D. Chirumamilla, M.D. ☐ J. Gill, M.D. ☐ C. Gilligan, M.D. ☐ P. Jin, M.D
☐ A. Lee, M.D. ☐ R. Moran, D.O. ☐ J. Nagda, M.D. ☐ C. Peeters-Asdourian, M.D.
☐ T. Simopoulos, M.D. ☐ M. Young, MD ☐ Other N.P. / M.D.: _____

Time Interval: ☐ 1 wk ☐ 2 to 3 wks ☐ 3 to 5 wks ☐ 4 wks ☐ 5 to 7 wks ☐ Other: _____
Location: ☐ Boston ☐ Chelsea ☐ Chestnut Hill ☐ Lexington ☐ Needham
Your Appointment will be: Date: __/__/__ Time: __:__ ○a.m. ○p.m.

Other Provider Appointments:
☐ J. Wootton, MDiv, PhD: ☐ Evaluation ☐ Evaluation for Spinal cord stimulator ☐ Follow up
☐ Cognitive Behavioral Therapy / Biofeedback

Time Interval: ☐ 1 wk ☐ 2 to 3 wks ☐ 3 to 5 wks ☐ 4 wks ☐ 5 to 7 wks ☐ Other: _____
Your Appointment will be: Date: __/__/__ Time: __:__ ○a.m. ○p.m.



Visit Type:

☐ Botulinum Toxin Injection			
☐ IV Return ☐ Medication Renewal - 4 wks			
☐ Procedure Cervical:	☐ 30 minutes	☐ 60 minutes	☐ Sedation
☐ Procedure Cryoablation:	☐ 60 minutes	☐ Sedation	
☐ Procedure Non-Fluoroscopy:	☐ 20 minutes	☐ 40 minutes	
☐ Procedure with Fluoroscopy:	☐ 30 minutes	☐ 60 minutes	☐ Sedation
☐ Procedure Radiofrequency	☐ 60 minutes	☐ Sedation	
☐ Return:	☐ 20 minutes	☐ 40 minutes	
☐ Synvisc®			
☐ Other: _____		____ minutes	

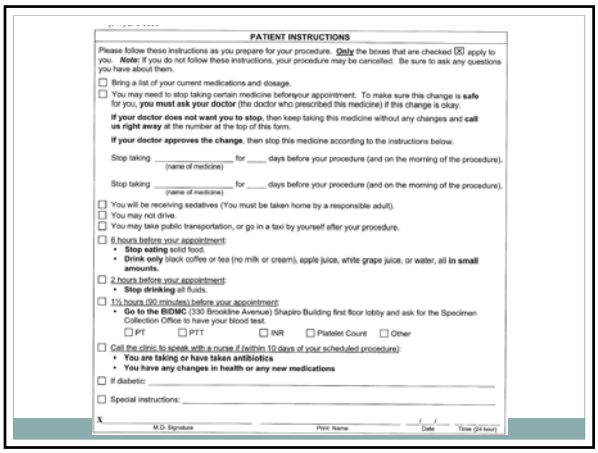
Procedure:

☐ Lumbar Epidural Steroid Injection	☐ Stellate Ganglion Block
☐ Caudal Injection (Base of Spine)	☐ Lumbar Sympathetic Block
☐ Cervical Epidural Steroid Injection	☐ Nerve Block Type: _____
☐ Medial Branch Block (Lumbar, Thoracic, Cervical)	☐ Joint / Bursa Injection: _____
☐ Sacroiliac Joint Injection	☐ Radiofrequency of: _____
☐ Transforaminal Epidural Steroid Injection	☐ Cryoanalgesia of: _____
☐ Greater Occipital Nerve Block	☐ Pump refill / program
☐ Trigger Point Injections	☐ Celiac Plexus Injection
☐ Facet Injection (Lumbar, Thoracic, Cervical)	☐ Other: _____

1st Appointment should be: _____ 2nd Appointment should be: _____

Resources: ☐ Room 4 or one Procedure Room only ☐ Interpreter
☐ Other: _____

Initial Eval is 40minutes, Routine follow up 20minutes, Fluoroscopic or Ultrasound guided procedures are 30minutes, and RF/Cryo are 60minutes.



PATIENT INSTRUCTIONS

Please follow these instructions as you prepare for your procedure. **Only** the boxes that are checked ☒ apply to you. **Note:** If you do not follow these instructions, your procedure may be cancelled. Be sure to ask any questions you have about them.

- ☐ Bring a list of your current medications and dosage.
- ☐ You may need to stop taking certain medicine before your appointment. To make sure this change is **safe** for you, **you must ask your doctor** (the doctor who prescribed this medicine) if this change is okay.

  If your doctor does not want you to stop, then keep taking this medicine without any changes and **call us right away** at the number at the top of this form.

  If your doctor approves the change, then stop this medicine according to the instructions below.

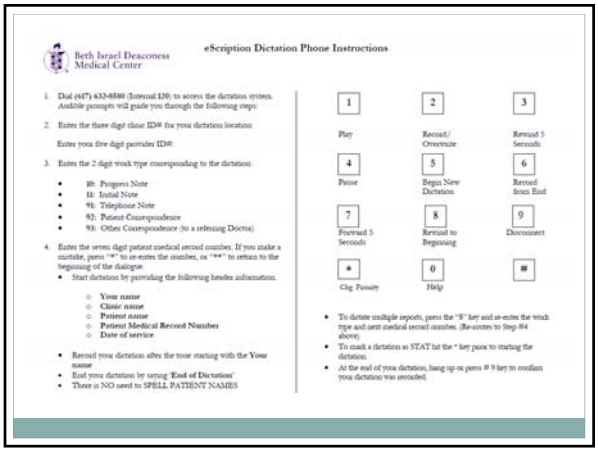
  Stop taking _____ (name of medicine) for ____ days before your procedure (and on the morning of the procedure).

  Stop taking _____ (name of medicine) for ____ days before your procedure (and on the morning of the procedure).
- ☐ You will be receiving sedatives (You must be taken home by a responsible adult).
- ☐ You may not drive.
- ☐ You may take public transportation, or go in a taxi by yourself after your procedure.
- ☐ 6 hours before your appointment:
  - **Stop eating** solid food.
  - **Drink only** black coffee or tea (no milk or cream), apple juice, white grape juice, or water, all **in small amounts.**
- ☐ 2 hours before your appointment:
  - **Stop drinking** all fluids.
- ☐ 1½ hours (90 minutes) before your appointment:
  - **Go to the BIDMC** (330 Brookline Avenue) Shapiro Building first floor lobby and ask for the Specimen Collection Office to have your blood test.

  ☐ PT ☐ PTT ☐ INR ☐ Platelet Count ☐ Other
- ☐ Call the clinic to speak with a nurse if (within 10 days of your scheduled procedure):
  - **You are taking or have taken antibiotics**
  - **You have any changes in health or any new medications**
- ☐ If diabetic: _____
- ☐ Special instructions: _____

X _____ _____ ____/____/____

M.D. Signature Print Name Date Time (24 hour)



Beth Israel Deaconess Medical Center

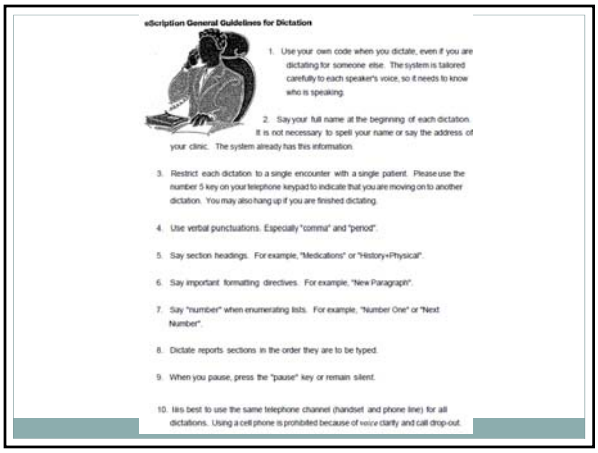
eScription Dictation Phone Instructions

1. Dial (617) 632-8580 (Internal 120) to access the dictation system. Audible prompts will guide you through the following steps:
2. Enter the three digit clinic ID# for you dictation location:

   Enter you five digit provider ID#:
3. Enter the 2 digit work type corresponding to the dictation:
   - 10: Progress Note
   - 11: Initial Note
   - 91: Telephone Note
   - 92: Patient Correspondence
   - 93: Other Correspondence (to a referring Doctor)
4. Enter the seven digit patient medical record number. If you make a mistake, press "*" to re-enter the number, or "**" to return to the beginning of the dialogue.
   - Start dictation by providing the following header information.
     - **Your name**
     - **Clinic name**
     - **Patient name**
     - **Patient Medical Record Number**
     - **Date of service**
   - Record you dictation after the tone starting with the **Your name**
   - End you dictation by saying '**End of Dictation**'
   - There is NO need to SPELL PATIENT NAMES

1 Play	2 Record/ Overwrite	3 Rewind 5 Seconds
4 Pause	5 Begin New Dictation	6 Record from End
7 Forward 5 Seconds	8 Rewind to Beginning	9 Disconnect
* Clig. Pausity	0 Help	#

- To dictate multiple reports, press the "#" key and re-enter the work type and next medical record number. (Re-enters to Step #4 above)
- To mark a dictation as STAT hit the * key prior to starting the dictation.
- At the end of you dictation, hang up or press # 9 key to confirm you dictation was recorded.



eScription General Guidelines for Dictation

1. Use your own code when you dictate, even if you are dictating for someone else. The system is tailored carefully to each speaker's voice, so it needs to know who is speaking.
2. Say your full name at the beginning of each dictation. It is not necessary to spell your name or say the address of your clinic. The system already has this information.
3. Restrict each dictation to a single encounter with a single patient. Please use the number 5 key on your telephone keypad to indicate that you are moving on to another dictation. You may also hang up if you are finished dictating.
4. Use verbal punctuations. Especially "comma" and "period".
5. Say section headings. For example, "Medications" or "History+Physical".
6. Say important formatting directives. For example, "New Paragraph".
7. Say "number" when enumerating lists. For example, "Number One" or "Next Number".
8. Dictate reports sections in the order they are to be typed.
9. When you pause, press the "pause" key or remain silent.
10. Itis best to use the same telephone channel (handset and phone line) for all dictations. Using a cell phone is prohibited because of voice clarity and call drop-out.

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.

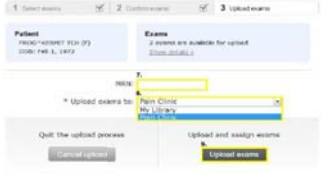
They can grant you access on the back end and then walk you through how to set up the app on your phone...(iphone only!)

LIFE IMAGE

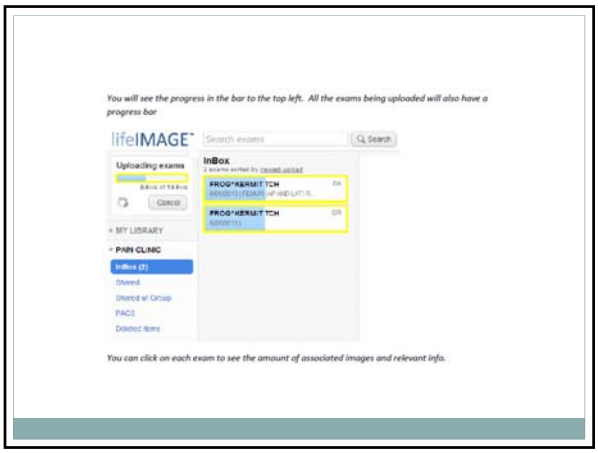
4. Click **Find Exams on CD/DVD** or **Browse for exams**

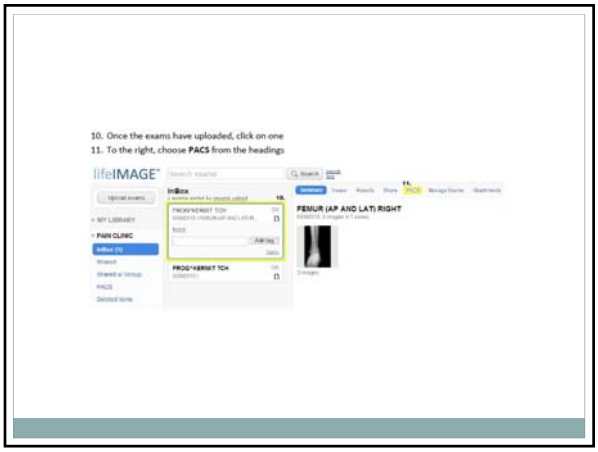
5. The exam descriptions are now shown on the screen. You can choose to select individual or all exams on the disk.
6. Click on **Continue** in the bottom right

7. In the **MRN box**, enter the patient's B.I. MRN
8. At the **"Upload Exams to"** tab, choose "Pain Clinic" or "My library"
9. Click **"Upload Exams"**



The exams will begin uploading


You will see the progress in the bar to the top left. All the exams being uploaded will also have a progress bar
lifeIMAGE
Search exams
Search
Uploading exams
Cancel
InBox
MY LIBRARY
PAIN CLINIC
Inbox (3)
Shared
Shared w/ Group
PACS
Deleted Items
You can click on each exam to see the amount of associated images and relevant info.


10. Once the exams have uploaded, click on one
11. To the right, choose PACS from the headings
lifeIMAGE
InBox
PACS
FEMUR (AP AND LAT) RIGHT


"Requesting Provider" and "Contact Email" are free text fields, so names and/or numbers can be added
12. At the bottom of the form, if there are multiple exams on the disc, select All from this CD
13. click Nominate Exam
CDs Only: Return or Destroy after 7 days
FEMUR (AP AND LAT) RIGHT
Only this exam
All from this CD
Nominate Exam

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.

- *Level C – Suspension of work after three findings in 12 month period for:*
  - Personnel not wearing required personnel radiation monitoring badges or not returning badges promptly for readout.
  - No record of sink disposal of radionuclides.
  - Not performing and/or documenting required surveys.

Responsibilities of Person Issued a Dosimeter

To ensure personnel exposure accuracy your responsibilities are as follows:

1. Change your dosimeter(s) on the first working day of the appropriate month and return the previous month's monitor(s) to the designated distribution area. The dosimeters are color coded for both whole body badges (bi-monthly color-schemes) and finger TLDs (3 alternating colors).
2. Wear the dosimeter in the correct location, i.e. collar/waist, when working with or near a radiation source. Dosimeters should be placed in a location that properly reflects your exposure conditions. Since conditions are more complex than others, such as for fluoroscopy, multiple dosimeters may be required by the RSO. In these cases the proper wear location is indicated on the dosimeter.
3. Store your dosimeter in a radiation-free area at the end of your work shift. For example, when not wearing your dosimeter, avoid leaving it in an x-ray room or on your lead apron.
4. Notify your supervisor if you lose your dosimeter.
5. Work to minimize your radiation exposure through as detailed in the ALARA program.
6. If you are pregnant or thinking of becoming pregnant, read the Declared Pregnancy Policy.
7. Retain your dosimeter for your own personal use. ***Do not give it to anyone else to wear***; it is recorded permanently in your exposure record history.

8. If you are also working at another institution with radiation involved, that institution is responsible for your monitoring when you are there and your dosimeter from this institution shall not be used. If you are being monitored at another institution, notify the Radiation Safety Officer of your exposure readings, as we are required to see that you do not exceed a total annual radiation exposure for the year working at all institutions.
9. When undergoing personal nuclear medicine diagnostic testing or medical/dental x-rays, do not wear your dosimeter. Radiation exposures as a results of medical care or those received in our everyday life's, such as from plane trip, are excluded from your occupational exposure record. Any decision about medically necessary radiation exposure should be made in cooperation with your physician.
10. Notify the Radiation Safety Office when you terminate work that may involve radiation exposure so that your dosimeter can be discontinued.

Declared Pregnancy Policy

In order to be considered a "Pregnant Worker" you must, in writing, voluntarily inform your employer and/or the Radiation Safety Officer. This declaration form can be found listed under the Forms section of the Online Radiation Safety Manual and can be done with confidentiality. When you formally declare your pregnancy, your exposure limit, as well as that for your embryo/fetus, will be restricted to 500 mrem for the entire pregnancy.

You have the option to make an appointment to meet with the Radiation Safety Officer if you have any questions. Your exposure history to date will be reviewed to see if you need to make any changes in your work assignments (usually this is not necessary) to comply with this limit. If you wear a lead apron, a monitor, to be worn under the lead apron, will be issued to estimate exposure to the embryo/fetus. If you already wear a dosimeter under you apron it will automatically be re-coded as a pregnancy monitor in Radiation Safety Office records for the duration of your pregnancy.

If you plan to eventually become pregnant, you should make certain to always wear your dosimeter(s) to develop an accurate record of your exposure. As stated above, if you routinely wear a lead apron, as in fluoroscopy procedures, you should make sure you have a waist dosimeter worn underneath the apron to develop this record.

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.

Didactic Curriculum

- 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 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.

The only excusable absences are when a fellow is:

- Sick
- Attending a Meeting
- On Vacation
- On Rotation at Children's Hospital

Boston Children's Hospital
Until every child is well

Per Departmental Guidelines for trainees attendance is required at **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.

Didactic Curriculum

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.

Didactic Curriculum

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 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 0r 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

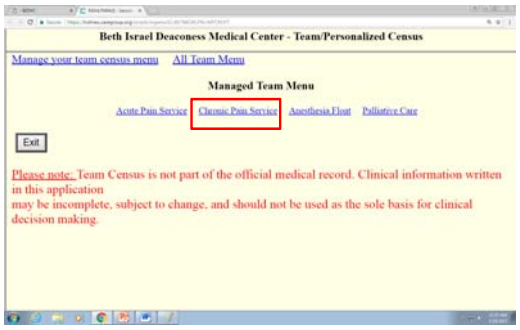
- Effective and efficient way to communicate information, method to standardize communication and allows parties to have common expectation related to what is to be communicated and how the communication is structured
  - S = Situation (a concise statement about the problem)
  - B = Background (pertinent 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)

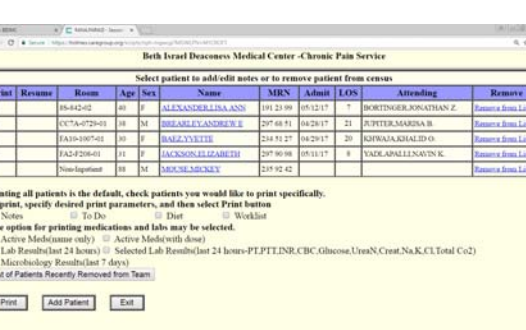
The page ID for CPS is 3-OUCH (36824), following weekly sign out, fellows will switch 3-OUCH's covered by status to the oncoming fellow.

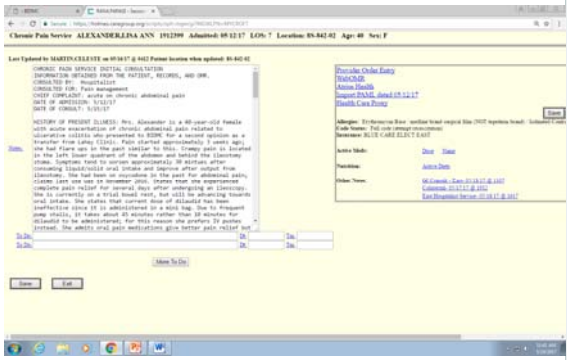
Do not sign out the pager to a telephone number or to another pager number .

CPS Census:

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





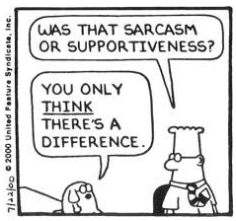


How are consults placed?

- 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 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.

BIDMC anesthesia trainees[2] 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 the training program.

Beth Israel Deaconess Medical Center

Department of Anesthesia, Critical Care, and Pain Medicine

Psych 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 psychosocial anamnesis
    - Presenting patient complaint
    - History of presenting pain complaint
    - Current level of functioning
    - Current identifiable stressors
    - Psychiatric history
    - Substance Abuse history
    - Medical history
    - Developmental and social history

  - A mental status examination – formal, informal, and/or psychometric
  - A dynamic formulation of the patient's situation, identifying pertinent psychosocial risk factors
    - Review and discussion – with the patient, where appropriate, of psychological 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 sensitivity toward the psychosocial risk factors affecting chronic pain
- Demonstrate mastery of the psychology curriculum
- Promulgate full written and monitored reports on a minimum of five patient interviews for the Online Medical Record (OMR), 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 natural history of various musculoskeletal pain disorders and be able to appropriately integrate therapeutic modalities.
- Learn the performance of a musculoskeletal exam.
- Emphasize both structure and function as it applies to diagnosing acute and chronic pain problems.
- performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain
- Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of 15 patients
- developing rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; and
- Fellows must demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of five patients
- integrating therapeutic modalities and surgical intervention in 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-up and treatment plans.
- 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.
- Demonstrate an understanding of the common diagnostic tests and imaging studies used in the inpatient and outpatient setting for patients with pain.
- Explain the rationale for each study ordered to evaluate pain 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 base of knowledge needed for the care of children with acute and chronic pain.
- Completion of a comprehensive pediatric medical history and physical exam while addressing a complete pain care history including: Patient's medical diagnosis, goals of care, psycho-social

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 assessment including physical, cognitive, 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 neuro-psychiatric co-morbidities in patients with life-threatening illnesses.
- Overcome discomfort of being present in the room of an actively dying patient and his/her family.
- Anticipate common questions from family members.
- Identify physical signs of imminent death (respiratory patterns, cool extremities)
- Manage common symptoms: secretions, delirium, tachypnea/dyspnea.
- Address emotional and spiritual concerns of family members (your "other patient").

New Innovations

Procedure and Case Logs

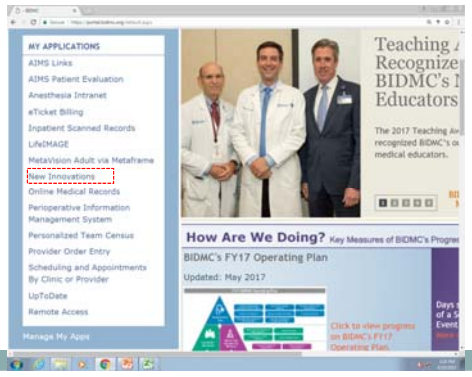
Fellows must keep their procedure logs current, and it is your responsibility to ensure that your logs are completed in a timely manner.

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 1: The fellow demonstrates milestones expected of an incoming fellow.

Level 2: The fellow is advancing and demonstrates additional milestones, but is not yet performing at a mid-fellowship level.

Level 3: The fellow continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for fellowship.

Level 4: The fellow has advanced so that he or she now substantially demonstrates the milestones targeted for fellowship. This level is designed as the graduation target.

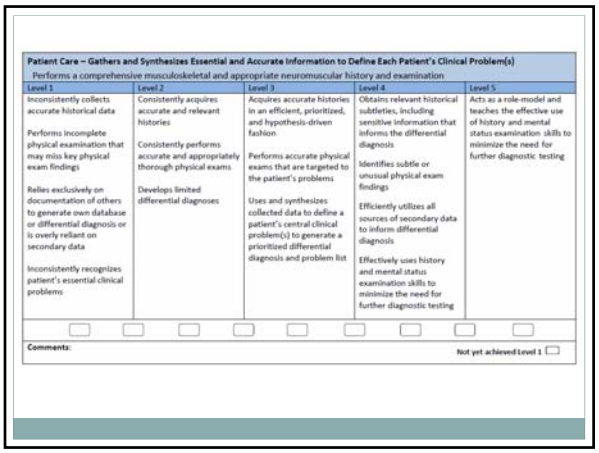
Level 5: The fellow has advanced beyond performance targets set for fellowship and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional fellows will reach this level.

Patient Care – Gathers and Synthesizes Essential and Accurate Information to Define Each Patient's Clinical Problem(s)
Performs a directed neurological history and performs detailed neurological examination

Level 1	Level 2	Level 3	Level 4	Level 5
Inconsistently collects accurate historical data Performs incomplete physical examination that may miss key physical exam findings Relies exclusively on documentation of others to generate own database or differential diagnosis or is overly reliant on secondary data Inconsistently recognizes patient's essential clinical problems	Consistently acquires accurate and relevant histories Consistently performs accurate and appropriately thorough physical exams Develops limited differential diagnoses	Acquires accurate histories in an efficient, prioritized, and hypothesis-driven fashion Performs accurate physical exams that are targeted to the patient's problems Uses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem list	Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis Identifies subtle or unusual physical exam findings Efficiently utilizes all sources of secondary data to inform differential diagnosis Effectively uses history and mental status examination skills to minimize the need for further diagnostic testing	Acts as a role-model and teaches the effective use of history and mental status examination skills to minimize the need for further diagnostic testing

Comments:

Not yet achieved Level 1 ☐



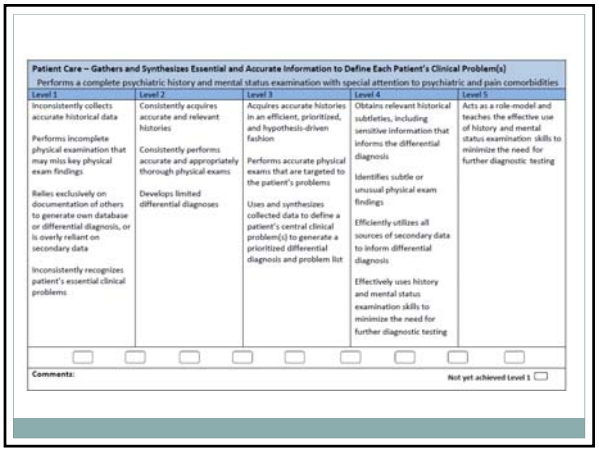
Patient Care – Gathers and Synthesizes Essential and Accurate Information to Define Each Patient's Clinical Problem(s)

Performs a comprehensive musculoskeletal and appropriate neuromuscular history and examination

Level 1	Level 2	Level 3	Level 4	Level 5
Inconsistently collects accurate historical data Performs incomplete physical examination that may miss key physical exam findings Relies exclusively on documentation of others to generate own database or differential diagnosis or is overly reliant on secondary data Inconsistently recognizes patient's essential clinical problems	Consistently acquires accurate and relevant histories Consistently performs accurate and appropriately thorough physical exams Develops limited differential diagnoses	Acquires accurate histories in an efficient, prioritized, and hypothesis-driven fashion Performs accurate physical exams that are targeted to the patient's problems Uses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem list	Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis Identifies subtle or unusual physical exam findings Efficiently utilizes all sources of secondary data to inform differential diagnosis Effectively uses history and mental status examination skills to minimize the need for further diagnostic testing	Acts as a role-model and teaches the effective use of history and mental status examination skills to minimize the need for further diagnostic testing

Comments:

Not yet achieved Level 1



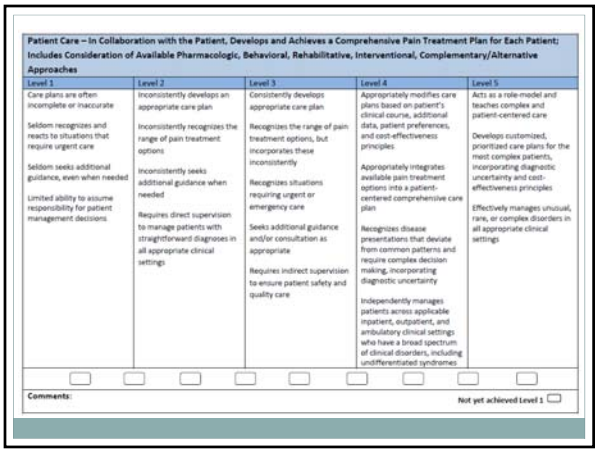
Patient Care – Gathers and Synthesizes Essential and Accurate Information to Define Each Patient's Clinical Problem(s)

Performs a complete psychiatric history and mental status examination with special attention to psychiatric and pain comorbidities

Level 1	Level 2	Level 3	Level 4	Level 5
Inconsistently collects accurate historical data Performs incomplete physical examination that may miss key physical exam findings Relies exclusively on documentation of others to generate own database or differential diagnosis, or is overly reliant on secondary data Inconsistently recognizes patient's essential clinical problems	Consistently acquires accurate and relevant histories Consistently performs accurate and appropriately thorough physical exams Develops limited differential diagnoses	Acquires accurate histories in an efficient, prioritized, and hypothesis-driven fashion Performs accurate physical exams that are targeted to the patient's problems Uses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem list	Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis Identifies subtle or unusual physical exam findings Efficiently utilizes all sources of secondary data to inform differential diagnosis Effectively uses history and mental status examination skills to minimize the need for further diagnostic testing	Acts as a role-model and teaches the effective use of history and mental status examination skills to minimize the need for further diagnostic testing

Comments:

Not yet achieved Level 1



Patient Care – In Collaboration with the Patient, Develops and Achieves a Comprehensive Pain Treatment Plan for Each Patient; Includes Consideration of Available Pharmacologic, Behavioral, Rehabilitative, Interventional, Complementary/Alternative Approaches

Level 1	Level 2	Level 3	Level 4	Level 5
Care plans are often incomplete or inaccurate Seldom recognizes and reacts to situations that require urgent care Seldom seeks additional guidance, even when needed Limited ability to assume responsibility for patient management decisions	Inconsistently develops an appropriate care plan Inconsistently recognizes the range of pain treatment options Inconsistently seeks additional guidance when needed Requires direct supervision to manage patients with straightforward diagnoses in all appropriate clinical settings	Consistently develops appropriate care plan Recognizes the range of pain treatment options, but incorporates these inconsistently Recognizes situations requiring urgent or emergency care Seeks additional guidance and/or consultation as appropriate Requires indirect supervision to ensure patient safety and quality care	Appropriately modifies care plans based on patient's clinical course, additional data, patient preferences, and cost-effectiveness principles Appropriately integrates available pain treatment options into a patient-centered comprehensive care plan Recognizes disease presentations that deviate from common patterns and require complex decision making, incorporating diagnostic uncertainty Independently manages patients across applicable inpatient, outpatient, and ambulatory clinical settings who have a broad spectrum of clinical disorders, including undifferentiated syndromes	Acts as a role-model and teaches complex and patient-centered care Develops customized, prioritized care plans for the most complex patients, incorporating diagnostic uncertainty and cost-effectiveness principles Effectively manages unusual, rare, or complex disorders in all appropriate clinical settings

Comments:

Not yet achieved Level 1

Patient Care – Demonstrates Skill in Performing and Interpreting Diagnostic and Therapeutic Interventions

- Appropriate use and interpretation of diagnostic laboratory and imaging studies
- Appropriate use and interpretation of electro-diagnostic studies
- Performs intravenous access, basic and advanced airway management, management of sedation, and basic and advanced cardiac life support
- Performs a wide range of invasive pain treatments involving the neuraxis, peripheral nerve and musculoskeletal system

Level 1	Level 2	Level 3	Level 4	Level 5
Observes but does not perform invasive procedures Inconsistently recognizes cases in which invasive procedures are unwarranted or unsafe Limited understanding of the indications, processes, or potential risks of the procedure Unable to describe risks and benefits of procedures Limited ability to recognize patients who would benefit from diagnostic testing Limited ability to interpret diagnostic tests	Possesses insufficient technical skill for safe completion of common invasive procedures with appropriate supervision Inattentive to patient safety and comfort when performing invasive procedures Recognizes the ethical principles and need to obtain informed consent for procedures, but ineffectively obtains it Inconsistently recognizes patients who would benefit from diagnostic testing Inconsistently interprets diagnostic tests	Possesses basic technical skill for the completion and interpretation of some common invasive procedures with appropriate supervision Inconsistently manages patient safety and comfort when performing invasive procedures Inconsistently recognizes appropriate patients, indications, and associated risks in the performance of invasive procedures Obtains and documents informed consent Recognizes patients who would benefit from diagnostic testing Interprets diagnostic tests with limited ability to integrate results into treatment plan	Consistently demonstrates technical skill to successfully and safely perform and interpret invasive procedures Maximizes patient comfort and safety when performing invasive procedures Consistently recognizes appropriate patients, indications, and associated risks in the performance of invasive procedures Effectively obtains and documents informed consent in challenging circumstances (e.g., language or cultural barriers) Consistently integrates results of diagnostic testing into treatment plan	Demonstrates skill to independently perform and interpret complex invasive procedures that are anticipated for future practice Demonstrates expertise to teach and supervise others in the performance of invasive procedures Designs consent instrument for a human subject research study; files an Institution Review Board (IRB) application Appropriately orders and interprets complex diagnostic testing and integrate results into treatment plan Quantifies evidence for risk-benefit analysis while obtaining informed consent for complex procedures or therapies.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Comments: **Not yet achieved Level 1** ☐

Patient Care – Requests and Provides Consultative Care

Level 1	Level 2	Level 3	Level 4	Level 5
Unable to address questions or concerns of others when acting as a consultant or utilizing consultant services Unable to recognize the need to utilize consultant services when appropriate for patient care	Inconsistently manages patients as a consultant to other physicians/health care teams Inconsistently applies risk assessment principles to patients while acting as a consultant Inconsistently formulates a clinical question for a consultant to address	Provides consultation services for patients with clinical problems requiring basic risk assessment Asks meaningful clinical questions that guide the input of consultants	Provides consultation services for patients with basic and complex clinical problems requiring detailed risk assessment Appropriately integrates recommendations from other consultants in order to effectively manage patient care	Provides consultation services for patients with very complex clinical problems requiring extensive risk assessment Models management of discordant recommendations from multiple consultants

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Comments: **Not yet achieved Level 1** ☐

Medical Knowledge – Possesses Clinical Knowledge

- Anatomy, physiology, and pharmacology of pain
- Assessment of pain
- Treatment of pain
- Interventional pain treatment

Level 1	Level 2	Level 3	Level 4	Level 5
Lacks the scientific, socioeconomic, or behavioral knowledge required to provide care for common pain conditions	Possesses insufficient scientific, socioeconomic, and behavioral knowledge required to provide care for common pain conditions	Possesses the scientific, socioeconomic, and behavioral knowledge required to provide care for common pain conditions	Possesses the scientific, socioeconomic, and behavioral knowledge required to provide care for complex pain conditions and comprehensive pain care	Possesses the scientific, socioeconomic, and behavioral knowledge required to successfully diagnose and treat uncommon, ambiguous, and complex pain conditions

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Comments: **Not yet achieved Level 1** ☐

Medical Knowledge – Demonstrates Knowledge of Diagnostic Laboratory, Diagnostic Imaging and Neuro-diagnostic Testing and Procedures

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates a limited foundational knowledge to apply diagnostic testing and procedures to patient care for common pain conditions	Inconsistently interprets basic diagnostic tests accurately Does not understand the concepts of pre-test probability and test performance characteristics Minimally understands the rationale and risks associated with common procedures	Consistently interprets basic diagnostic tests accurately Needs assistance to understand the concepts of pre-test probability and test performance characteristics Fully understands the rationale and risks associated with common procedures	Interprets complex diagnostic tests accurately while accounting for limitations and biases Knows the indications for, and limitations of, diagnostic testing and procedures Understands the concepts of pre-test probability and test performance characteristics Teaches the rationale and risks associated with common procedures and anticipates potential complications of procedures	Anticipates and accounts for subtle nuances of interpreting diagnostic tests and procedures Pursues knowledge of new and emerging diagnostic tests and procedures
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐

Comments: **Not yet achieved Level 1** ☐

Medical Knowledge – Participates in Scholarship (Foundation, Investigation, Analysis, and Dissemination)

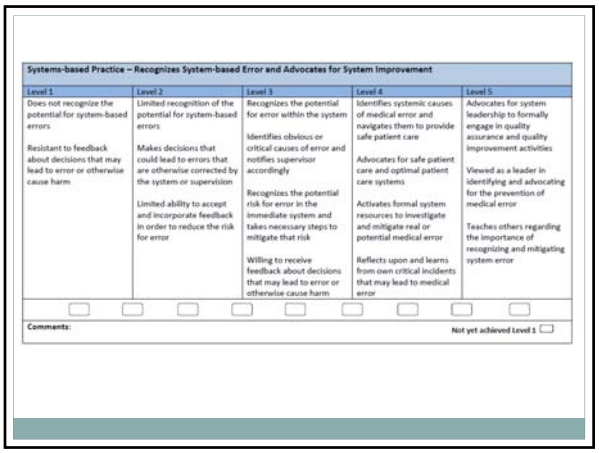
Level 1	Level 2	Level 3	Level 4	Level 5
Unaware of scientific inquiry or scholarly productivity in the field of pain medicine Has not yet performed scholarly investigation in the in the field of pain medicine Demonstrates limited critical thinking regarding clinical practice, quality improvement, patient safety, education, or research in the field of pain medicine Unable to effectively communicate and/or disseminate knowledge in the field of pain medicine	Interested in scholarly activity, but does not initiate or follow through Performs a literature search using relevant scholarly sources to identify pertinent articles Aware of basic statistical concepts, but has incomplete understanding of their application; inconsistently identifies methodological flaws Communicates rudimentary details of scientific work, including his or her own scholarly work; needs to improve ability to present in small groups	Identifies areas worthy of scholarly investigation and formulates a plan under supervision of a mentor Critically reads scientific literature and identifies major methodological flaws and inconsistencies within or between publications Understands and is able to apply basic statistical concepts, and can identify potential analytic methods for data or problem assessment Effectively presents at journal club, quality improvement meetings, clinical conferences, and/or is able to effectively describe and discuss his or her own scholarly work or research	Formulates ideas worthy of scholarly investigation Collaborates with other investigators to design and complete a project related to clinical practice, quality improvement, patient safety, education, or research Critiques specialized scientific literature effectively Dissects a problem into its many component parts and identifies strategies for solving Uses analytical methods of the field effectively Presents scholarly activity at local or regional meetings, and/or submits an abstract summarizing scholarly work to regional/state/ national meetings, and/or publishes non-peer- reviewed manuscript(s) (reviews, book chapters)	Independently formulates novel and important ideas worthy of scholarly investigation Leads a scholarly project advancing clinical practice, quality improvement, patient safety, education, or research Obtains independent research funding Critiques specialized scientific literature at a level consistent with participation in peer review Employs optimal statistical techniques Teaches analytic methods in chosen field to peers and others Effectively presents scholarly work at national and international meetings Publishes peer-reviewed manuscript(s) containing scholarly work (clinical practice, quality improvement, patient safety, education, or research)
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐

Comments: **Not yet achieved Level 1** ☐

Systems-based Practice – Works Effectively Within an Interprofessional Team (e.g., with peers, consultants, nursing, ancillary professionals, and other support personnel)

Level 1	Level 2	Level 3	Level 4	Level 5
Unable to recognize the contributions of other interprofessional team members Frequently requires reminders from team to complete physician responsibilities (e.g., talk to family, enter orders	Identifies roles of other team members, but does not recognize how/when to utilize them as resources Participates in team discussions when required, but does not actively seek input from other team members	Understands the roles and responsibilities of all team members, but uses them ineffectively Actively engages in team meetings and collaborative decision-making	Understands the roles and responsibilities of, and effectively partners with, all members of the team Efficiently coordinates activities of other team members to optimize care	Develops, trains, and inspires the team regarding unexpected events or new patient management strategies Viewed by other team members as a leader in the delivery of high-quality care
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐

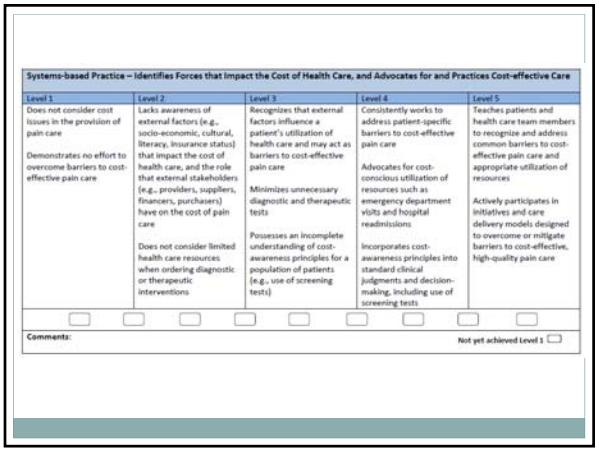
Comments: **Not yet achieved Level 1** ☐



Systems-based Practice – Recognizes System-based Error and Advocates for System Improvement

Level 1	Level 2	Level 3	Level 4	Level 5
Does not recognize the potential for system-based errors Resistant to feedback about decisions that may lead to error or otherwise cause harm	Limited recognition of the potential for system-based errors Makes decisions that could lead to errors that are otherwise corrected by the system or supervision Limited ability to accept and incorporate feedback in order to reduce the risk for error	Recognizes the potential for error within the system Identifies obvious or critical causes of error and notifies supervisor accordingly Recognizes the potential risk for error in the immediate system and takes necessary steps to mitigate that risk Willing to receive feedback about decisions that may lead to error or otherwise cause harm	Identifies systemic causes of medical error and navigates them to provide safe patient care Advocates for safe patient care and optimal patient care systems Activates formal system resources to investigate and mitigate real or potential medical error Reflects upon and learns from own critical incidents that may lead to medical error	Advocates for system leadership to formally engage in quality assurance and quality improvement activities Viewed as a leader in identifying and advocating for the prevention of medical error Teaches others regarding the importance of recognizing and mitigating system error

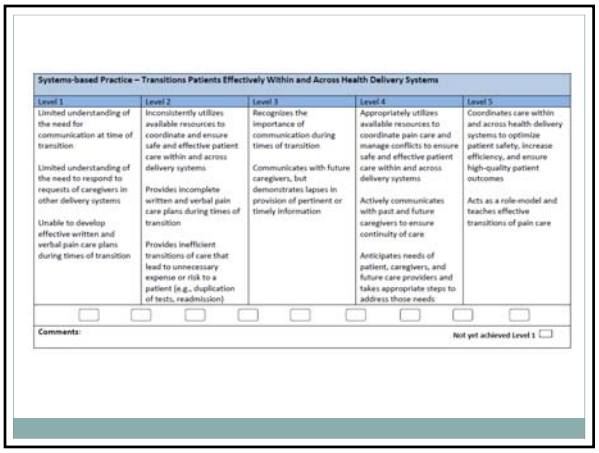
Comments: Not yet achieved Level 1 ☐



Systems-based Practice – Identifies Forces that Impact the Cost of Health Care, and Advocates for and Practices Cost-effective Care

Level 1	Level 2	Level 3	Level 4	Level 5
Does not consider cost issues in the provision of pain care Demonstrates no effort to overcome barriers to cost-effective pain care	Lacks awareness of external factors (e.g., socio-economic, cultural, literacy, insurance status) that impact the cost of health care, and the role that external stakeholders (e.g., providers, suppliers, financers, purchasers) have on the cost of pain care Does not consider limited health care resources when ordering diagnostic or therapeutic interventions	Recognizes that external factors influence a patient's utilization of health care and may act as barriers to cost-effective pain care Minimizes unnecessary diagnostic and therapeutic tests Possesses an incomplete understanding of cost-awareness principles for a population of patients (e.g., use of screening tests)	Consistently works to address patient-specific barriers to cost-effective pain care Advocates for cost-conscious utilization of resources such as emergency department visits and hospital readmissions Incorporates cost-awareness principles into standard clinical judgments and decision-making, including use of screening tests	Teaches patients and health care team members to recognize and address common barriers to cost-effective pain care and appropriate utilization of resources Actively participates in initiatives and care delivery models designed to overcome or mitigate barriers to cost-effective, high-quality pain care

Comments: Not yet achieved Level 1 ☐



Systems-based Practice – Transitions Patients Effectively Within and Across Health Delivery Systems

Level 1	Level 2	Level 3	Level 4	Level 5
Limited understanding of the need for communication at time of transition Limited understanding of the need to respond to requests of caregivers in other delivery systems Unable to develop effective written and verbal pain care plans during times of transition	Inconsistently utilizes available resources to coordinate and ensure safe and effective patient care within and across delivery systems Provides incomplete written and verbal pain care plans during times of transition Provides inefficient transitions of care that lead to unnecessary expense or risk to a patient (e.g., duplication of tests, readmission)	Recognizes the importance of communication during times of transition Communicates with future caregivers, but demonstrates lapses in provision of pertinent or timely information	Appropriately utilizes available resources to coordinate pain care and manage conflicts to ensure safe and effective patient care within and across delivery systems Actively communicates with past and future caregivers to ensure continuity of care Anticipates needs of patient, caregivers, and future care providers and takes appropriate steps to address those needs	Coordinates care within and across health delivery systems to optimize patient safety, increase efficiency, and ensure high-quality patient outcomes Acts as a role-model and teaches effective transitions of pain care

Comments: Not yet achieved Level 1 ☐

Practice-based Learning and Improvement – Monitors Practice with a Goal for Improvement

Level 1	Level 2	Level 3	Level 4	Level 5
Unable to self-reflect upon one's practice or performance Not concerned with opportunities for learning and self-improvement	Limited ability to self-reflect upon practice or performance Misses opportunities for learning and self-improvement	Inconsistently self-reflects upon practice or performance, and inconsistently acts upon those reflections Inconsistently acts upon opportunities for learning and self-improvement	Regularly self-reflects upon one's practice or performance, and consistently acts upon those reflections to improve practice Recognizes sub-optimal practice or performance as an opportunity for learning and self-improvement	Regularly seeks external validation regarding self-reflection to maximize practice improvement Actively and independently engages in self-improvement efforts and reflects upon the experience

Comments:

Not yet achieved Level 1 ☐

Practice-based Learning and Improvement – Learns and Improves via Performance Audit

Level 1	Level 2	Level 3	Level 4	Level 5
Unable to analyze one's own clinical performance data No participation in pain care related quality-improvement efforts	Limited ability to analyze own clinical performance data Nominally engaged in opportunities to achieve focused education and performance improvement	Analyzes own clinical performance gaps and identifies opportunities for improvement Participates in opportunities to achieve focused education and performance improvement Understands common principles and techniques of quality improvement and appreciates the responsibility to assess and improve care for a panel of patients	Analyzes own clinical performance data and actively works to improve performance Actively engages in opportunities to achieve focused education and performance improvement Demonstrates the ability to apply common principles and techniques of quality improvement to improve care for a panel of patients	Actively monitors clinical performance through various data sources Able to lead projects aimed at education and performance improvement Utilizes common principles and techniques of quality improvement to continuously improve pain care for a panel of patients

Comments:

Not yet achieved Level 1 ☐

Practice-based Learning and Improvement – Learns and Improves via Feedback

Level 1	Level 2	Level 3	Level 4	Level 5
Never solicits feedback Actively resists feedback from others	Rarely seeks and does not incorporate feedback Responds to unsolicited feedback in a defensive fashion Temporarily or superficially adjusts performance based on feedback	Solicits feedback only from supervisors and inconsistently incorporates feedback Is open to unsolicited feedback Inconsistently incorporates feedback	Solicits feedback from all members of the interprofessional team and patients Welcomes unsolicited feedback Consistently incorporates feedback Able to reconcile disparate or conflicting feedback	Performance continuously reflects incorporation of solicited and unsolicited feedback Role models the ability to reconcile disparate or conflicting feedback

Comments:

Not yet achieved Level 1 ☐

Practice-based Learning and Improvement – Learns and Improves at the Point of Care

Level 1	Level 2	Level 3	Level 4	Level 5
Fails to acknowledge uncertainty and reverts to a reflexive patterned response even when inaccurate Fails to seek or apply evidence when necessary	Rarely reconsiders an approach to a problem, asks for help, or seeks new information Can translate medical information needs into well-formed clinical questions with assistance Unfamiliar with strengths and weaknesses of the medical literature Has limited awareness of, or ability to use, information technology or decision support tools and guidelines Accepts the findings of clinical research studies without critical appraisal	Inconsistently reconsiders an approach to a problem, asks for help, or seeks new information Can translate medical information needs into well-formed clinical questions independently Aware of the strengths and weaknesses of medical information resources, but utilizes information technology without sophistication With assistance, appraises clinical research reports based on accepted criteria	Routinely reconsiders an approach to a problem, asks for help, or seeks new information Routinely translates new medical information needs into well-formed clinical questions Guided by the characteristics of clinical questions, efficiently searches medical information resources, including decision support tools and guidelines Independently appraises clinical research reports based on accepted criteria	Role-models how to appraise clinical research reports based on accepted criteria Has a systematic approach to track and pursue emerging clinical questions

Comments: Not yet achieved Level 1 ☐

Professionalism – Has Professional and Respectful Interactions with Patients, Caregivers, and Members of the Interprofessional Team (e.g., peers, consultants, nursing, ancillary professionals, and support personnel)

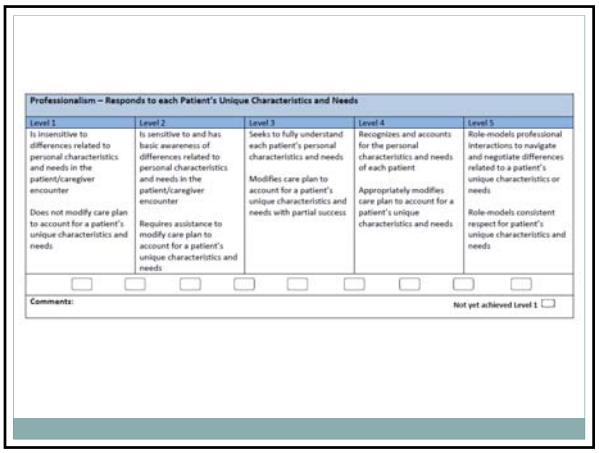
Level 1	Level 2	Level 3	Level 4	Level 5
Inconsistently demonstrates empathy, compassion, and respect for patients and caregivers Inconsistently demonstrates responsiveness to patients' and caregivers' needs in an appropriate fashion Inconsistently considers patient privacy and autonomy Inconsistently aware of physician and colleague self-care and wellness	Often demonstrates empathy, compassion, and respect for patients and caregivers Often demonstrates responsiveness to patients' and caregivers' needs in an appropriate fashion Often considers patient privacy and autonomy Often aware of physician and colleague self-care and wellness	Consistently respectful in interactions with patients, caregivers, and members of the interprofessional team, even in challenging situations Is available and responsive to needs and concerns of patients, caregivers, and members of the interprofessional team to ensure safe and effective patient care Emphasizes patient privacy and autonomy in all interactions Consistently aware of physician and colleague self-care and wellness	Demonstrates empathy, compassion, and respect to patients and caregivers in all situations Anticipates, advocates for, and actively works to meet the needs of patients and caregivers Demonstrates a responsiveness to patient needs that supersedes self-interest Positively acknowledges input of members of the interprofessional team and incorporates that input into plan of care, as appropriate Regularly reflects on, assesses, and recommends physician and colleague self-care and wellness	Role-models compassion, empathy, and respect for patients and caregivers Role-models appropriate anticipation and advocacy for patient and caregiver needs Fosters collegiality that promotes a high-functioning interprofessional team Teaches others regarding maintaining patient privacy and respecting patient autonomy Role-models personal self-care practice for others and promotes programs for colleague wellness

Comments: Not yet achieved Level 1 ☐

Professionalism – Accepts Responsibility and Follows through on Tasks

Level 1	Level 2	Level 3	Level 4	Level 5
Is unreliable in completing patient care responsibilities or assigned administrative tasks Shuns responsibilities expected of a physician professional	Completes most assigned tasks in a timely manner but may need reminders or other support Accepts professional responsibility only when assigned or mandatory	Completes administrative and patient care tasks in a timely manner in accordance with local practice and/or policy Completes assigned professional responsibilities without questioning or the need for reminders	Prioritizes multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner Willingly assumes professional responsibility regardless of the situation	Role models prioritizing many competing demands in order to complete tasks and responsibilities in a timely and effective manner Assists others to improve their ability to prioritize many competing tasks

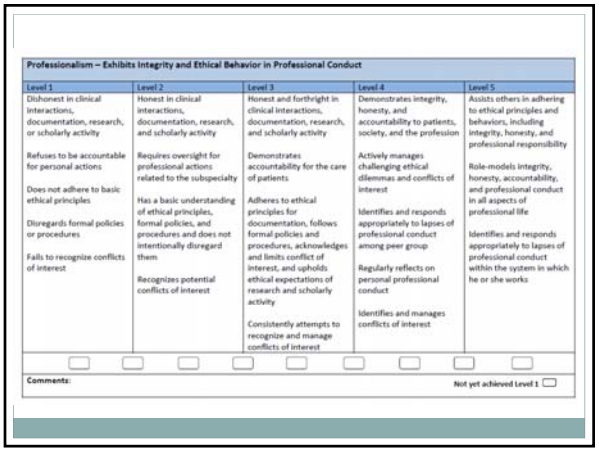
Comments: Not yet achieved Level 1 ☐



Professionalism – Responds to each Patient's Unique Characteristics and Needs

Level 1	Level 2	Level 3	Level 4	Level 5
Is insensitive to differences related to personal characteristics and needs in the patient/caregiver encounter Does not modify care plan to account for a patient's unique characteristics and needs	Is sensitive to and has basic awareness of differences related to personal characteristics and needs in the patient/caregiver encounter Requires assistance to modify care plan to account for a patient's unique characteristics and needs	Seeks to fully understand each patient's personal characteristics and needs Modifies care plan to account for a patient's unique characteristics and needs with partial success	Recognizes and accounts for the personal characteristics and needs of each patient Appropriately modifies care plan to account for a patient's unique characteristics and needs	Role-models professional interactions to navigate and negotiate differences related to a patient's unique characteristics or needs Role-models consistent respect for patient's unique characteristics and needs

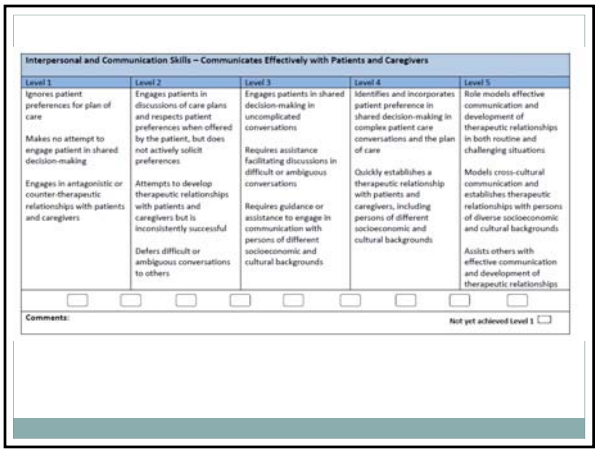
Comments: Not yet achieved Level 1 ☐



Professionalism – Exhibits Integrity and Ethical Behavior in Professional Conduct

Level 1	Level 2	Level 3	Level 4	Level 5
Dishonest in clinical interactions, documentation, research, or scholarly activity Refuses to be accountable for personal actions Does not adhere to basic ethical principles Disregards formal policies or procedures Fails to recognize conflicts of interest	Honest in clinical interactions, documentation, research, and scholarly activity Requires oversight for professional actions related to the subspecialty Has a basic understanding of ethical principles, formal policies, and procedures and does not intentionally disregard them Recognizes potential conflicts of interest	Honest and forthright in clinical interactions, documentation, research, and scholarly activity Demonstrates accountability for the care of patients Adheres to ethical principles for documentation, follows formal policies and procedures, acknowledges and limits conflict of interest, and upholds ethical expectations of research and scholarly activity Consistently attempts to recognize and manage conflicts of interest	Demonstrates integrity, honesty, and accountability to patients, society, and the profession Actively manages challenging ethical dilemmas and conflicts of interest Identifies and responds appropriately to lapses of professional conduct among peer group Regularly reflects on personal professional conduct Identifies and manages conflicts of interest	Assists others in adhering to ethical principles and behaviors, including integrity, honesty, and professional responsibility Role-models integrity, honesty, accountability, and professional conduct in all aspects of professional life Identifies and responds appropriately to lapses of professional conduct within the system in which he or she works

Comments: Not yet achieved Level 1 ☐



Interpersonal and Communication Skills – Communicates Effectively with Patients and Caregivers

Level 1	Level 2	Level 3	Level 4	Level 5
Ignores patient preferences for plan of care Makes no attempt to engage patient in shared decision-making Engages in antagonistic or counter-therapeutic relationships with patients and caregivers	Engages patients in discussions of care plans and respects patient preferences when offered by the patient, but does not actively solicit preferences Attempts to develop therapeutic relationships with patients and caregivers but is inconsistently successful Defers difficult or ambiguous conversations to others	Engages patients in shared decision-making in uncomplicated conversations Requires assistance facilitating discussions in difficult or ambiguous conversations Requires guidance or assistance to engage in communication with persons of different socioeconomic and cultural backgrounds	Identifies and incorporates patient preference in shared decision-making in complex patient care conversations and the plan of care Quickly establishes a therapeutic relationship with patients and caregivers, including persons of different socioeconomic and cultural backgrounds	Role models effective communication and development of therapeutic relationships in both routine and challenging situations Models cross-cultural communication and establishes therapeutic relationships with persons of diverse socioeconomic and cultural backgrounds Assists others with effective communication and development of therapeutic relationships

Comments: Not yet achieved Level 1 ☐

Interpersonal and Communication Skills – Communicates Effectively in Interprofessional Teams (e.g., with peers, consultants, nursing, ancillary professionals, and other support personnel)				
Level 1	Level 2	Level 3	Level 4	Level 5
Utilizes communication strategies that hamper collaboration and teamwork Verbal and/or non-verbal behaviors disrupt effective collaboration with team members	Uses unidirectional communication that fails to utilize the wisdom of team members Resists offers of collaborative input	Inconsistently engages in collaborative communication with appropriate members of the team Inconsistently employs verbal, non-verbal, and written communication strategies that facilitate collaborative care	Consistently and actively engages in collaborative communication with all members of the team Verbal, non-verbal, and written communication consistently acts to facilitate collaboration with team members to enhance patient care	Role models and teaches collaborative communication with the team to enhance patient care, even in challenging settings and with conflicting team member opinions
☐	☐	☐	☐	☐
Comments:				Not yet achieved Level 1 ☐

Interpersonal and Communication Skills – Appropriately Utilizes and Completion of Health Records				
Level 1	Level 2	Level 3	Level 4	Level 5
Provides health records that are missing significant portions of important clinical data Does not enter medical information and test results/interpretations into health record	Health records are disorganized and inaccurate Inconsistently enters medical information and test results/interpretations into health record	Health records are organized and accurate, but are superficial and miss key data or fail to communicate clinical reasoning Consistently enters medical information and test results/interpretations into health records	Patient-specific health records are organized, timely, accurate, comprehensive, and effectively communicate clinical reasoning Provides effective and prompt medical information and test results/interpretations to physicians and patients	Role models and teaches importance of organized, accurate, and comprehensive health records that are succinct and patient-specific
☐	☐	☐	☐	☐
Comments:				Not yet achieved Level 1 ☐

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?

	Among the Worst	Bottom Half	Average	Top Half	Among the Best
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 saff requests and answering pages in a timely fashion					
Maintaining confidentiality of patients					
Accepting responsibility for profesisonal actions					
Respecting a patient's culture, gender, disability, sexual orientation, age and religion					

Beth Israel Deaconess Medical Center

A teaching hospital of Harvard Medical School

ARNOLD-WARFIELD PAIN MANAGEMENT CENTER

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.

INSTRUCTIONS: Please answer the following six questions about the fellow's performance during your visit today. The fellow's picture is below. All answers to these questions will **remain** anonymous – your name is not required on this form. **Kindly complete this form during checkout.**

Physician Name/Picture: Date of Visit:

QUESTION	POOR	FAIR	GOOD	OUTSTANDING
1. How is the fellow at greeting you and being courteous and respectful during your visit?				
2. How is the fellow at listening to your concerns and addressing them?				
3. How is the fellow at informing you of what they will do during your visit?				
4. How is the fellow at explaining your health condition, the next steps and any prescribed medications in an understandable way?				
5. How is the fellow at encouraging you to ask questions and answering them?				

Would you recommend this physician to a friend and/or family member? YES ☐ NO ☐

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 bianunally 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

BIDMC anesthesia trainees[2] 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

PGY4/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 Competence Committee.

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

Conferences:

Attendance will be generally limited to one (1) non-local major meeting per year (e.g. AAPM, APS, ASIPP, ASA, IARS, NANS, SOAP, SAMBA, SCA, SCCM, or ASRA). Exceptions will be made on an individual basis for those with other roles at a meeting (e.g. committee member, delegate, etc.). Exceptions may also be granted for those presenting original research not already presented at another meeting.

In order for any non-local major meeting to be approved, trainees must plan on submitting their presentation for publication as well as patriciate in all of the following local presentation opportunities: NEARC, Harvard Anesthesia Night, BIDMC resident research day and, the Silverman Symposium.

In order to qualify for travel reimbursement, presented **case reports** must also be submitted as a letter or case report to an appropriate journal (e.g. Anesthesiology, A&A Case Reports, Journal of Cardiovascular and Thoracic Anesthesia, etc.). Reimbursement is not contingent upon publication, 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, airfare, hotel, food (reasonable), taxi to/from airport, with copies of receipts must be submitted. Workshops and other extra fees may be paid for from your education fund. As a reminder you must submit your reimbursement to the anesthesia education 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 their training program director 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.

EMAIL, WIFI ETC…

1. To add an Exchange account to your iPhone or iPod touch, tap **Settings**, then **Mail, Contacts, Calendars**, then **Add Account**, then **Microsoft Exchange**. Note, you can configure only One Exchange account per device.

2. On the next screen, enter the following information:

Email address: (your username@bidmc.harvard.edu)

Domain: **its.caregroup.org**

Username: (Your ITS/Outlook username)

Password: (Your ITS/Outlook password)

Description: (may be anything you like).

3. Your iPhone (or iPod touch) will now try to locate your Exchange server using Microsoft's Autodiscovery service. If the server cannot be located, the screen below is shown. Enter your front-end Exchange server's complete address **(mail.caregroup.org)** in the **Server** field.
Your iPhone or iPod touch will try to create a secure (SSL) connection to your Exchange server.

After successfully making a connection to the Exchange server, you must set a device passcode to protect your phone incase your phone is lost/stolen.

4. Choose which type(s) of data you would like to synchronize: Mail, Contacts, and Calendars. Note that by default, **only 3 days'** worth of email is synchronized. To synchronize more, go into Settings, then Mail, Contacts, Calendars, select your Exchange account, and tap on Mail days to sync.

***Note that after configuring an Exchange ActiveSync account, all existing contact and calendar information on the iPhone or iPod touch is overwritten. Additionally, iTunes no longer syncs contacts and calendars with your desktop computer. You can still sync your iPhone or iPod touch wirelessly with MobileMe services.

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.

Hospital WiFi Setup

The private network is not broadcasted, which means that you cannot see it, if you look for available networks.
The private wifi is ALWAYS on and allows you uninterrupted access.
Under wifi settings, got to add WI-FI network.

- The network is SSID "CGWD1".
- Security is "802.xEAP" (android) or "WPA Enterprise" (iphone).
- Username/identity: "its/XXX" where XXX is your bidmc username. **Please note the backslash, not forwardslash.**
- Enter your password, click ok and you are done.