JOHNS HOPKINS EMERGENCY MEDICINE RESIDENCY MANUAL

2024 – 2025

Johns Hopkins Emergency Medicine welcomes you!

Program Mission

The mission of the Johns Hopkins Department of Emergency Medicine Residency Program is to foster the clinical, humanistic and professional development of today's residents so that they will become tomorrow's leaders.

Pursuant to this mission, we provide a diverse clinical experience at three hospital sites, ensuring that residents have exposure to an academic urban environment (Johns Hopkins Hospital), an academic community hospital (Johns Hopkins Bayview Medical Center), and a suburban community hospital (Howard County Medical Center). The three sites allow for a wide variety of patient encounters from clinical, research and administrative standpoints.

Our program aims to:

- Recruit top candidates from a diverse applicant pool
- Under experienced mentorship, inspire residents to develop passion and expertise within a niche in emergency medicine
- Produce compassionate and engaged physicians who care and advocate for their patients and communities
- Train well-rounded and versatile clinicians who treat all patients seeking care
- Create an environment that promotes a focus on wellness and resiliency
- Develop critical skills around lifelong learning
- Nurture future leaders in emergency medicine and beyond

Resident education is at the heart of this department. To accomplish these goals, the Johns Hopkins Emergency Medicine Residency program has been designed to cultivate clinical and academic growth, through clinical experience, an integrated didactic program, and focused advanced specialty training (FAST) that includes teaching, research, administration and counseling in career development.

The Johns Hopkins Department of Emergency Medicine
Academic Year 2024-2025

Congratulations on being a member of the Johns Hopkins Department of Emergency Medicine for the academic year 2024-2025.

Our goal is to provide you with an outstanding education to prepare you for your future as an Emergency Physician. To meet this goal, our objectives are for you to:

- Acquire the skills and knowledge to be an **exceptional emergency physician**.
- Gain experience with leadership and develop the necessary management skills to become an **effective physician leader**.
- Learn the appropriate time management practices and decision-making skills to **develop a balance of professional and personal productivity.**

To help you achieve these objectives, this resident manual has been created. Please take time to read each page of this manual, because adherence to policies and procedures contained within it is a requirement for all residents. We modify many aspects of this portfolio annually as our residency program evolves.

As a member of the Johns Hopkins Department of Emergency Medicine Residency Program, one of the oldest programs in the history of emergency medicine, you inherit more than 50 years of tradition. Many great physicians have served in this residency program; many more will serve in the future. As you go through this program, remember that much will be expected from you, but it will not be just in the form of service. **More importantly, we expect your development to be extraordinary as an individual, as an Emergency Physician, and as a contributing member of society**. It is our hope that we challenge you in multiple ways so that when you are ready to leave this program, you will be prepared for all aspects of our profession and have the confidence to achieve, no matter how you choose to define it, success as an individual.

Please remember that effective communication is the basis of outstanding organizations. Please contact any of the people listed below if you have any questions, comments, or suggestions for improvement.

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Administrative Director for Education
Medical Training Program Manager

Brittney Root
Medical Training Program Administrator

Residency will be challenging, but there are **many people invested in you and the program** and eager to help you succeed. Although the entire faculty is committed to your education, there are key people in the residency program upon whom you can rely as an additional resource. JHED = JHH ED; JHBV = JH Bayview ED; JHHC = JH Howard County ED

Gabor Kelen, MD	Chairman, JH Emergency Medicine
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Emergency Medicine Milestones

On July 1, 2013, the ACGME introduced milestone achievements for all residency programs in Emergency Medicine. The goal of this system is to evaluate the progress residents are achieving during their residency in a way that allows for more individualized assessment and feedback for residents. This is one of the components of competency-based education.

Milestones are organized under 6 Core Competencies:

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

These milestones were updated to their second version on July 1, 2021. Within each of the core competencies, there are 22 "sub-competencies." Each sub-competency maps to one of the overarching 6 Core Competencies. Within each of these sub-competencies, there are milestone proficiency levels ranging from 1 through 5. The target for graduation is a Level 4 in all sub-competencies. The Program Director must report proficiency levels for every resident for each of the 22 sub-competencies twice per year to the ACGME.

The EM milestones are on the following pages, and we recommend that you review them thoroughly. To accurately evaluate each resident, there will be multiple data points collected, including end of shift evaluations, monthly New Innovations evaluations, bi-annual reviews, and many more.

Proficiency levels for each resident are evaluated every six months by the Clinical Competency Committee. The Committee consists of faculty from the Teaching College and other core educators within the program. The data is reviewed, and residents are assigned a numerical proficiency level for each sub-competency from the data collected during the year. During the six-month review, the Committee will address whether the data appears accurate for each resident, and if individual residents are below their peers for any specific items.

Each residency must fulfill this requirement of reporting to the ACGME twice a year, or there will be penalties from the ACGME – which affects the ability of the residency to graduate residents. Therefore, the responsibility of the residents in this process is very important. It is imperative that attendings are given end of shift evaluations, and that New Innovations evaluations are current and up-to-date. The residency leadership will be very involved in ensuring this requirement is fulfilled.

Data Points for Competency Based EM Assessment

End of Shift Evaluations:
Each resident is expected to seek at least one end-of-shift direct observation entrustable professional activity (EPA) assessment for all shifts in the JHH Adult and Bayview emergency departments. These evaluations should be completed by either an attending or PGY4 resident who has worked with you for at least 4 hours over the course of the shift. Evaluations are available online and should be completed in real-time during or immediately after the shift.

Overall:
At least 8 evaluations will be completed for every two weeks of EM rotation time. If you are on a four-week rotation, 8 should be complete within the first two weeks, and the second 8 the last two weeks. Do not cluster 16 evaluations for the last two weeks. We encourage you to ask for end of shift EPAs for every shift you work in the ED.

In general, you will select the attending for the team you are on. You can select the PGY4 if you believe they are in a better place to evaluate you than the attending based on contact time. When in a situation where you work with more than one attending, please select the attending who had the most contact time with you on shift.

Procedure for assigning end-of-shift evaluations:
At the end of all ED shifts, please have an attending or PGY4 complete a direct observation evaluation. Residents must have the New Innovations app downloaded on their phones. Ensure you are logged in and select "Direct Observation." These direct observations ask faculty/PGY4s to determine the level of supervision required to entrust you with completing certain responsibilities and tasks in the clinical arena (aka Entrustable Professional Activities or EPAs).

You can choose the domain(s) that you want feedback on, and the evaluator can give you free text feedback while providing an objective rating of the degree of supervision needed for the observed behavior (i.e., an assessment of competence).

End of Rotation Evaluations:
Every 2 weeks of each rotation block, electronic evaluations will be completed using the *"On-Demand Evaluation"* function on your New Innovations home page with input from faculty members and 4th year residents. You are required to select TWO SUPERVISORS to evaluate you for each of these evaluation triggers for a total of 2 evaluations per every 2-week block. One of these MUST be a faculty member, while the other can be either a second faculty or a PGY4 resident.

Nurse evaluations:
Every 2 weeks of each EM rotation block, electronic evaluations will be completed using the "*On-Demand Evaluation"* function on your New Innovations home page with input from nurses. You are required to select ONE nurse per evaluation trigger.

Simulation evaluations:
These will be completed by the faculty running the simulations sessions with you.

Biannual Review:
Your twice per year review with the program directors will take into account your self-evaluation, compiled New Innovations evaluations, resident report card, informal feedback, as well as all other non-clinical aspects of your performance.

Oral Boards:
You will take part in our twice-yearly oral board sessions in conference, which will generate an evaluation of your performance in this testing setting.

Resident Chart Reviews:
Every 6 months, you must complete 5 self chart reviews and 5 peer chart reviews to analyze documentation and your perceived care of the patient. Your self-assessment will be reviewed at your Biannual Review with the program directors.

Medical Knowledge: (In-Service/Step 3/Testing)
You are required to take the annual American Board of Emergency Medicine (ABEM) In-Training Exam every February. This information will be used to help guide your study plan as performance on standardized testing. Although not representative of your clinical performance, standardized examinations are required to become licensed. **You are required to take and pass USMLE Step 3 before the end of PGY2.** If you are a DO, you have the option to take the COMLEX Step 3 exam. **Please print out your score report when you receive the notification and send it to Christina Tarleton, otherwise you will have to pay money later to request a copy for us.**

EBM:
You are required to participate in EBM (Evidence Based Medicine conference) during your 2nd year. Your performance on this assignment will be evaluated to evaluate your understanding of the principles of EBM.

Patient Care 1: Emergency Stabilization				
Level 1	Level 2	Level 3	Level 4	Level 5
Detects when a patient's vital signs are abnormal	Identifies a patient who is unstable and requires immediate intervention	Identifies a patient with occult presentation that is at risk for instability or deterioration	Ascertains, in a timely fashion, when further clinical intervention for a patient is futile	
Assesses a patient's ABCs and performs basic interventions	Addresses the unstable vital signs and initiates advanced resuscitation procedures and protocols	Reassesses the patient's status after implementing a stabilizing intervention	Integrates hospital support services into the management of critically-ill or -injured patients	Manages patients with rare or complex presentations requiring emergency stabilization
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

Patient Care 2: Performance of a Focused History and Physical Exam				
Level 1	Level 2	Level 3	Level 4	Level 5
Elicits and communicates a reliable comprehensive patient history and performs a physical exam	Elicits and communicates a focused patient history and performs a focused physical exam that effectively address the patient's chief complaint and urgent issues	Prioritizes essential components of a patient history and physical exam, given a limited or dynamic circumstance	Using all potential sources of data, gathers those that are necessary for the beneficial management of patients	Models the effective use of a patient history and physical exam to minimize the need for further diagnostic testing
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

Patient Care 3: Diagnostic Studies				
Level 1	Level 2	Level 3	Level 4	Level 5
Determines the need for diagnostic studies	Selects appropriate diagnostic studies and reviews the risks, benefits, and contraindications of them	Given a limited or dynamic circumstance, prioritizes the diagnostic studies that are essential	Practices cost-effective ordering of diagnostic studies	Proposes alternatives when barriers exist to specific diagnostic studies
Demonstrates understanding of diagnostic testing principles	Interprets results of diagnostic testing (e.g., electrocardiogram (EKG), diagnostic radiology, point-of-care ultrasound)	Orders and performs diagnostic testing, considering the pre-test probability of disease and the likelihood of test results altering management	Considers the factors that impact post-test probability	In the context of the patient presentation, discriminates between subtle and/or conflicting diagnostic results
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Comments:				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

Patient Care 4: Diagnosis				
Level 1	Level 2	Level 3	Level 4	Level 5
Constructs a list of potential diagnoses based on the patient's chief complaint and initial assessment	Provides a prioritized differential diagnosis	Provides a diagnosis for common medical conditions and demonstrates the ability to modify a diagnosis based on a patient's clinical course and additional data	Provides a diagnosis for patients with multiple comorbidities or uncommon medical conditions, recognizing errors in clinical reasoning	Serves as a role model and educator to other learners for deriving diagnoses and recognizing errors in clinical reasoning
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Comments:				
				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

Patient Care 5: Pharmacotherapy				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes the different classifications of pharmacologic agents	Selects appropriate agent for therapeutic intervention	Considers array of drug therapy and selects appropriate agent based on mechanism of action and intended effect	Selects the appropriate agent based on patient preferences, allergies, cost, policies, and clinical guidelines	Participates in developing departmental and/or institutional policies on pharmacy and therapeutics
Consistently asks patients for drug allergies	Evaluates for potential adverse effects of pharmacotherapy and drug-to-drug interactions	Recognizes and acts upon common adverse effects and interactions	Recognizes and acts upon uncommon and unanticipated adverse effects and interactions	
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Comments:				
				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

Patient Care 6: Reassessment and Disposition				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes basic resources available (e.g., follow-up care, rehabilitation, transfer centers)	Makes a disposition decision for patients with routine conditions needing minimal resources	Makes a disposition decision for patients with routine conditions, with resource utilization	Makes disposition decision for patients with complex conditions, with resource utilization	Participates in institutional committees to develop systems that enhance safe patient disposition and maximizes resources
Describes basic patient education plans	Educates patients on simple discharge and admission plans	Educates patients regarding diagnosis, treatment plan, medication review and primary care physician/consultant appointments	Educates patients on complex discharge and admission plans, including complex transfers	
Identifies the need for patient re-evaluation	Monitors that necessary diagnostic and therapeutic interventions are performed	Identifies which patients will require ongoing emergency department evaluation and evaluates the effectiveness of diagnostic and therapeutic interventions	Evaluates changes in clinical status during a patient's emergency department course	Participates in the development of protocols to enhance patient safety
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Comments:				
				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

Patient Care 7: Multitasking (Task-Switching)				
Level 1	Level 2	Level 3	Level 4	Level 5
Manages a single patient amidst distractions	Task-switches between different patients of similar acuity	Employs task-switching in an efficient manner to manage multiple patients of varying acuity and at varying stages of work-up	Employs task-switching in an efficient manner to manage the emergency department	Employs task switching in an efficient manner to manage the emergency department under high-volume or surge situations
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Comments:				
Not Yet Completed Level 1 ☐ Not Yet Assessable ☐				

Patient Care 8: General Approach to Procedures				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies indications for a procedure and pertinent anatomy and physiology	Assesses indications, risks, benefits, and alternatives and obtains informed consent in low- to moderate-risk situations	Assesses indications, risks, and benefits and weighs alternatives in high-risk situations	Acts to mitigate modifiable risk factors in high-risk situations	
Performs basic therapeutic procedures (e.g., suturing, splinting)	Performs and interprets basic procedures, with assistance	Performs and interprets advanced procedures, with guidance	Independently performs and interprets advanced procedures	Teaches advanced procedures and independently performs rare, time-sensitive procedures
	Recognizes common complications	Manages common complications	Independently recognizes and manages complex and uncommon complications	Performs procedural peer review
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Comments:				
Not Yet Completed Level 1 ☐ Not Yet Assessable ☐				

Medical Knowledge 1: Scientific Knowledge				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates scientific knowledge of common presentations and conditions	Demonstrates scientific knowledge of complex presentations and conditions	Integrates scientific knowledge of comorbid conditions for complex presentations	Integrates scientific knowledge of uncommon, atypical, or complex comorbid conditions for complex presentations	Pursues and integrates new and emerging knowledge
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Comments:				
Not Yet Completed Level 1 ☐ Not Yet Assessable ☐				

Medical Knowledge 2: Treatment and Clinical Reasoning				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of treatment of common conditions	Demonstrates knowledge of treatment of patients with complex conditions	Demonstrates knowledge of the impact of patient factors on treatment	Demonstrates comprehensive knowledge of the varying patterns of disease presentation and alternative and adjuvant treatments of patients	Contributes to the body of knowledge on the varying patterns of disease presentation, and alternative and adjuvant treatments of patients
Identifies types of clinical reasoning errors within patient care, with substantial guidance	Identifies types of clinical reasoning errors within patient care	Applies clinical reasoning principles to retrospectively identify cognitive errors	Continually re-appraises one's clinical reasoning to prospectively minimize cognitive errors and manage uncertainty	Coaches others to recognize and avoid cognitive errors
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Comments:				
Not Yet Completed Level 1 ☐ Not Yet Assessable ☐				

Systems-Based Practice 1: Patient Safety				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems for preventing patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Acts as a role model and/or mentor for others in the disclosing of patient safety events
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Comments:				
Not Yet Completed Level 1 ☐				

Systems-Based Practice 2: Quality Improvement				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of basic quality improvement methodologies and metrics	Describes local quality improvement initiatives (e.g., emergency department throughput, testing turnaround times)	Participates in local quality improvement initiatives	Demonstrates the skills required for identifying, developing, implementing, and analyzing a quality improvement project	Creates, implements, and assesses quality improvement initiatives at the institutional or community level
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Comments:				
Not Yet Completed Level 1 ☐				

Systems-Based Practice 3: System Navigation for Patient-Centered Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of care coordination	In routine clinical situations, effectively coordinates patient care integrating the roles of interprofessional teams	In complex clinical situations, effectively coordinates patient care by integrating the roles of the interprofessional teams	Serves as a role model, effectively coordinates patient-centered care among different disciplines and specialties	Analyzes the process of care coordination and leads in the design and implementation of improvements
Identifies key elements for safe and effective transitions of care and hand-offs	In routine clinical situations, enables safe and effective transitions of care/hand-offs	In complex clinical situations, enables safe and effective transitions of care/hand-offs	Serves as a role model, advocates for safe and effective transitions of care/hand-offs within and across health care delivery systems, including outpatient settings	Improves quality of transitions of care within and across health care delivery systems to optimize patient outcomes
Demonstrates knowledge of population and community health needs and disparities	Identifies specific population and community health needs and inequities for their local population	Effectively uses local resources to meet the needs of a patient population and community	Participates in changing and adapting practice to provide for the needs of specific populations	Leads innovations and advocates for populations and communities with health care inequities
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Comments:

Not Yet Completed Level 1 ☐

Systems-Based Practice 4: Physician Role in Health Care Systems				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies key components of the complex health care system (e.g., hospital, skilled nursing facility, finance, personnel, technology)	Describes how components of a complex health care system are interrelated, and how this impacts patient care	Discusses how individual practice affects the broader system (e.g., length of stay, readmission rates, clinical efficiency)	Manages various components of the complex health care system to provide efficient and effective patient care and the transition of care	Advocates for or leads systems change that enhances high value, efficient, and effective patient care, and the transition of care
Describes basic health payment systems, including (e.g., government, private, public, uninsured care) practice models	Delivers care with consideration of each patient's payment model (e.g., insurance type)	Engages patients in shared decision making, informed by each patient's payment models	Advocates for patient care needs with consideration of the limitations of each patient's payment model	Participates in health policy advocacy activities
	Identifies basic knowledge domains required for medical practice (e.g., information technology, legal, billing, coding, financial, and personnel aspects)	Demonstrates efficient integration of information technology required for medical practice (e.g., electronic health record, documentation required for billing and coding)	Describes core administrative knowledge needed for the transition to practice (e.g., contract negotiation, malpractice insurance, government regulation, compliance)	Analyzes individual practice patterns and professional requirements
☐	☐	☐	☐	☐

Comments:

Not Yet Completed Level 1 ☐

Practice-Based Learning and Improvement 1: Evidence-Based and Informed Practice				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates how to access and use available evidence	Articulates the clinical questions that are necessary to guide evidence-based care	Locates and applies the best available evidence, integrating it with patient preference, to the care of complex patients	Critically appraises and applies evidence even in the face of uncertainty and of conflicting evidence to guide care that is tailored to the individual patient	Coaches others to critically appraise and apply evidence for complex patients, and/or participates in the development of guidelines
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Comments:				
				Not Yet Completed Level 1 ☐

Practice-Based Learning and Improvement 2: Reflective Practice and Commitment to Personal Growth				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates an openness to performance data (feedback and other input)	Demonstrates an openness to performance data and uses it to develop personal and professional goals	Seeks and accepts performance data for developing personal and professional goals	Using performance data, continually improves and measures the effectiveness of one's personal and professional goals	Acts as a role model for the development of personal and professional goals
	Identifies the factors that contribute to the gap(s) between expectations and actual performance	Analyzes and reflects upon the factors that contribute to gap(s) between expectations and actual performance	Analyzes, reflects on, and institutes behavioral change(s) to narrow the gap(s) between expectations and actual performance	Coaches others on reflective practice
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Comments:				
				Not Yet Completed Level 1 ☐

Professionalism 1: Professional Behavior and Ethical Principles				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates professional behavior in routine situations and in how to report professionalism lapses	Identifies and describes potential triggers and takes responsibility for professionalism lapses	Exhibits professional behavior in complex and/or stressful situations	Sets apart those situations that might trigger professionalism lapses and intervenes to prevent them in oneself and others	Coaches others when their behavior fails to meet professional expectations
Demonstrates knowledge of the ethical principles underlying patient care	Analyzes straightforward situations using ethical principles	Analyzes complex situations using ethical principles, and recognizes the need to seek help in managing and resolving them	Uses appropriate resources for managing and resolving ethical dilemmas	Identifies and addresses system-level factors that either induce or exacerbate ethical problems or impede their resolution
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐

Professionalism 2: Accountability/Conscientiousness				
Level 1	Level 2	Level 3	Level 4	Level 5
In routine situations, performs tasks and responsibilities with appropriate attention to detail Responds promptly to requests and reminders to complete tasks and responsibilities	In routine situations, performs tasks and responsibilities in a timely manner with appropriate attention to detail Takes responsibility for failure to complete tasks and responsibilities	In complex or stressful situations, performs tasks and responsibilities in a timely manner with appropriate attention to detail Recognizes situations that might impact one's own ability to complete tasks and responsibilities in a timely manner, and describes strategies for ensuring timely task completion in the future	Recognizes situations that might impact others' ability to complete tasks and responsibilities Proactively implements strategies to ensure that the needs of patients, teams, and systems are met	Takes ownership of system outcomes
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Comments: Not Yet Completed Level 1 ☐				

Professionalism 3: Self-Awareness and Well-Being				
Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes, with assistance, the status of one's personal and professional well-being	Independently recognizes the status of one's personal and professional well-being and engages in help-seeking behaviors	With assistance, proposes a plan to optimize personal and professional well-being	Independently develops a plan to optimize one's personal and professional well-being	Coaches others when their emotional responses or level of knowledge/skills fail to meet professional expectations
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Comments: Not Yet Completed Level 1 ☐				

This subcompetency is not intended to evaluate a resident's well-being. Rather, the intent is to ensure that each resident has the fundamental knowledge of factors that affect well-being, the mechanisms by which those factors affect well-being, and available resources and tools to improve well-being.

Interpersonal and Communication Skills 1: Patient- and Family-Centered Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Uses language and non-verbal behavior to reflect respect and establish rapport while accurately communicating one's own role within the health care system	Establishes a therapeutic relationship in straightforward encounters with patients using active listening and clear language	Establishes a therapeutic relationship in challenging patient encounters	Easily establishes therapeutic relationships with patients, regardless of the complexity of cases	Acts as a mentor to others in situational awareness and critical self-reflection with the aim of consistently developing positive therapeutic relationships and minimizing communication barriers
Identifies common barriers to effective communication (e.g., language, disability)	Identifies complex barriers to effective communication (e.g., health literacy, cultural, technology)	When prompted, reflects on one's personal biases, while attempting to minimize communication barriers	Independently recognizes personal biases of patients, while attempting to proactively minimize communication barriers	
With insight gained through an assessment of patient/family expectations coupled with an understanding of their health status and treatment options, adjusts one's communication strategies	Organizes and initiates communication with a patient/family by clarifying expectations and verifying one's understanding of the clinical situation	With guidance, sensitively and compassionately delivers medical information to patients, elicits patient/family values, learns their goals and preferences, and acknowledges uncertainty and conflict	Independently uses shared decision making with a patient/family to align their values, goals, and preferences with potential treatment options and ultimately to achieve a personalized care plan	Acts as a role model to exemplify shared decision making in patient/family communication that embodies various degrees of uncertainty/conflict
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐

Interpersonal and Communication Skills 2: Interprofessional and Team Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Respectfully requests a consultation	Clearly and concisely requests a consultation or other resources for patient care	Integrates recommendations made by various members of the health care team to optimize patient care	Acts as a role model for flexible communication strategies, i.e., those strategies that value input from all health care team members and that resolve conflict when needed	
Uses language that reflects the values all members of the health care team	Communicates information effectively with all health care team members	Engages in active listening to adapt to the communication styles of the team	Uses effective communication to lead or manage health care teams	Acts as a role model for communication skills necessary to lead or manage health care teams
Receives feedback in a respectful manner	Solicits feedback on performance as a member of the health care team	Communicates concerns and provides feedback to peers and learners	Communicates feedback and constructive criticism to superiors	In complex situations, facilitates regular health care team-based feedback
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐

Interpersonal and Communication Skills 3: Communication within Health Care Systems				
Level 1	Level 2	Level 3	Level 4	Level 5
Accurately documents information in the patient's record and safeguards the patient's personal information	Demonstrates organized diagnostic and therapeutic reasoning through the patient record in a timely manner	Concisely reports diagnostic and therapeutic reasoning in the patient record	Communicates clearly, concisely, and contemporaneously in an organized written form, including anticipatory guidance	Models feedback to improve others' written communication
Communicates through appropriate channels as required by institutional policy (e.g., patient safety reports, cell phone/pager usage)	Respectfully communicates concerns about the system	Uses appropriate channels to offer clear and constructive suggestions for improving the system	Initiates difficult conversations with appropriate stakeholders to improve the system	Facilitates dialogue regarding systems issues among larger community stakeholders (e.g., institution, the health care system, and/or the field)
☐	☐	☐	☐	☐
Comments:				
				Not Yet Completed Level 1 ☐

Goals and Objectives by post-graduate year

PGY1 year

The overall goal for the year is to develop the foundational skills of the practice of emergency medicine that includes, but is not limited to the following overall objectives:

1. Learn and practice appropriate use of hand hygiene and personal protective equipment (PPE)
2. Perform an appropriate focused history and physical exam
3. Demonstrate the ability to create, verbalize and document an appropriate differential of consequence
4. Demonstrate the ability to interpret basic radiologic studies and ECGs.
5. Develop and implement basic treatment plans through admission or discharge
6. Contribute to the health care team integrating well with supervising residents, faculty, nursing and support staff, and consultants
7. Gain experience with the management of critically ill and moderately ill patients
   a. Specific experience will be obtained in the leadership of Brain Attack Team (BAT) activations under the supervision of an attending or PGY4 resident
8. Demonstrate an ability to manage Emergency Department patients in a time-sensitive manner and to prioritize time-critical assessments and interventions
9. Maintain a portfolio, including timely reporting of performance reviews, logs, tracking of procedures and projects and potential goals
10. Demonstrate interest and early mastery of a narrow clinical topic via the creation of a 5-minute intern talk
11. Demonstrate skill in professionalism, interpersonal communication, and be open to re-direction when needed
12. Develop a basic understanding of the roles of supporting staff (Case Management, Social Work, Peer-Recovery) in the care of ED patients
13. Develop and maintain a learning plan as the foundation for establishing the practice of lifelong learning

PGY2 year

The overall goal for the year is to develop an advanced capability in the practice of emergency medicine with skills in efficiency that include but are not limited by the following overall objectives:

1. Perform an appropriate focused history and physical exam in a timely fashion
2. Demonstrate an ability to create, verbalize and document a relevant differential of consequence for multiple patients, including those with uncommon presentations
3. Develop and institute complex treatment plans for a variety of patients simultaneously
4. Demonstrate leadership by developing skills as a resident supervisor of a healthcare team, integrating medical students with other residents, faculty and nursing staff
5. Develop proficiency in multi-tasking to manage multiple ED patients of varying levels of acuity
6. Gain experience with the simultaneous management of multiple critically ill patients

7. Develop and hone resuscitation skills
8. Develop skills around being the team leader for multidisciplinary critical care response teams
9. Demonstrate skill in professionalism, interpersonal communication, and the ability to raise concerns to supervisors when others require guidance or redirection
10. Perform EMS Box consultation, under faculty supervision (as appropriate)
11. Successfully suggest and integrate varied supporting staff (Case Management, Social Work, Peer-Recovery) involvement in the care of ED patients
12. Maintain a portfolio, including timely reporting of performance reviews, logs, tracking of procedures and projects and potential goals
13. Develop search strategies for finding the best available evidence to a specific clinical question, and determine the applicability of those results to your clinical practice
14. Demonstrate interest and mastery of a narrow clinical topic via the creation of a 30-minute core content topic presentation
15. Demonstrate knowledge of the principles of Evidence Based Medicine (EBM) via the creation of a 60-minute mentored EBM presentation
16. Develop skill in slide preparation, lecture preparation, and overall presentation through a mentored experience
17. Modify, expand, and maintain a personal learning plan in the development of the practice of lifelong learning

PGY3 year

The overall goal for the year is to develop overall clinical competence in the practice of Emergency Medicine that includes but is not limited by the following overall objectives:

1. Perform an appropriate focused history and physical exam in a timely fashion
2. Demonstrate an ability to rapidly create, verbalize and document a relevant differential of consequence for multiple patients, regardless of complaint
3. Demonstrate growing leadership by serving as the resident supervisor of a healthcare team, integrating well with other residents, medical students, PA residents, faculty, and nursing staff
4. Demonstrate supervisory and teaching skills for medical students, PA residents, and the other junior residents working on their team
5. Develop proficiency in multi-tasking
6. Develop and institute complex treatment plans for a variety of patients simultaneously
7. Manage critically ill patients while overseeing the critical care team for both medical and traumatic presentations
8. Develop nuanced and evidence-based resuscitation skills
9. Demonstrate the ability to provide rapid and appropriate care in the treatment of all Emergency Department patients in a time-sensitive manner, including low acuity patients
10. Demonstrate skill in professionalism, interpersonal communication, and the ability to intervene when others require guidance or redirection
11. Demonstrate an awareness of the need to view the ED as a whole and not a geographic area
12. Demonstrate overall clinical competence in the practice of emergency medicine
13. Maintain a portfolio, including timely reporting of performance reviews, logs, tracking of procedures and projects and potential goals

14. Demonstrate interest and mastery of a narrow clinical topic via the creation of a 60-minute core content topic
15. Demonstrate advanced skills in slide preparation, lecture preparation, and overall presentation
16. Develop an understanding of how to conduct a systematic root-cause analysis, in the Mortality and Morbidity (M&M) format, by analyzing a case with a less than optimal outcome through a mentored process
17. Modify, expand, and maintain a personal learning plan in the development of the practice of lifelong learning

PGY4 year

The overall goal for the year is to develop independent and supervisory clinical competence in the practice of Emergency Medicine that includes but is not limited by the following overall objectives:

1. Demonstrate outstanding clinical competence in the practice of emergency medicine, while demonstrating excellence in clinical supervision, bedside teaching, and management of the ED as a whole
2. Perform highly focused history and physical examinations in an expeditious manner, while maintaining a calm, deliberate and compassionate approach to patient care
3. Demonstrate the ability to succinctly verbalize and document management plans, including relevant differentials of consequence for multiple patients
4. Develop and institute complex, tailored treatment plans for a variety of patients with varying pathophysiology and of differing acuity (including simultaneously managing those with severe injury and those with minor illness)
5. Demonstrate the ability to provide rapid and appropriate care in the treatment of all Emergency Department patients in a time-sensitive manner, including low acuity patients
6. Demonstrate excellence in evidence-based resuscitation
7. Oversee the management of critically ill patients while acting as a clinical and educational resource for the critical care team
8. Demonstrate clinical leadership by supervising residents and managing multiple resident care teams as well as providing education to residents, medical students, and clinical staff
9. Demonstrate clinical leadership by serving as a primary liaison between faculty and residents and serving as key negotiator with charge nurses, other clinical nursing leadership, and consultants from other services
10. Demonstrate skill in professionalism, interpersonal communication, and successful negotiation and/or conflict resolution and the ability to intervene when others require guidance or redirection
11. Maintain a portfolio in a timely and complete manner, including performance reviews, logs, tracking of procedures and projects and potential goals
12. Develop skills in didactic teaching by facilitating a small group
13. Developing advanced proficiency and generating scholarship in a focused area within the field of Emergency Medicine
14. Demonstrate skills in lifelong learning, including the ability to modify the approach to learning, when needed

CLINICAL ROTATION DESCRIPTIONS

Please note that the abbreviations in parenthesis within each description indicate the ACGME Core Competencies required during training.

MK = medical knowledge
SBP = systems-based practice
PR = professionalism
PBL = practice-based learning
ICS = interpersonal and communication skills
PC = patient care

EM1
Clinical Rotations

Rotation: **Anesthesia at Johns Hopkins Hospital (JHAnes)**
Year: **EM1**
Duration: **Two Weeks**

Educational Goal:

Develop the ability to evaluate, diagnose, and manage basic airways as well as the initial ability to evaluate, diagnose, and manage difficult airways.

Educational Objectives:

1. Describes upper airway anatomy including indicators of a difficult airway (PC, MK).
2. Identifies the compromised airway, performs basic airway maneuvers or adjuncts (jaw thrust / chin lift / oral airway / nasopharyngeal airway) and ventilates/oxygenates patient using BVM (PC, MK)
3. Describes elements of airway assessment and indications impacting the decision to intubate (PC, MK)
   - Taking an airway/anesthesia history and physically examining the airway
   - Understanding the indications and interpretation of ancillary laboratory and imaging techniques
4. Develop airway management skills using a variety of devices and techniques (PC, SBP, MK)
   - Bag-valve mask ventilation
   - Orotracheal intubation (direct laryngoscopy, video assisted laryngoscopy, bougie)
   - Airway adjuncts (oropharyngeal airways, nasopharyngeal airways)
   - Supraglottic device use (laryngeal mask airway)
   - Advanced airway management techniques for difficult airway management (e.g. nasolaryngoscopy, bronchoscopic intubation, cricothyrotomy)
5. Describes the pharmacology of agents used for rapid sequence intubation including specific indications and contraindications as well as pharmacology of agents used for maintenance of anesthesia (PC, SBP, MK)
   - Sedative hypnotics
   - Neuromuscular relaxants
   - Regional anesthetic
6. Apply airway management skills in both the scheduled and acute operating room cases (PC, MK, SBP, PBL)
   - Confirms proper tube placement
   - Uses airway algorithms in decision making for complicated patients
   - Uses airway adjuncts as indicated
   - Performs post-intubation assessment using multiple modalities
7. Performs various procedures required in patients:
   - Rapid sequence and/or elective oral intubation (MK, PC)
   - +/- nasal intubation (MK, PC)
   - Laryngeal mask airway (MK, PC)
   - Venous access
   - Central line placement
   - Arterial line placement
8. Employs appropriate methods of mechanical ventilation based on specific patient physiology (MK, PC)
9. Demonstrate effective communication with patients, their families, and professional associates (ICS).

10. Demonstrate respect, compassion, and integrity (PR).
11. Learn the basic resources available for the care of the O.R. patient (SBP).
12. Discusses indications, contraindications and possible complications of local anesthesia (MK, PC,).
13. Performs local anesthesia using appropriate doses of local anesthetic and appropriate technique to provide skin to sub-dermal anesthesia for procedures (MK, PC).
14. Knows the indications, contraindications, potential complications and appropriate doses of analgesic/sedative medications (MK, PC,)
15. Performs patient assessment and discusses with the patient the most appropriate analgesic/sedative medication and administers in the most appropriate dose and route (MK, PC).
16. Knows the anatomic landmarks, indications, contraindications, potential complications and appropriate doses of local anesthetics used for regional anesthesia (MK, PC).
17. Performs pre-sedation assessment, obtains informed consent and orders appropriate choice and dose of medications for procedural sedation (MK, PC, ICS)

Description of clinical experiences:
The EM1 resident will rotate for a two-week period on the Anesthesia Service as a full member of the Service. The resident will have exposure to a wide variety of patients. As an EM1, the resident will begin the airway evaluation with attending anesthesiologists on scheduled cases in the operating room. The resident will learn the basic approach to the assessment and management of the airway. As part of the time, the resident will observe and participate in regional anesthesia and procedural sedation. The resident along with the anesthesia team, including an attending anesthesiologist, will work approximately four 10-hour shifts each week from Monday through Thursday. The resident should be in scrubs and ready to work by 6:30am unless requested to be present earlier or later. If interesting cases are occurring on the weekend, the residents may be asked if they wish to attend. The EM1 resident will also attend one day of Otolaryngology clinic during their rotation to practice nasolaryngoscopy skills. The online nasolaryngoscopy module must be reviewed prior to attending clinic.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

The EM1 will have access to a wide variety of facilities and resources including, but not limited to medical records (computerized and library), ED library (EM texts, computer), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Harrison Medical Library, shower and hospital cafeteria.

Duties and Responsibilities include:
- ➢ Obtaining detailed patient histories
- ➢ Performing physical examinations
- ➢ Reviewing all laboratory values and diagnostic studies
- ➢ Documenting histories and physical examinations
- ➢ Performing all necessary airway procedures
- ➢ Performing any venous access procedures
- ➢ Performing any regional or local anesthesia procedures

The resident will devise a diagnostic and management plan that will be reviewed by the supervising attending anesthesiologist.

Description of didactic experiences:
Formal teaching will consist of frequent bedside teaching by the attending anesthesiologist and the Thursday morning conference, which starts at 7am and is held on all Thursdays except the first Thursday of the month. Residents are required to attend the EM weekly Friday morning conference and should be excused from all clinical responsibilities at this time.

Evaluation process:
At the end of each block, online evaluations with input from supervising faculty members will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations. Additionally, residents are expected to maintain procedure logs with a goal of 30 intubations over the rotation.

Feedback mechanisms:
All evaluations will be reviewed by the resident in both the semi-annual meetings with his/her appointed faculty advisor and the semi-annual meetings with the residency director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS),Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contact:
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Rotation: **Cardiac Care Unit (CCU) at Johns Hopkins Hospital**
Year: **EM1**
Duration: **Four Weeks**

Educational Goals

Develop the ability to evaluate, diagnose, stabilize, and treat the critically ill patient.

Educational Objectives

1. Gain clinical experience in state-of-the-art cardiopulmonary resuscitation. (PC, MK, PBL&I, ICS, Prof, SBP)
2. Practice the evaluation and management of acute chest pain. (PC, MK, PBL&I, ICS, Prof, SBP)
3. Gain an understanding of the many manifestations and complications of CAD, and obtain knowledge of current therapy of angina, MI, and of the complications of MI. (PC, MK, PBL&I, ICS, Prof, SBP)
4. Understand the various pathophysiologic states that result in cardiac failure, the clinical manifestations, complications, and therapeutic modalities available. (PC, MK, PBL&I, ICS, Prof, SBP)
5. Enhance skills in the interpretation of 12-lead EKG's and rhythm strips. (PC, MK)
6. Understand the various etiologies of pericarditis, the range of clinical manifestations, the evaluation, and therapeutic options. (PC, MK, PBL&I, ICS, Prof, SBP)
7. Gain an awareness of the basic design, functional modalities, potential malfunctions and management interventions for pacemakers and implantable automatic defibrillators. (PC, MK, PBL&I, ICS, Prof, SBP)
8. Learn the appropriate management of accelerated hypertension. (PC, MK, PBL&I, ICS, Prof, SBP)
9. Gain an awareness of the pathophysiology, risk factors, clinical presentation and timely management of aortic dissection and aneurysm. (PC, MK, PBL&I, ICS, Prof, SBP)
10. Evaluate and manage the emergent complications associated with recent cardiothoracic surgery. (PC, MK, PBL&I, ICS, Prof, SBP)
11. Provide an educational experience for the medical students on one's team. (PBL&I, Prof, SBP, ICS)
12. To learn the pathophysiology and common presentations of critical medical and cardiac conditions and disease processes including but not limited to: (PC, MK, SBP)
    - acute myocardial infarction and heart failure
    - cardiac dysrhythmias
    - cardiac tamponade
    - hypertensive emergencies
    - respiratory failure and severe respiratory distress
13. Gain exposure to and experience in the management of the above medical conditions (PK, PBL)
14. Demonstrate an ability to function well in an ICU setting by (PC, MK, IPS)
    - taking a medical history
    - performing a complete physical examination
    - understanding the indications and interpretation of ancillary laboratory and imaging techniques
15. Experience in (but not limited to) the following procedures (MK, PC):
    - venous access
    - central line placement

- arterial line placement
- Swan-Ganz catheter placement
- temporary cardiac pacing

16. Experience and training in medical resuscitation efforts, including anticipation and recognition of short and long-term complications (MK, ICS, SBP)
17. Experience and understanding of in hospital medical workups and patient outcomes (MK, SBP, PBL)

Expectations:

1. Evaluate and assess patients referred for admission to the CCU, supervised by the senior resident, fellow and attending physician.
2. Obtain accurate information from available sources (interviews with family, significant others, physical exam, medical records, diagnostic and therapeutic procedures) and communicate this information effectively to other members of the medical team.
3. Assess and critically evaluate current medical and scientific literature and apply this to the care of the patients in the CCU.
4. Demonstrate the ability to organize information, think critically, and solve problems.
5. Maintain comprehensive, timely and legible medical records documenting the care given to patients, procedures performed and care plan.
6. Discuss and implement plans and treatment goals under the supervision of the attending and fellow.
7. Function as part of a multi-disciplinary team.
8. Demonstrate respect, sensitivity, compassion, integrity, and altruism in relationships with patients and families.

***Description of clinical experiences*:**

The EM1 resident will rotate for four weeks on the CCU Service at Johns Hopkins Hospital as a full member of the Service. The resident will have exposure to a wide variety of critically ill patients under the direct supervision of the attending physician.

As an EM1, the resident will participate in the evaluation of admissions from the emergency department, general medical floors and outside facilities. The resident will remain in the hospital for admissions and acute patient management on shifts that are allowed under the current duty hours guidelines (no longer than 24 hours, plus 4 hours for transition, with 24 hours off (averaged over 4 weeks) and not to exceed 80 hours/wk averaged over 4 weeks). Residents must have 14 hours off after a 24-hour call. As directed by the CCU supervisors, the EM resident will carry the code pager and respond to all codes during this time.

You will receive your rotation schedule prior to the beginning of the experience. If you are asked to modify your schedule for any reason, you MUST contact the EM Chiefs AND Dr. Ritter or Dr. Ehmann.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

Facilities and Resources:

The EM1 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), online web data (Up-to-date, MD Consult,

Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, call room, locker-room, showers and several hospital cafeterias.

Duties and Responsibilities include:

1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Documenting histories and physical examinations
5. Writing daily progress notes
6. Performing all necessary procedures

The resident along with a senior medical resident will devise a diagnostic and management plan that will be reviewed by the supervising cardiology/critical care fellow and supervising attending physician. The entire CCU team will also formally review each patient during bedside rounds the following morning.

Description of didactic experiences:

Formal teaching will consist of daily teaching rounds led by both the attending physician and the critical care fellow.

Evaluation process:

At the end of each block, electronic evaluations (on New Innovations) with input from supervising faculty members, senior residents and fellows will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:

All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

First point of contact:
JHEM Chiefs
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Rotation Contact: Medicine ACS (please email any, but cc: all)
Salem Hernandez sherna23@jhmi.edu
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Rotation Contact: CCU Director
Dr. Thomas Metkus (tmetkus1@jhmi.edu)

Rotation: **Emergency Department at Bayview Medical Center (BVED)**
Year: **EM1**
Duration: **Two Weeks**

The EM1 resident will rotate for two weeks in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients.

Educational Goals & Overall Objectives:
Develop the fundamental skills of the practice of emergency medicine in a tertiary care Level 2 Trauma Center that includes the ability to, but is not limited by the following overall objectives:

1. Perform an appropriate focused history and physical exam
2. Demonstrate the ability to create, verbalize and document an appropriate differential of consequence.
3. Develop and implement basic treatment plans through admission or discharge.
4. Contribute to the health care team integrating well with supervising residents, faculty and nursing staff.
5. Gain experience with the management of critically ill patients
6. Demonstrate an ability to manage Emergency Department patients in a time-sensitive manner.

Specific Educational Objectives:
1. Demonstrate skill in **"Data Gathering"** that includes but not limited to:
   - Perform an appropriate focused history and physical exam (PC, MK, ICS, PR)
   - Perform clear verbal and written patient presentations that adequately reflect the patient's condition, including acuity, disease state.
   - Participate in the appropriate ordering and interpretation of ancillary tests (PC, MK, SBP)
   - Participate with senior residents and faculty in the essential and accurate information collection from all available sources (PC, SBP)
   - Demonstrate an appreciation of continuous data gathering on patients who present to the emergency department (PC, SBP)
   - Demonstrates an ability to identify all key elements in the patient's history, physical or other data sources that indicate a need for further investigation ("the red flag"). (PC, MK)
   - Understands the importance of obtaining the patient's explicit agenda for coming to the Emergency Department (PC, ICS, PR)
2. Demonstrate skill in **"Problem Solving"** that includes but not limited to:
   - Generate an appropriate and relevant differential of consequence for an undifferentiated patient (PC, MK)
   - Under the supervision of the health care team, determine the additional data elements required to make efficient patient management decisions (PC, MK, PBL)
   - Under the supervision of the health care team generate an expanded differential of consequence including the consideration of possible atypical presentations (PC, MK, PBL)
   - Notifies Attending Physician of any significant changes in patient condition. (PC, MK, PBL, SBP)
3. Demonstrate skill in **"Patient Management"** that includes but not limited to:
   - Create a basic treatment plan based on the differential of consequence (PC, MK, SBP)
   - Apply basic knowledge of pathophysiology in justifying patient care decisions. (PC, MK, SBP)
   - Under the guidance of the health care team, promptly recognize and institute appropriate emergency stabilization of the unstable patient (PC, MK, SBP)

- Understands the need to determine from each patient, the patient's explicit agenda in creating a management plan
- With the guidance of the attending or resident, create a management plan that addresses all the key elements of the patient's history, physical and other data sources that warrant further attention. (PC, MK, PBL, SBP)

4. Demonstrate a **"Medical Knowledge"** appropriate for level of training that includes but not limited to:
   - Demonstrates a basic fund of medical knowledge (MK)
   - Describe basic disease processes as they relate to the patients under their care. (PC, MK)
5. Demonstrate technical proficiency in **"Procedural Skills"** consistent with level of training that includes but not limited to:
   - Demonstrates understanding of informed consent. (PC, MK, P, SBP)
   - Provides clear and supportive information to patients and families regarding the need for procedural intervention (PC, MK, P, SBP)
   - Suturing, lumbar puncture, splinting, I/D abscess, venipuncture (PC, MK, P)
6. Demonstrate skill in **"Efficiency"** of care that includes but not limited to:
   - Effectively manages at least 1 patient per hour (PC, MK, SBP)
   - Demonstrates an ability to provide medical screening examinations of patients who are waiting for an evaluation room. (PC, MK, SBP)
   - Demonstrates an ability to prioritize tasks appropriately (PC, MK, SBP)
7. Demonstrate appropriate **"Interpersonal and Communication Skills"** that includes but not limited to:
   - Demonstrates effective information exchange with patients, their families, and professional associates (ICS, PR)
   - Shows an appreciation of appropriate conflict resolution skills (ICS, PR)
   - Works effectively with others in the health care team (ICS, PR)
   - Demonstrates an appropriate sensitivity in negotiating with individuals from a variety of cultures, backgrounds, education, and ethnicity. (PR, ICS)
   - Discuss treatment options with patients allowing patients to voice concerns, suggestions, and preferences. (PC, ICS)
8. Demonstrate appropriate **"Professionalism"** skills that include but not limited to:
   - Introduces self to patient and/or family. (PR)
   - Respectful of patient's privacy and confidentiality. (PR)
   - Demonstrates respect, compassion, and integrity. (PR)
   - Demonstrates a willingness to incorporate patient preferences during the ED and post ED course. (PR, ICS, PC)
   - Adheres to the Dress Code. (PR)
   - Maintains equanimity while in the ED. (PR)
9. Demonstrate skill in proper **"Documentation"** that includes but not limited to:
   - Medical record is complete and appropriate. (PC, SBP)
   - Documentation reflects patient condition and is consistent with the final disposition. (PC, SBP)
   - Documents progress notes and procedure notes when applicable. (PC, SBP)
10. Demonstrate an understanding of a **"Systems-Based Practice"** that includes but not limited to:
    - Understands basic resources available for the care of the emergency department patient. (SBP)

- Recognizes the importance of resource allocation and cost as they relate to patients, the hospital and other services. (PC, MK, SBP)

11. Demonstrate an awareness of the importance of **"Practice Based Learning and Improvement"** that includes but not limited to:
    - Uses appropriate information resources (i.e., texts, online web sites, etc.) for care of patients. (PBL, PC)
    - Demonstrates an interest in learning and willingness to investigate literature and other resources.
    - Seeks out instruction and incorporates new learning and feedback in the care of patients. (PC, MK, SBP)

Educational Expectations:

1. Exposure and experience in the initial evaluation of an undifferentiated patient population
2. Exposure and experience in the development of appropriate treatment plans
3. Exposure and experience in resuscitation efforts
4. Participate in the care of critically ill or injured adult and pediatric patients under the direction of attending faculty
5. Experience in (but not limited to) the following procedures under direct supervision by faculty:
    - maintaining cervical stabilization
    - venous access
    - arterial access
    - lumbar puncture
    - intubation
    - foley catheter insertion
    - thoracentesis
    - arthrocentesis
    - paracentesis
    - ultrasound
    - laceration repair
    - splinting techniques
    - cardioversion
    - management of acutely ill burn patients
    - incision and drainage, etc.

Duties and Responsibilities include:

1. Obtaining appropriately detailed patient histories
2. Performing physical examinations
3. Performing all necessary procedures under supervision of the faculty
4. Reviewing all laboratory values and diagnostic studies
5. Developing a differential of consequence and an appropriate management plan for each patient
6. Demonstrating efficient implementation of treatment resulting in timely disposition
7. Providing clear and concise documentation that adequately reflects patient condition and ED course
8. Creation of complete and relevant discharge instructions
9. Demonstrating professional interactions with faculty, staff, colleagues and consultants
10. The resident will devise a diagnostic and management plan that will be reviewed by the faculty.

Description of clinical experiences:
The EM1 will rotate for two weeks in the emergency department as a full member of the service.

As an EM1, the resident will be responsible for the initial evaluation of patients presenting to the ED under the supervision of the EM attending. They will primarily work in a limited clinical area.

Shifts are 12 hours and run from 7am-7pm (Purple) or 12PM-8PM (Flex). The schedule is available on Shift Admin and can be accessed via hopkinsem.org.

All Emergency Medicine resident(s) must follow the ACGME <u>Emergency Medicine</u> duty hours guidelines.

Facilities and Resources:
The EM1 will have access to a wide variety of facilities and resources including, but not limited to medical records (computerized and library), ED library (EM texts, computer), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Harrison Medical Library, ED lounge, shower and hospital cafeteria.

Description of didactic experiences:
Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12 pm. All residents in the ED are relieved from clinical duties by faculty members in order to allow them to attend conferences.

Evaluation process:
Several evaluation mechanisms may be used including, but not limited to:

- Faculty Review via End of Shift Evaluations and End of Rotation evaluations
- Oral Boards
- Procedure Logs
- Patient Logs
- Chart Reviews
- Biannual Review

At the midpoint and the endpoint of each 4-week block, electronic evaluations will be completed with input from faculty members. You are required to select TWO SUPERVISORY FACULTY at each of the midpoint and endpoint evaluations for completion. A Direct Observation form must also be requested at the end of each shift using the New Innovations app on your phone. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE, DO	OB, IS
Medical Knowledge	X	ERE, DO	OB, IS
Practice Based Learning	X	ERE, DO	FR, BR, PL
System Based Learning	X	ERE, DO	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE, DO	FR, BR
Professionalism	X	ERE, DO	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE) Direct Observation (DO)			

Rotation Contact:
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Rotation: **Emergency Department at Johns Hopkins Hospital (JHED)**
Year: **EM1**
Duration: **Sixteen Weeks**

The EM1 resident will rotate for fourteen weeks in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients.

Educational Goal & Overall Objectives:
Develop the fundamental skills of the practice of emergency medicine that includes but is not limited to the following overall objectives.

1. Perform an appropriate focused history and physical exam.
2. Demonstrate an ability to create, verbalize and document an appropriate differential of consequence.
3. Develop and implement basic treatment plans through admission or discharge.
4. Contribute to the health care team integrating well with supervising residents, faculty and nursing staff.
5. Gain experience with the management of critically ill and moderately ill patients
6. Demonstrate an ability to manage Emergency Department patients in a time-sensitive manner
7. Maintain a portfolio, including performance reviews, logs, tracking of procedures and projects and potential goals.

Specific Educational Objectives:
1. Demonstrate skill in **"Data Gathering"** that includes but not limited to:
   - Perform an appropriate focused history and physical exam (PC, MK, ICS, PR)
   - Perform clear verbal and written patient presentations that adequately reflect the patient's condition, including acuity, disease state.
   - Participate in the appropriate ordering and interpretation of ancillary tests (PC, MK, SBP)
   - Participate with senior residents and faculty in the essential and accurate information collection from all available sources (PC, SBP)
   - Demonstrate an appreciation of continuous data gathering on patients who present to the emergency department (PC, SBP)
   - Demonstrates an ability to identify all key elements in the patient's history, physical or other data sources that indicate a need for further investigation ("the red flag"). (PC, MK)
   - Understands the importance of obtaining the patient's explicit agenda for coming to the Emergency Department (PC, ICS, PR)
2. Demonstrate skill in **"Problem Solving"** that includes but not limited to:
   - Generate an appropriate and relevant differential of consequence for an undifferentiated patient (PC, MK)
   - Under the supervision of the health care team determine the additional data elements required to make efficient patient management decisions (PC, MK, PBL)
   - Under the supervision of the health care team generate an expanded differential of consequence including the consideration of possible atypical presentations (PC, MK, PBL)
   - Notifies Attending Physician of any significant changes in patient condition. (PC, MK, PBL, SBP)
3. Demonstrate skill in **"Patient Management"** that includes but not limited to:
   - Create a basic treatment plan based on the differential of consequence (PC, MK, SBP)
   - Apply basic knowledge of pathophysiology in justifying patient care decisions. (PC, MK, SB)

- Under the guidance of the health care team, promptly recognize and institute appropriate emergency stabilization of the unstable patient (PC, MK, SBP)
- Understands the need to determine from each patient, the patient's explicit agenda in creating a management plan
- With the guidance of the attending or resident, create a management plan that addresses all the key elements of the patient's history, physical and other data sources that warrant further attention. (PC, MK, PBL, SBP)

4. Demonstrate a **"Medical Knowledge"** appropriate for level of training that includes but not limited to:
   - Demonstrates a basic fund of medical knowledge (MK)
   - Describe basic disease processes as they relate to the patients under their care. (PC, MK)
5. Demonstrate technical proficiency in **"Procedural Skills"** consistent with level of training that includes but not limited to:
   - Demonstrates understanding of informed consent. (PC, MK, P, SBP)
   - Provides clear and supportive information to patients and families regarding the need for procedural intervention (PC, MK, P, SBP)
   - Suturing, lumbar puncture, splinting, I/D abscess, venipuncture (PC, MK, P)
6. Demonstrate skill in **"Efficiency"** of care that includes but not limited to:
   - Effectively manages at least 1 patient per hour (PC, MK, SBP)
   - Demonstrates an ability to provide medical screening examinations of patients who are waiting for an evaluation room. (PC, MK, SBP)
   - Demonstrates an ability to prioritize tasks appropriately (PC, MK, SBP)
7. Demonstrate appropriate **"Interpersonal and Communication Skills"** that includes but not limited to:
   - Demonstrates effective information exchange with patients, their families, and professional associates (ICS, PR)
   - Shows an appreciation of appropriate conflict resolution skills (ICS, PR)
   - Works effectively with others in the health care team (ICS, PR)
   - Demonstrates an appropriate sensitivity in negotiating with individuals from a variety of cultures, backgrounds, education, and ethnicity. (PR, ICS)
   - Discuss treatment options with patients allowing patient to voice concerns, suggestions, and preferences. (PC, ICS)
8. Demonstrate appropriate **"Professionalism"** skills that include but not limited to: Introduces self to patient and/or family (PR)
   - Respectful of patient's privacy and confidentiality (PR)
   - Demonstrates respect, compassion, and integrity (PR)
   - Demonstrates a willingness to incorporate patient preferences during the ED and post ED course. (PR, ICS, PC)
   - Adheres to the Dress Code (PR)
   - Maintains equanimity while in the ED (PR)
9. Demonstrate skill in proper **"Documentation"** that includes but not limited to:
   - Medical record is complete and appropriate (PC, SBP)
   - Documentation reflects patient condition and is consistent with the final disposition. (PC, SBP)
   - Documents progress notes and procedure notes when applicable. (PC, SBP)
10. Demonstrate an understanding of a **"Systems-Based Practice"** that includes but not limited to:

- Understands basic resources available for the care of the emergency department patient (SBP)
- Recognizes the importance of resource allocation and cost as they relate to patients, the hospital and other services (PC, MK, SBP)

11. Demonstrate an awareness of the importance of **"Practice Based Learning and Improvement"** that includes but not limited to:
    - Uses appropriate information resources (i.e., texts, online web sites, etc.) for the care of patients (PBL, PC)
    - Demonstrates an interest in learning and willingness to investigate literature and other resources.
    - Seeks out instruction and incorporates new learning and feedback in the care of patients (PC, MK, SBP)

Educational Expectations:

1. Exposure and experience in the initial evaluation of an undifferentiated patient population
2. Exposure and experience in the development of appropriate treatment plans
3. Exposure and experience in resuscitation efforts
4. Participate in the care of critically ill or injured adult and pediatric patients under the direction of attending faculty or resident
5. Experience in (but not limited to) the following procedures under direct supervision by faculty or the more senior residents:
    - maintaining cervical stabilization
    - venous access
    - arterial access
    - lumbar puncture
    - intubation (Trauma intubation can only be performed after completion of Anesthesia Rotation)
    - foley catheter insertion
    - thoracentesis
    - arthrocentesis
    - paracentesis
    - laceration repair
    - splinting techniques
    - cardioversion
    - incision and drainage

***Duties and Responsibilities include*:**

1. Obtaining appropriately detailed patient histories
2. Performing physical examinations of the patient
3. Performing all necessary procedures, diagnostic and therapeutic, under supervision of the faculty and senior residents
4. Reviewing all laboratory values and diagnostic studies
5. Developing a differential of consequence and an appropriate management plan for each patient
6. Demonstrating efficient implementation of treatment resulting in timely disposition.
7. Providing clear and concise documentation that adequately reflects patient condition and ED course
8. Creation of complete and relevant discharge instructions.
9. Provide efficient, competent, compassionate care to all patients with careful attention to

communications with patients and families.
10. Demonstrating professional interactions with faculty, staff, colleagues and consultants
11. The resident will devise diagnostic and management plans that will be reviewed by the EM attending.

Facilities and Resources:
The EM1 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker rooms, showers and several hospital cafeterias.

Description of clinical experience:
Interns will work approximately 50 hours a week. Shifts will be eight to twelve hours in length. The schedule will be available via Shift Admin and can be accessed via this site. You should plan to arrive 15 minutes prior to the beginning of your shift to obtain sign out on your patients and/or review patient materials. After handoff, both providers should visit all patients at the bedside to ensure patients are updated on plans and to reassess their clinical status.

All Emergency Medicine resident(s) must follow the ACGME <u>Emergency Medicine</u> duty hours guidelines.

Patients will be seen primarily by residents in the ED. As an EM1, the intern will be responsible for the initial evaluation of patients presenting to the ED under the supervision of the EM attending. The intern will devise a diagnostic and clinical instruction and management plan that will be reviewed by the senior EM residents or attending

Description of didactic experience:
Daily morning rounds begin at 7am. A medical minute will occur prior to sign-out, and residents who are working clinically are required to attend unless they are in the middle of a critical care. Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties by faculty members and advanced practice practitioners to attend conferences. You may also be paired with an attending for formal teaching and feedback in the form of a "teaching observation shift." During these periods an attending will focus primarily on your learning. We expect that if you are working with a teaching attending that you will provide them with areas of growth for which you are seeking specific feedback.

Evaluation process:
Several evaluation mechanisms will be used including, but not limited to:

- Teaching Observation Shifts (Faculty working one on one with a resident)
- End of Shift (Faculty review of resident performance based on a single shift)
- End of Rotation (Global assessment in New Innovations)
- Faculty Review
- Oral Boards
- Procedure Logs
- Patient Logs
- Chart Reviews
- Biannual Review

At the midpoint and the endpoint of each block, electronic evaluations will be completed with input from faculty members and 4th year residents. You must select TWO SUPERVISORY FACULTY and ONE FOURTH-YEAR RESIDENT at each midpoint and end-point evaluations for completion. You are expected to complete these as soon as possible, but no later than 2 weeks after the electronic request. A Direct Observation

form should also be requested at the end of each shift using the New Innovations app on your phone.

You will also be assigned evaluations by both faculty and 4th year residents. You are expected to complete these within a 2-week time frame.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE, DO	OB, IS
Medical Knowledge	X	ERE, DO	OB, IS
Practice Based Learning	X	ERE, DO	FR, BR, PL
System Based Learning	X	ERE, DO	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE, DO	FR, BR
Professionalism	X	ERE, DO	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE) Direct Observation (DO)			

Rotation Contact:
JHEM Chiefs
jhemchiefs@jhmi.edu

Dr. Kathryn Ritter
Kritter5@jhmi.edu

Rotation: **Emergency Medical Services at Johns Hopkins Hospital (EMS)/Radiology**
Year: **EM1**
Duration: **Two Weeks**
Director: **Nelson Tang, MD**

*****Note: The radiology rotation is integrated into the EMS rotation. For details of the radiology component, please see radiology section*****

Educational Goals:

1. To gain a basic understanding of the pre-hospital care of the acutely ill or injured patient.
2. To become familiar with the key elements of an Emergency Medical Services (EMS) system including levels of providers, transport modalities, equipment and dispatch.
3. To gain exposure to the roles and responsibilities of the EMS Medical Director.

Educational Objectives:

1. Learn the central events pertinent to the historical development of EMS(SBP)
2. Understand the different levels of EMS providers and describe the major distinctions and capabilities of each category (SBP, MK)
3. Identify the key issues and elements of EMS systems and systems design (SBP, MK, PC)
4. Understand the role of physician medical control in EMS and distinguish between the types of medical direction (SBP)
5. Observe the practice of emergency medical care in the pre- and out-of-hospital setting in a variety of EMS systems (PC, MK, SPB)
6. Become familiar with the equipment and personnel that make up Basic Life Support (BLS), Advanced Life Support (ALS) and Critical Care Transport (CCT) ambulances, as well as the training and experience that different units carry. (PC, MK, SBP, Prof, ICS)
7. Become familiar with the equipment, algorithms, and procedures used by base-station operators. (PC, MK, PBLI, Prof, SBP, ICS)
8. Satisfactorily complete an EMS Core Content resident self-study module as well as a set of EMS self-assessment questions (MK, PBLI)

Description of clinical experiences:

The EM1 will rotate for two weeks on the Emergency Medical Services (EMS) rotation. The resident will rotate under the supervision of the EMS Rotation Director and core EMS faculty. During this time, the resident will be scheduled for selected observational field experiences with EMS operational programs and develop an operational understanding of the provision of emergency medical care in the pre- and out-of-hospital setting.

Facilities and Resources:

The EM1 will have access to a wide variety of facilities and resources including, but not limited to, medical records (computerized and library), EM resident library (multiple EM texts, computers), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex etc), Welch Medical School Library, locker-rooms, showers and several hospital cafeterias.

Duties and responsibilities:

1. Complete two observational "ride-along" shifts with the Howard County Department of Fire & Rescue Services (HCDFRS) *(2 shifts; 8-12 hours in duration)*
2. Complete one observational "ride-along" shifts with the Johns Hopkins LIFELINE Critical Care Transport Program *(1 shift; 8-12 hours)*
3. Attend the weekly EMS Fellowship Core Curriculum Didactic Conferences (Tuesday mornings, when scheduled) during the weeks of the rotation.

4. Meet with EMS Rotation Director, EMS core faculty and/or the EMS Fellow to discuss EMS and other special operations activities they coordinate.
5. Complete a self-study module developed by the EMS Rotation Director containing selected text chapters, original literature and other supporting materials during the rotation.
6. Complete a set of self-assessment questions covering essential EMS concepts at the rotation's end.

The resident's role on each field experience is designed to be observational but with ample opportunity for exchange and interaction with all levels of EMS providers. The resident may function as medical control only with the specific and direct approval of the system medical director and EMS Rotation Director, on a case-by-case basis.

Description of didactic experiences:
The resident will be required to complete self-study during the rotation to include selected, pertinent EMS articles and a self-assessment "exam." Answers with explanation will be provided to the resident upon completion of this exam. Residents will attend EMS Fellowship conferences when they are scheduled to occur during the resident rotation. In addition, the resident will be expected to attend all Friday morning Emergency Medicine core conferences during the rotation period.

Evaluation Process:
Each resident must complete the core components for the successful completion of the EMS rotation. Each resident will complete an End-of-Rotation Report at the end of the rotation to self-report their EMS ride-along activities and EMS conference attendance. Means to evaluate resident knowledge of EMS include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
Direct feedback by the EMS Director will be provided

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)

Rotation Contact:
Dr. Nelson Tang
ntang@jhmi.edu

Rotation: **Medical Intensive Care Unit (MICU) at Johns Hopkins Hospital**
Year: **EM1**
Duration: **Four Weeks**

Educational Goals

Develop the ability to evaluate, diagnose, stabilize, and treat critically ill patients.

Educational Objectives

1. To learn the pathophysiology and common presentations of critical medical and cardiac conditions and disease processes including but not limited to: (PC, MK, SBP)
    - acute intestinal hemorrhage and hemorrhagic shock
    - diabetic ketoacidosis
    - liver failure and its complications
    - meningitis
    - respiratory failure and severe respiratory distress
    - septic shock
    - severe electrolyte imbalance
    - status epilepticus
    - uremia and untreated renal failure
2. To acquire a broad fund of knowledge for the diagnosis and management of both common and uncommon life-threatening illnesses (MK, PBL, PC)
3. Demonstrate an ability to function well in an ICU setting by: (PC, MK, ICS, PBL)
    - taking a medical history
    - performing a complete physical examination
    - understanding the indications and interpretation of ancillary laboratory and imaging techniques
    - Develop and implement effective patient management plans based on an integration of patient information, medical data and current scientific evidence
4. Experience in (but not limited to) the following procedures: (MK, PBL, PC)
    - venous access
    - central line placement
    - arterial line placement
    - Thoracentesis
    - Paracentesis
    - Arthrocentesis
    - Cardiopulmonary Resuscitation
5. Experience and training in medical resuscitation efforts, including anticipation and recognition of short and long-term complications (MK, ICS, SBP)
6. Experience and understanding of in-hospital medical workups and patient outcomes (MK, SBP, PBL)
7. To acquire skills and competence for understanding specialized equipment for monitoring and support of vital organ and system functions (MK, PC, PBL)
8. To learn how to communicate information to critically ill patients and their families in a way that is respectful, sensitive and compassionate and that demonstrates an understanding of preserving confidentiality (PR, ICS)
9. To understand the complications of life-sustaining therapies in the intensive care unit and how best to prevent, minimize, and treat these complications (MK, PBL, PC)

Expectations

1. Evaluate and assess patients referred for admission to the MICU, supervised by the senior resident, fellow and attending physician.
2. Obtain accurate information from available sources (interviews with family, significant others, physical exam, medical records, diagnostic and therapeutic procedures) and communicate this information effectively to other members of the medical team.
3. Assess and critically evaluate current medical and scientific literature and apply this to the care of the patients in the MICU.
4. Demonstrate the ability to organize information, think critically, and solve problems.
5. Maintain comprehensive, timely and legible medical records documenting the care given to patients, procedures performed and care plan.
6. Discuss and implement plans and treatment goals under the supervision of the attending and fellow.
7. Function as part of a multi-disciplinary team.
8. Demonstrate respect, sensitivity, compassion, integrity, and altruism in relationships with patients and families.

***Description of clinical experiences*:**

The EM1 resident will rotate for four weeks on the MICU Service at Johns Hopkins Hospital as a full member of the Service. The resident will have exposure to a wide variety of critically ill patients under the direct supervision of the attending physician.

As an EM1, the resident will participate in the evaluation of all admissions from the emergency department, general medical floors and outside facilities.

As an EM1, the resident will participate in the evaluation of all admissions from the emergency department, general medical floors and outside facilities. The resident will remain in hospital for admissions and acute patient management on shifts that are allowed under the current duty-hours guidelines (no longer than 24 hours, plus 4 hours for transition, with 24 hours off (averaged over 4 weeks) and not to exceed 80 hours/wk averaged over 4 weeks). Residents must have 14 hours off after a 24-hour call.

You will receive your rotation schedule before the experience begins. If you are asked to modify your schedule for any reason, you MUST contact the EM chiefs AND Dr. Ritter or Dr. Ehmann.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

Facilities and Resources:

The EM1 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical Library, call room, locker-room, showers and several hospital cafeterias.

Duties and Responsibilities include:

1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies

4. Documenting histories and physical examinations
5. Writing daily progress notes
6. Performing all necessary procedures

The resident along with a senior medical resident will devise a diagnostic and management plan that will be reviewed by the supervising critical care fellow and supervising attending physician. The entire MICU team will also formally review each patient during bedside rounds the following morning.

Description of didactic experiences:
Formal teaching will consist of daily teaching rounds led by the attending physician and the critical care fellow.

Evaluation process:
At the end of each block, electronic evaluations with input from supervising faculty members, senior residents and fellows will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

First point of contact:
JHEM Chiefs
jhemchiefs@jhmi.edu

Rotation Contact: Medicine ACS (please email any, but cc: all)
Salem Hernandez sherna23@jhmi.edu
Gloria Hong ghong11@jh.edu
Elizabeth Kiernan ekierna6@jhmi.edu
Michael Rose mrose32@jhmi.edu

Rotation: **Obstetrics at Johns Hopkins Hospital (OB)**
Year: **EM1**
Duration: **Three Weeks**

Education Goals:
Develop the ability to evaluate, diagnose, stabilize, and treat obstetrical patients in a labor and delivery suite

Educational Objectives:
1. Communicate effectively with patients, their families, and professional associates (ICS).
2. Demonstrate respect, compassion, and integrity (PR).
3. Demonstrate the ability to perform an appropriate history and physical exam (PC).
4. Demonstrate the ability to develop an appropriate differential of consequence and treatment plan (MK).
5. Demonstrate appropriate clinical decision-making skills (PC).
6. Learn the principles of fetal monitoring techniques (PC).
7. Demonstrate the ability to perform a vaginal delivery, for the **minimum TEN required deliveries with a goal of TWENTY** (PC).
8. Learn the principles of basic obstetrical ultrasonography (PC).
9. Learn the basic resources available for the care of the obstetrical patient (SBP).
10. Learn the appropriate information resources (i.e., textbooks, handbooks, online resources, etc.) available for the care of obstetrical patients (PBL).
11. Learn and practice the skills and techniques necessary to manage a NSVD. (PC, MK, PBL&I, ICS, Prof, SBP)
12. Learn and practice the evaluation and management of a pregnant woman with various medical complaints. (PC, MK, PBL&I, ICS, Prof, SBP)
13. Learn and practice the evaluation and management of women in the immediate post-partum period. (PC, MK, PBL&I, ICS, Prof, SBP)
14. Learn and practice the evaluation and management of labor in a pregnant woman. (PC, MK, PBL&I, ICS, Prof, SBP)

Educational Expectations:
- ➢ To learn the physiology of normal pregnancy and labor
- ➢ To learn the pathophysiology of complications of pregnancy:
  - abruption
  - chorioamnionitis
  - ectopic pregnancy
  - gestational hypertension
  - placenta previa
  - preeclampsia and eclampsia
  - premature rupture of membranes and preterm labor
  - vaginal bleeding
- ➢ To learn the pathophysiology of complicated labor and delivery:
  - breech presentation
  - fetal distress
  - precipitous delivery
  - shoulder dystocia
  - umbilical cord prolapse
  - post-partum hemorrhage
- ➢ Exposure and experience in the management of both normal and complicated

pregnancy, labor and delivery.

- ➢ To learn the interplay between medical conditions and their sequelae on pregnancy and the management of pregnancy:
  - asthma
  - diabetes
  - HIV-related illnesses
  - hypertension
  - infections
  - sickle cell disease
  - trauma
- ➢ Exposure and experience in the management of medical conditions and their sequelae during pregnancy.
- ➢ To learn the normal physiology of the neonate and the potential complications in the immediate neonatal period.
- ➢ Specific experience and training in:
  - taking an obstetric history
  - performing an obstetric examination
  - understanding the indications and interpretation of ancillary laboratory and imaging techniques
- ➢ Experience in (but not limited to) the following procedures:
  - normal vaginal delivery
  - episiotomy
  - episiotomy repair
  - suturing of vaginal lacerations
  - artificial rupture of membranes
  - ultrasound imaging in pregnancy
- ➢ Recognition and management of immediate and short-term postpartum complications
  - early and late postpartum hemorrhage
  - postpartum fever
- ➢ Recognition and management of neonatal complications prior to birth and immediately at birth
- ➢ Experience and training including anticipation and recognition of short and long-term complications following obstetrical procedures
- ➢ Experience and understanding of in hospital management and patient outcomes

Description of clinical experiences:

The EM1 will rotate for a three-week period on the Obstetrics Service as a full member of the Service. The resident will have exposure to a wide variety of normal and complicated pregnancies under the attending physician's supervision.

As an EM1, the resident will be responsible for the evaluation of all pregnant patients referred to the labor and delivery suite for acute evaluation. This will include patients in various stages of pregnancy and labor and with various medical conditions.

Those patients admitted to the labor and delivery suite after their initial evaluation are followed and managed by the resident with supervision by the senior resident and attending faculty

physician. All admitted patients will also be formally reviewed by the entire team, with the attending present, during rounds the following morning.

The resident, along with a senior surgical resident and attending physician, will cover obstetric admissions and acute patient management in the hospital.

Shifts will be twelve hours in length. The schedule typically is Monday through Saturday from 7am-7pm, with pre-rounding at 6:30am as appropriate. You may also do night float shifts during the rotation as well.

Standard Delivery Rotation: Deliveries should alternate through the learners who are on the service. Please remember that some procedures (C-section, complex breech delivery) might, as in our own department, be assigned to a more experienced learner.
In most cases, the delivery rotation should be:

- OB intern
- ED intern
- Sub-I (if applicable)

Of course, when you're not in a delivery, there is a lot of learning in OB triage, and you should work as part of the team in completing the other work of the day.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

Facilities and Resources:
The EM1 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, call rooms, locker rooms, showers and several hospital cafeterias.

Duties and Responsibilities include:

1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Performing bedside ultrasonography
5. Documenting history and physical examination
6. Writing progress notes
7. Performing all necessary procedures

The resident will devise a diagnostic and management plan that will be reviewed by the supervising senior resident and supervising attending physician.

Description of didactic experiences:
Formal teaching will consist of daily teaching rounds led by both attending faculty and senior obstetric residents, weekly teaching conferences with senior obstetric faculty and weekly emergency medicine teaching conferences on Friday morning from 7am-12pm. You should be excused from your clinical obligations to attend your EM Friday conference.

Evaluation process:
At the end of each block, written and/or electronic evaluations with input from supervising faculty members and senior residents will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Logging:
All deliveries should be logged with the appropriate supervisor. Should the appropriate supervisor not be available in New Innovations, please list Dr. Betty Chou as supervisor. In the comments box, you should indicate the correct supervising attending for the delivery.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

All residents rotating through OB must complete an "Infant Security Access Request Form" during orientation for access to the OB Department while you are on that rotation. Your documentation will be forwarded to Tanesha Stokes (tchalme1@jhmi.edu), Myka Shaw (mshaw13@jhu.edu), and Valerie Hall (vhall10@jhmi.edu) for processing at the beginning of the academic year. For any questions, contact the residency office.

Residency Office Contact Info:
410-955-6710
OB Chiefs gynobchiefs@gmail.com

Rotation: **Ophthalmology**
Year: **EM1**
Duration: **Four Weeks**

*****Note: The ophthalmology rotation is integrated into the HC Peds rotation. For details of the HC Peds component, please see HC Peds section*****

Educational Goals:
EM1 will become proficient in the evaluation and management of patients with emergent or urgent ophthalmologic complaints.

Educational Objectives:
1. Develop the history and physical exam skills needed to evaluate a patient presenting with an acute ophthalmologic disorder or injury (MK, PC)
2. Learn to recognize and treat emergent causes of visual loss (MK, PC)
3. Learn the principles of ocular trauma management (MK, PC, SBP)
4. Lean the evaluation and management of common ophthalmologic complaints (MK, PC)
5. Learn the use of diagnostic modalities available for the evaluation of ophthalmologic disorders (MK, PC, SBP)
6. Develop expertise in the slit lamp examination and PanOptic ophthalmoscope (MK)
7. Demonstrate effective communication with patients, their families, and professional associates (ICS)
8. Demonstrate respect, compassion, and integrity (PR)

Description of clinical experiences (more info and the rotation schedule can be found here):
The EM1 will rotate for four weeks on the ophthalmology rotation. The EM1 will have exposure to a wide variety of ophthalmologic conditions and will see these patients in conjunction with a member of the Ophthalmology consult staff in the JHED. Additional rotating residents will be provided with didactic and direct teaching sessions with ophthalmology faculty and residents as well as emergency medicine faculty and PGY4 residents.

Clinic / direct teaching with Dr. Woreta and team

Where:
Follow signs from the garage to the Outpatient Center, then go straight through a long hallway and keep going up TWO escalators. When you get off the second escalator turn RIGHT and the Wilmer entrance will be down that hall, on your right. Take the elevators in the main Wilmer lobby to level B. To the right you will see a sign "Patient Access Center for the Eye" pointing down a ramp on your right. Our front desk is at the bottom of that ramp – please tell the front desk staff that you are here and that you are the visiting EM Resident. If you need assistance, ask at the front desk to notify Kandace (lead technician).

Hopkins also has that new wayfinding app that might be useful:
https://www.hopkinsmedicine.org/patient_care/locations/find-your-way.html

When:
- The schedule is available here: https://docs.google.com/spreadsheets/d/1jahF1Fc6QK7VytXHc_ncSiz33aJp-kr83-WCRG_o1Ec/edit?gid=0#gid=0
- The rotation guide is available here: https://docs.google.com/document/d/1hEthpxCpYyIK9BLFJk8ZHtIdrLVNSylteKf0J78Ch-Y/edit#heading=h.iycbsuqxovhg

- You should try to arrive between 6:45-6:55 am so you are ready to go for Morning Rounds which start at 7am as directed in the ophthalmology schedule (generally Tuesday mornings). Morning Rounds is where the residents see the ED follow-up patients and inpatients. Morning Rounds last about an hour with no break before regular Morning clinic starts.
- You will have 1-on-1 teaching sessions with Emergency Medicine faculty to develop your examination skills. Please email them to set up a time for these educational sessions during your rotation.
    - Dr. Rodney Omron (romron1@jhmi.edu): PanOptic ophthalmoscope
    - Dr. Joshua Niforatos (jnifora1@jhmi.edu): slit lamp
- For days when you will be paired with a 4th-year resident, you should reference the signup sheet AND contact your PGY4 the week prior to your first session: https://docs.google.com/spreadsheets/d/1ryMJ6JWPuU3iLLxAbPTwqSxl8mP0Et3fjNzuPWjl90I/edit?gid=0#gid=0

Dress:
Business casual attire (e.g., collared shirt with tie, dress slacks, skirt, or other similarly clinic-appropriate attire). Long hair pulled back in a ponytail. Alternatively, you can wear scrubs and your white coat. ID badges are worn near breast pocket or collar area.

All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines.

Facilities and Resources:
The EM1 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), a curated list of ophthalmology resources, Welch Medical School Library, locker rooms, showers and several hospital cafeterias.

Duties and Responsibilities include:
1. Demonstrate an understanding of normal ocular anatomy.
2. Demonstrate the ability to perform an ocular examination.
3. Recognize and discuss the differential of abnormal fundoscopic findings.
4. Demonstrate the technique of slit lamp examination.
5. Demonstrate the ability to measure intraocular pressures.
6. Demonstrate the ability to patch an eye.
7. Describe the dosage, indications, complications, and contraindications of topical and systemic ophthalmologic medications.
8. Discuss the differential diagnosis of common presenting symptoms of ophthalmologic emergencies.

Description of didactic experiences:
Formal resident conferences occur each Friday morning from 7am to 12pm. All residents on this rotation are relieved from clinical duties to allow them to attend conferences.

Evaluation process:
Self-evaluation and direct feedback from the ophthalmology staff will be provided. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program

director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contact:

Dr. Fasika Woreta
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Dr. Rodney Omron
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Dr. Joshua Niforatos
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Rotation: **Introductory Emergency Ultrasound at Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center**
Year: **EM1**
Duration: **Two Weeks**

Educational Goals:

Develop the core knowledge base, image acquisition and interpretation skills, and framework for clinical integration to utilize point-of-care ultrasound in the clinical practice of Emergency Medicine

Educational Objectives:

GENERAL

1. Distinguish between consultative, clinical, point-of-care, and emergency ultrasound (MK, PC, SBP)
2. Recognize the primary clinical US applications (MK)
3. Discuss support for clinical US from key organizations including ACEP, AMA, ABEM, SAEM, and AIUM (MK, SBP)
4. Describe ACEP recommendations for training and credentialing in clinical US (MK, SBP)
5. Demonstrate the procedures for archiving ultrasound images and reporting ultrasound findings for training/credentialing and for clinical decision-making purposes (MK, PC)
6. Demonstrate the proper procedures for care, storage, and disinfection of the ultrasound machine and transducers to minimize damage and maintain equipment in working order (MK, PC, PROF).

ULTRASOUND PHYSICS AND INSTRUMENTATION

1. Explain ultrasound physics relevant to clinical US, including (MK):
    a. Piezoelectric effect
    b. Frequency
    c. Resolution
    d. Attenuation
    e. Echogenicity
    f. Doppler, including pulse wave, color, and power
    g. Aliasing
2. Operate the EUS system to obtain and interpret images adequate for clinical decision making, including (MK, PC):
    a. Knobology
    b. Imaging modes (B-mode, M-mode, Doppler modes)
    c. Gain
    d. Time gain compensation
    e. Focus
    f. Transducer/probe types
3. Recognize common ultrasound artifacts, including (MK):
    a. Reverberation
    b. Side lobe
    c. Mirror
    d. Shadowing
    e. Enhancement
    f. Ring down
4. Understand bio-effects of diagnostic ultrasound and apply the safety principle of ALARA (As Low As Reasonably Achievable) (MK, PC)

TRAUMA

1. Describe the indications, clinical algorithms, and limitations of EUS in blunt and penetrating thoracoabdominal trauma (MK, PC)
2. Perform the clinical US protocol for trauma in both primary and secondary studies (MK, PC)
3. Identify relevant US anatomy, including pleura, diaphragm, IVC, pericardium, liver, spleen, kidneys, bladder, prostate, and uterus (MK)
4. Recognize pathologic findings and pitfalls related to the detection of pneumothorax, hemothorax, pulmonary contusion, hemopericardium, cardiac activity, volume status, and hemoperitoneum (MK, PC)
5. Integrate trauma clinical US findings into individual patient, departmental, and disaster management (MK, PC, SBP)

AORTA

1. Describe the indications, clinical algorithm, and limitations of clinical US in the evaluation of thoracic and abdominal aortic pathology (MK, PC)
2. Perform clinical protocols to evaluate the abdominal and thoracic aorta, including measurement techniques (MK, PC)
3. Identify relevant US anatomy, including aorta with major branches, inferior vena cava, and vertebral bodies (MK)
4. Recognize pathologic findings and pitfalls when evaluating for abdominal and thoracic aortic aneurysm and aortic dissection (MK, PC)
5. Integrate aorta clinical US findings into individual patient and departmental management (MK, PC, SBP)

ECHOCARDIOGRAPHY AND HEMODYNAMIC ASSESSMENT

1. Describe the indications and limitations of cardiac clinical US (MK, PC)
2. Acquire images in standard echo windows (subxiphoid/subcostal, parasternal, and apical) and planes (4-chamber, long axis, short axis) (MK, PC)
3. Identify relevant US anatomy, including pericardium, cardiac chambers, valves, descending aorta, and IVC (MK)
4. Estimate qualitative left ventricular function and central venous pressure to guide hemodynamic assessment of patient (MK, PC)
5. Recognize cardiac arrest, pericardial effusion with or without pericardial tamponade, and dilation of the aortic root or descending aorta (MK, PC)
6. Advanced evaluation:
    1. Acquire view of the aortic arch and recognize arch dissection and/or aneurysm
    2. Identification of right ventricular dysfunction (MK, PC)
    3. Assessment of cardiac output and fluid responsiveness (MK, PC)
7. Procedural guidance: Pericardiocentesis, transvenous pacer, and central venous catheter placement (MK, PC)
8. Integrate emergency echocardiography findings into individual patient and departmental management (MK, PC, SBP)

THORACIC

1. Describe the indications and limitations of thoracic clinical US (MK, PC)
2. Perform clinical US protocols for the detection of (MK, PC):
    1. Pneumothorax
    2. Pleural effusion
    3. Interstitial lung fluid (CHF, ARDS, pneumonia, pulmonary contusion)
3. Identify relevant US anatomy of the thoracic structures (MK)
4. Recognize the relevant findings and pitfalls when evaluating for thoracic pathology (MK, PC)
5. Integrate thoracic EUS findings into individual patient and departmental management (MK, PC, SBP)

BILIARY

1. Describe the indications and limitations of EUS of the biliary tract (MK, PC)
2. Perform EUS protocols to evaluate the biliary tract (MK, PC)
3. Identify relevant US anatomy, including the gallbladder, portal triad, IVC, and liver (MK)
4. Recognize the relevant findings and pitfalls when evaluating for cholelithiasis and cholecystitis (MK, PC)
5. Integrate EUS of the biliary tract into individual patient and departmental management (MK, PC, SBP)

URINARY TRACT / RENAL

1. Describe the indications and limitations of clinical US of the kidneys and bladder (MK, PC)
2. Perform clinical US protocols to evaluate the urinary tract (MK, PC)
3. Identify relevant US anatomy, including renal cortex, renal pelvis, ureter, bladder, liver, spleen, uterus, or prostate (MK)
4. Recognize the relevant findings and pitfalls when evaluating for hydronephrosis, renal calculi, renal masses, bladder volume, pregnancy, and Foley catheter evaluation (MK, PC)
5. Integrate clinical US of the urinary tract into individual patient and departmental management (MK, PC, SBP)

A complete list of emergency ultrasound applications and the ACEP Emergency Ultrasound Imaging Criteria Compendium (which delineates specific indications, limitations, pitfalls, technique, and views) can be found online at http://www.acep.org/ultrasound

Description of Clinical Experience:

The EM1 resident will rotate for two weeks on the Introductory Ultrasound rotation. The rotation will take place in the Johns Hopkins Hospital and Johns Hopkins Bayview Emergency Departments.

The most up-to-date information about ultrasound rotation logistics and requirements can be found at https://sites.google.com/view/hopkinspocus/home/basic-pocus-rotation (also linked via www.HopkinsEM.org), and should be reviewed prior to the rotation**.**

The rotation is comprised of faculty-supervised and self-scheduled independent bedside scanning shifts, weekly image review/education sessions, assigned reading/videos/modules, and online knowledge assessments. On Friday morning, the resident will attend resident conference. Your schedule of supervised scanning shifts and QA meetings will be emailed to you before the US rotation starts. Emergency Ultrasound is a clinical rotation requiring the resident to be in the ED from Monday through Friday. In general, at least 6 hours a day should be devoted to ultrasound to fulfill rotation requirements. **Scheduling of non-ultrasound commitments during this rotation must be approved in advance by the Emergency Ultrasound faculty.**

All Emergency Medicine residents must follow the ACGME Emergency Medicine duty hours guidelines.

The focus of the Introductory Ultrasound rotation should be to gain proficiency in the life-saving and basic ultrasound applications of:

1. EFAST
2. Cardiac
3. Thoracic
4. Abdominal aortic aneurysm
5. Biliary
6. Renal/Urinary tract
7. Ultrasound-guided vascular access

The resident may also be introduced to the remaining ACEP core applications, including soft tissue, early pregnancy, DVT, musculoskeletal, and ocular ultrasound.

For quality assurance and safety reasons, all ultrasound exams performed by the resident must either be directly supervised by the Emergency Ultrasound faculty (or a credentialed EM attending) *or* have a confirmatory study as a gold standard (e.g. CT scan, CXR, or comprehensive ultrasound by radiology).

Emergency Ultrasound QA and Education Meetings
Weekly image review/education meetings take place every **Thursday from 9am-1pm**. The resident must attend every Thursday meeting during the rotation.

Qpath
All ultrasound images (at Johns Hopkins Hospital ED, Bayview Medical Center ED, and Howard County Medical Center ED) are uploaded and archived to the Qpath system. Residents must complete standardized reports of their ultrasound interpretations for all examinations on Qpath – this will allow tracking of studies for resident emergency ultrasound credentialing. A Qpath software tutorial will be provided at the beginning of the Emergency Ultrasound rotation.

Qpath is accessible from any campus computer or at home via VPN or cloud desktop at **qpath.jhmi.edu**. Though Qpath can be opened using any browser, it functions best using Google Chrome or Firefox.

For assurance of quality and safety, logging of ultrasound images for credit towards your graduation requirements must be completed within 1 week of the scan date.

Facilities and Resources:

During the Emergency Ultrasound rotations, the resident will have access to hospital and departmental facilities and resources including: the emergency medicine resident library (multiple emergency ultrasound and emergency medicine texts, computers), online web resources (Up-to-Date, MD Consult, Medline, full-text Emergency Ultrasound textbooks, full-text journals, Micromedex, etc.), medical records (computerized and library), Welch and JHU libraries, locker-rooms, showers, and hospital cafeterias.

Please refer to the Ultrasound page at www.hopkinsem.org for a current list of emergency ultrasound educational resources.

Duties and Responsibilities of the EM1 include:

1. Read the following chapters in Noble & Nelson's Manual of Emergency and Critical Care Ultrasound - 2nded. (Available online via Welch Library website):
    1. Ch 1: Fundamentals
    2. Ch 2: FAST
    3. Ch 3: Cardiac
    4. Ch 5: Abdominal Aorta
    5. Ch 6: Renal and Bladder
    6. Ch 7: Gallbladder
    7. Ch 9: Respiratory
    8. Ch 15: Vascular access
2. Complete the corresponding SAEM Academy of Emergency Ultrasound online examinations with a minimum score of 70% for each exam. Exams may be retaken until a passing score is obtained. Please screenshot or print out your certificates and submit at the end of the rotation.
3. Attend all scheduled faculty-supervised bedside scanning shifts
4. Document at least **100** technically adequate and correctly interpreted ultrasound examinations in Qpath

5. Attend all Wednesday ultrasound QA/education meetings while on rotation
6. Complete and submit the Emergency Ultrasound end-rotation checklist

Description of Didactic Experience:

Formal teaching will consist of bedside instruction by the ultrasound faculty and/or fellows, and weekly didactics during Wednesday QA/education meetings. Assigned reading/videos/modules are necessary to complement and solidify the concepts learned at the bedside and should be completed before and during the rotation. Additional ultrasound didactic resources are listed on the Ultrasound page on the hopkinsem.org website.

Evaluation process:

Successful completion of the EM Ultrasound rotation requires completion of the course's core components as described above. An end-of rotation checklist (available on www.HopkinsEM.org) must be submitted to the faculty on the last day of rotation.

Resident evaluation will be based on directly observed scanning and competency testing, scores on the SAEM Academy of Emergency Ultrasound online examinations, and review of images and reports on Qpath.

Feedback mechanisms:
Feedback to the EM-1 is provided by the Emergency Ultrasound faculty and/or fellows directly, and through New Innovations.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)

Rotation Contact:
Dr. Tiffany Fong - tfong3@jhmi.edu

Rotation Faculty:
Dr. Randall Rhyne - rrhyne@jhmi.edu
Dr. Eric Lieu - elieu1@jh.edu
Dr. David Suwondo - dsuwond1@jhu.edu
Dr. Harry Heverling – hheverl1@jhmi.edu

Rotation: **Pediatric Emergency Department at Johns Hopkins Hospital (JHPeds)**
Year: **EM1**
Duration: **Four Weeks**

Educational Goal:
Develop the ability to evaluate, diagnose, stabilize, and treat pediatric patients who present to the emergency department.

Educational Objectives:
1. Communicate effectively with patients, their families, and professional associates (ICS).
2. Demonstrate respect, compassion, and integrity (PR).
3. Demonstrate the ability to perform an appropriate history and physical exam (PC).
4. Demonstrate the ability to develop an appropriate differential of consequence and treatment plan (MK).
5. Demonstrate appropriate clinical decision-making skills (PC).
6. Develop the ability to assess the seriously ill child, with an emphasis on recognizing early signs and symptoms before further deterioration can occur. (PC, MK, ICS, Prof, SBP)
7. Master the evaluation and management of the critically ill or injured child during resuscitation. (PC, MK, ICS, Prof, SBP, PBL&I)
8. Master the evaluation and management of mild and moderately ill children who present to an emergency department (PC, MK, ICS, Prof, SBP, PBL&I)
9. Recognize the several categories of pediatric patients including the seriously ill, moderately ill and non-acute pediatric patients. (PC, MK)
10. Perform intraosseous infusion, ultrasound guided techniques, and lumbar punctures. (PC, MK, Prof, PBL&I, ICS, SBP)
11. Develop an approach to the management and disposition of the febrile child, considering such factors as age, source and severity of illness. (PC, MK, Prof, PBL&I, ICS, SBP)
12. Learn an approach to the pediatric patient with respiratory illness, gastrointestinal disorders, neurologic complaints, gynecologic disorders, cardiovascular disorders, painful conditions, and the poisoned patient utilizing history, physical examination and ancillary studies to arrive at a diagnosis allowing appropriate treatment and disposition. (PC, MK, Prof, PBL&I, ICS, SBP)
13. Develop an appropriate level of awareness of child abuse; learn in what circumstance child abuse occurs and how it may present. Evaluate the patient with suspected child abuse including sexual abuse. Learn the legal requirements and appropriate documentation. Understand the emotional factors affecting the patient and family. Understand the relative role of law enforcement, health care provider, and physicians. (PC, MK, Prof, PBL&I, ICS, SBP)

Educational Expectations
- ➢ Learn the normal development of the pediatric patient
- ➢ Learn the pathophysiology of abnormal conditions in the pediatric age group
- ➢ Exposure and experience in the management of pediatric emergencies
- ➢ Exposure and experience in the management of critically ill and injured patients
- ➢ Specific experience and training in:
  - taking a pediatric history
  - performing a pediatric physical examination
  - understanding the indications and interpretation of ancillary laboratory and
  - imaging techniques

6. Experience in (but not limited to) the following procedures:
   - venous access
   - arterial access
   - lumbar puncture
   - intubation
   - laceration repair
   - joint reduction
   - procedural sedation
7. Experience and training in pediatric resuscitation efforts, including anticipation and recognition of short and long-term complications
8. Understand the social/family aspects of pediatric emergency evaluation and care

Description of clinical experiences:
The EM1 will rotate for a four-week period on the Pediatric ED Service as a full member of the Service. The resident will have exposure to a wide variety of ill and injured pediatric patients under the direct supervision of the PEM attending and fellow when available.

As an EM1, the resident will be responsible for the evaluation of patients presenting to the pediatric emergency department.

Shifts will cover days, evenings, overnights and weekends and will be 9 to 12 hours in length.

All Emergency Medicine resident(s) must follow the ACGME <u>Emergency Medicine</u> duty hours guidelines.

You will receive your rotation schedule before the experience begins. If you are asked to modify your schedule for any reason, you MUST contact the EM chiefs AND Dr. Ritter or Dr. Ehmann.

Facilities and Resources:
The EM1 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker-room, shower and several hospital cafeterias.

Duties and Responsibilities include:
1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies, including historical data from previously obtained values and studies
4. Documenting histories and physical examinations
5. Performing all necessary procedures

The resident will devise a diagnostic and management plan that will be reviewed by the PEM attending physician and/or PEM fellow physician.

Description of didactic experiences:
Formal EM resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties to allow them to attend conferences. The Division of Pediatric EM also has didactics you must attend on Thursdays and Fridays from 12:15-1:15pm. You are relieved from clinical duties to attend them if you are working. There are also online lectures available for you. The EM chief residents should disseminate this schedule at the beginning of the block.

Evaluation process:
At the end of each block, electronic evaluations with input from supervising faculty members will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contact:
Dr. Lauren Kahl
lkahl4@jhmi.edu

Rotation: **Pediatric Emergency Department at Johns Hopkins Howard County Medical Center (HC Peds)/Ophthalmology**
Year: **EM1**
Duration: **Four Weeks**

*****Note: The ophthalmology rotation is integrated into the HC Peds rotations. For details of the ophthalmology component, please see ophthalmology section*****

Educational Goal:
Develop the ability to evaluate, diagnose, stabilize, and treat pediatric patients who present to a community emergency department.

Educational Objectives:
1. Communicate effectively with patients, their families, and professional associates (ICS).
2. Demonstrate respect, compassion, and integrity (PR).
3. Demonstrate the ability to perform an appropriate history and physical exam (PC).
4. Demonstrate the ability to develop an appropriate differential of consequence and treatment plan (MK).
5. Demonstrate appropriate clinical decision-making skills (PC).
6. Develop the ability to assess the seriously ill child, with an emphasis on recognizing early signs and symptoms before further deterioration can occur. (PC, MK, ICS, Prof, SBP)
7. Master the evaluation and management of the critically ill or injured child during resuscitation. (PC, MK, ICS, Prof, SBP, PBL&I)
8. Master the evaluation and management of mild and moderately ill children who present to an emergency department (PC, MK, ICS, Prof, SBP, PBL&I)
9. Recognize the several categories of pediatric patients including the seriously ill, moderately ill and non-acute pediatric patients. (PC, MK)
10. Perform intraosseous infusion, ultrasound guided techniques, and lumbar punctures. (PC, MK, Prof, PBL&I, ICS, SBP)
11. Develop an approach to the management and disposition of febrile children, considering such factors as age, source and severity of illness. (PC, MK, Prof, PBL&I, ICS, SBP)
12. Learn an approach to the pediatric patient with respiratory illness, gastrointestinal disorders, neurologic complaints, gynecologic disorders, cardiovascular disorders, painful conditions, and the poisoned patient utilizing history, physical examination and ancillary studies to arrive at a diagnosis allowing appropriate treatment and disposition. (PC, MK, Prof, PBL&I, ICS, SBP)
13. Develop an appropriate level of awareness of child abuse; learn in what circumstance child abuse occurs and how it may present. Evaluate the patient with suspected child abuse including sexual abuse. Learn the legal requirements and appropriate documentation. Understand the emotional factors affecting the patient and family. Understand the relative role of law enforcement, health care provider, and physicians. (PC, MK, Prof, PBL&I, ICS, SBP)

Educational Expectations
1. Learn the normal development of the pediatric patient
2. Learn the pathophysiology of abnormal conditions in the pediatric age group
3. Exposure and experience in the management of pediatric emergencies
4. Exposure and experience in the management of critically ill and injured patients
5. Specific experience and training in:
   - taking a pediatric history
   - performing a pediatric physical examination
   - understanding the indications and interpretation of ancillary laboratory and imaging techniques
6. Experience in (but not limited to) the following procedures:

- venous access
- arterial access
- lumbar puncture
- intubation
- fracture splinting
- laceration repairs
- Joint reduction
- Procedural sedation

7. Experience and training in pediatric resuscitation efforts, including anticipation and recognition of short- and long-term complications
8. Understand the social/family aspects of pediatric emergency evaluation and care

Description of clinical experiences:
The EM1 will rotate for a four-week period on the Pediatric ED Service as a full member of the Service. The resident will have exposure to a wide variety of ill and injured pediatric patients under the direct supervision of the EM attending.

As an EM1, the resident will be responsible for the evaluation of patients presenting to the pediatric emergency department.

Shifts will cover days, evenings and weekends and will be 8 hours in length. The EM Chiefs will email you with information about self-scheduling your shifts. Do not schedule any HoCo Peds shifts during the Tuesday Ophthalmology educational activities as shown on the schedule below:

https://docs.google.com/spreadsheets/d/1jahF1Fc6QK7VytXHc_ncSiz33aJp-kr83-WCRG_o1Ec/edit?gid=0#gid=0

All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines.

Facilities and Resources:
The EM1 will have access to a wide variety of facilities and resources including, but not limited to medical records (computerized and library), EM resident library (multiple EM texts, computers), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker-room, shower and the hospital cafeteria.

Duties and Responsibilities include:
1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Documenting histories and physical examinations
5. Performing all necessary procedures

The resident will devise a diagnostic and management plan to be reviewed by the attending physician.

Description of didactic experiences:
Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties to allow them to attend conferences.

Evaluation process:
At the end of each block, electronic evaluations with input from supervising faculty members will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contact:
Meng-Keong Choo, MD
Interim Chair, Pediatric Emergency Department
410-884-4888
mchoo1@jhmi.edu

HoCo Residency Liaison:
Nico Risko, MD MPH
Assistant Professor
JH Howard County Medical Center
Department of Emergency Medicine
nrisko1@jhmi.edu
cell: (617) 869-8141

Rotation: **Toxicology at Johns Hopkins Hospital (Tox)**
Year: **EM1**
Duration: **Two Weeks with integration of ECG course**

*****Note: The ECG rotation is integrated into the tox rotation. For details of the ECG component, please see ECG rotation section*****

Educational Goals:

1. To become familiar with basic management of the poisoned patient.
2. To understand the clinical presentations of common toxidromes.
3. To become familiar with toxicologic resources available to the Emergency Physician.

Educational Objectives:

1. To recognize the presentation of various toxidromes in the clinical setting (MK, PBL)
2. To describe possible management strategies for various toxidromes (PC, MK)
3. To list appropriate ancillary tests which should be performed in a suspected overdose (MK, PC)
4. To discuss decontamination strategies for various ingestions (PBL, MK, PC)
5. To discuss appropriate use of antidotes (MK, PC, PBL)
6. To discuss appropriate management of unintended drug toxicities (MK, PBL, PC)

Description of clinical experiences:
The EM1 will rotate for two weeks on the toxicology rotation. The resident will rotate under the supervision of a Board Certified Toxicologist, Dr. Andrew Stolbach. The EM1 resident will spend time daily at the Maryland Poison Center for rounds (Mon-Thurs 10am – 2pm, approximate hours). Be sure to arrive at Maryland PCC at 10am, pick a few cases (active/open cases from the previous 7 days) to discuss. Review them and be ready to "present" the as unknown ingestion/exposure. Subsequent assignments will be at the discretion of the Rotation Director and Residency Administration and may include:

- Completion of online tox modules (http://emcc.peaconline.org/) – you will be contacted by Dr. Heverling about these modules

Facilities and Resources:
The EM1 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker rooms, showers and several hospital cafeterias.

Duties and responsibilities:

1. Attend educational sessions at the Maryland Poison Center.
2. Complete online tutorials
3. Complete a simulation session
4. Complete a self-study readings, to be given by Course Director

Description of didactic experiences:
In addition, the resident will be expected to attend all Friday morning Emergency Medicine conference from 7am to 12pm.

Evaluation Process:
Means to evaluate resident knowledge of toxicology include semi-annual oral examinations and yearly in-service examinations, as well as simulation sessions during the rotation. A formal

evaluation will be provided by the Course Director at the end of the rotation.

Feedback mechanisms:
Direct feedback by the Course Director will be provided.

All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)

Rotation Contact:
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Rotation: **Radiology (Rads)**
Year: **EM1**
Duration: **Integrated and accounting for two weeks of educational content**

*****Note: The radiology rotation is integrated into the EMS rotation. For details of the EMS component, please see EMS section*****

Educational Goal:
The primary goal of this rotation is to develop the residents' ability to evaluate emergency images including plain radiographs, computed tomography (CT), ultrasound images, and magnetic resonance imaging (MRI) while emphasizing appropriate use of advanced imaging modalities.

Educational Objectives:
1. Demonstrate respect, compassion, and integrity (PR).
2. Demonstrate appropriate clinical decision-making skills (PC).
3. Demonstrate an understanding of value-based care and appropriate ordering (PC, SBP, PBL).
4. Name and apply decision rules to order appropriate tests (PC, SBP, PBL).
5. Correctly identify presence or absence of pathology on chest radiographs (MK).
6. Correctly identify the presence or absence of pathology on musculoskeletal (MSK) radiographs (MK).
7. Correctly identify presence or absence of pathology on CT images of the brain (MK).
8. Demonstrate the ability to develop an appropriate differential diagnosis based on radiographic findings (MK).
9. Learn how to appropriately order radiographs and advanced imaging modalities including ultrasound, computed tomography, and magnetic resonance imaging (SBP).
10. Learn the appropriate information resources (i.e., textbooks, handbooks, online resources, etc.) available for interpreting emergency images (PBL).

Educational Expectations:
1. To learn a standard approach to the evaluation of plain radiographs and CTs
2. To learn the radiographic appearance of the following:
   - CNS hemorrhage (subdural, epidural, subarachnoid, intraparenchymal)
   - MSK pathology (extremity fractures, joint dislocations, joint effusions)
   - Thoracic pathology (pneumonia, pneumothorax, hemothorax, pleural effusion, aortic dissection, and disease-specific findings including pneumocystis pneumonia and tuberculosis)
   - Abdominal pathology (appendicitis, diverticulitis, evidence of traumatic injury)
   - Pulmonary embolus
3. Exposure and experience to appropriately ordering emergency imaging studies

Description of clinical experiences:
The EM1 will rotate for a two-week period on the Emergency Radiology rotation, which is integrated with the EMS rotation. The resident will have exposure to a wide variety of emergency images.

The EM1 resident, as part of a radiology team, will participate in the evaluation of emergency department-ordered images. The EM1 daily experience will not exceed 16 hours.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

Facilities and Resources:

The EM1 will have access to a wide variety of facilities and resources including, but not limited to medical records (computerized and library), online web data (Up-to-date, MD Consult, Micromedex, etc.), Welch Library, staff lounge, call rooms, locker rooms, showers and hospital cafeterias.

Duties and Responsibilities include:

1. Interpreting plain radiographs
2. Interpreting CT images
3. Interpreting Ultrasound images
4. Arriving at didactic activities in a timely fashion

Description of radiology didactic experiences:

Residents will be expected to complete online modules, complete readings, and examine case files in the PACS system. Formal teaching will consist of a minimum of one in-person session with a radiologist, a minimum of one in-person session with an emergency medicine medical education fellow, didactic lectures, ED reading room time, and radiology conferences when available/appropriate. Residents are excused from their clinical commitments to attend their EM Friday conference.

Evaluation process:

At the end of each block, electronic evaluations with input from supervising faculty members will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:

All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contacts:

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Rotation: **ECG**
Year: **EM1**
Duration: **Two weeks integrated with Tox rotation**

*****Note: The ECG rotation is integrated into the Tox rotation. For details of the Tox rotation please see that section*****

Educational Goal:
The primary goal of this rotation is to develop the resident's ability to rapidly and accurately evaluate electrocardiograms (ECGs), to detect life-threatening pathology, and to initiate appropriate therapies based on ECG findings.

Educational Objectives:
1. Demonstrate respect, compassion, and integrity (PR).
2. Demonstrate appropriate clinical decision-making skills (PC).
3. Demonstrate an understanding of value-based care and appropriate ordering (PC, SBP, PBL).
4. Correctly evaluate ECGs for signs of ischemia and ischemia mimics (MK).
5. Correctly evaluate ECGs for dangerous causes of syncope (MK).
6. Correctly identify tachydysrhythmias, bradydysrhythmias
7. Correctly identify heart blocks / conduction delays, electrolyte abnormalities, and ECG findings associated with toxidromes (MK).

Educational Expectations:
1. To develop a systematic approach to ECG interpretation
2. Specific experience and training in interpreting the following ECG findings:
   - ischemia and ischemia mimics
   - tachydysrhythmias, bradydysrhythmias
   - heart block and conduction delays
   - dangerous causes of syncope (long-QT, Brugada, hypertrophic cardiomyopathy etc.)
   - indicators of electrolyte abnormalities
   - toxidrome-associated ECG findings

Description of clinical experiences:
The EM1 will rotate for a two-week period on the Emergency ECG rotation. The resident will have exposure to a wide variety of ECGs.

The EM1 resident, as part of an ECG interpretation course, will experience both in-person and didactic ECG interpretation sessions. The EM1 daily experience will not exceed 16 hours.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

Facilities and Resources:
The EM1 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), online web data (Up-to-date, MD Consult, Micromedex, etc.), Welch Library, staff lounge, call rooms, locker rooms, showers and hospital cafeterias.

Duties and Responsibilities include:

1. Use asynchronous to materials to prepare for in-person meetings
2. Interpret ECGs during in-person meetings
3. Arriving at didactic activities in a timely fashio

About 1 week before your rotation begins, email Dr. Weygandt for access to your materials and to schedule your in-person ECG meetings.

Description of radiology didactic experiences:

Residents will be expected to complete readings, review challenge ECGs, and independently study ECGs prior to ECG Friday review sessions. Formal teaching will consist of one weekly session with an attending, fellow, or senior resident.

Evaluation process:

At the end of each block, electronic evaluations with input from supervising faculty members will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:

All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contact:
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EM2
Clinical Rotations

Rotation: **Emergency Ultrasound at Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (Adv US)**
Year: **EM2**
Duration: **Two Weeks**

Educational Goals:

1. Demonstrate proficiency in point-of-care ultrasound image acquisition and interpretation, and appropriately integrate ultrasound into clinical practice
2. Expand knowledge and skill in the 15 core emergency ultrasound (EUS) applications defined by ACEP
3. Satisfy credentialing requirements in at least 5 core diagnostic emergency ultrasound applications

Educational Objectives:

The resident will continue to gain experience in all Introductory Emergency Ultrasound rotation objectives (please refer to the appropriate section of this Manual and www.hopkinsem.org), and expand knowledge and skills to include the additional core applications below.

By the end of the Ultrasound rotation, the resident should document at least 25-50 scans to meet credentialing requirements in at least 5 diagnostic applications (which must include FAST and echocardiography). Ultrasound-guided vascular access, requiring at least 5 documented scans, must be completed by the end of residency.

Specific learning objectives are summarized in the ACEP Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine, Appendix 3 (approved April 2023) and summarized below.

FIRST TRIMESTER PREGNANCY

1) Describe the indications, clinical algorithm, and limitations of clinical US in first-trimester pregnancy pain and vaginal bleeding (MK, PC)
2) Understand the utility of quantitative bHCG in the evaluation of first-trimester pregnancy pain and vaginal bleeding (MK)
3) Perform clinical US protocols for transabdominal and transvaginal views as appropriate, including fetal heart rate and gestational age measurement techniques (MK, PC)
4) Identify relevant US anatomy, including cervix, uterus, adnexa, bladder, and cul-de-sac (MK)
5) Recognize the relevant findings and pitfalls when evaluating for intrauterine pregnancy (IUP) and ectopic pregnancy (MK, PC):
   a) Early embryonic structures, including gestational sac, yolk sac, fetal pole, and fetal heart
   b) Location of embryonic structures in the pelvis
   c) Embryonic demise
   d) Molar pregnancy

   Findings of ectopic pregnancy, including pseudogestational sac, free fluid, and adnexal masses
6) Advanced evaluation
   a) Basic gynecologic clinical US including ovarian cysts, fibroids, tubo-ovarian abscess, ovarian torsion, ectopic pregnancy (MK, PC)
   b) Second and third trimester OB (MK, PC)
7) Integrate pregnancy emergency US findings into individual patient and departmental management (MK, PC, SBP)

DEEP VEIN THROMBOSIS (DVT)

1) Describe the indications and limitations of clinical US for detection of DVT (MK, PC)
2) Understand the differences between lower extremity venous clinical US and radiology or vascular lab performed "duplex evaluation" (MK, PC)
3) Perform clinical US protocols for the detection of DVT, including vessel identification, compression, Doppler imaging of respiratory variation and augmentation (MK, PC)
4) Identify relevant US anatomy of the upper and lower extremities including the deep venous and arterial systems, major nerves, and lymph nodes (MK)

5) Recognize the relevant findings and pitfalls when evaluating for DVT (MK, PC)
6) Integrate clinical US for DVT into individual patient and departmental management (MK, PC, SBP)

SKIN AND SOFT TISSUE

1) Describe the indications and limitations of skin and soft tissue clinical US (MK, PC)
2) Perform clinical US protocols for the evaluation of skin and soft tissue pathology (MK, PC)
3) Identify relevant US anatomy, including skin, adipose, and lymph nodes (MK)
4) Recognize the relevant findings and pitfalls when evaluating the following (MK, PC):
    a) Soft tissue infection (including abscess vs. cellulitis)
    b) Subcutanoeous fluid collection
    c) Foreign body location and removal
5) Integrate skin and soft tissue clinical US findings into individual patient and departmental management (MK, PC, SBP)

MUSCULOSKELETAL (MSK)

1) Describe the indications and limitations of MSK clinical US (MK, PC)
2) Perform clinical US protocols for the evaluation of MSK pathology (MK, PC)
3) Identify relevant US anatomy, including tendons, ligaments, muscles, bones, and joints
4) Recognize the relevant findings and pitfalls when evaluating the following (MK, PC):
    a) Tendon injury (laceration, rupture)
    b) Fractures
    c) Joint identification (including effusion and dislocation)
5) Integrate musculoskeletal clinical US findings into individual patient and departmental management (MK, PC, SBP)

OCULAR

1) Describe the indications, limitations, and relative contraindications of ocular clinical US (MK, PC)
2) Identify relevant US anatomy of the globe and orbital structures (MK)
3) Perform clinical US protocols for the detection of (MK, PC):
    a) Vitreous hemorrhage
    b) Posterior vitreous detachment
    c) Retinal detachment
    d) Optic nerve sheath diameter measurement
    e) Optic disc evaluation
4) Advanced evaluation
    a) Lens pathology
    b) Foreign body
    c) Globe rupture
    d) Retrobulbar hematoma
    e) Central retinal artery/vein occlusion
    f) Subretinal hemorrhage
5) Light reflex
6) Recognize the relevant findings and pitfalls when evaluating ocular pathology (MK, PC)
7) Integrate ocular clinical US into individual patient and departmental management (MK, PC, SBP)

BOWEL

1) Describe the indications and limitations of bowel clinical US (MK, PC)
2) Identify relevant US anatomy of bowel structures (MK)
3) Perform clinical US protocols for the detection of (MK, PC):
    a) Acute appendicitis
    b) Small and large bowel obstruction
    c) Pneumoperitoneum
    d) Diverticulitis
    e) Hernia

f) Intussusception and pyloric stenosis
g) Evaluation/placement of orogastric/nasogastric or percutaneous gastrostomy tube

4) Recognize the relevant findings and pitfalls when evaluating bowel pathology (MK, PC)
5) Integrate bowel clinical US into individual patient and departmental management (MK, PC, SBP)

THORACIC-AIRWAY

1) Recognize the sonographic findings of tracheal and esophageal anatomy, especially regarding EM procedures (MK, PC)
2) Integrate airway clinical ultrasound findings into individual patient and departmental management (MK, PC, SBP)

PROCEDURAL GUIDANCE

1) Describe the indications and limitations when using US guidance for bedside procedures (MK, PC)
2) Perform clinical US protocols for procedural guidance including both transverse and longitudinal approaches when appropriate. (MK, PC). These procedures may include:
   a) Vascular access: central and peripheral
   b) Confirmation of endotracheal intubation
   c) Pericardiocentesis
   d) Paracentesis
   e) Thoracentesis
   f) Foreign body detection and removal
   g) Evaluation and aspiration/drainage of body fluid
   h) Arthrocentesis
   i) Pacemaker placement and capture
   j) Abscess identification and drainage
   k) Regional anesthesia

3) Identify relevant US anatomy for each particular procedure (MK)
4) Recognize the relevant findings and pitfalls when performing clinical US for procedural guidance (MK, PC)
5) Integrate clinical US for procedural guidance into individual patient and departmental management (MK, PC, SBP)

A complete list of emergency ultrasound applications and the ACEP Emergency Ultrasound Imaging Criteria Compendium (which delineates specific indications, limitations, pitfalls, technique, and views) can be found online at http://www.acep.org/ultrasound

Description of Clinical Experience:

The resident will rotate for two weeks on the Advanced Emergency Ultrasound rotation in the Johns Hopkins and Johns Hopkins Bayview Emergency Departments, building on skills from the PGY-1 Introductory Emergency Ultrasound rotation. Focus will be on mastery of basic applications, developing skills in more advanced applications, accumulation of pathologic scans, and meeting numerical requirements for credentialing.

The most up-to-date information about ultrasound rotation logistics and requirements can be found at https://sites.google.com/view/hopkinspocus/home/basic-pocus-rotation (also linked via www.HopkinsEM.org), and should be reviewed prior to the rotation**.**

The Emergency Ultrasound rotation is comprised of faculty-supervised and self-scheduled independent bedside scanning shifts, weekly image review/education sessions, assigned reading/videos/modules, and online knowledge assessments. On Friday morning, the resident will attend resident conference. Your schedule of supervised scanning shifts and QA meetings will be emailed to you prior to the start of the US rotation. Emergency Ultrasound is a clinical rotation requiring the resident to be in the ED from Monday through Friday. In general, at least 6 hours a day should be devoted to ultrasound to fulfill rotation requirements. ***Scheduling of non-ultrasound commitments during this rotation must be approved in advance by the Emergency Ultrasound faculty.***

All Emergency Medicine residents must follow the ACGME Emergency Medicine duty hours guidelines.

During this two-week rotation, the resident is required to perform at least **100** high quality and correctly interpreted ultrasound studies, for a total of at least **200 scans by the end of the EM-2 year**. Among these, **25-50 scans per application** in each of the 5 core diagnostic applications should be completed. Competency in the Focused Assessment with Sonography in Trauma (FAST), echocardiography, and ultrasound-guided IV access is required, and the remaining applications may be chosen by the resident based on interest and anticipated future clinical utility. Residents are encouraged to complete requirements in all core emergency ultrasound applications to maximize their use of clinical ultrasound in attending practice. To attain credentialing, the resident must demonstrate experience through numeric requirements, medical knowledge through online knowledge assessments, and complete an observed competency assessment using a standardized checklist.

Completion of these requirements will enable the resident to be eligible to participate in Emergency Ultrasound electives during the PGY-3 year, where focus will be on advanced applications and completing credentialing in all ACEP core ultrasound applications.

ACEP Core Ultrasound Application	**Number required for credentialing**
Aorta	25-50
Bowel	25-50
Cardiac/Hemodynamic Assessment	25-50
Deep Vein Thrombosis	25-50
Hepatobiliary	25-50
Ocular	25-50
Pregnancy	25-50
Skin and Soft Tissue	25-50
Testicular	25-50
Thoracic/Airway	25-50
Trauma	25-50
Urinary Tract	25-50
Procedural Guidance	≥ 5
Ultrasound-Guided Nerve Blocks	≥ 5

For quality assurance and safety reasons, all ultrasound exams performed by the resident must either be directly supervised by the Emergency Ultrasound faculty (or a credentialed EM attending) *or* have a confirmatory study as a gold standard (e.g. CT scan, CXR, or comprehensive ultrasound by radiology).

Emergency Ultrasound QA and Education Meetings

Weekly image review/education meetings take place every **Thursday from 9am-1pm.** The resident must attend every Thursday meeting during the duration of the rotation.

Qpath

All ED ultrasound images (at Johns Hopkins Hospital ED, Bayview Medical Center ED, and Howard County General

Hospital ED) are uploaded and archived to the Qpath system. Residents must complete standardized reports of their ultrasound interpretations for all examinations on Qpath. This will allow tracking of studies for resident emergency ultrasound credentialing.

Qpath is accessible from any campus computer or at home via VPN or cloud desktop at **qpath.jhmi.edu**. Though Qpath can be opened using any browser, it functions best using Google Chrome or Firefox.

For assurance of quality and safety, logging of ultrasound images for credit towards your graduation requirements must be completed within 1 week of the scan date.

Facilities and Resources:

During the Emergency Ultrasound rotations, the resident will have access to hospital and departmental facilities and resources including: the emergency medicine resident library (multiple emergency ultrasound and emergency medicine texts, computers), online web resources (Up-to-Date, MD Consult, Medline, full-text Emergency Ultrasound textbooks, full-text journals, Micromedex, etc.), medical records (computerized and library), Welch and JHU libraries, locker-rooms, showers, and hospital cafeterias.

Please refer to the Ultrasound page at www.hopkinsem.org for a current list of emergency ultrasound educational resources.

Duties and Responsibilities include:

1. Read the following chapters in Noble & Nelson's Manual of Emergency and Critical Care Ultrasound-2nded. (available online via Welch Library website):
    1. Ch 4: First trimester ultrasound
    2. Ch 8: DVT
    3. Ch 10: Ocular
    4. Ch 11: Soft Tissue and Musculoskeletal
    5. Ch 12: Gastrointestinal
    6. Ch 14: Ultrasound in Shock
    7. Ch 16: Ultrasound for Procedural Guidance
2. Complete the corresponding SAEM Academy of Emergency Ultrasound online examinations with a minimum score of 70% for each exam. Exams may be retaken until a passing score is obtained. Please screenshot or print out your certificates and submit at the end of the rotation.
3. Attend all scheduled faculty-supervised bedside scanning shifts
4. Document at least **100** technically adequate and correctly interpreted ultrasound examinations, for a total of at least **200** by the end of the EM-2 year. Of these studies, at least 25-50 scans in 5 diagnostic ultrasound categories must be completed. Images and reports should be saved in Qpath.
5. Complete observed scanning competency assessments in 5 ultrasound applications by the end of the rotation
6. Attend all Thursday ultrasound QA/education meetings while on rotation.
7. Complete and submit the Emergency Ultrasound end-rotation checklist

Description of Didactic Experience:

Formal teaching will consist of bedside instruction by the ultrasound faculty and/or fellows, as well as weekly didactics during Wednesday QA/education meetings. Assigned reading/videos/modules are necessary to complement and solidify the concepts learned at bedside and should be completed before and during the rotation. Residents are encouraged to take advantage of additional ultrasound didactic resources, listed on the Ultrasound page on the hopkinsem.org website.

Evaluation process:

Successful completion of the EM Ultrasound rotation requires completion of the core components of the course as listed above. An end-of rotation checklist (available on www.HopkinsEM.org) must be submitted to the faculty on the last day of rotation.

Resident evaluation will be based on directly observed scanning and competency testing, scores on the SAEM Academy of Emergency Ultrasound online examinations, and review of images and reports on Qpath.

Feedback mechanisms:
Feedback to the EM-2 is provided by the Emergency Ultrasound faculty and/or fellows directly, as well as through New Innovations.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? YES ***X***

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice-Based Learning	X	ERE	FR, BR, PL
System-Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal, Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score(IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review(CR) End of Rotation Evaluation(ERE)

Rotation Contact:
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Rotation Faculty:
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Revised 6/2024 – T. Fong

Rotation: **Anesthesia at R Adams Cowley Shock Trauma Center (STC Anes)**
Year: **EM2**
Duration: **Four Weeks**

Educational Goal:
Develop the ability to evaluate, diagnose, and stabilize the airway of patients who are critically injured. Exposure to, and experience in, the management of the difficult airway.

Educational Objectives

The objective for the emergency medicine resident rotation at the Division of Anesthesiology in the R Adams Cowley Shock Trauma Center is to expose the resident to the initial evaluation of acutely injured patients, with emphasis placed on airway management. To achieve this objective, the rotation consists of the following:

1. Instruction in basic management skills, to include: (PC, SBP, MK):
    a. Patient assessment
    b. Placement of oral/nasal airways
    c. Mask ventilation
    d. Endotracheal intubation and LMA insertion
    e. Fluid Management
    f. Initial titration of pharmacologic agents including knowledge of various induction agents and paralytics including doses, onset, and duration of action.
2. Evaluation of the traumatized patient, from the initial transport (the heliport or ambulance bay) to the final disposition in the Trauma Resuscitation Unit or operating room. Emphasis will be placed on:
    a. Priority management (PC, SBP)
    b. Assessment and management of the airway (PC, MK)
    c. Indications for endotracheal intubation (PC, MK)
    d. Endotracheal intubation when deemed appropriate by the attending anesthesiologist. Emphasis will be placed on techniques appropriate for patients with presumed cervical spine injuries and full stomachs. (PC, MK)
    e. Placement of intravenous lines of catheters for invasive monitoring when appropriate. (PC)
3. Scheduled **ELECTRONIC** (online) didactic sessions with topics to include:
    a. Pregnancy & Trauma (PC, MK)
    b. Airway Pressure Release Ventilation (APRV) (PC, MK)
    c. Malignant Hyperthermia (PC, MK)
    d. Hemorrhagic Shock & Massive Transfusion (PC, MK)
    e. Pediatric Trauma (PC, MK)
    f. Traumatic Brain Injury (TBI) & Neurologic Injury (PC, MK)
    g. Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) (PC, MK)
    h. C-spine Injury & Airway (PC, MK)
    i. Vascular Trauma/Injury (PC, MK, SBP)
    j. Burns/Carbon Monoxide Poisoning (PC, MK, SBP)
    k. Acute Pain Management (PC, MK)
    l. Critical Care (PC, MK, SBP)

Description of clinical experiences:

The EM2 resident will rotate for a four-week period on the Trauma Anesthesia Service as a full member of the Service. The resident will have exposure to a wide variety of trauma patients. As an EM2, the resident will begin the airway evaluation with attending anesthesiologists on scheduled cases in the operating room at the trauma center. The resident will learn the basic approach to the assessment and management of the airway.

1. Prior to your first day, you should view the lectures on this website
   - All Airway Residents: https://anesweb.som.umaryland.edu/apps/login (Username: rotating-residents Password: RotatingResidents2019!)
   - Once in ANESWEB, select Education dropdown, select residency, scroll down to Rotation Information & select Trauma
   - You should review the lectures and the 10 papers
2. An orientation to the program on the first day of rotation is MANDATORY. During orientation, administrative needs will be handled, as well as a clinical orientation to equipment. Divisional, OR, and TRU policies and procedures will also be reviewed. EXPECT TO BE HERE FOR 12 HOURS.
3. Approximately 11-16 twelve-hour shifts 06:30 to 18:30 and 18:15 to 06:30 as assigned, which includes 1 weekend (Sat & Sun) day shift and 1 weekend (Sat & Sun) night shift.
   Hopkins EM residents will not be assigned nights during the first week of the rotation, or Fridays due to their program's conference. There is NO vacation time allowed during this rotation.
4. Parking will need to be paid for out of pocket ($160/month). You should suspend your parking downtown (save $60/month) – the difference can be covered by CME if you choose.
5. Attendance at scheduled Wednesday morning conference at 6:30am.
6. Observation of advanced techniques of airway management such as fiberoptic intubation.
7. Present a 10-minute review of a trauma, critical care, or anesthesia article, to the Division on the 3rd Wednesday of the month.
8. Each rotator must pass a pre- and post- rotation test. The passing score is 75%

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

The EM2 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), ED library (EM texts, computer), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical Library, ED lounge, shower and hospital cafeteria.

Duties and Responsibilities include:

- Obtaining detailed patient histories
- Performing physical examinations
- Reviewing all laboratory values and diagnostic studies
- Documenting histories and physical examinations
- Performing all necessary airway procedures

The resident will devise a diagnostic and management plan reviewed by the supervising attending trauma anesthesiologist.

Description of didactic experiences:

Formal teaching will consist of frequent bedside teaching by the attending anesthesiologist and weekly teaching conferences as stated above led by attending anesthesia faculty. Residents should make every effort to attend emergency medicine Friday morning conference from 7am to 12pm. Residents will not be scheduled a shift on Friday morning to allow them to attend morning conference.

Evaluation process:
At the end of each block, electronic and/or written evaluations with input from the supervising faculty members and fellows will be requested. Performance on pre and post-test with passing score of 75% and performance on 10-minute presentation at conference. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
At the end of the rotation, a written performance evaluation will be submitted to your Program Director.

All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS,
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contacts:
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Rotation: **Emergency Department at Johns Hopkins Bayview Medical Center (BVED)**
Year: **EM2**
Duration: **Eight weeks**

The EM2 resident will rotate for 8 weeks (divided into two four-week blocks) in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients.

Educational Goals & Overall Objectives:
Develop an advanced capability in the practice of emergency medicine in a tertiary care Level 2 Trauma Center with skills in efficiency that include but are not limited by the following overall objectives.

1. Perform an appropriate focused history and physical exam in a timely fashion
2. Demonstrate an ability to create, verbalize and document a relevant differential of consequence for multiple patients.
3. Demonstrate leadership by being a resident supervisor of a healthcare team, integrating well with other residents, faculty and nursing staff.
4. Develop proficiency in multi-tasking
5. Develop and institute complex treatment plans for a variety of patients simultaneously
6. Gain experience with the management of critically ill patients
7. Develop and hone resuscitation skills
8. Demonstrate an ability to provide rapid and appropriate care in the treatment of all Emergency Department patients in a time sensitive manner, including low acuity patients.

Educational Objectives:
1. Demonstrate skill in **"Data Gathering"** that includes but not limited to:
   - Perform an appropriate focused history and physical examination while managing multiple patients (PC, MK, ICS, PR)
   - Perform clear verbal and written patient presentations that adequately reflect the patient's condition, including acuity, disease state and anticipated disposition.
   - Demonstrate independence in ordering and interpretation of ancillary tests that are required for the management of multiple individual patients (PC, MK, SBP)
   - Reliably obtain essential and accurate information collected from all available sources (PC, SBP)
   - Demonstrate an ability to continuously gather data about patients during the entire course of patients' stay in the Emergency Department. (PC)
   - Demonstrates the ability to identify all key elements in the patient's history, physical or other data sources that indicate a need for further investigation ('the red flag"). (PC, MK)
   - Demonstrates an ability to obtain the patient's explicit agenda for coming to the Emergency Department (PC, ICS, PR)
2. Demonstrate skill in **"Problem Solving"** that includes but not limited to:
   - Generate an appropriate and relevant differential of consequence for undifferentiated patients while managing multiple patients (PC, MK)
   - Recognize the key data elements required to make efficient patient management decisions (PC, MK, PBL)

- Generate an expanded differential of consequence including the consideration of possible atypical presentations and all potential life and organ threats. (PC, MK, PBL)
- Demonstrates an ability to continually updates management plans based on patients changing condition or new data or availability of resources (PC, MK, SBP)
- Promptly involves the Attending Physician when there is a significant change in the health care condition of the patient (PC, SBP, PR)

3. Demonstrate skill in **"Patient Management"** that includes but not limited to:
   - Create a comprehensive treatment plan based on the differential of consequence (PC, MK, SBP)
   - Apply advanced knowledge of pathophysiology in developing patient management strategies. (PC, MK, SBP)
   - Under the guidance of the attending physician recognize and institute appropriate emergency stabilization of the unstable patient (PC, MK, SBP)
   - Demonstrates the ability to utilize the patient's explicit agenda in creating a management plan
   - Creates a management plan that addresses all the key elements of the patient's history, physical and other data sources that warrant further attention (Addresses the "red flags". (PC, MK, PBL, SBP)
4. Demonstrate **"Medical Knowledge"** appropriate for level of training that includes but not limited to:
   - Demonstrates advanced fund of medical knowledge (MK)
   - Describe complex disease processes as they relate to the patients under their care. (PC, MK,)
5. Demonstrate technical proficiency in **"Procedural Skills"** consistent with level of training that includes but not limited to:
   - Demonstrates understanding of informed consent. (PC, MK, P, SBP)
   - Provides clear and supportive information to patients and families regarding the need for procedural intervention (PC, MK, P, SBP)
   - Develop an understanding of the different therapeutic agents and dosages used in conscious sedation and rapid sequence intubation (PC, MK, P)
   - Suturing, lumbar puncture, splinting, I/D abscess, venipuncture (PC, MK, P)
6. Demonstrate skill in **"Efficiency"** of care that includes but not limited to:
   - Effectively manages 2 patients per hour (PC, MK, SBP)
   - Demonstrates an ability to provide rapid medical screening examinations of patients who are waiting for an evaluation room. (PC, MK, SBP)
   - Demonstrates an ability to prioritize tasks appropriately (PC, MK, SBP)
7. Demonstrate appropriate **"Interpersonal and Communication Skills"** that includes but not limited to:
   - Demonstrates effective information exchange with patients, their families, and professional associates (ICS, PR)
   - Shows an appreciation of appropriate conflict resolution skills (ICS, PR)
   - Works effectively with others in the health care team (ICS, PR)
   - Demonstrates an ability to persuade and negotiate with other health care professionals successfully. (PC, SBP, ICS)
   - Demonstrates an appropriate sensitivity in negotiating with individuals from a variety of cultures, backgrounds, education, and ethnicity. (PR, ICS)
   - Discuss treatment options with patients allowing patients to voice concerns, suggestions, and preferences. (PC, ICS)

8. Demonstrate appropriate **"Professionalism"** skills that includes but not limited to:
   - Introduces self to patient and/or family (PR, ICS)
   - Respectful of patient's privacy and confidentiality (PR)
   - Demonstrates respect, compassion, and integrity (PR)
   - Adheres to the dress code (PR)
   - Maintains equanimity while in the ED (PR)
9. Demonstrate skill in proper **"Documentation"** that includes but not limited to:
   - Medical record is complete and thorough and includes medical decision making and appropriate justification for the plan of treatment (PC)
   - Documentation reflects patient condition and is consistent with the final disposition. (PC, SBP)
   - Documentation of progress notes every 2 hours and procedure notes when indicated. (PC, SBP)
   - Documentation includes response to key interventions. (PC, SBP)
10. Demonstrate an understanding of a **"Systems-Based Practice"** that includes but not limited to:
   - Understands basic resources available for the care of the emergency department patient (SBP)
   - Recognizes the importance of resource allocation as they relate to patients, the hospital and other services, (PC, MK, SBP)
   - Demonstrates an ability to implement an appropriate treatment plan that factors in Emergency Department, Hospital and patient resources, as well as cost and availability. (SBP)
11. Demonstrate an awareness of the importance of **"Practice Based Learning and Improvement"** that includes but not limited to:
   - Uses appropriate information resources (ie, texts, online web sites, etc.) for the care of patient (PBL, PC)
   - Demonstrates an interest in learning willingness to investigate literature and other resources. (PBL, PC)
   - Actively seeks out instruction and incorporates new learning and feedback in the care of patient (PC, MK, SBP)
   - Demonstrates an ability to teach other residents, nurses, students, and other health care providers based on their clinical experiences, readings and instructions.

Educational Expectations:

1. Experience in the initial evaluation of an undifferentiated patient population
2. Experience in the development of appropriate treatment plans
3. Participate as the team leader for medical and surgical critical care patients
4. Experience in (but not limited to) the following procedures under direct supervision by faculty:
   - airway intubation
   - surgical airway
   - emergency thoracotomy
   - central venous access
   - arterial access
   - lumbar puncture
   - thoracentesis
   - arthrocentesis
   - paracentesis

- ultrasound
- laceration repair
- splinting techniques
- incision and drainage, etc.

6. Supervision of medical students

Duties and Responsibilities include:

1. Obtaining appropriately detailed patient histories
2. Performing physical examinations
3. Performing all necessary procedures under supervision of the faculty
4. Reviewing all laboratory values and diagnostic studies
5. Developing a differential of consequence and an appropriate management plan for each patient
6. Devising a diagnostic and management plan that will be reviewed by the EM attending
7. Demonstrating efficient implementation of treatment resulting in timely disposition.
8. Providing clear and concise documentation that adequately reflects patient condition and ED course.
9. Creation of complete and relevant discharge instructions.
10. Demonstrating professional interactions with faculty, staff, colleagues and consultants.

Description of clinical experiences:

The EM2 resident will rotate for eight weeks in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients.

As an EM2, the resident will be responsible for the initial evaluation of undifferentiated patients presenting to the ED under the direct supervision of the EM attending. IEM2 residents also start to learn to supervise and teach while working with PA students and medical students who are rotating at this institution.

All Emergency Medicine resident(s) must follow the ACGME <u>Emergency Medicine</u> duty hours guidelines.

Facilities and Resources:

The EM2 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), ED library (EM texts, computer), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Harrison Medical Library, ED lounge, shower and hospital cafeteria.

Description of didactic experiences:

Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties to allow them to attend conferences.

Evaluation process:

Teaching Observation Shifts (Faculty working one on one with a resident-SDOT)

- Shift Report (Faculty review of resident performance based on a single shift)
- Faculty Review
- Oral Boards
- Procedure Logs
- Patient Logs
- Chart Reviews
- Biannual Review

At the end of each block, written evaluations will be completed with input from faculty members. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with a residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contacts:
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Dr. Logan Weygandt
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Rotation: **Emergency Department at Johns Hopkins Hospital (JHED)**
Year: **EM2**
Duration: **Twenty-Two Weeks**

The EM2 resident will rotate for twenty-two weeks (divided into two- and four-week blocks) in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients.

Educational Goals & Overall Objectives:

Develop an advanced capability in the practice of emergency medicine with skills in efficiency that include but are not limited by the following overall objectives:

1. Perform an appropriate focused history and physical exam in a timely fashion
2. Demonstrate an ability to create, verbalize and document a relevant differential of consequence for multiple patients.
3. Demonstrate leadership by being a resident supervisor of a healthcare team, integrating well with other residents, faculty and nursing staff.
4. Develop proficiency in multi-tasking
5. Develop and institute complex treatment plans for a variety of patients simultaneously
6. Gain experience with the management of critically ill patients
7. Develop and hone resuscitation skills
8. Demonstrate an ability to provide rapid and appropriate care in the treatment of all Emergency Department patients in a time sensitive manner, including low acuity patients.

Specific Educational Objectives:

1. Demonstrate skill in **"Data Gathering"** that includes but not limited to:
   - Perform an appropriate focused history and physical examination while managing multiple patients (PC, MK, ICS, PR)
   - Perform clear verbal and written patient presentations that adequately reflect the patient's condition, including acuity, disease state and anticipated disposition.
   - Demonstrate independence in ordering and interpretation of ancillary tests that are required for the management of multiple individual patients (PC, MK, SBP)
   - Reliably obtain essential and accurate information collected from all available sources (PC, SBP)
   - Demonstrate an ability to continuously gather data about patients during the entire course of patients' stay in the Emergency Department. (PC)
   - Demonstrates the ability to identify all key elements in the patient's history, physical or other data sources that indicate a need for further investigation ('the red flag"). (PC, MK)
   - Demonstrates an ability to obtain the patient's explicit agenda for coming to the Emergency Department (PC, ICS, PR)
2. Demonstrate skill in **"Problem Solving"** that includes but not limited to:
   - Generate an appropriate and relevant differential of consequence for undifferentiated patients while managing multiple patients (PC, MK)
   - Recognize the key data elements required to make efficient patient management decisions (PC, MK, PBL)
   - Generate an expanded differential of consequence including the consideration of possible atypical presentations and all potential life and organ threats. (PC, MK, PBL)
   - Demonstrates an ability to continually updates management plans based on patients changing condition or new data or availability of resources (PC, MK, SBP)

- Promptly involves the Attending Physician when there is a significant change in the health care condition of the patient (PC, SBP, PR)

3. Demonstrate skill in **"Patient Management"** that includes but not limited to:
   - Create a comprehensive treatment plan based on the differential of consequence (PC, MK, SBP)
   - Apply advanced knowledge of pathophysiology in developing patient management strategies. (PC, MK, SBP)
   - Under the guidance of the attending physician recognize and institute appropriate emergency stabilization of the unstable patient (PC, MK, SBP)
   - Demonstrates the ability to utilize the patient's explicit agenda in creating a management plan
   - Creates a management plan that addresses all the key elements of the patient's history, physical and other data sources that warrant further attention (Addresses the "red flags". (PC, MK, PBL, SBP)
4. Demonstrate a **"Medical Knowledge"** appropriate for level of training that includes but not limited to:
   - Demonstrates advanced fund of medical knowledge (MK)
   - Describe complex disease processes as they relate to the patients under their care. (PC, MK)
5. Demonstrate technical proficiency in **"Procedural Skills"** consistent with level of training that includes but not limited to:
   - Demonstrates understanding of informed consent. (PC, MK, P, SBP)
   - Provides clear and supportive information to patients and families regarding the need for procedural intervention (PC, MK, P, SBP)
   - Develop an understanding of the different therapeutic agents and dosages used in conscious sedation and rapid sequence intubation (PC, MK, P)
   - Suturing, lumbar puncture, splinting, I/D abscess, venipuncture (PC, MK, P)
6. Demonstrate skill in **"Efficiency"** of care that includes but not limited to:
   - Effectively manages 2 patients per hour (PC, MK, SBP)
   - Demonstrates an ability to provide rapid medical screening examinations of patients who are waiting for an evaluation room. (PC, MK, SBP)
   - Demonstrates an ability to prioritize tasks appropriately (PC, MK, SBP)
7. Demonstrate appropriate **"Interpersonal and Communication Skills"** that includes but not limited to:
   - Demonstrates effective information exchange with patients, their families, and professional associates (ICS, PR)
   - Shows an appreciation of appropriate conflict resolution skills (ICS, PR)
   - Works effectively with others in the health care team (ICS, PR)
   - Demonstrates an ability to persuade and negotiate with other health care professionals successfully. (PC, SBP, ICS)
   - Demonstrates an appropriate sensitivity in negotiating with individuals from a variety of cultures, backgrounds, education, and ethnicity. (PR, ICS)
   - Discuss treatment options with patients allowing patients to voice concerns, suggestions, and preferences. (PC, ICS)
8. Demonstrate appropriate **"Professionalism"** skills that include but not limited to:
   - Introduces self to patient and/or family (PR, ICS)
   - Respectful of patient's privacy and confidentiality (PR)
   - Demonstrates respect, compassion, and integrity (PR)
   - Adheres to the dress code (PR)

- Maintains equanimity while in the ED (PR)

9. Demonstrate skill in proper **"Documentation"** that includes but not limited to:
   - Medical record is complete and thorough and includes medical decision making and appropriate justification for the plan of treatment (PC)
   - Documentation reflects patient condition and is consistent with the final disposition. (PC, SBP)
   - Documentation of progress notes every 2 hours and procedure notes when indicated. (PC, SBP)
   - Documentation includes response to key interventions. (PC, SBP)
10. Demonstrate an understanding of a **"Systems-Based Practice"** that includes but not limited to:
    - Understands basic resources available for the care of the emergency department patient (SBP)
    - Recognizes the importance of resource allocation as they relate to patients, the hospital and other services, (PC, MK, SBP)
    - Demonstrates an ability to implement an appropriate treatment plan that factors in Emergency Department, Hospital and patient resources, as well as cost and availability. (SBP,
11. Demonstrate an awareness of the importance of **"Practice Based Learning and Improvement"** that includes but not limited to:
    - Uses appropriate information resources (i.e., texts, online web sites, etc.) for the care of patient (PBL, PC)
    - Demonstrates an interest in learning willingness to investigate literature and other resources. (PBL, PC)
    - Actively seeks out instruction and incorporates new learning and feedback in the care of patient (PC, MK, SBP)
    - Demonstrates an ability to teach other residents, nurses, students, and other health care providers based on their clinical experiences, readings and instructions.

Educational Expectations

1. Experience in the initial evaluation of an undifferentiated patient population
2. Experience in the development of appropriate treatment plans
3. Participate as the team leader for medical and surgical critical care patients
4. Experience in (but not limited to) the following procedures under direct supervision by the EM faculty:
   - airway management
   - surgical airway
   - emergency thoracotomy
   - central venous access
   - arterial access
   - lumbar puncture
   - thoracentesis
   - arthrocentesis
   - paracentesis
   - ultrasound
   - laceration repair
   - splinting techniques
   - incision and drainage
5. Supervision of basic clerk medical students

6. Presentation of one 30-minute lecture at departmental resident conference.

Duties and Responsibilities include:

1. Obtaining appropriately detailed patient histories
2. Performing physical examinations
3. Performing all necessary procedures under supervision of the faculty or senior resident
4. Reviewing all laboratory values and diagnostic studies
5. Developing a differential of consequence and an appropriate management plan for each patient
6. Demonstrating efficient implementation of treatment resulting in timely disposition.
7. Providing clear and concise documentation that adequately reflects patient condition and ED course.
8. Creation of complete and relevant discharge instructions.
9. Demonstrating professional interactions with faculty, staff, colleagues and consultants.
10. Supervision and clinical instruction of medical students.
11. Provide efficient, competent, compassionate care to all patients with careful attention to communications with patients and families.
12. The resident will devise diagnostic and management plans that will be reviewed by the EM attending.

Description of clinical experiences:

As an EM2, the resident will be responsible for the initial evaluation of undifferentiated patients presenting to the ED under the direct supervision of the EM attending and senior 4th year resident. In addition to working in a primary clinical area, they will also serve as team members and assist other residents and medical students on their team with the care of their patients.
EM2 residents start to serve as leaders in critical care and trauma resuscitations.

Assignments may also include the purple team, in which you will be expected to split your patients among the blue and red attending. You will also be responsible for patients with ophthalmologic complaints during this assignment.

Second year residents will work approximately 45 hours a week. Shifts will be eight to twelve hours in length. The schedule will be posted on Shift Admin and can be accessed via this site. You should plan to arrive 15 minutes prior to the beginning of your shift to be present and prepared for team bedside rounds at change of shift.

All Emergency Medicine resident(s) must follow the ACGME <u>Emergency Medicine</u> duty hours guidelines.

Description of didactic experiences:

Daily morning rounds start at 7am. A medical minute will occur during the AM shift, and residents working clinically must attend unless they are in critical care.

Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties by faculty members and advanced practice practitioners to attend conferences.

Facilities and Resources:

The EM2 will have access to a wide variety of facilities and resources including (but not limited to): medical records (computerized and library), EM resident library (multiple EM texts,

computers), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker rooms, showers and several hospital cafeterias.

Evaluation process:
Several evaluation mechanisms will be used including, but not limited to:

- Teaching Observation Shifts (Faculty working one on one with a resident)
- End of Shift Evaluations
- End of Rotation Evaluations in New Innovations
- Oral Boards
- Procedure Logs
- Patient Logs
- Chart Reviews
- Biannual Review

Evaluation process:
At the mid-point and the end-point of each block, electronic evaluations will be completed with input from faculty members. You must select TWO SUPERVISORY FACULTY at each mid- and end-point evaluations for completion. Reciprocal evaluations will be generated about the faculty to be completed by the EM1-3, with the expectation that they will be completed within two weeks of assignment. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with a residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)

Rotation Contacts:
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Rotation: **Hand/Plastic Surgery at Johns Hopkins Bayview Medical Center (BV Hand)**
Year: **EM2**
Duration: **Two Weeks**

Educational Goal:
EM2 resident will function as the daily "on call" hand/plastic surgery resident. The resident will carry a designated plastic surgery consult pager and will respond to all inpatient and ED consults primarily. Supervision will be provided by a Plastic surgery fellow or attending. ED residents will be taught in both the OR and clinic with focused attending time.

Educational Objectives:
Patient Care:
1. Demonstrate the ability to perform an appropriate history and physical exam in patients with hand wounds/injuries and to thoroughly document historical and physical exam.
2. Develop expertise in the examination of the injured and infected hand.
3. Learn effective wound evaluation and management skills.
4. Learn appropriate methods for control of pain in patients with hand injuries including regional and local anesthetic blocks.
5. Learn appropriate follow-up techniques and management of the complications of burns, traumatic wounds, infections of the hand.
6. Demonstrate appropriate management of special wound types, including skin ulcers, human bites, animal bites, snakebites, plantar puncture wounds, dermal abrasions, high-pressure injection injuries and tar burns.
7. Demonstrate ability to apply wound dressings and splints.
8. Demonstrate ability to diagnose and manage complications of traumatic wounds.
9. Demonstrate ability to apply dressing splints in the appropriate positions, and be able to distinguish between the position of safety and the position of function.

Medical Knowledge:
1. Acquire in-depth knowledge of the anatomy of the hand and its relation to the clinical exam.
2. Demonstrate an understanding of wound pathophysiology, including cellular response, static and dynamic wound tensions, growth factors and tensile strength.
3. Describe the management of hand fractures.
4. Demonstrate an understanding of various imaging modalities in the detection of hand fractures and soft tissue foreign bodies.
5. Describe the techniques used for treatment and/or repair of extensor and flexor tendons, amputation of digits, disruption of collateral ligaments or joints, fractures of the phalanges, metacarpals, and carpal bones.
6. Describe the indications for immediate emergency consultation and delayed consultation by a plastic surgeon.

Interpersonal Skills:
1. Demonstrate the ability to articulate a patient's presentation, work-up and clinical course in a clear and concise manner.
2. Demonstrate the ability to work in a collegial fashion with hand surgery attendings and ancillary support staff.
3. Demonstrate the ability to work with injured patients.

Practice-Based Learning:

1. Apply scientific evidence to patients.
2. Identify and learn from errors.
3. Assist colleagues with management of hand injured patients who are evaluated in the ED.

Systems-Based Practice:

1. Improve understanding of rationale and cost effective use of radiographic and other diagnostic modalities in the management of hand-injured patients.
2. Understand limitations and benefits of admission.
3. Practice cost effective medical care.

Professionalism:

1. Demonstrate respect for patients and staff.
2. Demonstrate the ability to work in a collegial fashion with patients, their families and staff.
3. Dress appropriately.
4. Work with patients' needs in mind.
5. Adhere to standard ethical and moral principles.

Description of clinical responsibilities:

The EM2 will rotate for a two-week period on the Hand/Plastics Surgery Service as a full member of the Service. The resident will have exposure to a wide variety of patients under the direct supervision of the Hand/Plastic Surgery attending.

The EM2 resident, as part of a Hand/Plastics team, will participate in the evaluation of all admissions to the receiving unit.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

If you believe you are going to violate duty hours, please call the Plastics Chief on service or Dr Lifchez and notify Dr. Weygandt.

Weekly breakdown:

Monday – The resident will be in the OR with Dr. Lifchez with the following specifics/ exceptions:

1. OR procedures start at 7:30 or 8:30 depending on the week. The schedule is available in EPIC no later than 7 days prior to the OR day, but cases may be added after that time.
    a. The ER resident should be present in the OR no later than 15 minutes prior to the start of the first case. If there are inpatients on the plastic surgery service, the ER resident will round with the plastic surgery team prior to starting in the OR.
    b. He/she should read the clinic notes on the patients going to the OR that day.
    c. He/she should have some familiarity with the anatomy of the structure(s) being operated upon.
    d. He/she will not be expected to have consent discussions with patients, but for those patients that require H&P on the day of surgery (such as a patient who was seen in the ER initially and then brought back to the OR for definitive management), performing the H&P will help the resident familiarize him/herself with the patient's disorder that is being treated.

2. When daytime (up to 5pm) consultations are received, the ER resident will be the initial evaluator of such consultations.

Tuesday – The resident will be in the clinic with Dr. Lifchez.

1. The resident will be on call for plastic surgery from 7am Tuesday until 7am Wednesday (see call as described below in the Saturday section).
2. When a new consult comes in, the resident should leave clinic to evaluate that consult and discuss with the senior resident and/or attending; once the consult is complete, the resident should return to clinic
3. If there are no consults or acute issues requiring the resident's attention, he/she may go home after clinic has concluded.
4. The resident will attend Core curriculum at 6:30am if the topic is hand or nerve related. They may also attend non-hand Core Curriculum if they are interested in doing so.

Wednesday – The resident will be responsible for seeing consults during the day and then will attend the joint Plastic Surgery-Orthopedics Hand Conference from 5:30 to 6:30 PM in the JHOC-5 orthopedics conference room on the 1st and 3rd Wednesdays of the month. If the ER resident spent a large portion of Tuesday night in the hospital, he/she will be excused from clinical duties no later than 11am on Wednesday.

1. When a new consult comes in, the resident should evaluate that consult and discuss with the senior resident and/or attending.
2. If there are add-on surgeries during the day, the resident will be involved similarly to block surgery days (Monday & Thursday)
3. If there are no consults or acute issues requiring the resident's attention, he/she may go home after conference has concluded.

Thursday – The resident will be in the OR.

1. OR procedures start at 9:00. The schedule is available in EPR no later than 5 days prior to the OR day.

    a. The ED resident should be present no later than 15 minutes prior to the start of the first case.
    b. He/she should read the clinic notes on the patients going to the OR that day.
    c. He/she should have some familiarity with the anatomy of the structure(s) being operated upon.
    d. He/she will not be expected to have consent discussions with patients, but for those patients that require H&P on the day of surgery (such as a patient who was seen in the ER initially and then brought back to the OR for definitive management), performing the H&P will help the resident familiarize him/herself with the patient's disorder that is being treated.

2. When daytime (up to 6pm) consultations are received, the ER resident will be the initial evaluator of such consultations (with the exception of when he/she is dismissed post-call as described above).

Friday – The resident will attend EM didactic conference from 7am-12pm. The resident will engage in the Department of Emergency Medicine Clinical and/or educational duties at the discretion of the Emergency Medicine Department.

Saturday – The resident will be on call from home from 7am Saturday to 7am Sunday. If there are no inpatients on the hand/plastic surgery service, then the resident need not come into the hospital until a consultation is called. This point should be confirmed with the plastic surgery chief resident at the end of the day on Friday.

1. When a consultation is called, the resident will go in and evaluate the patient and discuss management with the backup senior resident.
2. The ED resident will then manage the patient alone or in conjunction with the senior resident as indicated by the patient's condition and the resident's knowledge/comfort level.
    a. Such activities may include closed reduction and splinting of fractures, suture of lacerations, debridement and dressing of wounds.
3. The ED resident may be at home when there are not acute in-hospital issues to manage. Calls regarding floor issues can often be managed over the phone and do not necessarily require the resident to come in.
4. The plastic surgery service alternates call for facial trauma with the ENT service. On the days when plastic surgery is on call for facial trauma (odd-numbered days) and the ED resident is on call, he/she will be on call for these issues as well.
5. The plastic surgery service alternates call for distal radius fractures with the orthopedic surgery service. On the days when the plastic surgery service is on call for distal radius fractures (odd-numbered days) and the ED resident is on call, he/she will be on call for these issues as well.
6. The ED resident will NOT cover the burn service. Inpatient consults for chronic wounds are shared with the burn surgery service on a weekly alternating basis from Monday 7am to Monday 7am. If there is any question regarding whether a consult should go to plastics or burn, the ER resident should check with the senior plastic surgery resident.

Sunday – The resident is post-call, but will round if there are active consults or inpatients.
1. If there are inpatients admitted to the service or consults who he/she has seen while on call, the resident will round with the plastic surgery resident on call Sunday morning. After rounding, the resident has no further clinical responsibilities for the day.
2. In the event there are no patients on the service and there are no new consults who the resident has seen while on call, the resident will not have to round on Sunday. Please speak to the resident on call for Sunday no later than early Sunday morning to confirm this.

Proactive behaviors exhibited by recent residents that should be emulated to maximize the educational benefit for residents on the Bayview Hand Surgery rotation. This includes:

1. Be present in the OR and clinic
    a. Time spent in clinic and the OR is the best opportunity to practice hand examination (even for non-traumatic hand conditions) and to see hand anatomy from "the inside" that may help residents better understand how this anatomy affects how patients present with hand injuries.
    b. For these reasons, when not seeing ED consults on clinic and OR days, every effort should be made to take advantage of these opportunities for learning under the direct supervision of the attendings on service.

2. Prepare for the OR
    a. Read the patient's clinic note.
    b. Look at the patient's x-rays in Carestream/EPIC (if available)
    c. Know the anatomy of the part of the hand/wrist/other area being operated on.
    d. For those patients that are not acute traumas, consider the initial presentation of these patients, as some will come into the ER with similar symptoms/presentation.

3. Pay attention when a nerve block or splinting technique is being demonstrated.
    a. This will allow the resident to perform the block/splint in future occasions while on the rotation.
    b. The need for certain blocks/technique may only occur once during the rotation; this is an opportunity for the resident to observe this technique for possible use in the ER in the future.

4. Ask questions.
    a. Many hand surgery disorders began as initial traumas or symptoms that may present to an Emergency Department.
    b. If the resident has a question during a patient clinic encounter or a critical step in an operating procedure, this question should be asked after exiting the patient room or after the critical step in the procedure.
5. Be a member of the team while on this rotation.
    a. Occasional patients will need preoperative H&Ps. This is an opportunity to learn more about the patient's condition.
    b. There is NOT a large inpatient plastic surgery census and NOT a large amount of 'scut' work to do. However, it is very helpful to the other residents on the team if the ER resident attends rounds on the plastic surgery patients, particularly those whose operation the ER resident has seen.

Facilities and Resources:
The EM2 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), on-line web data (Up-to-date, MD Consult, Micromedex, etc.), ED Library, staff lounge, call rooms, locker rooms, showers and hospital cafeterias.

Duties and Responsibilities include:

1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Documenting of histories and physical examinations
5. Performing all necessary procedures
6. The resident will devise a diagnostic and management plan that will be reviewed by the supervising attending physician or fellow.
7. Presence in the operating room and operative experience is considered an asset.
8. Case presentation at Wednesday didactics per director, Dr. Lifchez.

Description of didactic experiences:
Formal teaching will consist of weekly teaching conferences with attending faculty, fellows and residents on Wednesday morning. Residents are relieved of all clinical duties in order to attend EM Conference on Friday morning from 7am-12pm.

Evaluation process:
At the end of each block, written and/or electronic evaluations with input from supervising faculty members and residents will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in both the semi-annual meetings with his/her appointed faculty advisor and the semi-annual meetings with a residency director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)

Rotation Contact:

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Rotation: **Orthopedics at Johns Hopkins Bayview Medical Center (Ortho)**
Year: **EM2**
Duration: **Two Weeks**

Educational Goals:
Develop the ability to evaluate, diagnose, stabilize, and treat the patient with orthopedic complaints

Educational Objectives:
1. Demonstrate effective communication with patients, their families, and professional associates *(*ICS).*
2. Demonstrate respect, compassion, and integrity *(*PR).*
3. Demonstrate the ability to perform an appropriate history and physical exam targeted to the complaint and injury pattern *(*MK, PC)*
4. Demonstrate the ability to develop an appropriate differential diagnosis and treatment plan *(*MK, PC)*
5. Demonstrate appropriate clinical decision-making skills *(*PC).*
6. Demonstrate the ability to appropriately select imaging based on the suspected injury *(*MK, PC).*
7. Demonstrate the ability to accurately interpret imaging obtained to evaluate orthopedic injuries *(*MK, PC)*
8. Demonstrate procedural skills, particularly hematoma block, nerve block, reduction, and splinting, to the level of technical proficiency needed for indirect supervision *(*MK, PC)*
9. Demonstrate the ability to appropriately create a disposition plan based on the injury, and the risks associated with the post injury course *(*MK, PC, SBP)*
10. Learn the basic resources available for the care of the orthopedic patient *(*SBP).*
11. Learn the appropriate information resources (i.e., textbooks, handbooks, online resources, etc.) available for the care of orthopedic patients *(*PBL).*

Educational Expectations
1. Exposure to and experience in the management of acute orthopedic injuries
2. Experience in the radiologic evaluation of orthopedic injuries
3. Exposure to and experience in the reduction of fractures
4. Exposure to and experience in the use of hematoma blocks
5. Exposure to and experience in the use of finger traps and weights
6. Exposure to and experience in the reduction of joint dislocations:
    a. shoulder
    b. elbow
    c. finger
    d. hip
    e. knee
    f. ankle
7. Experience in splinting and casting of acute fractures and soft tissue injuries:
    a. Jones' compression dressing
    b. posterior ankle splint
    c. sugar tong splint
    d. long arm splints
    e. short arm cast
    f. thumb splint

g. thumb SPICA
h. universal hand dressing
i. gutter splints
j. finger splints

8. Experience in anticipation of short- and long-term complications.

Description of clinical experience:
The EM2 resident will rotate for a two-week period on the Orthopedic Service. The resident will have exposure to a wide variety of orthopedic injuries.

As an EM2 the resident will be responsible for the initial consultation and evaluation of orthopedic injuries in the Adult ED and the Pediatric ED under the supervision of the orthopedic attending, resident and advanced practice provider. The resident will assist in the initial management of these patients, including diagnostic evaluation, reduction, splinting and preparation for OR.

The resident may remain in the hospital for patient care that are allowed under the current duty hours guidelines (no longer than 24 scheduled hours at a time, with an additional 4-hours allowed for transition but during which NO new patient care is allowed; at least 14-hours off after call; one day off in every seven; and not to exceed 80 hours/week averaged over 4 weeks).

All Emergency Medicine resident(s) must follow the ACGME <u>Orthopedics</u> duty hours guidelines.

Facilities and Resources:
The EM2 will have access to a wide variety of facilities and resources including (but not limited to): medical records (computerized and library), on-line web data (Up-to-date, MD Consult, Micromedex, etc), Welch Medical School Library, staff lounge, call rooms, locker rooms, showers and hospital cafeterias.

Duties and Responsibilities include:
1. Taking patient histories
    a. Performing a focused examination
    a. Reviewing all radiographic studies
    b. Documenting histories and examinations
2. Assisting in and/or primary management of acute orthopedic injuries
3. Performing necessary fracture reductions, dislocation reductions and splinting/casting procedures.

The resident will work nights for their 2-week rotation. There will be emphasis on teaching and time in the clinic and with consults/reductions/procedures as well as some exposure in the OR if they are interested.

Description of didactic experiences:
The resident will be required to attend the weekly emergency medicine teaching conferences held on Friday morning from 7am- 12pm and should be excused from all clinical responsibilities during this time.

Evaluation process:
At the end of each block, electronic evaluations with input from supervising faculty members and resident will be requested.

Feedback mechanisms:
All evaluations will be reviewed by the resident in semi-annual meetings with a residency director.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described? YES **XX**

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation
Patient Care	X	ERE
Medical Knowledge	X	ERE
Practice Based Learning	X	ERE
System Based Learning	X	ERE
Interpersonal Skills and Communications	X	ERE
Professionalism	X	ERE
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Tintanelli questions(TQ), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)		

Rotation Contacts:
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Rotation: **Pediatric Anesthesia at Johns Hopkins Hospital (PA)**
Year: **EM2**
Duration: **Two Weeks**

Educational Goal:
Develop the ability to evaluate, diagnose and secure pediatric airways.

Educational Objectives:
1. Learn the normal anatomy and physiology of the pediatric airway and pulmonary system (PC, MK)
2. Develop airway management skills using a variety of devices and techniques (PC, SBP, MK)
   - nasal intubation
   - oral intubation
   - bag valve mask ventilation
   - laryngeal mask airway
3. Gain experience with a variety of pharmacologic anesthetic agents (PC, SBP, MK)
   - Sedative hypnotics
   - neuromuscular relaxants
   - regional anesthetics
4. Perform comprehensive evaluations of the pre-operative patients including (PC, MK, ICS, SBP)
   - taking a history
   - physical examination of the airway
   - understanding the indications and contraindications for choice of airway equipment and medication
5. Experience in the following procedures under direct supervision by Pediatric Anesthesiology faculty: (PC, MK)
   - oral intubation
   - nasal intubation
   - bag valve mask ventilation
   - laryngeal mask airway
   - venous access
   - central line placement
   - arterial line placement
   - cricothyroidotomy
6. To learn principles of fluid resuscitation in the pediatric patient
7. Demonstrate effective communication with patients, their families, and professional associates (ICS).
8. Demonstrate respect, compassion, and integrity (PR).
9. Demonstrate the correct use of bag-valve mouth device (PC).
10. Demonstrate the ability to perform an endotracheal intubation (PC).
11. Learn about the use of alternative airway devices (ie, LMA, etc.) (PC).
12. Learn the predictors of a potentially difficult endotracheal intubation (MK).
13. Learn the pharmokinetic properties of medications used in airway management (MK).
14. Learn the basic resources available for the care of the O.R. patient (SBP).

Description of clinical experiences:
The EM2 will rotate for a two-week period in pediatric anesthesia.

Location: Bloomberg 4 OR

Attire: Cobalt blue scrubs (contact Doris Thomas-Johnson for scrub access, email her at dthoma11@jhmi.edu)

Preparation: Dr. Dalesio or the coordinator will email you your OR room assignment the night before you are scheduled to begin your rotation. Please refrain from emailing prior to this. Find Dr. Dalesio on the first day to introduce yourself and proceed to your assigned room. As there are often multiple rotators, please stay in your assigned room for the entire day (unless specifically asked to move by an attending).

Completion of the following before the start of your rotation:

- Read Pediatric Airway Management by Santillanes and Gausche-Hill (2008): https://www.sciencedirect.com/science/article/pii/S0733862708000874?via%3Dihub
- View 5 min video on mask ventilation https://www.youtube.com/watch?v=n633414uaP8
- View 3 min video on oral/nasal airway insertion https://www.youtube.com/watch?v=4KwoRuZdfZ4
- View 2 min video on LMA insertion https://www.youtube.com/watch?v=aSeW4YyVf3M
- View 5 min video on intubation https://www.youtube.com/watch?v=Wxal2dIyPVI
- Review website: https://aneskey.com/direct-laryngoscopy-2/

Schedule: Please arrive at 0645 on the first day of your rotation for a simulation exercise. Thereafter, the start time is 0700 every day except Thursday when you can arrive at 0815. You are expected to be there from Monday to Thursday. Arriving early to help set up your assigned OR is both beneficial to your education and looked favorable upon by the attending anesthesiologists.

Responsibilities: You should receive a daily email by 4pm regarding room assignments for the next day. The email will list the room, the attending, and resident or CRNA you are with that day. Please do not email Dr. Dalesio seeking the schedule earlier than this (since it is not yet made). Let Dr. Dalesio know if he will be expecting you on Fridays so that you will be assigned to a room. Also, let him know if you will not be in on a specific day. There are often 2-5 rotators and never enough good rooms.

There are some conferences (called Pedi 20) that occur from 0640 to 0700 a few days a week and rotators are welcome to attend. You may call or email Cindy Hayes if you would like to be added to that schedule for Pedi 20.

Cases begin at approximately 0730 and the day will end around 1600-1700. Thursdays are an exception: Anesthesia has conferences on Thursday mornings, so cases begin 1 hour later, usually around 0830 (you do not need to go to their conference). You have access to the OR schedule via EPIC.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

Tips:

- Only your "Kids Kard" and a stethoscope are needed.
- Review Chapter 29 in Tintinalli's for Pediatric Airway Management.
- Miller's Anesthesia is one of the main Anesthesia texts

Facilities and Resources:
The EM2 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker-room, shower and several hospital cafeterias.

Duties and Responsibilities include:

1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Documenting histories and physical examinations
5. Performing all necessary procedures

Description of didactic experiences:
Formal teaching will consist of weekly teaching conferences with PICU attending and fellow. You are NOT required to attend PICU rounds during this rotation.

You are expected to make every effort to attend their Thursday Case Conference (8:30am) and their 1pm PICU attending lectures. We recommend you have the EM resident in the PICU tell you what they are discussing and at what time, so you can determine the possible benefit to you. We recognize there are a lot of rare disorders that are taken care of in the PICU, and as such, some of these lectures may not be the best use of your time. Please use your discretion in making this decision.

Residents are also expected to attend Friday morning conference from 7am-12pm.

Evaluation process:
At the end of each block, electronic evaluations with input from supervising faculty members and fellows will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS,
Medical Knowledge	X	ERE	OB, IS,
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)

Rotation Contact:

Nick Dalesio, MD
Associate Professor
Director of Pediatric Anesthesia Clinical Operations
Director of Pediatric Difficult Airway Program
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Otolaryngology/Head & Neck Surgery
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Rotation: **Pediatric Intensive Care Unit at Johns Hopkins Hospital (PICU)**
Year: **EM2**
Duration: **Four Weeks**

Education Goal:
To gain experience managing critically ill pediatric patients in an ICU setting.

Educational Objectives:
1. Perform histories and physical examinations on children of different ages and recognize abnormal physical findings and concerning historical elements. (PC, MK, ICS, Prof)
2. Recognize the seriously ill child requiring admission to the ICU. (SBP, MK, PC, ICS, Prof)
3. Differentiate between compensated, uncompensated, and terminal shock. (MK, PC)
4. Perform resuscitation of seriously ill child, including resuscitation of hypovolemic and septic shock. (PC, MK, ICS, SBP, PBL&I, Prof)
5. Recognize the child in respiratory distress. (PC, MK)
6. State the indications for endotracheal intubation and perform endotracheal intubation in children. (PC, MK)
7. Perform arterial puncture for blood gas examination in children. (PC)
8. Recognize the child with inspiratory stridor and state the differential diagnosis of stridor. (PC, MK)
9. Compare and contrast the presentation, evaluation, and treatment of patients with croup, epiglottitis, and upper airway foreign bodies. (PC, MK, PBL&I, ICS, SBP)
10. State indications for hospitalization of children with croup. (PC, MK, PBL&I, ICS, SBP)
11. State the differential diagnosis of wheezing in children. (PC, MK)
12. State the indications for hospitalization of children with wheezing. (PC, MK, PBL&I, ICS, SBP)
13. Manage patients with respiratory failure of various etiologies. (PC, MK, PBL&I, Prof, SBP)
14. Manage patients with hemodynamic instability of various etiologies. (PC, MK, PBL&I, Prof, SBP)
15. Select appropriate settings for mechanical ventilation in children. (PC, MK)
16. Compare and contrast clinical presentations and management of different types of congenital heart disease. (PC, MK, PBL&I, ICS, SBP)
17. Recognize the cyanotic child, and state causes of cyanosis in children. (PC, MK, PBL&I, Prof, ICS, SBP)
18. Recognize and manage the child in congestive heart failure. (PC, MK, PBL&I, Prof, ICS, SBP)
19. State the clinical manifestations of bacteremia, sepsis, meningitis, and pneumonia in children. (PC, MK)
20. Select appropriate antibiotic therapy for sepsis, meningitis, and pneumonia in children of different ages. (PC, MK, SBP)
21. State the differential diagnosis and appropriate workup of petechiae in children. (PC, MK, PBL&I, Prof, ICS, SBP)
22. State the differential diagnosis of altered mental status or altered consciousness in children and select appropriate diagnostic tests. (PC, MK, PBL&I, Prof, ICS, SBP)
23. Perform lumbar puncture in children. (PC, Prof, ICS)
24. Recognize the signs and symptoms of increased intracranial pressure in children. (PC, MK, PBL&I, Prof, ICS, SBP)
25. State the differential diagnosis of seizures in children and select appropriate therapy for the acute management of the child with seizure. (PC, MK, PBL&I, Prof, ICS, SBP)
26. Perform ongoing ICU management of children with poisoning and drug overdose. (PC, MK,

PBL&I, Prof, ICS, SBP)

27. Compare and contrast clinical presentations and management of traumatic injuries in adults and children. (PC, MK, PBL&I, Prof, ICS, SBP)
28. State the indications for hospitalization of traumatized pediatric patients. (PC, MK, PBL&I, Prof, ICS, SBP)
29. Perform venipuncture and intravenous access techniques on critically ill children. (PC, ICS, Prof)
30. Manage fluid and electrolyte and acid-base disorders in children. (PC, MK, PBL&I, Prof, ICS, SBP)
31. Select appropriate medications for analgesia and sedation for children with pain and anxiety. (PC, MK, PBL&I, Prof, ICS, SBP)
32. Recognize brain death in children. (PC, MK, PBL&I, Prof, ICS, SBP)

Educational Expectations:

1. To learn the normal development of the pediatric patient
2. To learn the pathophysiology of abnormal conditions in the pediatric age group
   - acute neurological processes
   - status asthmaticus
   - bacteremia and sepsis
   - cardiac disease
   - diabetes complications
   - drug overdose
   - gastrointestinal hemorrhage
   - HIV-related illness
   - meningitis
   - pyelonephritis
   - respiratory distress and respiratory failure
   - status epilepticus
   - trauma-related injuries
3. Exposure to and experience in the management of pediatric emergencies
4. Exposure and experience in the management of critically ill and injured pediatric patients.
5. Specific experience and training in:
   - taking a pediatric history
   - performing a pediatric physical examination
   - understanding the indications and interpretation of ancillary laboratory and imaging techniques
6. Experience in (but not limited to) the following procedures:
   - venous access
   - venous cutdown
   - arterial access
   - lumbar puncture
   - intubation
7. Exposure to and experience in pediatric airway management in the operating room.
8. Experience in resuscitation of pediatric trauma in the ED
9. Experience and training in pediatric resuscitation efforts, including anticipation and recognition of short and long-term complications

Description of clinical experiences:
The EM2 will rotate for a four-week period on the PICU Service as a full member of the Service. The resident will have exposure to a wide variety of critically ill and injured pediatric patients under the direct supervision of the PICU attending physician and PICU fellow.

There are three PICU teams:

1. Red
   - General critical care, including:
     - Status asthmaticus
     - Bronchiolitis or pneumonia with respiratory insufficiency
     - DKA
     - Non-complex status epilepticus
     - Hypovolemic/septic shock
     - More common post-surgical procedures like T&A and non-complex posterior spinal fusions
     - Chronically critically ill children (generally former premature infants with long term ventilation needs)
2. Blue
   - Neuro critical care
3. Green
   - Cardiac critical care

EM2 residents will be assigned to the Red Team – for roughly two weeks of day shifts– depending on the number of PICU resident rotators. While you will also spend one week of nights on the Blue team and one week of nights on the Red team. If this is not the case, please let Dr. Ehmann, Dr. Weygandt, and the EM Chiefs know as soon as your schedule is sent to you.

EM2 residents will be responsible for the evaluation of admissions from the emergency department, operating room, general pediatric floors and outside facilities.

The resident will remain in-hospital for admissions and acute patient management when on call. Call shifts will not exceed 24 hours plus 4 hours for transition of patient care. There is a call room for the PICU. It is room 4444, the call room that shares a bathroom with the PICU Attending call room (4440). Look for the signage on the Rooms. This call room may be used by the PICU residents with 24+ hour shifts (Friday/Saturday nights) **- note the room is reserved for the residents on these nights – ACGME requirement:** the 2nd PICU attending if called in, the Cardiac Resource Attending, the Gold Fellow if called in and doesn't want to go home, any PICU staff member who needs a bed because of an unusual shift or circumstance. There will be a sign-up book at the PICU front desk so please check in with the CCSR and sign up for the room when needed. The CCSR will also have the combination to the room.

Your schedules are made by the pediatric chief residents. Please contact the JHEM chiefs if you have questions about your schedule, and they will put you in touch with the pediatric chiefs.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

Facilities and Resources:
The EM2 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), PICU conference room (reference books), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, call room, shower and several hospital cafeterias.

Duties and Responsibilities include:
1. Taking detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Documenting histories and physical examinations
5. Writing progress notes
6. Performing necessary procedures

Description of didactic experiences:
Formal teaching will consist of daily patient-based case conferences led by both the PICU attending faculty and PICU fellows and other PICU-wide conferences (schedule to be given to resident at orientation). Residents are expected to attend weekly emergency medicine conferences on Friday mornings from 7am-12pm, when their clinical schedule allows without violating duty hours (typically when assigned to days but not to nights).

Evaluation process:
Before the transition to nights, the resident will have a mid-month evaluation by the PICU fellows and/or faculty. At the end of each block, electronic evaluations with input from supervising PICU faculty members and fellows will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contacts:
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Rotation: **Research at Johns Hopkins Hospital (Res)**
Year: **EM2**
Duration: **Two Weeks**

Educational Goals:
EM2 will demonstrate an understanding of basic research methodology and the principles of evidence-based medicine by applying specific skills to perform an evidence-based search. EM2 residents will also learn about the available FAST opportunities and meet with at least two possible FAST directors during this time.

Educational Objectives:
1. Engage in self-directed learning using an online research and evidence based medical education series (MK, PBL, PC, SBP)
2. Develop an understanding of how to search medical literature. (MK, PBL)
3. Develop an understanding of how to evaluate medical literature. (MK, PBL)
4. Learn to recognize specific study methods in medical literature. (MK, PBL)
5. Learn the principles of scientific writing (MK, SBP)
6. Learn how to formulate a clinical study question, including developing a hypothesis and judging its relevance. (MK, PBL, SBP)
7. Participate in a mentored approach to the following:
    a. Asking a clinical question, and finding out what is known about the subject
    b. Identifying gaps in the current knowledge base
    c. Identify study designs that are *appropriate* and *feasible* for addressing one or more of those gaps
8. Develop an understanding of basic biostatistics. (MK, PBL, SBP)
9. Demonstrate effective communication with mentors, supervisors, and professional associates (ICS).
10. Demonstrate innovation, diligence, and persistence with appropriate follow up (PR).
11. Learn about the available FAST programs and narrow down those of interest (PR, PBL, SBP, ICS)
12. OPTIONAL: Engage in a scholarly activity (e.g. QI project or development of FAST proposal) with the approval and supervision of a faculty mentor with the oversight of the Assistant Clinical Director and /or research committee. (SBP, MK)
13. OPTIONAL: Prepare and submit a written and oral presentation about the above-described scholarly project defending its relevance to patient care. (MK, PBL, ICS, PR, SBP, PC)

Description of experiences:
The overarching goals of the research rotation are (1) to ensure residents have a foundational understanding of clinical research design and evidence-based medicine, so that they are able to critically assess medical literature and FOAM (free open-access medication) resources and (2) to provide opportunity for early development of FAST projects through interaction with potential FAST mentors early in residency and completion of a structured literature review related to a topic of their choosing.

REQUIREMENTS FOR RESIDENT:
1. The resident is required to set up a meeting with Dr. Jeremiah Hinson at least 2 weeks prior to the start of the research rotation so that the rotation can be planned and be of maximum benefit to the resident. Dr. Hinson will work to pair the resident with at least one faculty mentor who

shares academic interests with the resident, who may serve as a primary or secondary mentor for the resident's research rotation project (see below). This meeting can be held in person or over the phone.

2. The resident is responsible for completing a series of online educational modules (accessible via hopkinsem.org.org and Hopkins EM Research Division Website) by the end of this rotation. They can be completed at any time prior to the rotation but must be completed by the end of the rotation. A link to these modules will also be sent out at the beginning of the year, and a workbook to accompany the modules will be provided by Dr. Hinson at the beginning of the 2-week research rotation. If you would like the workbook earlier, email Dr. Hinson (hinson@jhmi.edu) to obtain.

3. The resident is responsible for independently investigating a research question of their choosing and writing up their findings in the form of either: a formal literature review, a topic review to be published on EBMConsult.com or elsewhere, or to serve as an introduction for their FAST proposal (and potentially as the introduction for subsequent related manuscripts). This write-up should be submitted to the resident's mentor, Drs. Regan, Hinson and Mary Rode by the end of the rotation. As above, residents will be encouraged to choose clinical questions that may lead to the development of a research project or FAST interest, but this is not required. Residents should meet with Katie Lobner, our clinical informatics specialist, to review the available databases and decide on search terms for the clinical questions s/he will be answering during this rotation. Each resident will be assigned to one of our faculty mentors (assigned by Dr. Hinson and/or Mary Rode following the meeting with Dr. Hinson described above) and will be required to meet with them both at the beginning of their research rotation to formulate and narrow the question, as well as at the end, to review their focused literature review used to answer the clinical question.

***In some cases, residents may have already identified a specific goal they would like to pursue during their research rotation, including execution of an already designed research project or writing up results of a completed project for publication. While all residents will be required to complete the learning modules described above, research activities like these may substitute the literature review described above with prior approval from Drs. Hinson and Regan.

4. Except under extenuating circumstances, research rotation residents will be expected to attend a weekly Research Division meeting, which takes place at MTW each Monday at 12pm. Ongoing departmental research projects and funding opportunities are discussed at this meeting, and it will be expected that the resident informally presents the research question they are pursuing. These are low-key, low-stress meetings and resident involvement is meant to expose the resident to ongoing research activities within the department.

Facilities and Resources:

The resident will have access to a wide variety of facilities and resources including, but not limited to: Departmental research manual (on hopkinsem.org), medical records (computerized and library), EM resident library (multiple EM texts, computers), online web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, computers, locker rooms, showers and several hospital cafeterias.

Duties and Responsibilities include:

1. Demonstrate an understanding of basic statistics.
2. Demonstrate the ability to create a scholarly project
3. Recognize and discuss the different types of research methods.
4. Demonstrate an ability to critique the medical literature
5. Demonstrate the ability to work with a research mentor.
6. Demonstrate an ability to interface with the research committee
7. Prepare a written and oral presentation on the clinical question

Description of didactic experiences:

Formal resident conferences occur each Friday morning from 7am to 12pm. All residents on this rotation are relieved from clinical duties to attend conferences. Residents will be expected to attend any Research Committee meeting that takes place during the rotation.

Evaluation process and Feedback

At the end of each rotation, informal feedback will be provided to the resident on their written submission. Formal feedback will be provided after the presentation at the quarterly research meeting.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Contacts:

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EM3
Clinical Rotations

Rotation: **Burn ICU/Plastic Surgery at Johns Hopkins Bayview Medical Center (BV Burn)**
Year: **EM3**
Duration: **Two Weeks**

Goal:
Develop the ability to evaluate, diagnose, stabilize, and treat critically ill and injured burn patients.

Objectives:
1. Demonstrate effective communication with patients, their families, and professional associates (ICS).
2. Demonstrate respect, compassion, and integrity (PR).
3. Demonstrate the ability to perform an appropriate history and physical exam (PC)
4. Demonstrate the ability to develop an appropriate differential diagnosis and treatment plan (MK).
5. Demonstrate appropriate clinical decision-making skills (PC)
6. Understand the pathophysiology of burn injuries (MK)
7. Understand the complications of major burns, including sepsis, hypovolemia and compartment syndrome (MK, PC, SBP)
8. Understand the pathophysiology of morbidity and mortality in patients sustaining major burns (MK).
9. Learn the principles of hemodynamic monitoring and ventilator management (PC).
10. Demonstrate procedural skills that are technically proficient with level of training (PC).
11. Learn the basic resources available for the care of the burn ICU patient (SBP).
12. Learn the appropriate information resources (i.e., textbooks, handbooks, online resources, etc.) available for the care of burn ICU patient (PBL).
13. To recognize and treat major and minor burns, including inhalation, thermal, chemical and electrical injuries (MK, PC, SBP)
14. Demonstrate management of the critically ill burn patient (MK, PC, SBP)
15. Learn suture selection and wound closure techniques to appropriately treat a variety of wounds and lacerations (MK, PC, SBP)
16. Understand the indications for procedural interventions in burn management and plastic surgery (MK, PC, SBP)
17. Develop experience with (but not limited to) the following procedures:
    - venous access
    - venous cutdown
    - central line access, in particular subclavian lines
    - arterial puncture
    - arterial access
    - debridement and local wound care
    - intubation/trach placement
    - bronchoscopy
    - escharotomy
    - skin grafting
    - tendon repairs
    - plastic repair suturing technique
18. Gain understanding of in-hospital burn therapy, course and patient outcomes (PC, MK, SBP)

Description of clinical experiences:
The EM3 will rotate for two weeks on the Burn ICU/Plastic Surgery Service as a full member of the Service. The resident will have exposure to a wide variety of injured burn and plastic surgery patients under the direct supervision of the Burn/Plastic Surgery attending physician. The resident will remain in hospital for admissions, emergency department consultations and acute patient management. The resident will work as part of the burn team in accordance with ACGME guidelines. The resident may remain in hospital on shifts that are allowed under the current duty hours guidelines (no longer than 24 hours, plus 4 hours for transition, with 24 hours off (averaged over 4 weeks) and not to exceed 80 hours/wk averaged over 4 weeks). Residents must have 14 hours off after a 24-hour call.

All Emergency Medicine resident(s) must follow the ACGME duty hours guidelines of their host department.

As an EM3, the resident will be responsible for evaluating all admissions to the Burn ICU and the inpatient floor service, consisting of burn and plastic surgery patients. In addition, the resident will perform consults in the emergency department, evaluating both burn injuries and plastic surgery wounds and fractures. The resident will assist in the operating room for skin grafting of burn injuries and skin closure in plastic surgery patients.

Facilities and Resources:
The EM3 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Harrison Medical Library, staff lounge, call rooms, showers and hospital cafeteria.

Duties and Responsibilities include:
- Taking detailed patient histories
- Performing physical examinations
- Reviewing all laboratory values and diagnostic studies
- Documenting histories and physical examinations
- Writing progress notes
- Performing necessary procedures

Description of didactic experiences:
Formal teaching will consist of daily teaching rounds led by both the Plastic Surgery attending and the Burn ICU fellow. Weekly conferences will occur and are led by the director of the Burn ICU. The resident is encouraged to attend the weekly EM resident conferences if their schedule allows.

Evaluation process:
At the end of each block, electronic and/or written evaluations with input from the supervising faculty members and fellows will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with a residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) , Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)

Rotation Contacts:

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Valerie Spatafore
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Rotation: **Elective**
Year: **EM3**
Duration: **Four weeks**

The EM3 resident will rotate for four weeks (either 1 four-week consecutive block or 2 two-week blocks) on an elective rotation. The elective rotations provide the EM3 with the opportunity to engage in activities of their choosing to enhance their ability to succeed as emergency medicine physicians. The core competency of practice-based learning and improvement relates to the ability to investigate and evaluate one's own patient care and professional development and to identify areas that need improvement.

Learning Objectives:
The objective of the elective rotation is to allow EM3 residents time in the residency curriculum to focus on areas identified as needing improvement or growth, provide the resident with the opportunity to participate in an area of expertise that he/she would not otherwise have the opportunity to experience during residency training, or engage the resident in additional or focused experiences already represented in the core curriculum.

Educational Objectives (by core competency):
1. *Patient Care*: Elective rotations on a specialty service or in an ambulatory setting would be expected to enhance the residents' ability to provide patient care that is compassionate, well informed and effective for the treatment of emergency-medicine specific health problems.
2. *Medical Knowledge*: Elective rotations on a specialty service or in an ambulatory setting would be expected to enhance the resident's medical knowledge and the application of this knowledge to patient care. Other experiences that would enhance a resident's medical knowledge include additional research electives or electives focused on the acquisition of knowledge through self-directed learning and focused reviews of the literature.
3. *Practice-Based Learning and Improvement*: Elective rotations in which residents examine their own practice or practice patterns in a specific clinical setting would be expected to enhance a resident's ability to investigate and evaluate their own patient care, appraisal, and assimilation of scientific evidence. A resident might review her/his patients from the emergency department with specific conditions (e.g., chest pain, DKA) to determine how often clinical targets (e.g., delivery of aspirin, optimal glycemic control) are being achieved and to analyze ways in which practice can be improved.
4. *Interpersonal and Communication Skills*: Elective rotations in which communication skills are examined and in which specific programs are engaged in an effort to improve these skills would be expected to enhance a resident's ability to provide effective information exchange and teaming with patients, their families and other health professionals. Example elective rotations include learning Spanish or learning American Sign Language, or an elective experience with the Palliative Care Service to enhance communication skills with the patients at end of life.
5. *Professionalism*: Elective rotations with a specialty or in an ambulatory setting would be expected to enhance a resident's ability to carry out professional responsibilities, adhere to ethical principles, and be sensitive to a diverse population. Specific experiences that might enhance a resident's competence in professionalism include an elective rotation in medical ethics or caring for an underserved patient population at home or abroad.

6. *Systems-based Practice*: Elective rotations in which residents learn about the larger content of emergency medicine within the larger health care system would be expected to enhance the resident's abilities in this core competency. Residents can work with the Program Director to develop specific experiences.

Educational Expectations:

1. The EM3 resident is expected to engage in continuous investigation and evaluation of his/her own practice and learning during residency training. As a result of this process, residents should identify areas in need of improvement in which additional training would be interesting, educational, and would contribute to professional growth and development.
2. The EM3 resident is expected to demonstrate to the Program Director evidence of this continuous investigation and evaluation during regularly scheduled feedback sessions, through the completion of self-evaluation forms, review of the individual learning portfolio, and discussion.
3. The EM3 resident must plan electives with the Program Director **at least 3 months** before the scheduled elective rotation.
4. Elective rotations may take place within the Hopkins system or at facilities elsewhere in the United States and abroad. Off-site electives require completion of paperwork (see appendix), including explicit delineation of goals and objectives, activities planned, and assignment of a supervisor who will be primarily responsible for facilitating and monitoring your progress during your elective.
5. It is expected that the proposed elective rotation will advance or build the resident's abilities in one or more of the core competencies.

Facilities and Resources:

The EM3 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), ED library (EM texts, computer), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical Library, ED lounge, shower and hospital cafeteria.

Description of clinical experiences:

The resident's clinical experience will vary depending on the elective experience.

For in-house electives, residents will need to complete a brief elective form with goals and objectives of the rotation, the supervisor of the experience, as well as the evaluation method to be used.

For out of Hopkins electives, residents must complete a separate form that will require approval by Dr. Ehmann and the Associate Dean for Graduate Medical Affairs. This must be completed <u>at least 8 weeks before</u> the start of the elective. Please see the Appendix for the Forms.

Description of didactic experiences:

The didactic experience for the resident will vary depending on the elective experience. If the elective occurs within the Johns Hopkins Hospital System, it is expected that the resident will attend didactic resident conference on Fridays from 7am-12pm.

Evaluation process:
Formal written and/or electronic evaluations will be submitted for each elective rotation. It is expected that faculty preceptors provide mid-rotation verbal feedback to residents on elective rotations.

Feedback mechanisms:
It is expected that faculty preceptors provide mid-rotation verbal feedback to residents on elective rotations. All written evaluations will be reviewed by the resident in semi-annual meetings with the residency director.

****Please see the Appendix section for the appropriate elective forms, as well as possible elective options and contact information.**

Rotation: **Emergency Department at Johns Hopkins Bayview Medical Center (BVED)**
Year: **EM3**
Duration: **Eight Weeks**

The EM3 resident will rotate for eight weeks (divided into two- and four-week blocks) in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients.

Educational Goals:

Develop overall clinical competence in the practice of Emergency Medicine at a tertiary care Level 2 Trauma Center that includes but is not limited by the following overall objectives:

1. Perform an appropriate focused history and physical exam in a timely fashion
2. Demonstrate an ability to rapidly create, verbalize and document a relevant differential of consequence for multiple patients.
3. Demonstrate leadership by consistently serving as the resident supervisor of a healthcare team, integrating well with other residents, faculty and nursing staff.
4. Develop proficiency in multi-tasking and interpersonal negotiations
5. Develop and institute complex treatment plans for a variety of patients simultaneously
6. Manage critically ill patients while overseeing the critical care team
7. Develop and hone resuscitation skills
8. Demonstrate an ability to provide rapid and appropriate care in the treatment of all Emergency Department patients in time sensitive manner, including low acuity patients.
9. Acquire necessary administrative skills
10. Demonstrate supervisory and teaching skills
11. Demonstrate overall clinical competence in the practice of emergency medicine

Educational Objectives:

1. Demonstrate skill in **"Data Gathering"** that includes but not limited to:
   - Perform an efficient, but thorough focused history and physical examination while managing multiple patients (PC, MK, ICS, PR)
   - Rapidly perform clear verbal and written patient presentations that adequately reflect the patient's condition, including acuity, disease state and anticipated disposition.
   - Independently order and interpret ancillary tests that are required for the management of multiple individual patients (PC, MK, SBP)
   - Reliably and efficiently obtain essential and accurate information collected from all available sources (PC, SBP)
   - Show an ability to continuously gather data about patients during their stay in the Emergency Department. (PC)
   - Rapidly identify all key elements in the patient's history, physical or other data sources that indicate a need for further investigation ('the red flag"). (PC, MK)
   - Demonstrates an ability to obtain the patient's explicit agenda for coming to the Emergency Department while assessing their medical needs (PC, ICS, PR)
2. Demonstrate skill in **"Problem Solving"** that includes but not limited to:
   - Generate an appropriate and relevant differential of consequence for undifferentiated patients while managing multiple patients (PC, MK)
   - Recognize the key data elements required to make efficient patient management decisions (PC, MK, PBL)

- Generate an expanded differential of consequence including the consideration of possible atypical presentations and all potential life and organ threats and likely post Emergency Department complications. (PC, MK, PBL)
- Continually update management plans based on patients changing condition or new data or availability of resources (PC, MK, SBP)
- Promptly involves the Attending Physician when there is a significant change in the health care condition of the patient (PC, SBP, PR)

3. Demonstrate skill in **"Patient Management"** that includes but not limited to:
   - Create a comprehensive treatment plan based on the differential of consequence (PC, MK, SBP)
   - Apply sophisticated knowledge of pathophysiology in developing patient management strategies. (PC, MK, SBP)
   - Recognize and institute appropriate emergency stabilization of the unstable patient (PC, MK, SBP)
   - Utilize the patient's explicit agenda in creating a management plan (PC)
   - Implement a management plan that addresses all the key elements of the patient's history, physical and other data sources that warrant further attention (Addresses the "red flags". (PC, MK, PBL, SBP)
4. Demonstrate a **"Medical Knowledge"** appropriate for level of training that includes but not limited to:
   - Demonstrates a sophisticated fund of medical knowledge (MK)
   - Describe complex disease processes as they relate to the patients under their care. (PC, MK,)
5. Demonstrate technical proficiency in **"Procedural Skills"** consistent with level of training that includes but not limited to:
   - Demonstrates understanding of informed consent. (PC, MK, P, SBP)
   - Provides clear and supportive information to patients and families regarding the need for procedural intervention (PC, MK, P, SBP)
   - Describe the different therapeutic agents, dosages and other interventions used in conscious sedation and rapid sequence intubation (PC, MK, P)
   - Suturing, lumbar puncture, splinting, I/D abscess, venipuncture (PC, MK, P)
6. Demonstrate skill in **"Efficiency"** of care that includes but not limited to:
   - Effectively manages 2 patients per hour (PC, MK, SBP)
   - Consistently provides rapid medical screening examinations of patients who are waiting for an evaluation room. (PC, MK, SBP)
   - Able to prioritize tasks appropriately (PC, MK, SBP)
7. Demonstrate appropriate **"Interpersonal and Communication Skills"** that includes but not limited to:
   - Demonstrates effective information exchange with patients, their families, and professional associates (ICS, PR)
   - Shows an appreciation of appropriate conflict resolution skills (ICS, PR)
   - Works effectively with others in the health care team (ICS, PR)
   - Demonstrates an ability to persuade and negotiate with other health care professionals successfully. (PC, SBP, ICS)
   - Demonstrates an appropriate sensitivity in negotiating with individuals from a variety of cultures, backgrounds, education, and ethnicity. (PR, ICS)
   - Discuss treatment options with patients allowing patients to voice concerns, suggestions, and preferences. (PC, ICS)

8. Demonstrate appropriate **"Professionalism"** skills that include, but not limited to:
   - Introduces self to patient and/or family (PR, ICS)
   - Respectful of patient's privacy and confidentiality (PR)
   - Demonstrates respect, compassion, and integrity (PR)
   - Adheres to the dress code (PR)
   - Maintains equanimity while in the ED (PR)
9. Demonstrate skill in proper **"Documentation"** that includes but not limited to:
   - Medical record is complete and thorough and includes medical decision making, appropriate justification for the plan of treatment, consultants involved and condition of patient on discharge or transfer (PC)
   - Documentation reflects patient condition and is consistent with the final disposition. (PC, SBP)
   - Documentation of progress notes every 2 hours and procedure notes when indicated. (PC, SBP)
   - Documentation includes response to key interventions. (PC, SBP)
10. Demonstrate an understanding of a **"Systems-Based Practice"** that includes but not limited to:
    - Judiciously utilizes available resources for the care of the emergency department patient (SBP)
    - Recognizes the importance of resource allocation as they relate to patients, the hospital, and other services (PC, MK, SBP)
    - Demonstrates an ability to implement an appropriate treatment plan that factors in Emergency Department, Hospital and patient resources, as well as cost and availability. (SBP, PC)
    - Discharged patients have clear and concise follow up instructions (PC, SBP)
11. Demonstrate an awareness of the importance of **"Practice Based Learning and Improvement"** that includes but not limited to:
    - Uses appropriate information resources (i.e., texts, online web sites, etc.) for the care of patients (PBL, PC)
    - Demonstrates an interest in learning and willingness to investigate literature and other resources. (PBL, PC)
    - Actively seeks out instruction and incorporates new learning and feedback in the care of patients (PC, MK, SBP)
    - Actively teaches other residents, nurses, students, and other health care providers based on their clinical experiences, readings and instructions. (PC, ICS, MK, PBL)

Educational Expectations:

- ➢ Experience in the initial evaluation of an undifferentiated patient population
- ➢ Experience in the development of appropriate treatment plans
- ➢ Participate as the team leader for medical and surgical critical care patients under the direction of attending faculty
- ➢ Experience in (but not limited to) the following procedures under direct supervision by faculty:
  - airway management
  - surgical airway
  - emergency thoracotomy
  - central venous access
  - arterial access
  - lumbar puncture

- thoracentesis
- arthrocentesis
- paracentesis
- ultrasound
- laceration repair
- splinting techniques
- incision and drainage, etc.

➢ Provide pre-hospital EMS consultation by radio
➢ Supervision of medical students, less-senior emergency medicine residents and PA residents.

***Duties and Responsibilities include*:**

1. Obtaining appropriately detailed patient histories
2. Performing physical examinations of the patient
3. Performing all necessary procedures under supervision of the faculty or SAR
4. Reviewing all laboratory values and diagnostic studies
5. Developing a differential of consequence and an appropriate management plan for each patient
6. Demonstrating efficient implementation of treatment resulting in timely disposition
7. Providing clear and concise documentation that adequately reflects patient condition and ED course
8. Creation of complete and relevant discharge instructions.
9. Demonstrating professional interactions with faculty, staff, colleagues and consultants

Facilities and Resources:

The EM3 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), ED library (EM texts, computer), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Harrison Medical Library, ED lounge, shower and hospital cafeteria.

Description of clinical experiences:

The EM3 resident will rotate for eight weeks in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients.

As an EM3, the resident will be responsible for the initial evaluation of undifferentiated patients presenting to the ED under the direct supervision of the EM attending. In addition to working in the general ED, they will serve as the primary doctor on the orange side of the department, which is the primary clinical area for critically ill patients. EM3 residents continue to supervise and teach while working with medical students who are rotating at this institution.

All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines.

Description of didactic experiences:

Daily evening rounds will begin with a short presentation by the attending faculty member, which may include a clinical topic, a review of a journal article or an administrative topic. Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm.
All residents in the ED are relieved from clinical duties by faculty members or ED Physician Assistants to attend conferences.

Evaluation process:
Several evaluation mechanisms may be used including, but not limited to:

- Teaching Observation Shifts (Faculty working one on one with a resident-SDOT)
- Shift Report (Faculty review of resident performance based on a single shift)
- Faculty Review
- Oral Boards
- Procedure Logs
- Patient Logs
- Chart Reviews
- Biannual Review

At the mid-point and the endpoint of each block, electronic evaluations will be completed with input from faculty members. You must select TWO SUPERVISORY FACULTY at each mid- and end-point evaluations for completion. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR

Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)

Rotations Contacts:

EM Chief Residents
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Dr. Michael Ehmann
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Rotation: **Emergency Department at Johns Hopkins Hospital (JHED)**
Year: **EM3**
Duration: **Twenty-six Weeks**

The EM3 resident will rotate for twenty-four weeks (divided into two- and four-week blocks) in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients.

Educational Goals & Overall Objectives:
Develop overall clinical competence in the practice of Emergency Medicine that includes but is not limited by the following overall objectives:

1. Perform an appropriate focused history and physical exam in a timely fashion
2. Demonstrate an ability to rapidly create, verbalize and document a relevant differential of consequence for multiple patients
3. Demonstrate leadership by consistently serving as the resident supervisor of a healthcare team, integrating well with other residents, faculty and nursing staff
4. Develop proficiency in multi-tasking and interpersonal negotiations
5. Develop and institute complex treatment plans for a variety of patients simultaneously
6. Manage critically ill patients while overseeing the critical care team
7. Develop and hone resuscitation skills
8. Demonstrate an ability to provide rapid and appropriate care in the treatment of all Emergency Department patients in time sensitive manner, including low acuity patients
9. Acquire necessary administrative skills
10. Demonstrate supervisory and teaching skills
11. Demonstrate overall clinical competence in the practice of emergency medicine

Specific Educational Objectives:
1. Demonstrate skill in **"Data Gathering"** that includes but not limited to:
   - Perform an efficient, but thorough focused history and physical examination while managing multiple patients (PC, MK, ICS, PR)
   - Rapidly perform clear verbal and written patient presentations that adequately reflect the patient's condition, including acuity, disease state and anticipated disposition.
   - Independently order and interpret ancillary tests that are required for the management of multiple individual patients (PC, MK, SBP)
   - Reliably and efficiently obtain essential and accurate information collected from all available sources (PC, SBP)
   - Show an ability to continuously gather data about patients during their stay in the Emergency Department. (PC)
   - Rapidly identify all key elements in the patient's history, physical or other data sources that indicate a need for further investigation ('the red flag"). (PC, MK)
   - Demonstrates an ability to obtain the patient's explicit agenda for coming to the Emergency Department while assessing their medical needs (PC, ICS, PR)
2. Demonstrate skill in **"Problem Solving"** that includes but not limited to:
   - Generate an appropriate and relevant differential of consequence for undifferentiated patients while managing multiple patients (PC, MK)
   - Recognize the key data elements required to make efficient patient management decisions (PC, MK, PBL)

- Generate an expanded differential of consequence including the consideration of possible atypical presentations and all potential life and organ threats and post Emergency Department complications. (PC, MK, PBL)
- Continually update management plans based on patients changing condition or new data or availability of resources (PC, MK, SBP)
- Promptly involves the Attending Physician when there is a significant change in the health care condition of the patient (PC, SBP, PR)

3. Demonstrate skill in **"Patient Management"** that includes but not limited to:
   - Create a comprehensive treatment plan based on the differential of consequence (PC, MK, SBP)
   - Apply sophisticated knowledge of pathophysiology in developing patient management strategies. (PC, MK, SBP)
   - Recognize and institute appropriate emergency stabilization of the unstable patient (PC, MK, SBP)
   - Utilize the patient's explicit agenda in creating a management plan (PC)
   - Implement a management plan that addresses all the key elements of the patient's history, physical and other data sources that warrant further attention, addresses the "red flags". (PC, MK, PBL, SBP)
4. Demonstrate a **"Medical Knowledge"** appropriate for level of training that includes but not limited to:
   - Demonstrates a sophisticated fund of medical knowledge (MK)
   - Describe complex disease processes as they relate to the patients under their care. (PC, MK)
5. Demonstrate technical proficiency in **"Procedural Skills"** consistent with level of training that includes but not limited to:
   - Demonstrates understanding of informed consent. (PC, MK, P, SBP)
   - Provides clear and supportive information to patients and families regarding the need for procedural intervention (PC, MK, P, SBP)
   - Describe the different therapeutic agents, dosages and other interventions used in conscious sedation and rapid sequence intubation (PC, MK, P)
   - Suturing, lumbar puncture, splinting, I/D abscess, venipuncture (PC, MK, P)
6. Demonstrate skill in **"Efficiency"** of care that includes but not limited to:
   - Effectively manages 2 patients per hour (PC, MK, SBP)
   - Consistently provides rapid medical screening examinations of patients who are waiting for an evaluation room. (PC, MK, SBP)
   - Able to prioritize tasks appropriately (PC, MK, SBP)
7. Demonstrate appropriate **"Interpersonal and Communication Skills"** that includes but not limited to:
   - Demonstrates effective information exchange with patients, their families, and professional associates (ICS, PR)
   - Shows an appreciation of appropriate conflict resolution skills (ICS, PR)
   - Works effectively with others in the health care team (ICS, PR)
   - Demonstrates an ability to persuade and negotiate with other health care professionals successfully. (PC, SBP, ICS)
   - Demonstrates an appropriate sensitivity in negotiating with individuals from a variety of cultures, backgrounds, education, and ethnicity. (PR, ICS)
   - Discuss treatment options with patients allowing patients to voice concerns, suggestions, and preferences. (PC, ICS)
8. Demonstrate appropriate **"Professionalism"** skills that includes, but not limited to:

- Introduces self to patient and/or family (PR, ICS)
- Respectful of patient's privacy and confidentiality (PR)
- Demonstrates respect, compassion, and integrity (PR)
- Adheres to the dress code (PR)
- Maintains equanimity while in the ED (PR)

9. Demonstrate skill in proper **"Documentation"** that includes but not limited to:
   - Medical record is complete and thorough and includes medical decision making, appropriate justification for the plan of treatment, consultants involved and condition of patient on discharge or transfer (PC)
   - Documentation reflects patient condition and is consistent with the final disposition. (PC, SBP)
   - Documentation of progress notes every 2 hours and procedure notes when indicated. (PC, SBP)
   - Documentation includes response to key interventions. (PC, SBP)
10. Demonstrate an understanding of a **"Systems-Based Practice"** that includes but not limited to:
   - Judiciously utilizes available resources for the care of the emergency department patient (SBP)
   - Recognizes the importance of resource allocation as they relate to patients, the hospital, and other services, (PC, MK, SBP)
   - Demonstrates an ability to implement an appropriate treatment plan that factors in Emergency Department, Hospital, and patient resources, as well as cost and availability. (SBP, PC)
   - Discharged patients have clear and concise follow up instructions (PC, SBP)
11. Demonstrate an awareness of the importance of **"Practice Based Learning and Improvement"** that includes but not limited to:
   - Uses appropriate information resources (i.e., texts, online web sites, etc.) for the care of patients
   - (PBL, PC)
   - Demonstrates an interest in learning and willingness to investigate literature and other resources. (PBL, PC)
   - Actively seeks out instruction and incorporates new learning and feedback in the care of patients (PC, MK, SBP)
   - Actively teaches other residents, nurses, students, and other health care providers based on their clinical experiences, readings and instructions. (PC, ICS, MK, PBL)

Educational Expectations:

- ➢ Experience in the initial evaluation of an undifferentiated patient population
- ➢ Experience in the development of appropriate treatment plans
- ➢ Participate as the team leader for medical and surgical critical care patients under the direction of attending faculty
- ➢ Experience in (but not limited to) the following procedures under direct supervision by the EM faculty:
  - airway management
  - surgical airway
  - emergency thoracotomy
  - central venous access
  - arterial access
  - lumbar puncture

- thoracentesis
- arthrocentesis
- paracentesis
- ultrasound
- laceration repair
- splinting techniques
- incision and drainage, etc.

➢ Supervision of medical students, interns and junior residents

➢ Preparation of one 60-minute lecture for resident conference and one month of EBM responsibilities at resident conference.

Duties and Responsibilities include:

1. Obtaining appropriately detailed patient histories
2. Performing physical examinations of the patient
3. Performing all necessary procedures under supervision of the faculty
4. Reviewing all laboratory values and diagnostic studies
5. Developing a differential of consequence and an appropriate management plan for each patient
6. Demonstrating efficient implementation of treatment resulting in timely disposition
7. Providing clear and concise documentation that adequately reflects patient condition and ED course
8. Creation of complete and relevant discharge instructions.
9. Demonstrating professional interactions with faculty, staff, colleagues and consultants
10. Supervision and clinical instruction of medical students.
11. Serve as team leader in the triage system. Work with charge nurse and attending to expedite patient care in the era of ED overcrowding.
12. Responsible for supervising first and second year residents, medical students, and PA's.
13. Provide efficient, competent, compassionate care to all patients with careful attention to communications with patients and families.
14. The resident will devise a diagnostic and management plan that will be reviewed by the faculty.

Description of clinical experiences:

The EM3 resident will rotate for twenty-four weeks (divided into two- and four-week blocks) in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients. Shifts will be eight to twelve hours in length. The schedule will be posted on Shift Admin and can be accessed via this site. You should plan to arrive 15 minutes prior to the beginning of your shift to obtain sign out on your patients/review information on your patients. During/after handoff, both providers should visit the bedside of all patients to ensure patients are up to date on plans and to reassess their clinical status. You may also be assigned to the purple team, where you will present to both the Red and Blue attending. You will be responsible for the eye patients in this assignment when purple is not staffed.

As an EM3, the resident will be responsible for the initial evaluation of undifferentiated patients presenting to the ED under the direct supervision of the EM attending. In addition to working in a primary patient care area, EM3 residents serve as team leaders and supervise/teach other residents and medical students who are rotating in the ED. EM3 residents also serve as leaders in critical care and trauma resuscitations.

All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines.

Facilities and Resources:
The EM3 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker rooms, showers and several hospital cafeterias.

Description of didactic experiences:
Daily morning rounds at 7am. A medical minute will occur during the AM shift, and residents working clinically must attend unless they are in the middle of critical care.
Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties to allow them to attend conferences.

Facilities and Resources:
The EM3 will have access to a wide variety of facilities and resources including (but not limited to): medical records (computerized and library), EM resident library (multiple EM texts, computers), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker rooms, showers and several hospital cafeterias.

Evaluation process:
At the mid-point and the endpoint of each block, electronic evaluations will be completed with input from faculty members. You must select TWO SUPERVISORY FACULTY at each mid- and end-point evaluations for completion. Reciprocal evaluations will be generated about the faculty to be completed by the EM1-3, with the expectation that they will be completed within two weeks of assignment.

Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Several evaluation mechanisms will be used including, but not limited to:
- Teaching Observation Shifts (Faculty working one on one with a resident)
- End of Shift Evaluations
- End of Rotation Evaluations in New Innovations
- Oral Boards
- Procedure Logs
- Patient Logs
- Chart Reviews
- Biannual Review

All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotations Contacts:

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Rotation: **Emergency Medicine at Howard County Medical Center (HCED)**
Year: **EM3**
Duration: **Four weeks**

Educational Goals:
Develop an advanced capability in the practice of emergency medicine with skills in efficiency at a community hospital that includes but is not limited by the following overall objectives.

Overall Objectives:
1. Perform an appropriate focused history and physical exam in a timely fashion
2. Demonstrate an ability to rapidly create, verbalize and document a relevant differential of consequence for multiple patients.
3. Demonstrate leadership by consistently serving as the resident supervisor of a healthcare team, integrating well with other residents, faculty and nursing staff.
4. Develop proficiency in multi-tasking and interpersonal negotiations
5. Develop and institute complex treatment plans for a variety of patients simultaneously
6. Manage critically ill patients while overseeing the critical care team
7. Develop and hone resuscitation skills
8. Demonstrate an ability to provide rapid and appropriate care in the treatment of all Emergency Department patients in a time sensitive manner, including low acuity patients.
9. Acquire necessary administrative skills
10. Demonstrate supervisory and teaching skills
11. Demonstrate overall clinical competence in the practice of emergency medicine

Educational Objectives:
1. Become familiar with the practice of Emergency Medicine in a community hospital setting. (PC, MK, PBL&I, Prof, ICS, SBP)
2. Experience the different challenges to patient care in a private community hospital setting, including arranging follow-up for indigent patients, dealing with HMO providers, and obtaining consultation from an on-call panel physician. (PC, MK, PBL&I, Prof, ICS, SBP)
3. Develop confidence and improve the rate at which patient care can be delivered in a busy environment. (PC, MK, PBL&I, Prof, ICS, SBP)
4. Develop insight into alternative practice tracks followed by many of these private practices Emergency Medicine physicians (learn pros/cons of private practice). (SBP, PBL&I, Prof)
5. Gain experience managing major trauma patients in a high patient volume trauma center. (PC, MK, PBL&I, Prof, ICS, SBP)

Educational Expectations:
1. Demonstrate expertise in the initial evaluation of an undifferentiated patient population.
2. Develop expertise in creating appropriate treatment plans for patients in a community hospital setting
3. Experience in community Emergency Medicine practice
4. Participate as the team leader for medical and surgical critical care patients under the direction of attending faculty
5. Gain experience in (but not limited to) the following procedures under direct supervision by the EM faculty:
   - airway management
   - surgical airway

- emergency thoracotomy
- central venous access
- arterial access
- lumbar puncture
- thoracentesis
- arthrocentesis
- paracentesis
- ultrasound
- laceration repair
- splinting techniques
- incision and drainage, etc.

Description of clinical experiences:
The EM3 resident will rotate for four weeks in the emergency department as a full member of the service. The resident will have exposure to a wide variety of ill and injured patients. Residents are required to be present at each shift for which they have signed up, unless precluded by jeopardy activations. In this case, notice must be provided to the HCMC ED rotation contacts.

As an EM3, the resident will be responsible for the initial evaluation of undifferentiated patients presenting to the ED under the direct supervision of the EM attending.

Shifts will cover days, evenings and weekends and will be 8-12 hours in length. ***All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines.***

Facilities and Resources:
The EM3 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), ED library (multiple EM texts, computers), on-line web data (Micromedex, etc.), ED lounge, shower and hospital cafeteria.

Duties and Responsibilities include:
1. Obtaining appropriately detailed patient histories
2. Performing physical examinations of the patient
3. Performing all necessary procedures under supervision of the faculty
4. Reviewing all laboratory values and diagnostic studies
5. Developing a differential of consequence and an appropriate management plan for each patient
6. Demonstrating efficient implementation of treatment resulting in timely disposition
7. Providing clear and concise documentation that adequately reflects patient condition and ED course
8. Creation of complete and relevant discharge instructions.
9. Demonstrating professional interactions with faculty, staff, colleagues and consultants
10. The resident will devise a diagnostic and management plan that will be reviewed by the faculty.

Description of didactic experiences:
Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties to attend conferences.

Evaluation process:
At the end of each block, electronic evaluations will be completed with input from faculty members. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contact:

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Rotation: **Medical Intensive Care Unit (MICU) at Howard County Medical Center**
Year: **EM3**
Duration: **Two Weeks**

Educational Goals

Advanced ICU experience where the senior resident will assess, diagnose, stabilize, and treat a critically ill patient. After the initial stabilization, the resident will manage critically ill patients longitudinally during their stay in the intensive care unit under the supervision of the ICU attending.

Educational Objectives

1. Apply knowledge of pathophysiology and common presentations of critical medical and cardiac conditions and disease processes to effectively treat conditions including but not limited to: (PC, MK, SBP)
    - acute intestinal hemorrhage and hemorrhagic shock
    - diabetic ketoacidosis
    - liver failure and its complications
    - meningitis
    - respiratory failure and severe respiratory distress
    - septic shock
    - severe electrolyte imbalance
    - status epilepticus
    - uremia and untreated renal failure
    - stroke requiring TPA administration
    - acute coronary syndrome status post STEMI with catheterization
2. Demonstrate an ability to function well in an ICU setting by: (PC, MK, ICS, PBL)
    - taking a medical history
    - performing a complete physical examination
    - understanding the indications and interpretation of ancillary laboratory and imaging techniques
    - Develop and implement effective patient management plans based on an integration of patient information, medical data and current scientific evidence
3. Performance (but not limited to) the following procedures: (MK, PBL, PC)
    - Venous access
    - Central line placement
    - Arterial line placement
    - Thoracentesis
    - Paracentesis
    - Arthrocentesis
    - Bronchoscopy
    - Intubation
4. Lead medical resuscitation efforts, including anticipation and recognition of short and long-term complications (MK, ICS, SBP)
5. Experience an understanding of in hospital medical workups and patient outcomes (MK, SBP, PBL)
6. Effectively use specialized equipment for monitoring and support of vital organ and system functions (MK, PC, PBL)

7. Communicate information to critically ill patients and their families in a way that is respectful, sensitive and compassionate and that demonstrates an understanding of preserving confidentiality (PR, ICS)
8. Mitigate the risk of complications of life-sustaining therapies in the intensive care unit to the benefit patients receive from such therapies (MK, PC, PBL, SBP)

Expectations

1. Evaluate and assess patients in the emergency department referred for admission to the MICU.
2. Obtain accurate information from available sources (interviews with family, significant others, physical exam, admitting team, medical records, diagnostic and therapeutic procedures)
   To critically evaluate information and construct a plan for evaluation and management.
3. Assess and critically evaluate current medical and scientific literature and apply this to the care of the patients in the MICU.
4. Demonstrate the ability to organize information, think critically, and solve problems.
5. Maintain comprehensive, timely and legible medical records documenting the care given to patients, procedures performed and care plan.
6. Discuss and implement plans and treatment goals under the supervision of the attending and fellow.
7. Function as part of a multi-disciplinary team, demonstrating respect, integrity and effective communication skills.
8. Demonstrate respect, sensitivity, compassion, integrity, and altruism in relationships with patients and families.

***Description of clinical experiences*:**

The EM3 resident will rotate for two weeks on the MICU Service at Howard County Medical Center as a full member of the Service. The resident will have exposure to a wide variety of critically ill patients under the direct or indirect supervision (immediately available if needed) of the attending physician.

As an EM3, the resident will participate in the evaluation of all admissions from the emergency department, general medical floors and outside facilities.

The resident will remain in hospital for admissions and acute patient management that are allowed under the current duty hours guidelines (no longer than 24 scheduled hours at a time, with an additional 4-hours allowed for transition but during which NO new patient care is allowed; at least 14-hours off after call; one day off in every seven; and not to exceed 80 hours/week averaged over 4 weeks. For shift work, resident must have 8 hours off between shifts and should have 10 hours off before returning to work).

Week 1 – 50 hours

Monday 7a-5p (10 hours) FIRST DAY
Tuesday 7a-5p (10 hours)
Wednesday 7a-5p (10 hours)
Thursday 7a-5p (10 hours)
Friday OFF for conference
Saturday 7a-5p (10 hours)
Sunday OFF

Week 2 – 58 hours

Monday 9a-9p (12 hours)
Tuesday 9a-9p (12 hours)
Wednesday 9a-9p (12 hours)
Thursday 7a-5p (10 hours)
Friday OFF for conference
Saturday 8a-8p (12 hours)
Sunday OFF

All Emergency Medicine resident(s) must follow the ACGME Internal Medicine duty hours guidelines.

Facilities and Resources:

The EM3 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical Library, call room, locker-room, showers and several hospital cafeterias.

Duties and Responsibilities include:

1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Documenting histories and physical examinations
5. Writing daily progress notes
6. Creating and implementing a diagnostic and treatment plan
7. Performing all necessary procedures
8. Management of multiple ICU patients under supervision of an intensivist

Description of didactic experiences:

Formal teaching will consist of daily teaching rounds led by the attending physician.

Evaluation process:

At the end of each block, electronic evaluations with input from supervising faculty members will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:

All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, ISHN,
Medical Knowledge	X	ERE	OB, ISHN,
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Harwood/Nuss questions(HN), Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

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Rotation: **Pediatric Emergency Medicine at Johns Hopkins Howard County Medical Center (HCPeds)**
Year: **EM3**
Duration: **Two Weeks**

Educational Goal:
Develop the ability to evaluate, diagnose, stabilize, and treat pediatric patients who present to a community emergency department.

Educational Objectives:
1. Communicate effectively with patients, their families, and professional associates (ICS).
2. Demonstrate respect, compassion, and integrity (PR).
3. Demonstrate the ability to perform an appropriate history and physical exam (PC).
4. Demonstrate the ability to develop an appropriate differential of consequence and treatment plan (MK).
5. Demonstrate appropriate clinical decision-making skills (PC).
6. Master the ability to assess the seriously ill child, with an emphasis on recognizing early signs and symptoms before further deterioration can occur. (PC, MK, ICS, Prof, SBP)
7. Master the evaluation and management of the critically ill or injured child during resuscitation. (PC, MK, ICS, Prof, SBP, PBL&I)
8. Master the evaluation and management of mild and moderately ill children who present to an emergency department (PC, MK, ICS, Prof, SBP, PBL&I)
9. Recognize the several categories of pediatric patients including the seriously ill, moderately ill and non-acute pediatric patients. (PC, MK)
10. Demonstrate an ability to rapidly create, verbalize and document a relevant differential of consequence for multiple pediatric patients (PC, MK)
11. Demonstrate leadership by consistently serving as the resident supervisor of a healthcare team, integrating well with other residents, faculty and nursing staff (Prof, PBL&I)
12. Manage critically ill pediatric patients while overseeing the critical care team (PC, MK)
13. Perform intraosseous infusion, venous cut down techniques, and lumbar punctures. (PC, MK, Prof, PBL&I, ICS, SBP)
14. Master approach to the management and disposition of a febrile child, considering such factors as age, source and severity of illness. (PC, MK, Prof, PBL&I, ICS, SBP)
15. Demonstrate an evidence-based approach to the pediatric patient with respiratory illness, gastrointestinal disorders, neurologic complaints, gynecologic disorders, cardiovascular disorders, painful conditions, and the poisoned patient utilizing history, physical examination and ancillary studies to arrive at a diagnosis allowing appropriate treatment and disposition. (PC, MK, Prof, PBL&I, ICS, SBP)
16. Develop an appropriate level of awareness of child abuse; learn in what circumstance child abuse occurs and how it may present. Evaluate the patient with suspected child abuse including sexual abuse. Learn the legal requirements and appropriate documentation. Understand the emotional factors affecting the patient and family. Understand the relative role of law enforcement, health care provider, and physicians. (PC, MK, Prof, PBL&I, ICS, SBP)

Educational Expectations:
1. Learn the normal development of the pediatric patient
2. Learn the pathophysiology of abnormal conditions in the pediatric age group
3. Exposure and experience in the management of pediatric emergencies

4. Exposure and experience in the management of the critically ill and injured patient
5. Specific experience and training in:
    - taking a pediatric history
    - performing a pediatric physical examination
    - understanding the indications and interpretation of ancillary laboratory and
    - imaging techniques
6. Experience in (but not limited to) the following procedures:
    - venous access
    - venous cutdown
    - arterial access
    - lumbar puncture
    - intubation
    - fracture splinting
    - laceration repairs
7. Experience and training in pediatric resuscitation efforts, including anticipation and recognition of short and long-term complications
8. Understand the social-family aspects of pediatric emergency evaluation and care

Description of clinical experiences:
The EM3 will rotate for a two-week period on the Pediatric ED Service as a full member of the Service. The resident will have exposure to a wide variety of ill and injured pediatric patients under the direct supervision of the EM attending.

As an EM3, the resident will be responsible for the evaluation of patients presenting to the pediatric emergency department.

Shifts will cover days, evenings and weekends and will be 8-12 hours in length.

All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines*.*

Facilities and Resources:
The EM3 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker-room, shower and the hospital cafeteria.

Duties and Responsibilities include:
1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Documenting histories and physical examinations
5. Performing all necessary procedures
6. Supervise medical students and less-senior residents

The resident will devise a diagnostic and management plan reviewed by the attending pediatric emergency medicine physician.

Description of didactic experiences:
Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties in order to allow them to attend conferences.

Evaluation process:
At the end of each block, electronic evaluations with input from supervising faculty members will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contact:
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EM4
Clinical Rotations

Rotation: **Emergency Department at Johns Hopkins Hospital (JHED4)**
Year: **EM4**
Duration: **Forty-six Weeks**

The EM4 resident will rotate for forty-six weeks (divided into two- and four-week blocks) in the emergency department as a full member of the service. On average, the EM4 will be expected to complete 1080 clinical hours in various emergency department clinical settings. The resident will have exposure to a wide variety of ill and injured patients.

As an EM4, the resident will be responsible for the initial and supervisory evaluation of undifferentiated patients presenting to the ED and for supervising medical care teams under the direct supervision of the EM attending.

Educational Goals & Overall Objectives:
Develop overall independent and supervisory clinical competence in the practice of Emergency Medicine that includes but is not limited by the following overall objectives:

1. Perform highly focused history and physical examinations in an expeditious but deliberate and caring manner.
2. Demonstrate an ability to succinctly verbalize and document management plans including relevant differential of consequence for multiple patients.
3. Show clinical leadership by supervising residents, managing multiple resident care teams, and educating residents and medical students.
4. Demonstrate clinical leadership by serving as a primary liaison between faculty and residents and serving as key negotiator between charge nurses and other clinical nursing leadership.
5. Develop excellence in multi-tasking
6. Hone skills in interpersonal communication and negotiation
7. Develop and institute complex treatment plans for a variety of patients including those with severe injury and those with minor illnesses simultaneously
8. Oversee the management of critically ill patients while acting as a clinical and education resource for the critical care team
9. Demonstrate excellence in resuscitation
10. Demonstrate an ability to provide rapid and appropriate care in the treatment of all Emergency Department patients in a time sensitive manner, including low acuity patients.
11. Demonstrate administrative skills with respect to residency program and education
12. Demonstrate excellence in clinical supervision and clinical teaching, including bedside and didactic education
13. Demonstrate outstanding clinical competence in the practice of emergency medicine
14. Maintain a portfolio, including performance reviews, logs, tracking of procedures and projects and potential goals.

Specific Educational Objectives:
1. Demonstrate excellence in **"Data Gathering"** that includes but not limited to:
    - Perform an efficient, but thorough focused history and physical examination while managing multiple patients (PC, MK, ICS, PR)
    - Deliver clear verbal and written patient presentations that adequately reflect the patient's condition, including acuity, disease state and anticipated disposition. (PC, ICS, MK, SBP)
    - Independently order and interpret ancillary tests that are required for the management of multiple individual patients (PC, MK, SBP)

- Reliably and efficiently obtain essential and accurate information collected from all available sources including medical students and other residents and nurses (PC, SBP)
- Demonstrate an ability to continuously gather data about patients during the entire course of patients' stay in the Emergency Department. (PC)
- Rapidly identify all key elements in the patient's history, physical or other data sources that indicate a need for further investigation ('the red flag"). (PC, MK)
- Demonstrates an ability to obtain the patient's explicit agenda for coming to the Emergency Department while assessing their medical needs (PC, ICS, PR)

2. Demonstrate excellence in **"Problem Solving"** that includes but not limited to:
   - Generate an appropriate and relevant differential of consequence for undifferentiated patients while managing multiple patients (PC, MK)
   - Recognize the key data elements required to make efficient patient management decisions (PC, MK, PBL)
   - Generate an expanded differential of consequence including the consideration of possible atypical presentations and all potential life and organ threats and likely post Emergency Department complications. (PC, MK, PBL)
   - Continually update management plans based on patients changing condition or new data or availability of resources (PC, MK, SBP)
   - Promptly involves the Attending Physician when there is a significant change in the health care condition of the patient (PC, SBP, PR)
3. Demonstrate excellence in **"Patient Management"** that includes but not limited to:
   - Create a comprehensive treatment plan based on the differential of consequence (PC, MK, SBP)
   - Apply sophisticated knowledge of pathophysiology in developing patient management strategies. (PC, MK, SBP)
   - Recognize and institute appropriate emergency stabilization of the unstable patient (PC, MK, SBP)
   - Utilize the patient's explicit agenda in creating a management plan (PC)
   - Implement a management plan that addresses all the key elements of the patient's history, physical and other data sources that warrant further attention, addresses the "red flags". (PC, MK, PBL, SBP)
4. Demonstrate a comprehensive **Medical Knowledge** that includes but not limited to:
   - Demonstrates a sophisticated fund of emergency medicine knowledge (MK)
   - Describe complex disease processes as they relate to the patients under their care. (PC, ICS, MK)
   - Demonstrate knowledge application to patient care situations to promote health and safety (MK, PC, SBP)
5. Demonstrate excellence in **"Procedural Skills"** consistent with level of training that includes but not limited to:
   - Demonstrates understanding and application of informed consent. (PC, MK, SBP)
   - Provides clear and supportive information to patients and families regarding the need for procedural intervention (PC, MK, ICS, SBP)
   - Describe the different therapeutic agents, dosages and other interventions used in conscious sedation and rapid sequence intubation (PC, MK)
   - Demonstrates excellence in suturing, lumbar puncture, splinting, I/D abscess, venipuncture, central line placement (PC, MK)
6. Demonstrate excellence in **"Efficiency"** of care that includes but not limited to:
   - Effectively manages more than 2 patients per hour (PC, MK, SBP)

- Consistently provides rapid medical screening examinations of patients who are waiting for an evaluation room. (PC, MK, SBP)
- Able to prioritize tasks appropriately (PC, MK, SBP)

7. Demonstrate excellence in **"Interpersonal and Communication Skills"** that includes but not limited to:
   - Demonstrates effective information exchange with patients, their families, and professional associates (ICS, PR)
   - Shows an appreciation of appropriate conflict resolution skills (ICS, PR)
   - Works effectively and efficiently with others in the health care team (ICS, PR)
   - Demonstrates an ability to persuade and negotiate with other health care professionals successfully. (PC, SBP, ICS)
   - Demonstrates an appropriate sensitivity in negotiating with individuals from a variety of cultures, backgrounds, education, and ethnicity. (PR, ICS)
   - Discuss treatment options with patients allowing patient to voice concerns, suggestions, and preferences. (PC, ICS)
8. Demonstrate excellence in **"Professionalism"** skills that includes but not limited to:
   - Introduces self to patient and/or family (PR, ICS)
   - Respectful of patient's privacy and confidentiality (PR)
   - Demonstrates respect, compassion, and integrity (PR)
   - Adheres to the dress code (PR)
   - Maintains equanimity while in the ED (PR)
9. Demonstrate excellence in proper **"Documentation"** that includes but not limited to:
   - Medical record is complete and thorough and includes medical decision making, appropriate justification for the plan of treatment, consultants involved and condition of patient on discharge or transfer (PC)
   - Documentation reflects the patient's condition and is consistent with the final disposition. (PC, SBP)
   - Documentation of progress notes every 2 hours and procedure notes when indicated. (PC, SBP)
   - Documentation includes response to key interventions. (PC, SBP)
10. Demonstrate excellence in **"Systems-Based Practice"** that includes but not limited to:
    - Judiciously utilizes available resources for the care of the emergency department patient (SBP)
    - Recognizes the importance of resource allocation as they relate to patients, the hospital and other services, (PC, MK, SBP)
    - Demonstrates an ability to implement an appropriate treatment plan that factors in Emergency Department, Hospital and patient resources, as well as cost and availability. (SBP, PC)
    - Discharged patients have clear and concise follow up instructions (PC, SBP)
11. Demonstrate excellence in **"Practice Based Learning and Improvement"** that includes but not limited to:
    - Uses appropriate information resources (i.e., texts, online web sites, etc.) for the care of patients (PBL, PC)
    - Demonstrates an interest in learning and willingness to investigate literature and other resources. (PBL, PC)
    - Actively seeks out instruction and incorporates new learning and feedback in the care of patients (PC, MK, SBP)
    - Actively teaches other residents, nurses, students, and other health care providers based on their clinical experiences, readings and instructions (PC, ICS, MK, PBL)

Educational Expectations:

1. Experience in the initial evaluation of an undifferentiated patient population
2. Experience in the development of appropriate treatment plans
3. Participate as the supervisor for multiple patient care teams both for medical and surgical critical care patients under the direction of attending faculty
4. Experience in (but not limited to) the following procedures under direct supervision by the EM faculty:
   - airway management
   - surgical airway
   - emergency thoracotomy
   - central venous access
   - arterial access
   - lumbar puncture
   - thoracentesis
   - arthrocentesis
   - paracentesis
   - ultrasound
   - laceration repair
   - splinting techniques
   - Incision and drainage, etc.
5. Provide pre-hospital EMS consultation by radio
6. Supervision of medical students, interns and junior residents
7. Delivery of a succinct "medical minute" at 7AM shift change
8. Preparation of one case conference and serving as a teaching attending at departmental resident conference

Duties and Responsibilities include:

1. Obtaining appropriately detailed patient histories
2. Performing physical examinations of the patient
3. Performing all necessary procedures under supervision of the faculty
4. Reviewing all laboratory values and diagnostic studies
5. Developing a differential of consequence and an appropriate management plan for each patient
6. Demonstrating efficient implementation of treatment resulting in timely disposition
7. Providing clear and concise documentation that adequately reflects patient condition and ED course
8. Creation of complete and relevant discharge instructions.
9. Demonstrating professional interactions with faculty, staff, colleagues and consultants
10. Supervision and clinical instruction of medical students.
11. Serve as team leader in the triage system. Work with charge nurse and attending to expedite patient care in the era of ED overcrowding.
12. Responsible for supervising first, second- and third-year residents, medical students, and PAs.
13. Provide efficient, competent, compassionate care to all patients with careful attention to communications with patients and families.
14. The resident will devise a diagnostic and management plan that will be reviewed by the faculty.
15. The resident will coordinate with the attendings and charge nurses to provide supervision for the residents and midlevel providers.
16. Screen and/or disposition patients in the upfront process when assigned a RAP shift

17. See patients primarily when assigned a Purple or Blue shift. During your purple shift you will also be required to see the eye patients.

All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines.

Facilities and Resources:
The EM4 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Library, locker rooms, showers and several hospital cafeterias.

Description of didactic experiences:
Daily morning rounds at 7am. During the 7am shift, the EM4 will give a short presentation as a medical minute. During that time, all residents who are not engaging in the immediate stabilization of a patient are excused from duty. The medical minutes may include a clinical topic, a review of a journal article or an administrative topic. Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties by faculty members and APPs in order to allow them to attend conferences.

Evaluation process:
End-of-shift evaluations should be assigned at the end of each shift to supervising faculty.
At the mid-point and the end-point of each rotation block, broader electronic evaluations will be completed with input from faculty members. You are required to select TWO SUPERVISORY FACULTY at each of the mid-point and end-point evaluations for completion. In addition, EM4 residents may be selected as supervisory residents by EM1-3 residents and are responsible for completing these evaluations within two weeks off their assignment. Reciprocal evaluations will be generated about the EM4 to be completed by the EM1-3. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback Sources:
Several evaluation mechanisms will be used including, but not limited to:

- Teaching Observation Shifts (Faculty working one on one with a resident)
- End of Shift Evaluations
- End of Rotation Evaluations in New Innovations
- Oral Boards
- Procedure Logs
- Patient Logs
- Chart Reviews
- Biannual Review

All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contacts:

JHEM PGY4 Chiefs
JHEMPGY4@gmail.com

JHEM Chiefs
jhemchiefs@jhmi.edu

Dr. Michael Ehmann
Mehmann1@jhmi.edu

Rotation: **Pediatric Emergency Medicine at Johns Hopkins Howard County Medical Center (HC Peds)**
Year: **EM4**
Duration: **Two Weeks**

Educational Goal:
Develop the ability to evaluate, diagnose, stabilize, and treat pediatric patients who present to a community emergency department.

Educational Objectives:
1. Communicate effectively with patients, their families, and professional associates (ICS).
2. Demonstrate respect, compassion, and integrity (PR).
3. Demonstrate the ability to perform an appropriate history and physical exam (PC).
4. Demonstrate the ability to develop an appropriate differential of consequence and treatment plan (MK).
5. Demonstrate appropriate clinical decision-making skills (PC).
6. Master the ability to assess the seriously ill child, with an emphasis on recognizing early signs and symptoms before further deterioration can occur. (PC, MK, ICS, Prof, SBP)
7. Master the evaluation and management of the critically ill or injured child during resuscitation. (PC, MK, ICS, Prof, SBP, PBL&I)
8. Master the evaluation and management of mild and moderately ill children who present to an emergency department (PC, MK, ICS, Prof, SBP, PBL&I)
9. Recognize the several categories of pediatric patients including the seriously ill, moderately ill and non-acute pediatric patients. (PC, MK)
10. Demonstrate an ability to rapidly create, verbalize and document a relevant differential of consequence for multiple pediatric patients (PC, MK)
11. Demonstrate leadership by consistently serving as the resident supervisor of a healthcare team, integrating well with other residents, faculty and nursing staff (Prof, PBL&I)
12. Manage critically ill pediatric patients while overseeing the critical care team (PC, MK)
13. Perform intraosseous infusion, venous cut down techniques, and lumbar punctures. (PC, MK, Prof, PBL&I, ICS, SBP)
14. Master approach to the management and disposition of the febrile child, considering such factors as age, source and severity of illness. (PC, MK, Prof, PBL&I, ICS, SBP)
15. Demonstrate an evidence-based approach to the pediatric patient with respiratory illness, gastrointestinal disorders, neurologic complaints, gynecologic disorders, cardiovascular disorders, painful conditions, and the poisoned patient utilizing history, physical examination and ancillary studies to arrive at a diagnosis allowing appropriate treatment and disposition. (PC, MK, Prof, PBL&I, ICS, SBP)
16. Develop an appropriate level of awareness of child abuse; learn in what circumstance child abuse occurs and how it may present. Evaluate the patient with suspected child abuse including sexual abuse. Learn the legal requirements and appropriate documentation. Understand the emotional factors affecting the patient and family. Understand the relative role of law enforcement, health care provider, and physicians. (PC, MK, Prof, PBL&I, ICS, SBP)

Educational Expectations
1. Learn the normal development of the pediatric patient
2. Learn the pathophysiology of abnormal conditions in the pediatric age group

3. Exposure and experience in the management of pediatric emergencies
4. Exposure and experience in the management of the critically ill and injured patient
5. Specific experience and training in:
   - taking a pediatric history
   - performing a pediatric physical examination
   - understanding the indications and interpretation of ancillary laboratory and
   - imaging techniques
6. Experience in (but not limited to) the following procedures:
   - venous access
   - venous cutdown
   - arterial access
   - lumbar puncture
   - intubation
   - fracture splinting
   - laceration repairs
7. Experience and training in pediatric resuscitation efforts, including anticipation and recognition of short and long-term complications
8. Understand the social-family aspects of pediatric emergency evaluation and care

Description of clinical experiences:
The EM4 will rotate for a two-week period on the Pediatric ED Service as a full member of the Service. The resident will have exposure to a wide variety of ill and injured pediatric patients under the direct supervision of the EM attending.

As an EM4, the resident will evaluate patients presenting to the pediatric emergency department.

Shifts will cover days, evenings and weekends and will be 8-12 hours in length.

All Emergency Medicine resident(s) must follow the ACGME Emergency Medicine duty hours guidelines.

Facilities and Resources:
The EM4 will have access to a wide variety of facilities and resources including, but not limited to: medical records (computerized and library), EM resident library (multiple EM texts, computers), on-line web data (Up-to-date, MD Consult, Medline, full-text journals, Micromedex, etc.), Welch Medical School Library, locker-room, shower and the hospital cafeteria.

Duties and Responsibilities include:
1. Obtaining detailed patient histories
2. Performing physical examinations
3. Reviewing all laboratory values and diagnostic studies
4. Documenting histories and physical examinations
5. Performing all necessary procedures
6. Supervise medical students and less-senior residents

The resident will devise a diagnostic and management plan reviewed by the attending pediatric emergency medicine physician.

Description of didactic experiences:
Formal resident conferences, including Grand Rounds, occur each Friday morning from 7am to 12pm. All residents in the ED are relieved from clinical duties in order to allow them to attend conferences.

Evaluation process:
At the end of each block, electronic evaluations with input from supervising faculty members will be requested. Other means used in the evaluation process will include semi-annual oral examinations and yearly in-service examinations.

Feedback mechanisms:
All evaluations will be reviewed by the resident in the semi-annual meetings with the residency program director.

Core Competencies	Embedded in goals, objectives, duties	Monitored during rotation	Evaluated Asynchronously
Patient Care	X	ERE	OB, IS
Medical Knowledge	X	ERE	OB, IS
Practice Based Learning	X	ERE	FR, BR, PL
System Based Learning	X	ERE	FR, BR, PtL, CR
Interpersonal Skills and Communications	X	ERE	FR, BR
Professionalism	X	ERE	FR, BR
Shift Report (SR) Faculty review (FR), Oral boards (OB), in-service score (IS) Biannual Review (BR) Procedure Log (PL) Patient Log (PtL), Chart Review (CR) End of Rotation Evaluation (ERE)			

Rotation Contact:
Meng-Keong Choo, MD
Interim Chair, Pediatric Emergency Department
410-884-4888
mchoo1@jhmi.edu

HoCo Residency Liaison:
Nico Risko, MD MPH
Assistant Professor
JH Howard County Medical Center
Department of Emergency Medicine
nrisko1@jhmi.edu
Cell: (617) 869-8141

PGY 4 Year – Fast Track Curriculum Overview (FAST)

Broad Design of the Year:

The structure of the year is a longitudinal experience split between

1. Developing skills as an academic clinical attending
2. Developing proficiency in a focused area within the field of Emergency Medicine

Details:

1. **Clinical Time**

   Each 4th year resident will work a minimum of 1080 clinical hours a year. This is a 50% commitment for a full-time faculty member and equates to 24 hours/week when the time is spread over a 46-week year (4 weeks allotted to vacation and two weeks are in HoCo Peds). The 4th year role will be staffed in the Johns Hopkins Hospital ED and will function 24/7. This time commitment requires approximately 8,736 hours of time a year. Approximately 70-75% of your time will be spent in this 4th year role. The remaining 25-30% of your clinical time will be divided amongst primary provider roles that need to be filled (Upfront, primary ED shifts, HoCo Peds).

   The role for the 4th year resident will be like that of the attending. 4th year residents will be assigned to an area of the ED to run. They are responsible for the care, disposition and flow of all patients in that area and the supervision of the junior residents and students working in that area. These junior residents will be expected to present most of their cases to the 4th year resident who will offer direction and teaching about the case. The 4th year resident and attending (who provides the ultimate level of supervision) will remain in constant contact about the management and disposition of their patients. The attending will both hear cases WITH the 4th year resident, to provide feedback and guidance to the 4th year, as well as hear cases FROM the 4th year, to provide a degree of increasing independence. 4th year residents will learn about department and patient flow and will see a small number of primary patients. 4th year residents will write Supervisory (Fellow-level) notes on all patients they supervise.

   (Note: attendings are still responsible for seeing all patients and writing notes as per the supervision requirement from RRC)

2. **FAST Protected Time**

   Each 4th year resident will have approximately 50% of their time to work on their FAST. The FAST program was designed to give residents a longitudinal experience instead of short periods of 'elective,' with the premise that this would enable for a more productive and 'realistic to faculty life' working environment. A formal declaration needs to be prepared by the resident regarding the goals and objectives of their year, as well as budgetary needs and plans for a domestic conference they will attend. (see appendix for the FAST Application Forms)

   a. ***Scholarly work***

      All residents are required to complete scholarly work within their track. Residents will work together with their track mentor, Dr. Regan and Dr. Hinson to create a proposal. This proposal should include budgetary needs, support staff, statistical assistance etc., if there are any. All residents and track mentors are required to meet with Drs. Regan and Hinson during their PGY3 year, at the latest, but can meet as soon as they are ready to start their scholarly project.

These meetings are typically held in the 2nd half of 3rd year before the 4th year starts, however, a resident who is ready to begin their work sooner should request a meeting as soon as they are ready. All scholarly work will be presented at least once in Friday conference.

3. **Conference**

Resident attendance must be at 80%, excluding vacation.

4. **Schedule**

It is expected that certain residents will need blocks of time for clinical work (critical care) or for away work (international, disaster) or for electives they wish to pursue (Please see the Appendix section for the appropriate elective forms, as well as possible elective options and contact information).

As such, the 4th year class will need to meet as a group to determine need for away time and how the schedule will be divided to meet the minimum staffing numbers in the department. The 4th year role is an essential role in the department, and must be filled. As more residents take time off in a certain block, the hours will need to be disseminated across the remaining residents. Suggested time frame for this meeting is no later than March of the third year. The Schedule APD will run this meeting with the emeritus chief residents entering their PGY4 year.

5. **Teaching Activities**

All PGY4 residents will complete the following teaching activities:

- Teaching attending for one month (didactics, small groups, labs)
- One case conference presentation
- FAST content teaching as determined by FAST leader
- Teaching shifts

6. **Quality Improvement Project**

Projects are required as part of the longitudinal QI process.

7. **Evaluation**

All residents will receive formal New Innovations evaluations on their clinical rotations. To meet the requirement for graduation, the PGY4 must receive a final evaluation of “meets expectations” from their FAST Track Director, as well as a final evaluation of “meets expectations” from the Directors of QI and Research with regards to the respective projects. In addition, residents must complete their ultrasound competency assessments as part of the formal ultrasound training program.

Focused Advanced Specialized Training (FAST)
Declaration and Proposal Form
Johns Hopkins Emergency Medicine Residency

Please read these instructions carefully. Applications that do not follow these instructions with regards to type size, length, format, and supporting documentation will be summarily rejected. No extension of the deadline will be granted.

Before submitting your application, please be sure that the following items have been addressed:

- Information page is included as the first page of the application packet and is fully completed (sample attached)
- Type size is no smaller than 11 pt. font, single-spaced and margins are 1 inch
- Completed and Signed Mentorship Contract is included in the application packet
- Completed non-JHH FAST project/elective/experience form(s)
- Budget is complete, justified and has been reviewed by your FAST mentor and FAST track leader
- IRB application has been initiated, or explanation of why IRB approval is not needed has been included

Focused Advanced Specialized Training (FAST) Johns Hopkins Emergency Medicine Residency

SENIOR RESIDENT PROPOSAL

Applications Deadline	TBD
Notification of award	TBD
Funding Period	July 1, TBD - June 30, TBD
Funding Amount	Variable

FAST OVERVIEW

The Department of Emergency Medicine (EM) at Johns Hopkins is committed to training residents with full capacity to become local, national and international leaders in the ever-expanding field of EM. The Johns Hopkins four-year program is unique and offers unparalleled opportunity for academic and professional development, owing largely to our **Focused Advanced Specialty Training (FAST)** program.

Years 1-3 of EM residency at Johns Hopkins follow a format similar to 3-year EM residencies across the country. The 4th year follows the format of a traditional *subspecialty fellowship*. Johns Hopkins has developed formally approved fellowships, and the FAST tracks align with most of these fellowship areas.

Clinical Commitment: Once in the 4th year, each resident works clinically in the ED for a total of approximately 1,080 hours annually - in both primary patient care and supervisory roles. This represents and approximate 50% clinical commitment for a full-time faculty member, with 4 weeks allotted to vacation. The role for the 4th year resident will be similar to that of the attending: Fourth year residents will be assigned an area of the ED to supervise; they are responsible for the care, disposition and flow of all of the patients in that area, as well as supervision of the junior residents and students who are working in that area. These junior residents will be expected to present most of their cases to the 4th year resident who will offer direction and teaching about the case. The 4th year resident and attending (who provides the ultimate level of supervision) will remain in constant contact about the management and disposition of their patients. The attending will hear cases *with* the 4th year resident, to provide feedback and guidance to the 4th year, as well as hear cases *from* the 4th year resident. This allows the attending physician to provide a degree of increasing independence and to titrate based on the capacity and needs of individual residents and the department at any point in time. Fourth year residents will learn about patient flow and department-level management. They will also see an increasing number of primary patients over the course of the year as they develop the ability to multitask more efficiently. Fourth year residents are required to write notes on *all* patients they supervise. *Attending physicians retain responsibility for seeing all patients and writing notes as per the supervision requirement from RRC.*

Teaching Commitment: The Johns Hopkins EM residency training program is strengthened by peer-to-peer teaching. While opportunities for peer teaching abound throughout residency, residents assume a more formal teaching role during 4th year. As on-shift clinical supervisors, 4th year residents are tasked as primary clinical instructors for junior residents on their team. In addition, each 4th year

resident is required to participate as a "teaching attending" for one month of the year. You will be treated the same as any other faculty member and as such, are required to be present for the entirety of the conferences that take place during that month as well as be expected to run small groups, provide didactic lectures, or perform any other required needs for the month. Fourth year residents will also be targeted (similar to attending physicians) to provide additional education over the course of the year (core content, intern orientation, small group days) – often on topics related to their chosen FAST track.

Protected Time for Academic and Professional Development: Fourth-year residents spend the remainder or their nonclinical time (50% commitment) working toward completion of the goals and objectives of their FAST track(s). We believe this longitudinal yearlong experience enables residents to be productive and offers ample opportunity for participation in research, teaching, course work in our school of public health, international electives and other opportunities. Further subspecialty fellowship training in the area chosen, should it be pursued, is one year less than the standard program. Since many fellowships are two years long, one major advantage to the program is that the FAST track chosen may be considered equivalent to the completion of an entire year of a fellowship (similar to advanced placement) at Johns Hopkins (only available for non-ACGME fellowships).

While declaration of the FAST track chosen by a resident can occur as late as the third year, residents are encouraged to begin exploring potential FAST tracks as early as possible (during years 1 and 2 of residency). This allows the resident to fully explore possibilities, while also committing to an area of focus with sufficient time to establish important relationships and make substantial achievements in their area of subspecialty focus prior to post-residency job search and graduation.

FAST PROPOSAL EXPECTATIONS

The Johns Hopkins Department of EM and EM Residency training program devote significant human and capital resources to the FAST program. The over-arching aim of the FAST Program is to equip Johns Hopkins EM residents with tools and skills needed to excel in the subspecialty area *of their own choosing*. Thus, the standing expectation is that FAST plans be rigorous and targeted toward development in a specific area. While training plans will vary based on chosen FAST track and the career goals and objectives of the individual trainee, all FAST Proposals must specifically address how trainees will meet the following requirements during the 4th year:

SPECIALIZED TRAINING

- FAST proposals should clearly define the academic and professional goals of the individual resident and describe how the training plan proposed furthers progress toward those goals.
- *The majority of effort over the FAST experience will be spent working toward these goals.*
- Individual academic and professional goals should be defined in a Personal Statement.
- A specific section of the FAST proposal entitled *Training Plan* should be devoted to academic and professional development in each area of focus (FAST track) chosen and should reflect the individual's goals and objectives as described in the Personal Statement.

SCHOLARLY PROJECT

- Prior to graduation, each resident is required to complete a scholarly project.
- The project must aim to advance knowledge or practice in the FAST track subspecialty field.
- Scholarly projects should be developed in close collaboration with a faculty mentor and executed with sufficient rigor to facilitate dissemination of results outside Johns Hopkins.
- All scholarly projects must be designed with clear objective(s) and deliverable(s) that are achievable within the FAST timeframe.
- Many scholarly projects will be research-based, with a primary objective related to

hypothesis-testing and a research manuscript serving as the project deliverable. This is however, not required. Resident and mentor teams may propose alternate formats for the scholarly project, as long as justification is supplied, along with clearly stated project objectives, deliverables and a plan for knowledge dissemination.

FAST TRACKS

As described above, FAST tracks were originally developed to align with fellowships offered within the Johns Hopkins Department of EM. The number of FAST tracks has since grown. All existing tracks, with faculty leaders, are listed in the table below. While your primary mentor may be different than the track leader, all work within a track must be approved by and conducted under the ultimate supervision of the track leader. If your academic and professional goals are not aligned with any of the tracks below, please contact the Program Director, Dr. Regan, and Dr. Hinson at the earliest point possible. In such a case we will work to meet your objectives within an existing track and would consider opening a new track.

Table 1. Focused Advanced Specialized Training Tracks and Faculty Leaders

FAST Interest Area	Faculty Track Leaders
Administration & Leadership	Edana Mann, MD Jonathan Hansen, MD, MBA
Critical Care	Adam Laytin, MD, MPH
Digital Health	Jeremiah Hinson, MD, PhD Paul Nagy, PhD
Disaster Preparedness & Austere Medicine	Lee Jenkins, MD, MPH
EMS/Special Operations	Nelson Tang, MD Asa Margolis, DO, MPH, MS Matthew Levy, DO, MSc
Geriatric Emergency Medicine	Phil Magidson, MD, MPH
Global Health	Valerie Osula, MD MPH Bhakti Hansoti, MBBCh, MBChB, MPH
Health Humanities	Kamna Balhara, MD, MA Nathan Irvin, MD, MSHPR
Medical Education	Linda Regan, MD, MEd Jules Jung, MD, MEd
Palliative Care	Balakrishna (Balu) Vemula, MD
Pediatric EM	Jen Anders, MD
Research	Richard Rothman, MD, PhD Jeremiah Hinson, MD, PhD
Social Emergency Medicine	Nathan Irvin, MD Michelle Patch, PhD, MSN, APRN-CNS, ACNS-BC
Toxicology	Andrew Stolbach, MD, FACT
Ultrasound	Tiffany Fong, MD

KNOWLEDGE DISSEMINATION

Departmental and residency leadership encourage that all discoveries resulting from work supported in part or whole by the Johns Hopkins EM Residency FAST Program be made available to the public and scientific community through approved scientific channels such as national meetings and peer-reviewed publications. Publications and presentations should acknowledge the support of the Johns Hopkins EM Residency FAST Program. Records and copies of all abstracts and publications (or similar products) should be shared with FAST program administration.

PROGRESS REPORTS AND MONEY MANAGEMENT

Ongoing FAST funds dispersal is contingent on demonstration of appropriate progress and timely reporting. Progress reports must be submitted to the FAST leadership team at the timepoints detailed below. Incomplete submissions or failure to submit by the deadline will place FAST funds in jeopardy. Unless otherwise instructed, residents should submit progress reports (.doc or .pdf) by email to their mentorship team, Drs. Regan and Hinson, with Mary Rode copied.

June 1 or July 1 (variable by year):

½ page progress report detailing status of IRB application (if applicable), any updates to training plan or scholarly project and any unanticipated barriers encountered to date

September 1:

1-page progress report detailing (as applicable):

- training completed to date

- training outstanding
- IRB application status (if applicable)
- scholarly project progress to date (and comparison to timeline proposed)
- any unanticipated barriers encountered to date
- any planned or completed presentations/publications

February 1:

1-page progress report detailing (as applicable):

- training completed to date
- training outstanding
- IRB application status (if applicable)
- scholarly project progress to date (and comparison to timeline proposed)
- any unanticipated barriers encountered to date
- any planned or completed presentations/publications

ORAL PROPOSAL PRESENTATION

All awardees will be required to share details of their FAST proposal with the JH EM Residency program via oral presentation during resident conference, on a date in June of their 3rd year of residency that will be specified in the future. Presentation format should mirror that described in items 4-6 in *Application Instructions* below.

FINAL FAST PRESENTATION

All awardees will be required to share FAST progress and outcomes with the entire Department of Emergency Medicine via oral presentation during resident conference, on a date in June of their 4th year of residency that will be specified in the future. While presentation introductions may include a summary of FAST training experiences, the primary focus of 4th year presentations should be on the scholarly project.

APPLICATION INSTRUCTIONS

Do not submit an incomplete application. An application will be considered incomplete if it is illegible, if it fails to follow instructions, or if the material presented is insufficient to permit an adequate review.

The application consists of the following sections:

1. TABLE OF CONTENTS

See attached example

2. INFORMATION PAGE

List the names of the applicant, FAST Track(s) of focus and all faculty members that will be involved in overseeing the project. A specific faculty member is already assigned as leader for each FAST Track and will be required to sign off on each resident's proposal to complete their FAST Track. If a different faculty member will serve as your principal, day-to-day FAST Track Mentor, this faculty member should also be listed. The same procedure should be followed if pursuit of a secondary FAST Track is proposed. Finally, the faculty member who will serve as the primary mentor for your scholarly project should be listed, along with to total funds requested for your FAST.

3. PROPOSAL SUMMARY (limit ½ page)

Brief summary of proposed training program and scholarly project. Include FAST track, broad training objectives, coursework or training to be completed and a very brief overview of scholarly project. *This 1-2 paragraph summary should allow the reviewer to understand what you are proposing to do (training and scholarly project) in 5 minutes or less.*

4. PERSONAL STATEMENT (limit 1 page)

The applicant should compose and submit a personal statement that addresses:

a. The applicant's academic/professional career goals (consider immediate and long-term goals)
b. How the proposed training plan and scholarly project will help the applicant achieve these goals
c. Any additional pertinent experience or interests the applicant wishes the committee to consider

5. TRAINING PLAN (limit 2 pages)

Please use the following subheadings:

Training Objectives

- List succinctly the specific objectives of the proposed training (2-5 objectives).

Example:

Training Objective 1: To develop expertise in the performance of bedside ultrasound

Training Objective 2: To gain experience with administration of a departmental ultrasound program

Training Objective 3: …

Training Activities

- Describe specific training activities that will be completed to meet each objective. When writing these activities, please link them to the training objectives above. Please be sure to include what you will do, how much you will do of it, when it will be completed, and who will be supervising. Activities may include local, regional or national educational courses, institutional leadership roles and responsibilities, participation in electives, attendance at

administrative meetings, or the completion of scholarly activities.

Conference

- Travel and registration to one national domestic conference will be supported. Identify the conference that you plan to attend and provide a brief explanation of why this conference is most ideally aligned with your training objectives.

6. PROPOSED SCHOLARLY PROJECT (limit 2 pages)

Please use the following subheadings:

Background and Significance (limit ½ page)

- Explain the importance of the problem or critical barrier to progress in the field that the proposed project addresses.
- Explain how the proposed project will improve scientific knowledge, technical capability, and/or clinical practice in one or more broad fields.
- Describe how the concepts, methods, technologies, treatments, services, or preventative interventions that drive this field will be changed if the proposed aims are achieved.

Specific Aims (limit ½ page)

- First, state concisely the goals of the proposed research and summarize the expected outcome(s), including the impact that the results of the proposed research will exert on the research field(s) involved.
- List succinctly the Specific Aims of the research proposed, e.g., to test a stated hypothesis, create a novel design, solve a specific problem, challenge an existing paradigm or clinical practice, address a critical barrier to progress in the field, or develop new technology. See example applications and documents uploaded to HopkinsEM.org for guidance on writing Specific Aims.

Approach (limit 1 page)

- Describe the overall strategy, methodology, and analyses to be used to accomplish the specific aims of the project.
- Include a project timeline with clearly defined milestones.
- Discuss potential problems, alternative strategies, and benchmarks for success anticipated to achieve the aims.
- If the project is in the early stages of development, describe any strategy to establish feasibility, and address the management of any high-risk aspects of the proposed work.

Preliminary Studies (up to 1/2 page)

- Include information on Preliminary Studies. Discuss the applicant's and mentor's preliminary studies, data, and or experience pertinent to this project. Preliminary data can be an essential part of a research grant application and help to establish the likelihood of success of the proposed project.

7. LITERATURE CITED

8. ETHICS

Assurance of human subjects protection is integral to the FAST proposal review process. *FAST funding is contingent on initiation of an institutional review board (IRB) application for scholarly project approval, or explanation of why the project does not require IRB approval*. Please provide the IRB application title and number, or a brief statement explaining why an IRB application will not be submitted. *IRB applications must be initiated at time of proposal submission, but may be in draft form and do not need to be submitted.*

9. MENTORSHIP CONTRACT

Complete attached document and submit with all signatures in place.

10. BUDGET

Use the FAST budget template hosted in the FAST subsection on www.hopkinsem.org

11. APPENDIX

Include any additional information you think would be supportive to your application. Examples include letters of support from collaborators, flyers/brochures for courses or conferences that you plan to attend, abstracts/manuscripts in preparation or submitted that demonstrate interest in the subspecialty area you propose to pursue, targeted job descriptions, etc.

12. FAST elective planning form

One form must be completed for every non-JHH FAST project, elective, rotation or experience planned for the 4th year. This is not needed for any regional or national conferences.

Applicant (Last, first, middle): _____

Table of Contents

Information Page

Full Name of Resident Physician Applicant: _____

Primary FAST Track: _____

Primary FAST Track Faculty Leader: _____

Principal Primary FAST Track Mentor (if different from Track Leader):

_____

Additional Primary FAST Track Mentors (if applicable): _____

_____

_____

Secondary FAST Track (if applicable): _____

Secondary FAST Track Faculty Leader: _____

Principal Secondary FAST Track Mentor (if different from Track Leader):

_____

Additional Secondary FAST Track Mentors (if applicable):

_____

_____

_____

Scholarly Project Title: _____

Scholarly Project Mentor: _____

Total Amount of Funding Requested for the Year: _____

Emergency Medicine Residency
FAST Mentorship Agreement

A successful mentee/mentor relationship requires a commitment on the part of both partners. The following agreement provides a starting framework for the partnership. Each party should keep a copy of this agreement and make every effort to fulfill the terms of the agreement. A third copy will be kept on file with residency leadership.

Check all that apply:

- ☐ FAST Track Leader
- ☐ Primary FAST Mentor
- ☐ Secondary FAST Mentor
- ☐ Scholarly Project Mentor

Mentor name: _____

Mentee name: _____

MENTEE GOALS AND EXPECTATIONS

The mentee should establish with the mentor specific professional development or personal growth goals they hope to meet over the year (e.g, gain skills necessary for success in …, leadership skill development, etc.) and define their expectations of the mentor (how will your mentor help you achieve these goals?). ***Goals should be specific and measurable and expectations clearly defined:***

These goals and expectations should be derived from the FAST declaration and proposal, but feel free to include whatever you think is important to you - and make it clear what you are hoping to get out of the relationship. A bulleted list is probably best.

MENTOR EXPECTATIONS

The mentor should also define their expectations of the mentee (e.g. keep me apprised of progress at regular intervals, respond to emails promptly, arrive at meetings with an agenda, etc.):

Example:

I expect the mentee to:

- *Arrive to meetings with me prepared, and to provide a meeting agenda 1 week ahead of time*
- *Provide me with monthly progress reports (can be in the form of an email) related to their project*
- *Update me immediately if they are encountering unanticipated barriers to meeting the goals outlined above*
- *Consult me prior to formally involving other residents or students in the work that we are doing, so that we can make decisions together*
- *Provide drafts of any presentation materials (written or oral) at least 2 weeks before their due date*

MEETING AND COMMUNICATION PLAN

Both parties should agree on a target meeting schedule (with location if possible) and communication strategy to ensure that the mentee is receiving adequate mentorship and is on-target to meet the goals defined above.

Example:
We will meet at least once per month (in person, by phone or videoconference (e.g. Skype) to discuss progress on the goals above and to ensure that the mentee is on-target to achieve the goals set forth above. We will meet in person no less than once every 2 months. The mentor will be available by email and phone to answer questions and provide guidance on an ad-hoc basis.

AFFIRMATION:

I agree to the mentoring relationship terms detailed above.

_____

Mentor Signature and Date Mentee Signature and Date

For Scholarly Project Mentor-Mentee Relationship Only:

*Under the supervision of my Mentor, I agree to prepare a complete application for my scholarly project to the JHU Institutional Review Board (IRB) by **June 1 of my PGY3 year**, and to respond to all comments from my mentor and the IRB related to this application within one week.*

_____

Mentee Signature and Date

*I agree to supervise and oversee the scholarly project of the mentee, including submission of an IRB application for the project. I will work closely with the resident in preparation of this IRB application, providing timely feedback and ensuring that an application is submitted to the JHU IRB by **June 1 of the mentee's PGY3 year**.*

_____

Mentor Signature and Date

One form must be completed for EACH non-JHH FAST project/elective/experience which is not part of the training program's standard rotations

Name of Hopkins Resident:	Date submitted:	
Host Institution: (Name and location)		
Specialty Rotation at Host Institution:		
Preceptor at Host Institution and preceptor's email address and phone number (if known at this time):		
Period of Rotation: (Specific dates-mm/dd/yy)	From:	To:

For international rotations, the GME office requires that you register with the Johns Hopkins Global Travel Assistance Program (www.traveloracle.healix.com/johnshopkins) Policy Number: JH18492

For out-of-state rotations, you will be required to provide evidence that the appropriate out-of-state licensure has been obtained (this is state-dependent)

Are the duties of this project/elective/experience: ___Clinical ___Non-Clinical ___Research

NOTE: <u>AT LEAST 8 WEEKS PRIOR TO THE START OF YOUR PROJECT/ELECTIVE/EXPERIENCE</u>, YOU MUST COMPLETE THE AWAY ELECTIVE PAPERWORK. This will require a preceptor signature (who will be assisting/supervising your work at the host institution), along with the goals and objectives of your rotation. This paperwork will need to be submitted to Christina for approval by the Program Director and the DIO. If this paperwork is not submitted in the appropriate amount of time, forfeiture of the rotation may be possible.

RESIDENCY REQUIREMENTS

Chart Reviews

Each resident must review 80 chart reviews over the course of their residency training. 10 of these must be completed over each 6-month period of time, 5 of which must be a review of the resident's own charts and 5 of which must be a review of a peer's charts, for a total of 20 per PGY year. Each resident must meet the minimum of at least 80 chart reviews/patient follow-ups by December 31st of the PGY4 year.

- A chart review should include a review for completeness, appropriate level of detail (depending on acuity), timing of documentation, and perceived quality of care.
- Every 6 months, residents will need to perform 5 self chart reviews and 5 peer chart reviews of ED provider notes. For self chart reviews, residents should choose to review 5 patients for whom they have written the ED provider note during the previous 6 months. For peer chart reviews, each resident will be emailed 5 assigned charts to review. For the charts that have been reviewed by a peer, residents will receive the results of the reviews but will not know the identities of their reviewers.
- Patient follow-ups require residents to identify a patient who was either discharged or admitted. We encourage you to do approximately half and half. Residents must then either contact the patient or use other means (such as chart review) to determine their condition and post ED (or post-management) course. Please use this as an opportunity to get valuable feedback and closure that is often not available at the time of discharge or admission from the ED.
- Chart reviews and patient follow-ups are entered in Qualtrics. It contains the following information:

Assessment of documentation:

Patient's Initials: _____

HIPAA Compliant Medical Record No: _____

Date of Pt Record: _____

Date Reviewed: _____

HPI:

Are discrepancies between H&P and other notes addressed?	Yes	No	Needs improvement	N/A
Is the H&P succinct, readable, and able to provide story of patient's presentation without extraneous material?	Yes	No	Needs improvement	N/A
Previous records and notes reviewed and documented?	Yes	No	Needs improvement	N/A
Is the history medically-appropriate?	Yes	No	Needs improvement	N/A
Is a relevant ROS documented?	Yes	No	Needs improvement	N/A
Is the physical exam medically-appropriate?:	Yes	No	Needs improvement	N/A

Medical Decision Making:

Was there a final ED diagnosis(es) described?	Yes	No	Needs improvement	N/A
Are differential diagnoses and reasoning behind evaluation documented?	Yes	No	Needs improvement	N/A
Is a plan documented?	Yes	No	Needs improvement	N/A
Interpretation of lab results documented?	Yes	No	Needs improvement	N/A
Interpretation and/or radiology reads of	Yes	No	Needs improvement	N/A

diagnostic imaging documented?				
Interpretation of ECGs documented?	Yes	No	Needs improvement	N/A
Are consults/discussions documented?	Yes	No	Needs improvement	N/A
Was history obtained from other independent historians and was this documented?	Yes	No	Needs improvement	N/A
Is it documented/addressed if care was affected by relevant social determinants of health?	Yes	No	Needs improvement	N/A
Is the ED course documented such that the sequence of events during ED stay is clear?	Yes	No	Needs improvement	N/A
Are significant events time-stamped?	Yes	No	Needs improvement	N/A
If discharged and applicable, was a re-assessment of the patient documented?	Yes	No	Needs improvement	N/A
If the patient was present over multiple shifts, was a hand-off note documented?	Yes	No	Needs improvement	N/A
Were procedure notes documented?	Yes	No	Needs improvement	N/A
Was the supervisory Attending listed?	Yes	No	Needs improvement	N/A

Disposition:

Was the final clinical impression entered under the dispo tab?	Yes	No	Needs improvement	N/A
Was the disposition documented?	Yes	No	Needs improvement	N/A
If discharged, was provision of return precautions and outpatient plan documented?	Yes	No	Needs improvement	N/A
If the patient left AMA, was decision-making capacity documented?	Yes	No	Needs improvement	N/A
If applicable, were incidental findings recorded under the dispo tab?	Yes	No	Needs improvement	N/A

Quality of Care

Appropriate ordering of diagnostic studies?	Yes	No	Needs improvement	N/A
Bedside tests performed when appropriate?	Yes	No	Needs improvement	N/A
Prioritized essential testing?	Yes	No	Needs improvement	N/A
If procedure done, was consent documented with risks/benefits reviewed?	Yes	No	Needs improvement	N/A
Considered pre-test probability of disease and likelihood of test results altering management?	Yes	No	Needs improvement	N/A
Practiced cost-effective care?	Yes	No	Needs improvement	N/A
Patient correctly admitted or discharged?	Yes	No	Needs improvement	N/A
Correctly selected level of care if admitted?	Yes	No	Needs improvement	N/A

Comments about patient follow-up and/or chart review:

Procedure Log Policy

You must keep a procedure log on all patients on whom you perform an invasive or diagnostic procedure. Credit towards your graduation requirement for ALL required procedures (including key index procedures and ultrasound) will be given only to procedures logged **within three months** of the date of completion of the procedure. Key index procedures (see below) logged after the three-month window will be considered non-verifiable by faculty, and thus ineligible for credit. Ultrasounds logged after the three-month window will be subject to QA but will be ineligible for credit.

This log shall include the patient's number, date, name of procedure, supervisor and complications or other applicable notes. Location of performance (i.e., real clinical encounter versus simulated/cadaveric encounter) must be recorded, as programs are required to report these distinctions to the ACGME. **The required number of procedures must be completed by December 31st of your PGY4 year.** However, you should continue to log until the end of your 4th year, as many employers ask for recent numbers of procedures.

This log should be kept electronically in New Innovations. You can obtain a summary copy in NI by going to Logger → View Procedures or Resident Reports. At the end of residency, the entire procedure log will be kept in the resident's file.

PROCEDURE REQUIREMENTS:
Below are the minimum number of procedures required by the RRC/ACGME for graduation **(in bold)** as well as the suggested number of procedures required by the department for non-RRC/ACGME required procedures (non-bold).

Your procedures entered in New Innovations will not count until 5 competency assessment procedure cards on the following procedures are completed and turned in:

1. **Central Line- Internal Jugular**
2. **Central Line- Subclavian**
3. **Central Line- Femoral**
4. **Lumbar Puncture**
5. **Chest Tube**
6. **Arterial Line**
7. **Procedural Sedation**

Abscess incision and drainage	10
Adult Medical and Non-trauma Resuscitation	**45**
Adult Trauma Resuscitations	**35**
Arterial puncture and cannulation	10
Arthrocentesis	10
Cardiac pacing	**6**
Cardioversion/Defibrillation (each shock = 1)	10
Central venous access	**20**
Chest tube (Thoracostomy)	**10**
Closed Fracture Splinting With or Without Reduction	15

Cricothyrotomy	**3**
Dislocation reduction	**10**
Intubation, naso and oro	**35**
Laceration repair	15
Lumbar puncture	**15**
Nasal packing	3
Paracentesis	No Minimum Required
Pediatric Medical Resuscitation	**15**
Pediatric Trauma Resuscitation	**10**
Pericardiocentesis	**3**
Procedural Sedation	**15**
Thoracentesis	No Minimum Required
Thoracotomy	No Minimum Required
Vaginal delivery	**10**

Emergency Bedside Ultrasound Graduation Requirements (<u>Minimum</u> of 25 for 6 of the following categories. MUST do #1, #2 and #3)		**150**
1.	E-FAST **(REQUIRED)****	**25**
2.	Procedural **(REQUIRED VASCULAR ACCESS**) **	**5**
3.	Cardiac **(REQUIRED)****	**25**
4.	First Trimester Pregnancy – transabdominal/transvaginal	**25 EACH**
5.	AAA	**25**
6.	Renal	**25**
7.	Biliary	**25**
8.	DVT	**25**
9.	Soft Tissue – Musculoskeletal	**25**
10.	Thoracic	**25**
11.	Ocular	**25**

RESIDENT CONFERENCE: ATTENDANCE

The residency requires each EM 2, 3 and 4 residents to attend at least 80% of all resident conferences during the year (attendance at off-service conferences does not count). EM1 residents are required to be at 70% of resident conference. It is expected that residents will attend all resident conferences while they are on their emergency medicine blocks and off-service rotations which afford them the ability to attend. You can supplement your conference attendance with Individualized Interactive Instruction, as needed, up to a maximum of 35 hours per year (see section below).

Conference start time is 7:00 am. **You are expected to be in your seat and ready at 7am.** It is expected that you will be on time unless you are post night shift. Patterns of continued tardiness will be addressed by residency leadership.

1. Off-service rotations where the resident ***should be at EM resident conference***:
    a. EM1
        1. JHED/BVED
        2. OB
        3. JH Peds
        4. HC Peds/Ophthalmology
        5. JHH Anesthesia
        6. Radiology/EMS
        7. Toxicology/EKG
        8. Ultrasound
    b. EM2
        1. JHED/BVED
        2. Peds Anesthesia
        3. Advanced Ultrasound
        4. Hand
        5. Research
        6. BV Ortho
        7. Shock Trauma Anesthesia
    c. EM3
        1. JHED/BVED/HCED
        2. Elective
        3. Burn (excused if post call)
        4. HC Peds
        5. HC ICU
2. Off-service rotations where the resident is ***not expected to be at EM resident conference***:
    a. EM1
        1. MICU
        2. CCU
    b. EM2
        1. PICU
    c. EM3
        1. Burn (if post call)

3. Residents are not required to attend conference when they are on scheduled vacation. The resident attendance record will be available to be viewed at any time on hopkinsem.org

Residents who do not meet the required annual conference % attendance requirement will first be asked to complete Individualized Interactive Instruction (III) activities for credit. If they still cannot make their attendance, the following may apply:

a. EM1-3 residents will be notified by the Program Director or the Assistant/Associate Program Director that you have not met the requirement and may be issued a Letter of Counseling for Feedback and Improvement. Additional conference attendance hours may be added to the minimum conference attendance for the following PGY year, decreasing the number of conferences missed over the entirety of residency training. Residents may lose their elective time to ensure minimum attendance at conference is assured.
b. EM4 residents will not be allowed to sit for their written board exam until their graduation requirement is met to attend 80% of conference. This may mean attending conference after graduation until the number of days are met.

Individualized Interactive Instruction (III)

For an activity to qualify as individualized interactive instruction, the following four criteria must be met:

1. The program director must monitor resident participation.
2. There must be an evaluation component.
3. There must be faculty oversight.
4. The activity must be monitored for effectiveness.

The following opportunities are currently available:

1. Journal club: 1 JC = 2.5 III hours
   a. Attendance sheet – signed by faculty member
   b. Faculty member present for majority of JC
   c. Write up by everyone that attended
2. Simulation (above your required sim sessions for the year): 1 sim hour = 1 III hour
3. ALIEM Air Series modules for CME
   a. Forward completed CME certificates to chiefs and Dr. Ritter for documentation of completion
   b. One module = hours assigned by module designers (i.e. 5-hour module = 5 III hours)
4. Humanities Sessions offered throughout the year as part of the H3EM curriculum (1-hour attendance = 1 hour III)
5. Dizziness Curriculum = 1 Curriculum hour = 1 III hour
6. Resuscitation review: 1 review = 1 III hour
   a. Faculty member must be present for resuscitation review
   b. Post-session write up must be completed to receive credit
7. PGY1 emotional transitions curriculum (l session = 1 III hour)
8. Any additional offerings, typically approved on an annual basis, and disseminated directly by the PDs

**** **Individualized Interactive Instruction (III)** will max out at 35 hours (equivalent of 7 conference days). It can be a combination of any of the above for a TOTAL of 35 hours. After 35 hours, you cannot use III for conference credit. You must track your own III and email documentation of completion to the Chiefs and Dr. Ritter.

****Sullivan modules are separate: these are for the 5th hour of conference during our shortened 4-hour days during interview season. They are required, and do not count towards the above.

Resident Conference: Lecture Requirements

Residents are required to give lectures at weekly resident conference. The requirements for contribution are:

EM1: 5 Minute Intern Talks

EM2: One 30-minute core content lecture, EBM

EM3: One 60-minute core content lecture, Chairman's Hour, M&M

EM4: Case conference, Small group facilitations as directed by small group faculty leaders during your designated month as teaching attendings

A list of lecture topics and lecture dates for the year will be distributed by the rising Education Chief. You will be asked to submit your top choices for topics and lecture dates. If there is a particular lecture topic you would like to present that is outside the core topic list, please contact the Assistant/Associate Program Director for topic consideration.

5 Minute Intern Talk:

A short intern lecture that conveys practical teaching in a "5-minute talk" format, while also giving the interns experience teaching a large group. These talks will primarily take place on small group days, where there is usually some down time as we transition to large group lectures, or between large group lectures. They will be **5 slides** and **5 minutes** with minimal to no time for questions. The goal is to give our intern classes an opportunity to prepare and deliver a short talk on an applicable, key point of EM teaching. ***Lectures must be submitted to Dr. Ritter at least two weeks in advance for review. The chiefs and Dr. Ritter will coordinate the schedule and topics with you the second half of the academic year.***

Core Content Lecture:

EM2 and EM3 residents are required to prepare lectures covering core content topics in emergency medicine. EM2 residents present a 30-minute talk, and EM3 residents present a 60-minute talk. All residents are provided with one-on-one assistance from the assistant/associate program director for content and slide preparation.
EM2 lectures must be submitted to Dr. Weygandt and EM3 lectures must be submitted to Dr. Ritter at least two weeks in advance for review.

Case Conference:

EM4 residents are required to prepare a case conference, which occur on a monthly basis. These 60-minute sessions allow EM4s to choose a topic of their choosing and moderate a case-based discussion with practical teaching pearls for the audience. ***Lectures must be submitted to Dr. Ehmann at least two weeks in advance for review.***

Chairman's Hour:

This conference, held 12 times a year, is devoted to the discussion of patients with interesting and/or difficult management problems that may involve deceptive presentations. Cases are presented by EM3 residents in a co-run session with our chairman, Dr. Kelen. These sessions

heavily rely on audience participation and on faculty and senior resident panel involvement. ***Meet with Dr. Kelen at least one month in advance to plan (contact Laurie Atkinson latkins8@jhmi.edu to schedule your meeting).***

M&M:
A monthly one-hour mortality and morbidity conference is held to discuss cases submitted by faculty, residents or nurses, or that are obtained via our hospital reporting system. An EM3 resident leads the session in conjunction with a faculty mentor. These multidisciplinary discussions allow for all members of our patient care teams to follow the case presentation and discussion of the case by an analysis of a standard set of factors known to contribute to error in the emergency department. This involves a systems-based approach, which analyzes not only errors in judgment or decision-making, but also contributing factors, such as failures in teamwork and communication, availability of departmental and institutional resources, and societal factors. These sessions help make recommendations to our clinical leadership to remedy deficits identified. ***Review with Dr. Saheed or Dr. Hansen and your M&M faculty mentor in advance.***

Evidence-Based Medicine (EBM) – EM2 Residents:

Educational Goals:
The goal of evidence practice base hour is to teach how to:
1. Critically appraise an article (MK)
2. Analyze the statistics required how to clinically apply the literature (MK, PBL)
3. Build a database of reviewed material (PR, MK)
4. Collect data into your curriculum life to keep track of your repository of medical knowledge (MK)
5. Learn from the experience and thought process of colleagues (MK, PBL, ISC, PR)
6. Develop ideas for future research (MK, SBP)

Educational Objectives:
Two-year curriculum of EBM will cover:
1. Statistics (MK)
   a. Sensitivity
   b. Specificity
   c. P-value
   d. Prevalence
   e. Pretest and Posttestprobability
   f. Positive predictive value
   g. Negative predictive value
   h. Relative Risk
   i. Odds Ratio
   j. Intention to treat
   k. Number needed to treat
   l. Receiver Operator Curse
2. Critical appraisal of the literature (MK, SBP, PBL)
   a. Is this question relevant to your practice?
   b. Do the methods allow the question to be answered?
   c. Did they study what they intended to study?
   d. Sample size allowed for appropriate power calculations?

e. Inclusion and exclusion criteria and its effect on external validity
f. Sources of bias
g. Independent evaluation of the results
h. Do the results match the question?
i. Do they draw conclusions that were not studied?
j. Current medical issues
k. Bad articles that will be quoted to you by other services

Description of the educational experience:
Each PGY2 resident is responsible for preparing one 45-minute EBM lecture and facilitating a 15-minute evidence-based discussion on the topic during resident conference. Residents will be assigned a presentation date and primary EBM faculty mentor at the beginning of their PGY2 year. Ideally, PGY2 residents will only schedule their EBM lecture to occur after they have completed their PGY2 Research rotation.

REQUIREMENTS

- 4 weeks before presentation: Being considering potential EBM topics that you are interested in presenting. If you have no ideas, read the suggestions below and reach out to EBM faculty team to discuss options.
- 3 weeks before presentation: Submit your EBM topic (as PICO) to EBM faculty team for approval.
- 2 weeks before presentation: Share a near-final draft of your EBM lecture with your primary EBM Faculty Mentor.
- Day of presentation: Deliver your EBM presentation.
- 1 week after presentation: Submit your final presentation slides to the EBM Faculty group; and draft and submit to your EBM Faculty Mentor and one faculty member or senior resident from the list below either a Journal Article Summary or an EBM Focused Article on your topic to submit to EBMConsult.com for consideration of publication

TIMELINE
4 weeks out: Begin thinking about topics that interest you, constructing a clinical question using the PICO format, and then exploring the literature.

APPROACH 1: Choose a specific topic or question up-front (e.g., Why do we do “x"?), then build your question, and eventually a lecture, around that question. This can make for a great talk if our current practice is evidence-based, and you may choose to discuss a landmark study in EM that explains why (think: Rivers’ EGDT trial for sepsis or the NEJM trial that led to adoption of Hb 7 as a transfusion target in acute UGIB). It can also make for a great talk if there is good evidence against our current practice and may lead to practice change. This approach can be more frustrating for other topics, where data is really lacking or treatment decisions are based on dogma or pathophysiology (for example, almost all of toxicology), and you struggle to put evidence together in a way that makes sense for a 1-hour EBM presentation.

APPROACH 2: Start with an important study (either landmark or late breaking) that either is the basis of our current practice, may inform a change in current practice, or is currently being discussed/debated in the EM community. An example of such an article is the 2016 NEJM article that called into question the practice of I&D alone for abscess management after demonstrating a clear benefit with addition of PO antibiotics (presented in EBM by Dr. Garfinkel). Focus on a specific article allows you to provide context to the group (why was

this performed? [PICO]), to discuss interpretation of the study, and to wrestle with whether certain studies should indeed change the way you manage your patients.

It can be challenging to pick a topic - here are several suggestions for where to look for great ideas:

- NEJM Journal Watch for EM (this is an awesome resource): https://www.jwatch.org/emergency-medicine
- Annals of Emergency Medicine Journal Club (this is also an awesome resource): https://www.annemergmed.com/content/journalclub
- Emergency Medicine Literature of Note (blog): http://www.emlitofnote.com/
- Trip medical database to search for existing evidence on a particular topic: https://www.tripdatabase.com/Home

The best EBM topics are concise, focused and clinically relevant. After you have selected a topic, consider asking yourself the following three questions:

1. Is the topic narrow enough to be able to identify one or two take home pearls for my audience?
2. Is the topic directly, clinically relevant to the practice of emergency medicine?
3. If a member of the audience has a clinical shift immediately following my lecture, will they be able to take the aforementioned pearls and potentially apply them in real time?

If the answers to the above three questions are "yes", then the topic is likely a good choice for EBM. If you answered any question with "no" or "maybe", you should reach out to your faculty mentor for guidance and to discuss in more detail.

3 weeks out: You should have selected a topic and had that topic reviewed and approved by the EBM faculty team. Once approved, representatives of the JHH and JHBMC clinical operations leadership teams should be contacted via email and advised of the topic selected (allowing them to weigh in on the topic as needed).

EBM Faculty Team
Dr. Peter Fredericks peter@jhmi.edu
Dr. Joshua Niforatos jnifora1@jhmi.edu
Mary Rode mrode4@jhmi.edu

JHH Clinical Operations Leadership Contacts
Dr. Mustapha Saheed msaheed1@jhmi.edu
Dr. Susie Peterson speter14@jhmi.edu
Dr. Edana Mann emann10@jhmi.edu
Dr. Dan Swedien dswedie1@jhmi.edu

JHBMC Clinical Operations Leadership Contact
Dr. Jonathan Hansen jhansen7@jhmi.edu
Dr. Phil Magidson pmagids1@jhmi.edu

2 weeks out: Send a working draft of your presentation and the specific paper(s) on which you will focus to your primary EBM Faculty Mentor. We will review and give you helpful comments (re: content, direction, and presentation style-oriented things).

Resource for how to prepare an effective large-group lecture presentation:
https://improveteaching.med.jhmi.edu/lectures-new/

1 week after presentation: Submit your final presentation slides to the EBM Faculty group and write either a Journal Article Summary or an EBM Focused Article (depending on the topic of your EBM presentation) using the blank templates found here: https://www.ebmconsult.com/articles/author-center. Submit to your primary EBM Faculty Mentor and one faculty member or senior resident from the list below for editorial review. Once finalized, submit the Journal Article Summary or EBM Focused Article to EBMConsult.com within 1 week of finalization for consideration of online publication.

Kamna Balhara
Michael Ehmann
Jeremiah Hinson
Jules Jung
Eili Klein
Phil Magidson
Edana Mann
Amelia Pousson
Linda Regan
Logan Weygandt

FINAL NOTE: If you do not have a strong EBM/biostats/epi background, you have access to a series of high quality, on-line educational modules focused on EBM and research concepts for the non-researcher (accessible via https://www.hopkinsem.org/). You should have received an email from a representative at High-Yield MED Reviews with login information for the modules. These modules were developed by a former resident in this program, who is providing them to you free of charge!

Program Director Review Meetings

Biannual Review:
Every resident must have a biannual review (at the end of six months and 12 months) with one of the residency directors to review your progress and portfolio. Interns will also have an additional review with a residency director within the first few months of intern year.

You are required to have the following:

- An up-to-date procedure log (for PGY4s, all required procedures must be logged before December 31st)
- Up-to-date evaluations
- Self-assessment form to be completed via Qualtrics before the meeting and provided to the PD **at least 24 hours PRIOR TO the meeting**
- At least 10 chart reviews and patient follow-ups per half year in New Innovations (for PGY4s, 80 chart reviews/patient follow-ups must be logged before December 31st)
- Review of milestones and comments from the CCC committee

End-of-Residency Requirements:
At the completion of your residency, you must meet with the Program Director for a final written end-of-residency evaluation per the RRC. You must bring the completed End-of-Residency Review Form with you to this meeting.

The Residency Review Commission and Johns Hopkins GME office requires that a final written evaluation be given to each resident prior to their graduation from the residency program. The resident is to give the Program Director the following information so that a comprehensive review can be completed. *Fourth year residents should gather this information, FILL IN THE INFORMATION BELOW, and bring everything with you so your comprehensive review can be completed prior to graduation.*

We will not certify that you have successfully completed this program until all documentation has been submitted and approved by the Program Director.

NOTE: the following documentation in BOLD must be met and completed by December 31 of your PGY4 year. If these requirements are not met, you will not be allowed to moonlight, and will not be permitted to participate in electives or FAST-related travel, or any conferences until the requirements are met.

1st - 2nd- 3rd year residents:
Please note that this is the information you need to track. When you come for your review, please gather this information, to the best of your ability, and bring the information to your review.

1. **Procedure logs and procedure competency cards: *summary form* will be printed from New Innovations**
2. **Chart Reviews and Patient Follow-ups (80 total)**
3. **Ultrasound scans summary: see below for numbers required, then contact Dr. Fong to make sure these requirements have been met. Dr. Fong will send Christina your US letter.**
4. Electives completed, include dates, description of the rotation and goals and objectives
5. Evaluation of each rotation (this can be brief, but it must be complete)
6. Oral Examinations (dates)

7. Scholarly/Research project(s): *What is topic/ briefly explain project; any project before or outside your Fast Track deliverable that you have worked on.*
8. Quality Improvement project(s): *Summary of projects worked on and outcomes*
9. All publications and presentations during residency
10. List any positions held during residency
11. Any scholarships received during residency
12. List any written projects, publications or description of outstanding achievements
13. Fast Track experience:
    a. Has the Fast Track experience lived up to your original expectations of the focused year? Why or why not?
    b. How would you change the Fast Track process to maximize the benefit of this program?
    c. What advice would you give to the PGY1-3s in regards to the FAST program? (Either before they got to their declaration and/or start of their 4th year?)
14. Copy of USMLE or COMLEX Certified Transcript of Scores for Step 2 & 3
15. Forwarding information:
    - *What is your new position? Where are you going? List your home address, phone, email (forwarding) information.*
16. Turn in your pager and versus badge to Christina after your last shift. (Pagers cost $150 to replace if they are lost.)

Emergency Bedside Ultrasound Graduation Requirements **Must complete 6 categories: Minimum of 25 for 5 of the following categories and 5 for Procedural. (*MUST do #1, #2, and #3 and then 3 others of your choice)***	**150**
1. E-FAST **(REQUIRED)****	**25**
2. Procedural **(REQUIRED VASCULAR ACCESS**) **	**5**
3. Cardiac **(REQUIRED)****	**25**
4. First Trimester Pregnancy – transabdominal/transvaginal	**25 each**
5. AAA	**25**
6. Renal	**25**
7. Biliary	**25**
8. DVT	**25**
9. Soft Tissue - Musculoskeletal	**25**
10. Thoracic	**25**
11. Ocular	**25**

Longitudinal Ultrasound Scanning Requirements
Year: EM3, EM4

Rationale:

Training and maintenance of proficiency in point-of-care ultrasound (POCUS) is longitudinal and best accomplished through integration of ultrasound in routine patient care in the ED with timely feedback on image acquisition and interpretation.

Requirement:

After completion of the EM1 year Basic Ultrasound and EM2 Advanced Ultrasound rotations, residents will be required to continue their ultrasound education with continued image reporting, QA, skills training, and observed performance.

1. EM 3 and 4 residents are required to perform, record and submit to QPath a minimum of **25 ultrasound scans per 6 months** each year to enable quality assurance and provide educational feedback.

2. EM 3 and 4 residents are required to meet with an ultrasound faculty for at least **one scan shift per year** during a designated rotation (e.g., Research, HCGH Peds, or PGY4 JHED) to refresh old skills, build new skills, and to complete a yearly observed assessment.

End of Residency Requirement:

Each PGY4 resident is required to meet criteria for credentialing in at least 6 different ultrasound applications (including minimum of 25-50 scans per application), written exam, and observed ultrasound competency assessments for the indications for which they are seeking to be included in their POCUS credentialing letter upon graduation. This must occur prior to your final Exit Interview meeting with Dr. Ehmann, which takes place in June.

Simulation

Year: **EM1, EM2, EM3, EM4**
Duration: **Longitudinally throughout EM1-4 (see Simulation Schedule)**

Educational Goal
Simulation is a valuable means of teaching rare and or lifesaving actions in a controlled setting to allow for direct observation and remediation.

Educational Objectives:

Interns are expected to:

- Determine the necessity of diagnostic studies
- Order appropriate diagnostic studies
- Perform appropriate bedside diagnostic studies and procedures
- Manage a single patient amidst distractions
- Task switching between different patients
- Describe upper airway anatomy
- Perform basic airway maneuvers or adjuncts (jaw thrust/chin lift/oral airway/ nasopharyngeal airway) and ventilates/oxygenates patient using BVM
- Describes element of airway assessment and indications impacting the airway management
- Describe the pharmacology of agents used for rapid sequence intubation including specific indications and contraindications
- Perform rapid sequence intubation in patients without adjuncts
- Confirms proper endotracheal tube placement using multiple modalities

PGY2-4 residents are expected to perform the following:

- Manage and prioritizes critically ill or injured patients
- Prioritize critical initial stabilization actions in the resuscitation of a critically ill or injured patient
- Reassess after implementing a stabilizing intervention
- Evaluate the validity of a DNR order
- Prioritize essential testing
- Interpret results of a diagnostic study, recognizing limitations and risks, seeking interpretive assistance when appropriate
- Reviews risks, benefits, contraindications, and alternatives to a diagnostic study or procedure
- Use all available medical information to develop a list of ranked differential diagnoses including those with the greatest potential for morbidity or mortality
- Correctly identify “sick versus not sick” patients
- Revise a differential diagnosis in response to changes in a patient’s course over time
- Synthesize all of the available data and narrows and prioritizes the list of weighted differential diagnoses to determine appropriate management
- Use pattern recognition to identify discriminating features between similar patients and avoids premature closure
- Use flexible communication strategies and adjusts them based on the clinical situation to resolve specific ED challenges, such as drug seeking behavior, delivering bad news, unexpected outcomes, medical errors, and high-risk refusal of-care patients

Duties and Responsibilities:
Residents will be notified of the simulation schedule via email at the beginning of each year. The schedule will also be available on hopkinsem.org.

Group Simulation: Each resident will participate in a group simulation that focuses on Crisis Resource Management and team leadership.

Individual Simulation
EM1: *Three individualized simulations over the year will take place at MTW. Topics will include data gathering, resource utilization, creation of differential diagnosis and plans*
EM2: *Two individualized simulations. Pediatric resuscitation at Blalock, Transvenous Pacer Practice with Dr. Omron (MTW or JHH downtown). Please schedule your TV pacer sim by contacting Dr. Omron via email.*
EM3: *Two individual simulations. Neonatal resuscitation and advanced resuscitation.*
EM4*: One individualized simulation. Topic chosen by resident with sim plan made by 12/31.*

No Show Policy:
- If a simulation session is scheduled at the JHOC Sim Center and is missed, it cannot be made up (they are incredibly hard to schedule). We will try, but cannot guarantee, to make up the session.
- If a session cannot be made up, you will receive an assignment that covers the learning objectives for that session. Please return the assignment to Dr. Rice within 10 days.

Description of didactic experiences:
Simulation faculty will lead the simulation either at the Mount Washington simulation center, the Blalock Simulation center, or in the emergency department with an in-situ trainer. Assessments may at times be performed using milestone checklists during simulation. Residents will be informed of any assessments during the simulation at the beginning of their simulation session.

Feedback mechanisms:
At 6-month intervals, residents will be informed of their progress at their semiannual meetings with their program directors.

Contact:
Julie Rice, MD
Assistant Professor
jrice24@jhmi.edu
Cell: (425) 280-6132

Documentation Requirements

This policy applies to all EDs in the Hopkins system that use EPIC.

The Hopkins-wide institutional policy on acceptable charting practices is that charts must be completed and signed within 2 weeks.

For **active** patients (those still in the ED at the time of your handoff regardless of disposition), you are required to complete your charting **before** you leave the hospital. It is important for your colleagues who remain to take care of the patient, to discuss their management and care, and to provide handoff on the patients when they are admitted. It is essential that the chart reflects their care, any changes in patient status, and your decision-making from your time as their physician.

For **inactive patients** (discharged or admitted but whose charts are still incomplete), please attempt to complete these within 48 hours of your care. When patients are seen in the aftercare clinic or by a follow up provider without a completed ED chart; it is very hard for subsequent providers to understand what has occurred for the patient during their time in the ED and what is needed for their follow up.

For quality assurance of emergency ultrasounds performed as part of a patient's clinical care, within 1 week of the scan date, an Epic procedure note (attested by the attending of record) should be written and signed, and the study images and clips should be submitted to Qpath for quality review by the Ultrasound Division.

It is your responsibility to check your EPIC INBASKET **at least once per week** to ensure any incomplete or inadequately documented charts are completed. Compliance with documentation is an essential component of your professional responsibility and lapses in professionalism may lead to disciplinary action within the program.

Accountability Goals and Next Steps:

1. Goal: **0 outstanding charts at 14 days** after the patient encounter. The list of outstanding charts for each provider is sent to the whole department from Geeta Khatri on a weekly basis. Please take the time to read Geeta's emails and track your EPIC inbox. **We will not be sending other notifications.** If your name appears on the weekly email list, complete your charts ASAP.

2. Residents who appear on the weekly email list in the "15-24" days old column will be required to schedule as many 4-hour blocks in the residency office as necessary to complete their charts. You will meet with the APDs/PDs to create this schedule, and to ensure your adherence.

3. Residents who appear on the weekly email list in the "25-30" days old column will be required to schedule as many 4-hour blocks in the residency office as necessary to complete their charts. Residents will meet with program leadership and will be issued a Letter of Counseling for Feedback and Improvement. As a reminder, a Letter of Counseling for Feedback and Improvement is not punitive nor is it reportable to the institution or future employers. It is a document that expresses ways in which delinquent areas in a resident's development can be remedied.

4. If, after the above, a resident still has incomplete charts, or if a resident frequently and regularly appears on the 25-30 day list, the resident will meet with the PDs for formal action and

receive a “Notice of Concern” at the PDs’ discretion. As a reminder, a Notice of Concern is a formal disciplinary action and must be disclosed to the Associate Dean of GME and future employers.

Please note the goal of this policy is to help you develop your charting skills and time management and is meant to be incremental to allow for each of you to catch up (without penalty) when needed. We recognize there are challenges in the ED every day that sometimes prohibit efficient charting, however, this is a core skill for the practice of EM and while we prefer setting you up for success, we must also adhere to the institution’s policy.

LICENSING EXAMINATION

All residents must complete either the United States Licensing Examination (USMLE) Step 3 or COMLEX-USA Level 3 exam before completion of their second year of residency training. According to JH EM Policy:

Step 1 and Step 2 should be taken prior to entering the residency.

Step 3 – should be taken during the PGY1 or PGY2 year of training and **must be completed by the end of the PGY2 year of training.**

Residents will provide their Program Director with a transcript of their scores for Step 2 (if not in their original application) and Step 3 upon successful completion. Please PRINT AND SAVE A PDF COPY of these as soon as you obtain your score report. They are only available for a short period of time, after which you have to pay for them.

Any resident who does not sit for USMLE Step 3 or COMLEX Level 3 before June 30th of their EM2 year will be ineligible for EM3 Elective, additional shifts for pay, moonlighting, and departmentally supported travel (including EM3 class conference or other conferences) until the exam has been taken and passed.

Residency Policies

Academic Alerts and Development Policies

Academic alerts serve as a notification that goals and expectations (e.g., behavioral, academic, performance) are not being met. While some alerts may be considered disciplinary and are disclosable outside of the department, the majority of alerts that a resident would receive are developmental and not disclosable if the resident remediates the issue without persistent deficiencies.

Letter of Counseling for Feedback and Improvement

What?

A Letter of Counseling for Feedback and Improvement may be issued by the Training Program Director to a Resident to informally address a deficiency or concern that needs to be remedied or improved.

Letters of Counseling for Feedback and Improvement describe the nature of the concern and provide suggestions for remedial actions or changes required on the part of the Postdoctoral Trainee.

How?

Letters of Counseling for Feedback and Improvement will be provided in writing and signed by all parties.

The Residency Leadership can issue a Letter of Counseling for Feedback and Improvement at any time without convening a Training Evaluation Committee.

Reporting?

Letters of Counseling for Feedback and Improvement are not official disciplinary actions but may be escalated to formal disciplinary action if continued deficiencies occur. As Letters of Counseling for Feedback and Improvement are not official disciplinary actions, they are not reportable to the Dean's Office nor to places of employment (or potential employment) after graduation.

Outcomes?

Successful remediation of the deficiency or concern (timelines will be variable based on the issue) will allow cessation of any remediation plans.

Failure to achieve improvement, or a repetition of the conduct, may lead to a Notice of Concern or other actions.

Notice of Concern

What?

A Notice of Concern may be issued by the Program Director to address a deficiency of concern that needs to be immediately addressed by the resident.

A Notice of Concern will detail the nature of the problem and detail remedial actions required on the part of the resident.

A resident who has received a Notice of Concern may lose their right to determine how their elective time will be spent.

How?
A Notice of Concern will be issued in writing and signed by all parties.

A Notice of Concern will be issued only after the Trainee Evaluation Committee (the Clinical Competency Committee or another ad hoc committee with a minimum of 3 faculty) has reviewed the concerns, documentation of remedial work and prior efforts to remediate the problem. The resident will be provided with the names of those faculty members on this committee as well as the decision of the committee. The resident may provide this committee with a written statement responding to a Notice of Concern. The Trainee Evaluation Committee must reply to the trainee within 10 working days. A meeting with the resident may be requested.

Reporting?
A Notice of Concern is reported to the Associate Dean for Graduate Medical Education as well as to the Vice President of Medical Affairs.

A Notice of Concern DOES require reporting when graduates are applying for employment after graduation.

Outcomes?
Successful remediation of the deficiency or concern (timelines will be variable based on the issue) will allow cessation of any remediation plans.

Failure to achieve improvement or repetition of the behavior may lead to other actions, including probation, suspension or dismissal.

Residents receiving either of the above may be required to complete an Individual Development Plan. See below.

Academic Probation

Probation shall be used for Residents in jeopardy of not successfully completing the training program requirements or who are not performing or behaving satisfactorily.

1. A resident placed on academic probation will receive a written notification that must be signed by all parties. This letter will detail the nature of the problem and suggest remedial actions required on the part of the resident as well as the time frame for when they are to be completed.

2. A probationary period will be in effect for a minimum of 30 days but can be extended by the program director.

3. Notification of academic probation will be sent to the Associate Dean for Graduate Medical Education as well as to the Vice President of Medical Affairs.

4. Academic Probation will be issued only after the Trainee Evaluation Committee (the Clinical Competency Committee or another ad hoc committee with a minimum of 3 faculty members) has reviewed the concerns, documentation of remedial work and prior efforts to remediate the problem. The resident will be provided with the names of those faculty members on this committee as well as the decision of the committee. The resident may provide this committee with a written statement responding to a Notice of Concern. The Trainee Evaluation Committee must reply to the trainee within 10 working days. A meeting with the resident may be requested.

5. A resident who is on academic probation may lose the right to determine how their CME funding will be spent and may lose their right to determine how their elective time will be spent.

Academic Suspension and Dismissal

1. A resident can be suspended immediately, pending review, if an offense is so serious that it poses an immediate and serious danger to patients, faculty or staff, or to the institution.

2. If a resident, who is on academic probation, fails to improve his/her performance, or fails to demonstrate satisfactory improvement, then suspension or dismissal proceedings may begin.

3. Academic dismissal proceedings will consist of a review of the resident's performance by the Resident Evaluation Committee as listed above in "Notice of Concern."

4. If academic dismissal proceedings result in a conclusive decision that the resident is unfit to practice Emergency Medicine, institutional guidelines will be followed to remove the individual from the residency program.

Non-renewal or non-promotion of residents/fellows:

The ACGME's Institutional Requirements stipulate that if the program director anticipates that a resident's or fellow's contract will not be renewed, or if the resident/fellow will not be promoted, the resident/fellow must be notified IN WRITING at least 4 months prior to the end of the current agreement. The exact language is asfollows:

1. Non-renewal of appointment or non-promotion: In instances where a resident's agreement will not be renewed, or when a resident will not be promoted to the next level of training, the Sponsoring Institution must ensure that its programs provide the resident(s) with a written notice of intent no later than four months prior to the end of the resident's current agreement. If the primary reason(s) for the nonrenewal or non-promotion occurs within the four months prior to the end of the agreement, the Sponsoring Institution must ensure that its programs provide the resident(s) with as much written notice of the intent not to renew or not to promote, as circumstances will reasonably allow, prior to the end of the agreement.

2. Residents must be allowed to implement the institution's grievance procedures if they receive a written notice either of intent not to renew their agreement(s) or of intent to renew their agreement(s) but not to promote them to the next level of training.

If, at any time, you plan not to renew a resident/fellow contract or to retain a resident/fellow without promotion following their current year of training, please notify the Dean's Office ASAP.

FYI, the institution's grievance procedure can be found at
https://hpo.johnshopkins.edu/som/policies/501/37864/policy_37864.pdf?r12smSESSION=NO

Individual Development Plans (IDP)

1. When resident performance reaches the level of concern that warrants intervention, that resident must meet with one of the residency directors. See policy above on alert, probation and suspension.

2. Combined with recommendations from the Clinical Competency Committee, the Trainee Evaluation Committee (if applicable), the residency directors and the resident will jointly develop an IDP to meet the performance expectations of the individual resident.

3. Individual Development Plans will be crafted to meet the education needs of the resident. Plans will be focused on performance measures as they relate to the core competencies.

4. Internal resources in general will be utilized first to assist the resident in their education plan; however, should internal resources not be sufficient, then external resources will be solicited.

5. Individual Development Plans (IDP) will be written out and signed by the resident. After a maximum of three months, progress will be formally reviewed and the need for extension of the IDP will determined.

Dress Code

It is the policy of the Johns Hopkins Department of Emergency Medicine that ALL Interns, Residents, and Faculty dress in appropriate attire while in the Emergency Department or Institution. This policy applies to Johns Hopkins Hospital, Bayview Medical Center, Howard County Medical Center or any Johns Hopkins Institution.

1. When working clinically, preferred options are:

   JHH-issued green/surgical blue scrubs or personal black scrubs (no other colors or scrubs from other institutions)*

   OR

   Business casual attire (e.g., collared shirt with tie/bowtie and dress slacks, skirt/blowse, or other similarly clinic-appropriate attire)

   ** If wearing scrubs, you may wear a solid colored short or long-sleeve t-shirt (no logos) under your scrub top. T-shirt sleeves should not be visible past the sleeve of the scrub top. You may wear departmentally-approved sweatshirts or fleeces that have the JHH logo over your scrub top.*

   White coats are recommended during times when frequent protective gowning is not required (e.g. non-pandemic times).

2. When at conference or other meetings/training sessions/institution functions on Hopkins campuses:

   Clean single-color scrubs, but white coat **not** required. Departmentally-approved sweatshirts/fleeces may be worn over scrubs.

   OR

   Business casual attire (e.g., collared shirt with tie, dress slacks, skirt, or other similarly clinic-appropriate attire).

JEANS ARE NOT ALLOWED TO BE WORN AT ANY TIME!

We individually and collectively represent the Department so please put your best foot forward.

Duty Hours Policy

The Emergency Medicine (EM) residency program adheres to the duty hours regulations described in the ACGME Common Program Requirements for Emergency Medicine. The EM residency program adheres to these requirements to ensure that residents receive clinical training within a framework that promotes patient safety and resident well-being while supporting the principles of professional development.

"Duty hours" include hours worked in clinical assignments as well as required activities related to the residency program, such as conferences. Duty hours also include any approved moonlighting activity (see "Moonlighting" section below).

When an Emergency Medicine resident is on an **EMERGENCY MEDICINE ROTATION *(e.g., JHED, BVED, HCED, JHH Peds ED, HoCo Peds ED)***, the following duty hours rules apply:

1. Duty hours are limited to 60 scheduled clinical hours per week (including moonlighting) and no more than 72 hours per week for all duty hours activities (including educational)
2. Residents are required to have at least one 24-hour period of consecutive time off during every 7-day period (measured from 7AM on switch day to 7AM seven days later [e.g., if switch day is Thursday, the 7-day period is defined as 7AM Thursday to 7AM Thursday]). This is NOT an average. This time off should be free of all required activities including planned educational conferences.
3. While working in the emergency department, residents may not work longer than 12 continuous scheduled hours
4. There must be at least an equivalent period of continuous time off between scheduled work periods
    a. For example, if a resident works an 8-hour shift, they require 8 hours off before their next scheduled work period. If a resident works a 10-hour shift, they require 10-hours off and so forth.
    b. Residents are allowed to participate in planned educational experiences without an equivalent period of time off between the end of work and the beginning of conference, provided they DO have an equivalent amount of continuous time off (i.e. excluding conference time) BEFORE the next scheduled work period.
    c. The "equivalent period of time off" is defined as the SCHEDULED CLINICAL shift length ONLY that occurred within the 24-hr cycle in question and not additional time the resident may have spent completing documentation etc.
    d. Examples of common questions are listed here on the ACGME's website https://www.acgme.org/Specialties/Emergency-Medicine/Program-Requirements-and-FAQs-and-Applications

When an Emergency Medicine resident is on an **OFF-SERVICE ROTATION**, the resident adheres to their host specialty-specific RRC duty hours guidelines (e.g. when rotating in the MICU, EM residents adhere to Internal Medicine duty hours; when rotating on Bayview Hand Surgery, EM residents adhere to Plastic Surgery duty hours, etc). Therefore, when an Emergency Medicine resident is on an **OFF-SERVICE ROTATION**, the following duty hours rules apply:

1. Duty hours are limited to a maximum of 80 hours per week (inclusive of ALL time- clinical, educational, moonlighting, etc.)
2. Residents are required to have one consecutive 24-hour period off per week. This can be averaged for the rotation.

3. Residents may work up to 24 consecutive clinical hours. They may work an additional 4 hours for a maximum of 28 hours. These additional 4 hours is for transition of patient care and/or education. Residents may NOT be assigned new patients or new clinical duties during these 4 additional hours.
    a. Residents should have at least 14 consecutive hours of time off after working 24 hours of in-house clinical time.
4. Minimum recommended time off between scheduled duty periods:
    a. Residents SHOULD have 8 hours free of duty between scheduled duty periods
5. Residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).
6. At home call: Time spent at the hospital must be included in duty hours reporting.

Jeopardy

1. Residents are assigned to jeopardy status during select rotations during their training (see Jeopardy Policy)
2. Duty hours rules apply to jeopardy shifts and residents may not work longer than 12 hours, unless in situations of extreme need (e.g., severe weather, disaster, etc. See Resident Disaster Deployment Plan)
3. Residents who are activated to jeopardy must include the hours activated as part of their duty hours.

Duty Hours Reporting

Logging the hours that you work (aka duty hours) is a requirement of the residency, the institution and the credentialing body for the residency (RRC). See page 201 for additional information regarding the duty hours policy.

Effective February 1st, 2021, the GME Office created a new, simple attestation system that has been built by the Office of Information Technology.

1. Each month, the day after the end of each block, Christina will send the link to the new attestation tool (https://gme.med.jhmi.edu/dutyhourcompliance/)
2. You will enter your JHED ID to access the site.
3. You will be presented with an initial question asking you if you have worked on an ED rotation over the last block.
    a. "Are you a resident working in the ED?"
    b. This applies to all ED locations including JHH Adult and Peds ED, BVED, HCED and HC Peds ED
4. If you select yes, you will receive one set of 3 questions linked to EM duty hours. If you select no, you will receive a different set of 3 questions linked to non-EM duty hours. With each set of questions, the "compliant" response is listed as the default. (See screenshots below)
5. If all statements are accurate – meaning you did **not violate duty hours** – all you do is hit submit and you are done!
6. If you **have violated duty hours** on any rotation over the last 4-weeks, please change the response to the pertinent question. You will be given the opportunity to choose the rotation(s) where violations occurred and provide an explanation for the violation. (See screenshot on slide #4)
7. Christina will email a reminder one week later

What to do if you have non-EM and EM rotations in the same block?

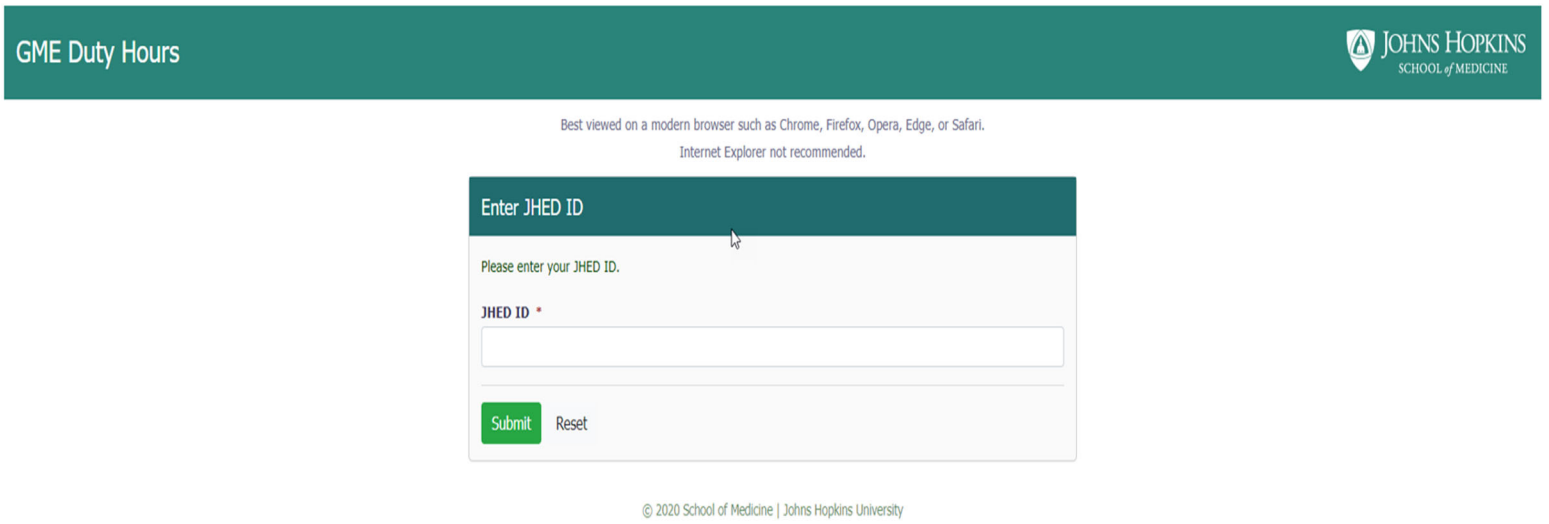
You may be on both an EM and a non-EM rotation during the previous 4-weeks:

- If you have not violated duty hours on either rotation, simply select "Yes" for EM rotation and submit with the compliant answers.
- If you did violate, please select the duty hours questions for the type of rotation (either EM or non-EM), select the rotation from the list provided and explain what happened.

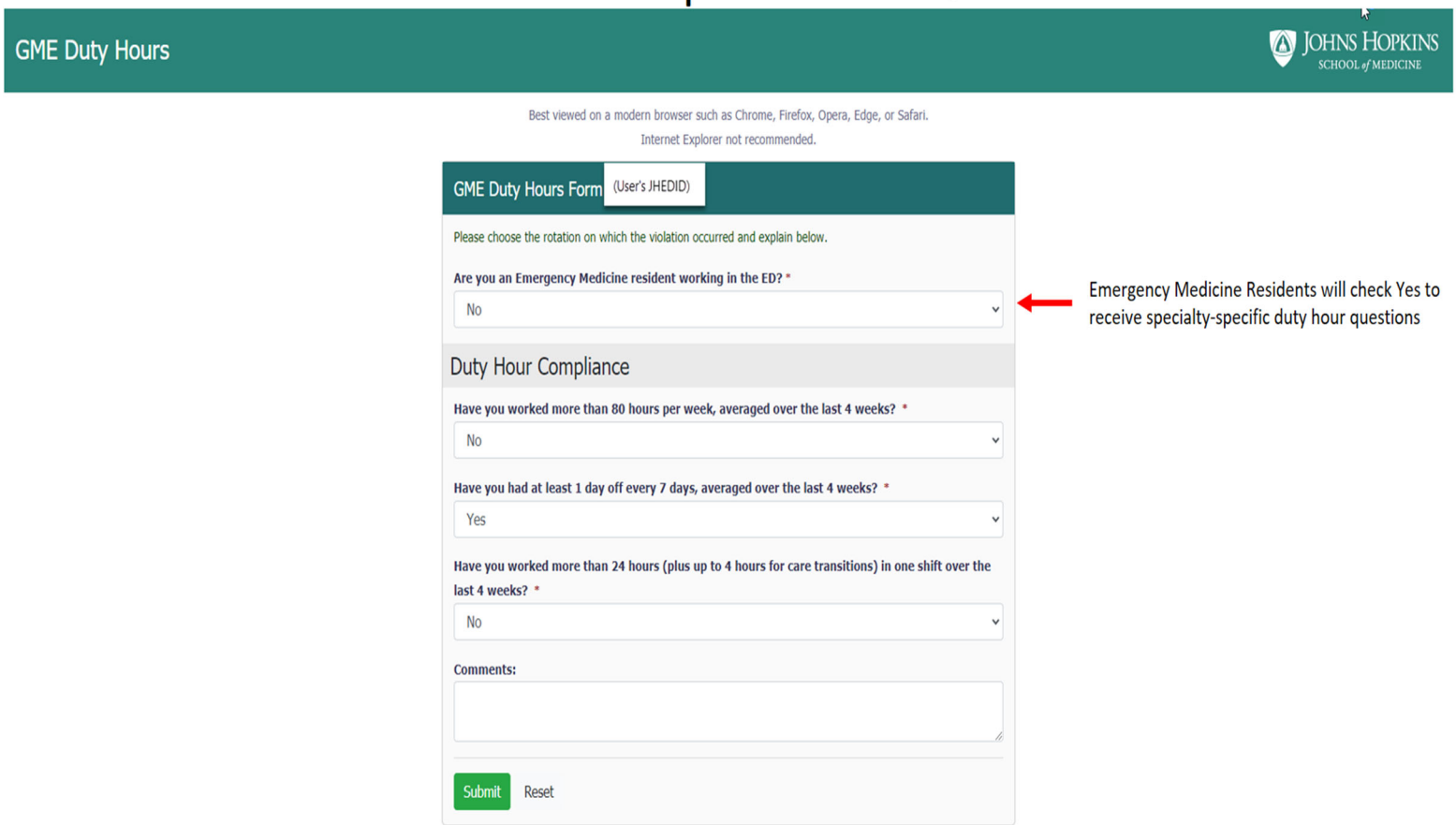
The attested duty hours should reflect the *actual time* that you worked (vs. the scheduled time). ***Please note, however, that this time should NOT include your time to sign out.*** Additional time attested to should be related to continued patient care if it was required after your shift was completed.

It is important to note that any trainee who works "Additional Shifts" or "Moonlighting" shifts MUST log these shifts in New Innovations (not the GME tool) because that is our only system for tracking this work and must be completed for compliance oversight. Leaves of absence and vacations are excluded from attestation and do not need to be logged.

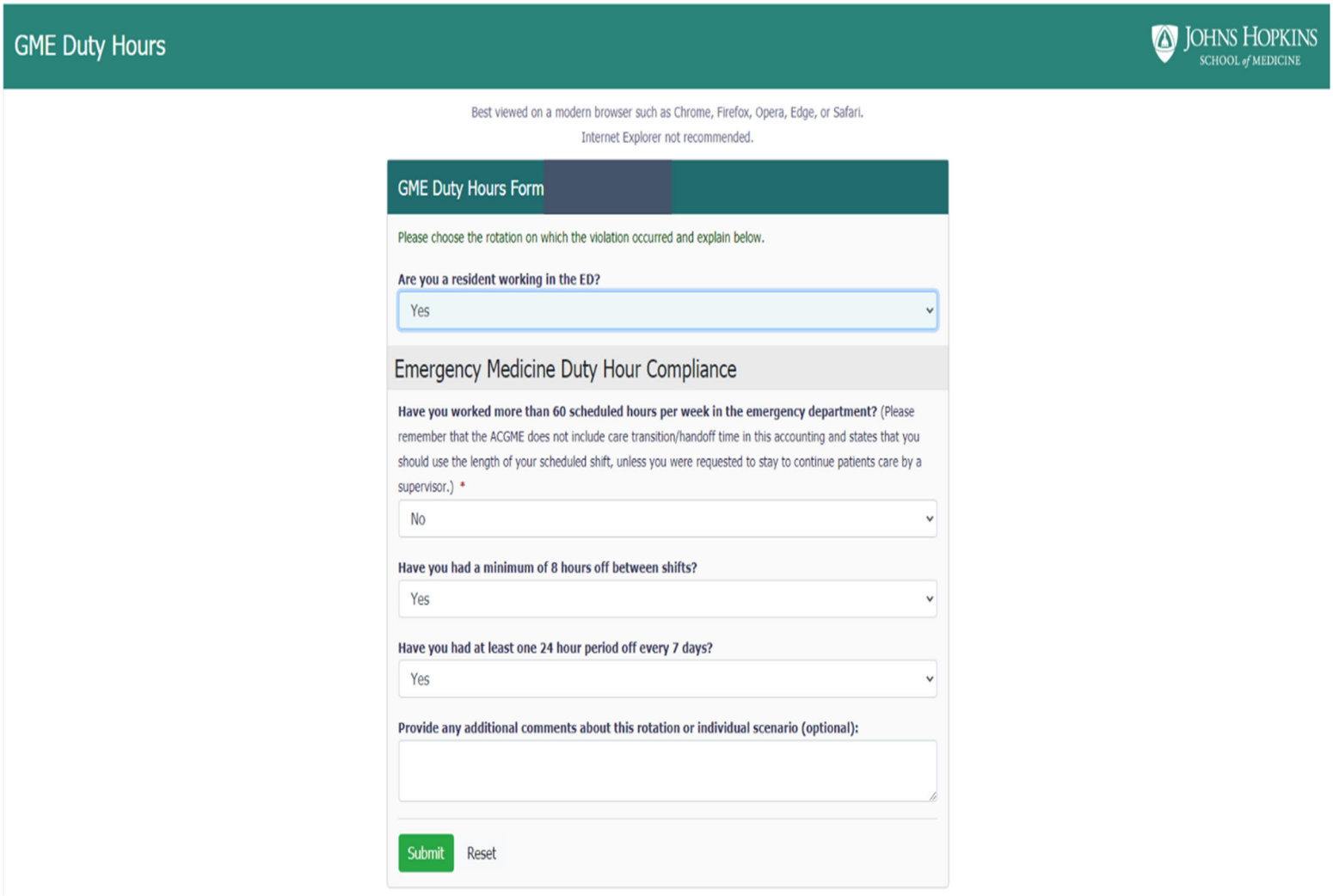
Trainee View - Log In Screen



Trainee View – Compliance Questions



Emergency Medicine Residents will check Yes to receive specialty-specific duty hour questions


GME Duty Hours
JOHNS HOPKINS
SCHOOL of MEDICINE
Best viewed on a modern browser such as Chrome, Firefox, Opera, Edge, or Safari.
Internet Explorer not recommended.
GME Duty Hours Form
Please choose the rotation on which the violation occurred and explain below.
Are you a resident working in the ED?
Yes
Emergency Medicine Duty Hour Compliance
Have you worked more than 60 scheduled hours per week in the emergency department? (Please remember that the ACGME does not include care transition/handoff time in this accounting and states that you should use the length of your scheduled shift, unless you were requested to stay to continue patients care by a supervisor.) *
No
Have you had a minimum of 8 hours off between shifts?
Yes
Have you had at least one 24 hour period off every 7 days?
Yes
Provide any additional comments about this rotation or individual scenario (optional):
Submit
Reset

Are you a resident working in the ED?

Yes

Emergency Medicine Duty Hour Compliance

Have you worked more than 60 scheduled hours per week in the emergency department? (Please remember that the ACGME does not include care transition/handoff time in this accounting and states that you should use the length of your scheduled shift, unless you were requested to stay to continue patients care by a supervisor.) *

No

Have you had a minimum of 8 hours off between shifts?

Yes

Have you had at least one 24 hour period off every 7 days?

No

Please choose the relevant rotation(s):

	Start Date	Program	Rotation
☐	Dec 29, 2020	[redacted]	
☐	Jan 05, 2021		
☐	Jan 12, 2021		
☐	Jan 26, 2021		

Please explain the reason for the violation(s) selected above:

Provide any additional comments about this rotation or individual scenario (optional):

Failure to Log Hours

The following are the guidelines for ensuring compliance with duty hours input:

Timely duty hours reporting:

- Residents are required *to attest to their duty hours once a month.*
- An initial reminder will be sent each month – the day after the end of each block.
    - Residents on this list have one week to submit their duty hours attestation.
- ***Appearance on the list again one week later will result in disciplinary action from the program, including assigned time in the program offices to complete duty hours logging.***
- Compliance is monitored by the Program Director as well as the GMEC.

Moonlighting and Additional Shift Policy

Moonlighting

1. PGY 1, 2 and 3 residents are not permitted to moonlight in any Emergency Department setting, however, may work additional shifts within Johns Hopkins Hospitals (see below) for payment in certain circumstances approved by the Program Director.
2. PGY 4 residents in good standing are permitted to moonlight internally or externally to Johns Hopkins as per the "Moonlighting in the PGY4 Year" section of the Residency Manual
3. Residents on visas are not permitted to moonlight, due to federal regulations

Additional Shifts

1. PGY 1-4 residents in good standing are permitted to work "additional shifts" for pay.
2. These are shifts in which the resident works in the same capacity as a resident physician (i.e., are not practicing independently as they would be while moonlighting) but receive additional pay for volunteering to work incremental hours
    - These shifts may occur in the Emergency Department during times of extenuating scheduling circumstances or may occur elsewhere in the hospital (e.g., ICU, Pediatric Emergency Department)
3. Residents on visas are not permitted to work additional shifts for pay, due to federal regulations

Hours Logging

1. Moonlighting and additional shift hours must adhere to the same limitations as documented in the Duty Hours section of the manual.
2. Moonlighting and Additional Shift hours must be logged in New Innovations
    - Moonlighting shifts must be logged using the "moonlighting" designation
    - Additional shifts must be logged using the "additional shift" designation
3. Payment for these shifts is withheld until hours are logged.

Monitoring

1. Residents are required to keep accurate records of their moonlighting and additional shift hours in the online New Innovations system.
2. All moonlighting and additional shifts must be approved in writing by Dr. Ehmann ***before signing up*** to ensure duty hours violations do not occur.

Moonlighting in the PGY4 Year

EM4 residents can moonlight at urgent care facilities or in the RAP area of JHH and JHBMC if they are in good standing. All moonlighting requests must be approved by the Program Director and the Dean's office. Applications are available online, and in the Emergency Medicine office. Moonlighting hours are not part of the mandatory annual hours required by the residency program (i.e. 1080 clinical hours).

- Duty hour regulations apply to moonlighting, must be logged, and cannot violate ACGME guidelines
- For Residents currently working on clinical services, the limit for moonlighting hours is up to 600 hours per year.
- All moonlighting activities require independent medical licensure and DEA registration
- Moonlighting activities that are independent of Johns Hopkins require malpractice insurance.
- Residents leaving a moonlighting shift must have at least 8 hours without duties for rest prior to commencement of standard resident duties.
    - This includes possible jeopardy shifts (i.e. a moonlighting resident cannot work an overnight moonlighting shift that ends at 7AM if they are scheduled to start a jeopardy shift at 7AM)
- Residents who violate any of the above policies are subject to suspension of moonlighting privileges. If a resident moonlights while privileges are suspended, he/she is subject to termination under this policy.

Requirements

Your education and meeting your residency graduation requirements are of paramount importance, and we wish to ensure that you are well-positioned to meet those requirements safely while also taking the time to moonlight.

These requirements shouldn't be burdensome as they are part and parcel of your progress and requirements as a senior resident nearing graduation! The Clinical and Educational teams have agreed that we must ensure that your basic residency requirements are met before you are given the opportunity to take on additional clinical responsibilities.

So, to be able to moonlight/sign up for extra shifts for pay as a PGY4, we require that, as of June 30 of your PGY3 year, you meet the following criteria to be eligible for these shifts next year:

- Completion of minimum of 60 chart reviews and follow ups (and then complete 80 by Dec 31 to continue moonlighting in latter half of year)
- Completion of all requirements for US for at least 4 indications (and then complete at least 6 by Dec 31 to continue moonlighting in latter half of year)
- Progress towards procedures required by the RRC for graduation (and have all graduation requirement procedures done and logged by Dec 31 to continue moonlighting in latter half of year) – specifically, by June 30 of PGY3, you should have completed:
    - 100% of required adult medical (45) and trauma (35) resuscitations, intubations (35), central venous access (20), and vaginal deliveries (10), pediatric medical (15) and trauma (10) resuscitations
    - Up to date log of all high-acuity procedures completed in cadaver lab (cric, chest tube, etc)
    - Up to date log of all cardiac pacing completed with Dr. Omron in SIM and in clinical setting
    - Meeting 80% of remaining procedures required by RRC/ACGME for graduation

- PGY3 Sullivan modules (and then complete PGY4 Sullivan modules by Dec 31 of PGY4 in order to continue moonlighting in latter half of year)

Many of you will probably apply for your Maryland license at some point during your PGY3 year, and the fee is usually reimbursed by the department if you intend to moonlight at JH. However, if you are unable to meet the requirements noted above, and the department has paid for your license but you subsequently are unable to moonlight/sign up for extra shifts due to incomplete requirements, you will be expected to reimburse the department for the MD license fees.

Additional considerations include:

1. Educational opportunities
    - During the first half of the year, we will not allow any moonlighting that requires sacrificing an educational commitment (eg, no moonlighting from Thursday 7PM to Friday 7PM, and no moonlighting on Saturday-Wednesday, if signing up for a moonlighting shift would mandate missing Friday conference to avoid violating duty hours), as there is no allowance for missing educational opportunities for moonlighting opportunities
    - During the second half of the year, we will analyze moonlighting requests that might interfere with Friday conference on a case-by-case basis and approve only if the resident's conference attendance is well over the required minimum to date.
2. Your health and wellness!
    - Scheduling of moonlighting/extra pay shifts will be reviewed by residency and clinical teams to ensure that schedules remain sustainable and not overly onerous as we value your wellness and are mindful of ensuring each of you do not sacrifice your well-being for moonlighting opportunities.

Elective Policy

Each EM3 resident will have one block (four weeks) elective during their EM3 year. In addition, EM4 residents can schedule additional elective time during their final year of training.

1. Residents who wish to do an away elective must submit a request in writing at least twelve (12) weeks (90 days) in advance of the elective start date. Electives must be approved by the residency executive committee and the Dean's office (see appendix for Elective Rotation Form).

2. All elective requests will be dependent on the resident's good academic standing. Residents who are on academic probation may lose the right to determine their elective, whereupon the Residency Director(s) will determine how that month will be spent.

3. If no elective request submission is completed twelve (12) weeks prior to the start date, it will be assumed that the resident is working in the JHED during their elective block and will be scheduled accordingly.

4. Only one away elective will be allowed during the first three years of residency, except in special situations approved by the PD.

5. It is possible that certain 2nd year rotations can be delayed until the 3rd year to move the elective to the 2nd year. Requests to move the elective into the 2nd year must be discussed with the Program Director for approval.

6. Residents must plan their elective experience and remain cognizant of their ability to meet their annual conference attendance requirement regardless of the elective location.

Code of Conduct for Work and Travel Abroad as a

Representative of Johns Hopkins Resident Physicians

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1. I will hold myself to the highest standards of professionalism, respect and courtesy.

2. I will treat all persons, including patients, families, visitors, employees, trainees, and colleagues with respect, courtesy, caring, dignity.

3. I will recognize and sensitively attend to the needs of individuals from diverse backgrounds.

4. I understand the same standards of professionalism apply when I am abroad as when I am in my home institution, including disclosing my status as a trainee, discussion of patient care with a supervising preceptor, and obtaining consent for medical care or procedures in an ethically and culturally appropriate manner.

5. I will be sensitive to cultural differences in standard(s) of care, and I will respect unfamiliar but contextually appropriate diagnostic and treatment paradigms.

6. When engaged in clinical care, I will care for patients under the direct supervision of the local preceptor. I will only deliver clinical care within the scope of my abilities in the practice of Emergency Medicine.

7. When performing research, I will ensure that I maintain the same ethical and institutional safeguards that are in place at my home institution; including obtaining appropriate institutional review board approval and informed consent, when required.

8. I will respect the patient's decision-making capacity and right to privacy. This includes participation in photographs and social media.

9. I will be responsible for my own personal health and well-being including personal safety during the elective. This includes, but is not limited to: obtaining safe modes of travel (e.g. not riding scooters, motorcycles, or ATVs), making responsible decisions regarding my personal safety at night, and understanding inherent safety risks that are possible when traveling abroad.

10. I will demonstrate cultural competence throughout my elective experience, through all facets of my personal and professional behavior.

11. I will not drink to excess or use illicit drugs.

Consequences for violation of the code of conduct:
At the discretion of the residency leadership, residents who violate the code of conduct may be removed from the rotation, asked to return financial support provided by the residency, and/or considered for formal academic disciplinary action.

Appendix
Code of Conduct for specific rotations

Bermuda
No scooters, motorcycles, or ATVs

Africa
1. No scooters, motorcycles, or ATVs
2. FAA approved airlines for travel, intercontinental included, only
3. HIV prophylaxis for needle sticks

Middle East
1. Appropriate attire when required
2. No scooters, motorcycles, or ATVs

Europe
No scooters, motorcycles, or ATVs

***According to WHO, tourists are 10x more likely to die as a result of trauma than infectious disease.**

JHU institutional policy
https://studentaffairs.jhu.edu/policies-guidelines/student-code/

I have read and understand the departmental and institutional code of conduct policies. I will follow it to the best of my ability, and adhere to the standards set before me as a representative of Johns Hopkins and Emergency Medicine as a specialty.

Signature_____Date _____

Printed Name _____

Witness _____

Jeopardy Policy

1. All residents will be assigned approximately sixteen weeks of jeopardy during their residency training according to the jeopardy block schedule (see below).
2. For every PGY class, only continuous 24 hours jeopardy coverage is permitted. Meaning, (as an example) if you are on a jeopardy block and want someone to cover your jeopardy, you cannot ask 3 people to cover you from 7-3pm/3pm-11pm/11pm-7am; you will have to find one person to cover you for 24 hours straight from 7am-7am. If there is a specific situation where you think you cannot achieve that and you require less than 24 hours of coverage, please e-mail Dr. Ehmann to discuss.
3. The only events that will be considered for activation of the jeopardy system will be acute illness or family death. All other events requiring scheduling adjustments (such as elective procedures, interviews, child care, etc) must be addressed in some other way.
4. If a resident is considering activating jeopardy on any rotation, the EM scheduling chief resident must be notified as soon as possible to allow appropriate time for arranging coverage.
    - *All jeopardy calls must go through the scheduling chief resident at the time of activation of the system. If the scheduling chief is not available, the admin chief resident must be notified. If the scheduling and admin chiefs are not available, the education chief must be notified.*
    - *If the chief residents are not available, the PGY class APD must be notified*
    - *If the chief residents and PGY class APD are not available, the PD must be notified*
    - *If the chief residents, the APDs, and Dr. Ehmann are not available, Dr. Regan must be notified.*
    - *If none of the above are available, please contact the on-shift JHH ED Attendings for assistance*
5. To activate the jeopardy system, the resident should call the designated EM chief resident first to gain approval. Once approval is granted, the primary jeopardy person will be notified both by the chief resident and by the activating resident. Repayment of the shift should be addressed at the time of these conversations.
6. Jeopardy residents must remain within a **one-hour** radius of Baltimore. Residents may not be on jeopardy during vacation!
7. For the duration that you are on jeopardy, residents may not be under the influence of ANY substances that might impair judgment. This includes alcohol, illicit drugs, and certain medications. If you are activated for jeopardy and believe you are under the influence of any substance, you MUST alert the chief residents that you cannot work.
8. All jeopardizations are to be paid back hour for hour in similar shifts (weekend for weekend, night for night, weekday for weekday).
9. Within one week of jeopardy activation, the resident activated for jeopardy coverage must identify an equivalent shift within the next block that he/she will have paid back by the covered resident. If both residents prefer, or if a shift is not identified within one week, the Chief Residents will identify and assign a shift for pay back during the next block. When the responsible residents are not in the ED in the next block, a shift will be selected during the next block in which both residents are either assigned to, or available to work in, the ED.
10. If a resident fails to be available for jeopardy activation, they must pay back the department twice the time covered and are placed on academic alert.
11. All activations of this system will be tracked by the chiefs and reported to the Residency Executive Committee.
12. There will be no PGY1-3 jeopardy during the Christmas and New Year's holidays; PGY4 primary and secondary jeopardy covers all resident shifts during these holidays.
13. There will be no resident jeopardy for fellows or PA staff. Fellows and PA staff will arrange

their own separate jeopardy system to be administered by their respective fellowship and fellowship directors or administrative staff.

14. Non-EM rotators scheduled in the ED: IM covers missed shifts by IM residents and/or interns.
15. If the jeopardy resident for a particular class is unavailable to be activated (for duty hours or any other reason), the next most senior jeopardy resident will be activated (i.e. PGY2 jeopardy resident is unavailable so PGY3 jeopardy resident will be activated) in order of seniority.
16. When jeopardy activation is for an off-service rotation and a more-senior resident is activated, the jeopardized senior resident works the simultaneous ED shift for the JHED co-resident of the activating resident; that co-resident, originally assigned to the ED, will report to the off-service rotation for the activating resident (e.g. PGY2 jeopardy resident is activated for a PGY1 MICU shift: the EM intern working clinically in the ED will cover the activating resident's MICU shift and the PGY2 jeopardy resident will work the EM intern's ED shift).

Fourth Year Pre-Attending Jeopardy Policy

1. PGY4s will be assigned to jeopardy shifts by the PGY4 scheduler
2. The only events that will be considered for activation of the jeopardy system will be unplanned emergencies (i.e. does not include finding coverage to participate in an event in your specific niche). All other events requiring scheduling adjustments require the resident to find appropriate coverage.
3. All jeopardy calls must go through the PGY3 Chief Residents at the time of activation of the system.
4. All jeopardy repayment should be hour for hour in similar shifts (weekend for weekend, weekday for weekday), unless both parties agree otherwise
5. If a resident fails to be available for jeopardy activation, they must pay back the department twice the time covered.
6. Payback must be arranged and reported to the chief residents, who will track and review with the Residency Executive Committee.
7. To activate the jeopardy system, the activating PGY4 should call the PGY3 chief residents. Once approval is granted, the primary jeopardy person will be notified. Repayment of the shifts will be facilitated by the chief residents via email.
8. PGY4 residents may be required to cover non-fourth year roles / residents in the department when situations arise that require this. When a PGY4 jeopardy resident is activated for a non-PGY4 resident, Dr. Ehmann or the Program Director on call that day must be notified when jeopardy is activated.

	PGY1*	PGY2**	PGY3***	PGY4
Monday	HCPeds	Research	HCED	PGY4
Tuesday	HCPeds	Research	HCPED****	PGY4
Wednesday	HCPeds	Research	HCED	PGY4
Thursday	HCPeds	Research	HCED	PGY4
Friday	HCPeds	Ortho	HCED	PGY4
Saturday	US, Anesthesia, Rads-EMS, Tox-EKG	PA, Adv-US	HCED	PGY4
Sunday	US, Anesthesia, Rads-EMS, Tox-EKG	Research	HCED	PGY4

*HCPED resident must self-schedule to have 24 consecutive hours off every weekend
**1/2 blocks without Res, Adv-US, Ortho or PA will be covered by PGY3 and PGY4
***HCED resident must self-schedule to have 24 consecutive hours off every Tuesday
****HCPEDs not essential staff so can skip a Wednesday shift if called in for Tuesday night

Resident Disaster Deployment Plan

Introduction

The Johns Hopkins Emergency Medicine Residency Program [Residency Program] is a vital component of the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center's Emergency Departments' ability to treat all patients, regardless of circumstance.

This plan is designed to ensure that the Residency Program can continue to serve the community during any situation, including all-cause disasters, epidemics/pandemics, mass casualty incidents and other times of crisis.

The Residency Program is dedicated to supporting our institutions to the best of its ability and recognizes that sometimes circumstances dictate that we focus our resources on our core clinical mission – Emergency Medicine.

Please note that the Residency Program Director (or designee) [PD] may adjust this response plan, as needed, to meet the needs of the specific situation and will communicate with departmental and institutional leadership.

Objective

To ensure that the Johns Hopkins Emergency Medicine Residency Program can continue to serve the community during any situation, including all-cause disasters, epidemics/pandemics, mass casualty incidents and other times of crisis.

Priorities

This list is the order in which the Residency Program will prioritize resident scheduling. The goal will always be to fill all shifts, however, if this is impossible, the following priority order will be followed.

1. Emergency Department Rotations
    a. Johns Hopkins Hospital Emergency Departments (AED and PED)
        i. Priority shifts that must be staffed
            1. Red: PGY4, Senior, Junior
            2. Blue: Senior, Junior
            3. South B (Purple)
        ii. Other shifts that may or may not be staffed at PD discretion
            1. South A (RAP)
            2. Pediatric Emergency Department longitudinal shifts
    b. Bayview Emergency Department
        i. Priority shifts that must be staffed
            1. All PGY2 and PGY3 shifts
        ii. Other shifts that may or may not be staffed at PD discretion
            1. Tuesday "double coverage" A & P shifts
            2. All PGY1 shifts
    c. Intensive Care Unit Rotations
        i. MICU – PGY1
        ii. CCU – PGY1
        iii. PICU – PGY2
    d. All Other Rotations (in order of least essential > most essential for staffing)
        i. Elect – PGY3 (should be cancelled first)

ii. HC-ICU – PGY3
iii. Res – PGY2
iv. Tox-EKG – PGY1
v. Rads-EMS – PGY1
vi. Ortho – PGY2
vii. BVHand – PGY2
viii. Adv US – PGY2
ix. US – PGY1
x. PA – PGY2
xi. JH Anes – PGY1
xii. HCED – PGY3
xiii. HCPeds – PGY1, PGY3 and PGY4
xiv. BVBurn – PGY3
xv. OB – PGY1
xvi. STC-Anest – PGY2
xvii. JHPeds – PGY1 (should be cancelled last)

e. National/Regional Conferences, Classwide Retreats and Vacations
   i. Please note that these may be cancelled at any time at the discretion of the PD

Emergency Plan

- **Level 1 (No Threat): Routine Operations**
  - Notification
    - No additional notification to Residents required
  - Priorities
    - Safety of personnel
    - Maintain standard and normal operations
  - Operational Impact
    - None
  - Staffing Contingencies
    - None
    - Continue with primary jeopardy plan
  - Other
    - None

- **Level 2 (Alert for Identified Threat): Routine operations are not disrupted**
  - Notification
    - Residents to be notified of potential threat (via email and in person, if safe to do so)
  - Priorities
    - Safety of personnel (including consideration of especially at-risk staff members, depending on threat)
    - Maintain standard and normal operations
  - Operational impact
    - None
  - Staffing contingencies
    - Expanded back-up jeopardy system established

        - Residents on all Other Rotations (see above) and those included in expanded back-up jeopardy system notified that they may be needed to provide additional coverage for priority staffing in the ED
        - Reassignment of residents to priority areas at the discretion of the PD
        - Consider reassignment of residents with high-risk health conditions based on threat and at the discretion of the PD
    - Other
        - None

- **Level 3 (Active Threat): Contingency operations necessary**
    - Definition
        - Normal operations expected to be, or are, disrupted (eg, multiple residents expected to be, or are, unavailable simultaneously due to illness, quarantine, etc)
    - Notification
        - Residents to be notified of active threat (via email and online/group texting thread/channel)
        - Consider individual phone calls from PD/APDs to members of each Residency class
    - Priorities
        - Safety of personnel (including consideration of especially at-risk staff members, depending on threat)
        - Staffing the Emergency Departments
        - Staffing the ICUs
        - Staffing of any non-essential rotation thought to be high need/high impact, as able
    - Operational impact
        - Additional burden to the health care system
            - For Disaster/MCIs refer to internal disaster plans of each institution
        - Normal operations expected to be imminently disrupted or are already disrupted
        - Clinical burden exceeds system capacity, unlikely to staff any non-EM or non-ICU rotations
    - Staffing Contingencies:
        - Residents on all Other Rotations (see above) and those included in expanded back-up jeopardy system notified that they may likely be needed to provide additional coverage for priority staffing in the ED
        - At PD discretion, some or all residents may be called in
        - When activated, primary jeopardy goal within 1 hour and expanded back-up jeopardy activation within 3 hours
    - Other
        - Cancellation of the following is at the discretion of the PD
            - Electives
            - Travel to National/Regional Conferences
            - Non-essential rotations
            - Vacations
        - Change ED shift times to 12 hours at the discretion of the PD

- **Level 4 (Critical Threat): Crisis operations**
    - Definition
        - Normal operations significantly disrupted with inability to staff EDs
    - Notification
        - Residents to be notified of critical threat (via email and establish online/group texting thread/channel
        - Individual phone calls from PD/APDs to members of each Residency class
    - Priorities
        - Safety of personnel (including consideration of especially at-risk staff members, depending on threat)
        - Staffing the Johns Hopkins Hospital Emergency Department
        - Staffing the Bayview Emergency Department at the discretion of the PD
        - Staffing any non-JHED rotation determined to be high need/high impact (as able, although extremely unlikely)
    - Operational Impact
        - Normal operations are significantly disrupted
        - Unable to staff Emergency Departments
        - Clinical burden exceeds system capacity, unlikely to staff any non-EM rotations
    - Staffing Contingencies:
        - Residents on all Other Rotations (see above) and those included in expanded back-up jeopardy system notified that they will be needed to provide additional coverage for priority staffing in the ED
        - At PD discretion, any resident may be called in
        - When activated, goal within 1 hour for all residents
    - Other
        - Cancellation of the following
            - All non-Emergency Medicine rotations
            - All electives
            - All travel
            - All vacations
        - Shift lengths at the discretion of the PD
            - Consider 12 to 24-hour shifts

PARENTAL LEAVE POLICY

The Department of Emergency Medicine Residency supports residents taking time off as new parents. When a resident becomes aware they or their partner are pregnant, they should arrange a time to meet with the residency leadership as soon as they are comfortable doing so to discuss scheduling changes that will meet their needs.

Please note there are two policies that govern how a resident may choose to proceed: the ABEM Policy on Parental, Caregiver and Medical Leave and the Johns Hopkins New Child Accommodations Policy. The ABEM Policy allows for up to 8 weeks of time off ONLY when the first 6 weeks of that leave have already been used for family or medical leave. This 8-week timeframe is INCLUSIVE of the resident's vacation time and must be decided by the program director based on the resident's progress meeting milestones and attainment of required competencies. Should a resident be deemed by the PD to need more clinical experience to progress to the next year, residents must be aware that ABEM would NOT allow for leaves of more than 6 weeks at a time during a single academic year without requiring extension of residency training. ABEM Link.

The JHU New Child Accommodations policy states that postdoctoral trainees may request from their school a "new child accommodation" for 8 weeks. A new child accommodation is designed to make it possible to maintain the parent's existing status, and to facilitate their return to full participation in classwork, research, teaching, and clinical training in a seamless manner. Individuals who have teaching or research duties should work collaboratively to support the program's responsibility in identifying a substitute for any duties or recurring responsibilities for the duration of the accommodation period. Those requesting an accommodation will not be expected to assume sole responsibility for finding their own temporary replacement, but must work with their program and supervisor(s) to delineate the responsibilities to be addressed.

The JHU Policy below applies equally to birth and non-birth parents of any gender. To the extent possible, the request should be submitted in advance of the beginning of the accommodation. Retroactive requests (more than one week after the new child accommodation has begun) will not automatically be granted but handled on a case-by-case basis.An accommodation is to be taken continuously and not intermittently and is not to continue beyond the end date of any appointment

More details and contact information can be found at
https://www.jhu.edu/assets/uploads/2017/06/newchildaccommgradandpostdoc.pdf

Policy Statement

Johns Hopkins University recognizes the importance of balancing the family and academic responsibilities faced by new parents and promoting the well-being of their families. The University is supportive of accommodating eligible full-time graduate students and full-time postdoctoral fellows, scholars and trainees (collectively "postdoctoral trainees") who are expecting a new child. Consistent with grant funding policies that place a limit of 8 weeks for parental leave, all eligible full-time graduate students and postdoctoral trainees shall receive no less than 8 weeks of fully-paid new child accommodations.

Each school has in place provisions for taking a formal leave of absence, which is an option at any time for students and trainees who are new parents. Electing this option relieves students of all university responsibilities but comes with consequences that may suspend students' privileges and access to university benefits and resources. This option may also have visa consequences for international students. The goal of this Policy is to put in place a set of guidelines for full-time graduate students and postdoctoral trainees who have new family additions who do not elect a formal leave of absence.

Purpose

The University is committed to providing a learning environment supportive of its students in their pursuit of productive and fulfilling academic, professional, and personal lives. The purpose of this Policy is to provide an overview of the eligibility requirements, benefits provided, and procedures required to utilize new child accommodations.

Definitions

All Divisions of the University

Eligible Full-Time Graduate Student	A full-time graduate student who is admitted to a graduate program, and engaged in a full-time program of courses, credits, seminars and/or research as approved by the Chair of the department/program or designated faculty member. The Chair of the department/program or designated faculty member certifies each student's status at the beginning of every semester or quarter. Students may not be simultaneously enrolled at another university.
Eligible Full-Time Postdoctoral Trainee	A postdoctoral trainee is one who: • Has been awarded or has completed the requirements for a doctoral degree (e.g. Ph.D., M.D., D.D.S., Pharm.D., D.V.M., D.P.H., D.N.S.) or foreign equivalent, is engaged in a temporary or defined period of mentored advanced training to enhance the professional skills and research independence needed to pursue his or her chosen career path, and is paid through Johns Hopkins University payroll; • Has been issued a formal letter of appointment by the University (via the relevant school/entity) that sets forth the salary, terms, and expectations of the appointment; and • The expected duration of the position will exceed six months. The designated faculty member or Principal Investigator shall determine the full-time status of a postdoctoral trainee. Throughout the University, postdoctoral trainees are commonly referred to as "fellows". For the purposes of this Policy only, the term "Postdoctoral Trainee" shall apply to postdoctoral fellows, scholars, and trainees. **School of Medicine only** For the purposes of this Policy only, "postdoctoral trainees" shall apply to interns, residents, fellows, and trainees (otherwise known as "postdoctoral trainees" or "house staff").
Child	Biological or adopted child, or stepchild.
Parent	Biological, adoptive, or surrogate parent, or the domestic or marital partner of a biological or adoptive parent.

	For the purposes of confirming the family relationship, eligible full-time graduate students and full-time postdoctoral trainees must provide the University with a copy of one official document (birth certificate, hospital discharge papers, adoption paperwork, or pediatrician note) within 15 days of the birth or placement. Domestic or marital partners of biological or adoptive parents will be required to provide the University with documentation to confirm the existence of the partnership (e.g., marriage license, affidavit of marriage/domestic partnership).

Policy

New child accommodations. Full-time graduate students and postdoctoral trainees may request from their school a "new child accommodation" for 8 weeks. A new child accommodation is designed to make it possible to maintain the parent's existing status, and to facilitate their return to full participation in classwork, research, teaching, and clinical training in a seamless manner.

Individuals who have teaching or research duties should work collaboratively to support the program's responsibility in identifying a substitute for any duties or recurring responsibilities for the duration of the accommodation period. Those requesting an accommodation will not be expected to assume sole responsibility for finding their own temporary replacement, but must work with their program and supervisor(s) to delineate the responsibilities to be addressed.

The Policy applies equally to birth and non-birth parents of any gender. Accommodations begin on the day the student or trainee indicates they are no longer fully engaged in their professional and academic activities due to a new child and, to the extent possible, should be requested in advance of the beginning of the accommodation. Retroactive requests (more than one week after the new child accommodation has begun) will not automatically be granted but handled on a case-by-case basis. An accommodation is to be taken continuously and not intermittently and is not to continue beyond the end date of any appointment.

Full-time graduate students: Students approved for a new child accommodation are guaranteed to retain the same rights and privileges as all other students, including remaining registered and matriculated in a degree program. If the student is receiving tuition, stipend support, and benefits from a training grant, fellowship, or scholarship, these will remain unchanged during the accommodation period contingent on the policies of the entity providing funding. Fully-funded students will not lose any financial support during the approved accommodation period, but the accommodation will not provide financial support or additional benefits if none were already in place. Further, students receiving less than full-funding support or who receive wages for other types of employment or federal work-study are not guaranteed such support during the accommodation period. Students should consult the Office of Student Financial Services for questions regarding financial support during accommodation periods.

During this time and to the extent the student can remain enrolled, the student is expected to work with their advisor, program administrator, and department to reschedule course assignments, examinations, and other academic requirements. To the extent that the demands of caring for a new child allow, students are expected to keep up with classes in which they are registered and participate in seminars. Faculty are expected to work with the student to make arrangements for

submitting work for completion of requirements, including assigning 'incomplete' grades consistent with school policies. Students will be granted a one-term extension of university and departmental requirements and academic milestones. Students in a primarily coursework- only program (e.g., master's students) or programs with specific course requirements that may only be offered during specific periods of time may have to revise their degree completion timeline based on when courses are offered as part of the normal academic schedule.

Full-time postdoctoral trainees: Individuals approved for a new child accommodation are guaranteed to retain the rights and privileges as employed postdoctoral trainees. Financial support will remain unchanged during the accommodation period, contingent on the policies of the funding entity supporting the trainee. This accommodation assures that the parent will not lose any financial support during the accommodation period; it does not provide financial support or additional benefits if none was already in place. No appointment period is extended by this accommodation, unless there is an explicit extension of the appointment agreed upon by the appropriate school official.

Postdoctoral trainees in accredited training programs (e.g. School of Medicine internships, residencies, and fellowships) may be required by certifying boards to make up time spent utilizing a new child accommodation in order to sit for the board exam. If additional months of training are necessary to complete program requirements as set by the applicable certifying board, an extended appointment period with salary and benefits will be granted.

Accommodations for Pregnant Students and Post-Doctoral Trainees. Pregnant graduate students and postdoctoral trainees are entitled to supportive and reasonable accommodations as necessary during pregnancy to assist with limited mobility, the handling of hazardous materials, and the possible adjustment of work hours and/or responsibilities. Individuals should work the disability coordinator of their schools (graduate student) or Occupational Health Services (postdoctoral trainees) to request these accommodations.

Additional accommodations. Separate from this university-wide Policy, new parents may combine (as per applicable school policies) a new child accommodation request with paid sick or vacation leave, short-term disability leave, or a change from full-time to part-time status. Graduate students who work as research or teaching assistants and postdoctoral trainees may also request unpaid leave be extended for up to 12 weeks as per the Family and Medical Leave Act. These accommodations are subject to the applicable university and school policies.

Johns Hopkins prohibits discrimination on the basis of any characteristic protected by applicable law, including discrimination on the basis of pregnancy. Any graduate student or postdoctoral trainee who believes that he or she has not been treated equitably under the provisions of this Policy, or has experienced retaliation because of seeking or obtaining accommodations of this Policy, may file a grievance with the Office of Institutional Equity.

Who is Governed by this Policy

- All full-time graduate students (masters and doctoral)
- All full-time postdoctoral trainees (including School of Medicine interns, residents and fellows)

Exceptions/Exclusions (if applicable)

Policy Enforcement

All Divisions of the University

Violations	Johns Hopkins University prohibits discrimination on the basis of any characteristic protected by applicable law, including discrimination on the basis of pregnancy. A faculty member, Principal Investigator, Training Program Director or other designated new child accommodation divisional contacts may not deny a request to use a new child accommodation without the express authorization of the Provost or their designee. Any student or trainee who believes that he or she has not been treated equitably under the provisions of this Policy, or has experienced retaliation because of seeking or obtaining accommodations of this Policy, may contact the appropriate divisional Dean or the Office of Institutional Equity. Failure of University faculty, staff, agents or offices responsible for providing the new child accommodations in accordance with this Policy and other applicable University, divisional, and unit policies, procedures, and applicable federal, state, and local laws or otherwise failing to follow the procedures outlined in this Policy is an explicit violation of this Policy.

Procedures

All Divisions

Graduate Students Requesting New Child Accommodations	Eligible graduate students who plan to utilize a new child accommodation are expected to notify the Chair of the department/program or designated faculty or staff member* as soon as the student is aware of the need to use a new child accommodation to facilitate appropriate scheduling. This should ideally be at least 90 days before the proposed start date of the new child accommodation. *For any questions you have about this process at your school or division, we have provided a list of useful divisional or school contacts below.
Postdoctoral Trainees Requesting New Child Accommodations	Postdoctoral trainees who plan to utilize new child accommodations are expected to notify their designated divisional faculty member or Training Program Director* as soon as the trainee is aware of the need to use a new child accommodation to facilitate appropriate scheduling.

	* For any questions you have about this process at your school or division, we have provided a list of useful divisional or school contacts below.
International Postdoctoral Trainees Requesting New Child Accommodations	In addition to following the Procedures outlined above, International postdoctoral trainees should consult with the Office of International Services.

Related Resources

All units

University Policies and Documents
Bloomberg School of Public Health: Leave of Absence Carey Business School: Leave of Absence Homewood (KSAS & WSE): Graduate Student Leave of Absence Homewood (KSAS & WSE): Postdoctoral Leave of Absence Peabody Institute: Leave of Absence School of Advanced International Studies: Deferral and Leave of Absence School of Education: Leave of Absence School of Medicine: Non-Medical Leave of Absence Policy for Postdoctoral Trainees School of Nursing: Leave of Absence or Withdrawal Breastfeeding Support Program
University Forms and Systems
Breastfeeding Support Program Registration Form

LEAVE FOR RESIDENTS

ABEM requires that residents must complete at least 46 weeks of training a year. Leaves of absence, vacation time, sick time, etc., that exceeds six (6) weeks in an academic year would require extension of the residency program. Such leave time cannot be accrued from year to year.

ABEM allows for a maximum of 8 weeks off per academic year for parental or sick leave without altering the date of graduation, provided the program director believes competency can been achieved without an extension in training.

Residents must have a minimum of 30 weeks of EM time in their final year and can work no more than 50 weeks of training in each year (ensuring they have 2 weeks of vacation).

The ABEM Policy on leave for residents

Policy#4.2-122 April 2021

Policy on Parental, Caregiver, and Medical Leave

BACKGROUND

This policy addresses specific instances where Emergency Medicine (EM) residents may take leave from training and still meet the training requirements needed to be eligible for certification by the American Board of Emergency Medicine (ABEM). This policy pertains only to personal or familial needs, including the birth and care of a newborn, adopted, or foster child ("parental leave"); care of an immediate family member (child, spouse, or parent) with a serious health condition ("caregiver leave"); or the trainee's own serious health condition ("medical leave"). Absences outside of these reasons may require extension of training (see Policy on EM Residency Training Requirements).

POLICY

The following criteria must be met to fulfill ABEM's eligibility requirements for certification in EM:

- The minimum amount of total training required to become proficient in the specialty is 138 weeks for an EM1-3 program and 184 weeks for an EM1-4 program.
- A minimum of 46 weeks of training is required for every training level.

  NOTE: An exception to the two bullet points above is that program directors, at their discretion, can grant an additional two weeks of time away from training per year to accommodate leaves of absence for parental, caregiver, and personal medical leave, or vacation time, provided that the program director attests that the resident is expected to meet competency expectations without an extension of training.
- In the final year of training, a resident must complete at least 30 weeks of training in the emergency department, including experiences dedicated to the care of pediatric patients less than 18 years of age, under the supervision of Emergency Medicine faculty members.
- Maximum training time per academic year must not exceed 50 weeks of training per academic year to ensure at least two weeks off per academic year.

PROCEDURES

The Board independently verifies with the residency director that a physician who has used this policy to obtain two additional weeks leave of absence has successfully completed the training necessary to fulfill the Board's eligibility criteria without extension of training.

These criteria cannot be appealed.

EXCEPTION

Residents who have been granted equivalent credit for training in other specialties or American Osteopathic Association–approved Advanced Standing Credit are not eligible for leaves of absence greater than six weeks per level of training without extension of training.

Residents in combined training programs are not eligible for additional leave and must adhere to the applicable combined training program guidelines.

National Conference Attendance Policy

Purpose:
This department strongly supports resident attendance and participation on a national level. The purpose of this policy is to provide guidance on planning and attending national emergency medicine conferences while ensuring coverage in the emergency department.

Policy:
Residents will be protected to attend the following conferences based on post-graduate year. This conference is funded by the residency. Additional conference funding will be evaluated on a case-by-case basis. Residents are expected to always act professionally.

EM-1: Maryland ACEP
EM-2: CORD, Maryland ACEP (when able)
EM-3: SAEM, Maryland ACEP (when able)
EM-4: A domestic conference that is relevant to their FAST focus. Some FAST mentors may have input into the choice of conference. This should be discussed with the individual FAST leaders. Maryland ACEP (when able)

The following parameters should be followed:

1. Each EM-4 resident will be reimbursed for one national conference of his/her choice.
2. During all major conference times, the EM-4 coverage will be maintained in the emergency department. The only allowed exception is for the end of year 4th year retreat.
3. All EM-4s will be free from staffing the emergency department for a retreat separate from conference time near the end of the academic year. The retreat, in June, will consist of 48 hours of consecutive time off. The retreat can be funded with wellness money provided equal distribution of funds to all resident classes to ensure equity, but the department will not specifically fund the retreat.

Clinical coverage:
While away, residents will be covered as follows:
EM-1s can be covered by any more senior resident.
EM-2s can be covered by any more senior resident.
EM-3s can be covered by any more senior resident (exceptions may be made during ACEP with PD approval)
EM-4s can be covered at the end of the academic year for their retreat by EM-3s for the EM-4 retreat.
Purple shifts can be covered by any non-intern resident.

If multiple residents wish to attend the same conference and ED staffing becomes a concern, priority will be based on:

1. Presenting at the conference.
2. Holding an appointed position in the hosting organization requiring attendance or participation in the conference.

The dates of protected time will be the dates of the conference plus 1 day-before allowing for travel.

For those residents attending a national conference for abstract/poster or didactic presentations (outside of the standard conference for their PGY level):

- Only 1 resident per presentation will be permitted to attend
- The cost of poster printing will be covered by the residency program
- Conference registration will be covered by the residency program for the date of the presentation only
- The presenting resident's hotel and per diems will be covered by the residency program from the day before the presentation until the day after. For instance, if your presentation is on the 15th, the program will cover your stay for the 14th – 16th, at most.
    - All efforts will be made to share rooms if more than one resident attends the conference.
- The policies listed above apply only to domestic conferences; if a resident has the opportunity to present at an international conference, the residency program will cover only the international conference registration fee (for the date of the presentation, as per above). Funding for international travel and accommodation must be supplied by the resident via other means.

Professionalism Policy

Professionalism is one of the 6 ACGME core competencies. There are many elements of professionalism, and we encourage you to help continue to develop the evolving construct of this attribute. Listed below are the characteristics used to measure professionalism within our residency program.

1. **Careful and Considered Communication**
   As emergency physicians, you are going to interact with other people. It is imperative that you choose your words carefully, that you consider what you say and how you say it. Remember that body language and facial expressions also communicate your message and thoughts without using words.

   Rumors and inappropriate comments can be very injurious, and as a physician leader, it will be your responsibility to avoid causing harm or injury by carefully selecting your words and tone of voice. Avoid rumors and gossip whenever possible. Failure to do so can adversely impact your professional well-being and the well-being of those around you.

2. **Punctuality**
   Being on time is not just a desirable attribute, it is necessary. However, arriving on time for your shift is not sufficient. A famous basketball coach once remarked that being on time is a bad habit. His reasoning was that players who show up at 8pm for 8pm game would not be effective. We ascribe to this same principle - you need to be early to mentally prepare and to focus on highly compassionate and efficient care for your patients. **Our expectation is that you arrive at least 15 minutes before each shift**. Habitual or repeated tardiness will be noted.

3. **Adherence to Policy**
   In this portfolio are listed a number of policies and requirements. Residents are expected to read the policies and requirements thoroughly to become familiar with the details. Adherence to all policies and requirements are mandatory.

   In addition, there will be times when you will be requested to perform an administrative task by a specified date, i.e. submit a proposal, or meet for your biannual review. These dates and times must be respected.

4. **Dress and Decorum**
   Resident's attire must be appropriate for a physician at Johns Hopkins. Our department has a dress code that all residents (and faculty) are expected to follow. **Blue jeans are not appropriate attire and should never be worn in the department or ED offices.**

5. Alcohol Usage

It is the expectation of the residency program that residents will drink responsibly. Unfortunately, our profession is one that is at high risk for substance abuse and as such, we are always on high alert about excessive alcohol usage by any of our colleagues. The following should be considered:

- While at any residency sponsored event, you should drink in moderation.
- It is NEVER acceptable to drink before heading to work. You should plan your drinking with the assumption that ANY alcohol remaining in your system is grounds for suspension if you are tested.
- All faculty and residents/fellows have a duty to report to an appropriate supervisor, in confidence, concerns about possible impairment in themselves and others.
- If you suspect anyone is under the influence at work, you must report it immediately. If you know someone is heading to work and is drinking, you must report it immediately.
- If it is determined there is concern for impairment, the program director has the right to send you for an evaluation for counseling and treatment. Refusal to participate in this process is considered grounds for disciplinary action and may lead to suspension or dismissal from the program.

JOHNS HOPKINS MEDICINE	Johns Hopkins School of Medicine **Graduate Medical Education (GME) Policies and Forms**	*Policy Number*	P&F012
		Effective Date	05/24/2023
	Subject **GMEC Physician Impairment Policy**	*Page*	1 of 3
		Supersedes	07/01/2019

Keywords: clinical fellow, impairment, professional behavior, resident, substance abuse

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I. PURPOSE

Impairment of performance by resident/fellow physicians can put patients at risk. Impairment shall be managed as a medical/ behavioral illness. Implicit in this concept is the existence of criteria permitting diagnosis, opportunity for treatment, and with successful progress toward recovery, the possibility of returning to training in an appropriate capacity. Impairment may result from depression or other behavioral problems, from physical impairment, from medical illness, and from substance abuse and consequent chemical dependency.

The goals of this policy are to (1) prevent or minimize the occurrence of impairment, including substance abuse, among residents/fellow in residency training programs sponsored by The Johns Hopkins University School of Medicine, (2) protect patients from risks associated with care given by impaired resident/fellow physicians, and (3) compassionately confront problems of impairment to effect diagnosis, relief from patient care responsibilities if necessary, treatment as indicated, and appropriate rehabilitation.

II. IDENTIFICATION OF IMPAIRMENT

Listed below are signs and symptoms of impairment. Isolated instances of any of these may not impair ability to perform adequately, but if they are noted on a continued basis or if multiple signs are observed, reporting may be indicated. The signs and symptoms may include:

1. Physical signs such as fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, eating disorders.
2. Family stability disturbances.
3. Social changes such as withdrawal from outside activities, isolation from peers, inappropriate behavior, undependability and unpredictability, aggressive behavior and argumentativeness.
4. Professional behavior problems such as unexplained absences, tardiness, decreasing quality or interest in work, inappropriate orders, behavioral changes, altered interaction with other staff and inadequate professional performance.
5. Behavioral signs such as mood changes, depression, slowness, lapses of attention, chronic exhaustion, risk taking behavior, excessive cheerfulness, and flat affect.
6. Drug use indicators such as excessive agitation or edginess, dilated or pinpoint pupils, self-medication with psychotropic drugs, stereotypical behavior, alcohol on breath at work, uncontrolled drinking at social events, blackouts, and binge drinking.

III. SCOPE

This policy applies to all residents/fellows participating in training programs sponsored by The Johns Hopkins University School of Medicine.

IV. RESPONSIBILITY

It is the responsibility of the program directors and faculty to communicate this policy to their residents/fellows and to enforce its provisions. Faculty and residents/fellows who suspect that a resident/fellow is suffering impairment shall follow this policy and its procedures.

V. PROCEDURE

A. Education

1. To try and minimize the incidence of impairment, a program has been developed to educate residents/fellows about physician impairment, including problems of substance abuse, its incidence and nature and risks to the physician and patients. Education includes knowledge concerning signs and symptoms of impairment. All residents/ fellows shall be informed at orientation about physician impairment, this policy and the resources available. All residents/fellows shall be given a copy of the University's Policy on Alcohol on Alcohol and Drug Abuse and Drug-Free Environment. All residents/fellows shall receive information regarding the counseling and referral resources available at the hospital at which the training program is based. At the Johns Hopkins Hospital, this consists principally of the Johns Hopkins Employee Assistance Program (JHEAP) and the Professional Assistance Committee (PAC). At the Johns Hopkins Bayview Medical Center, services are provided through the Community Psychiatry Program. In addition, residents/fellows training shall include participation in departmental presentations given by JHEAP and other professionals regarding physician impairment.

B. Counseling and Management

1. The following services are available to residents/fellows and their families:
   a. Assessment and identification of personal, family, or work-related problems
   b. Brief counseling and crisis intervention
   c. Follow-up appointments when indicated
   d. Referral to resources within Johns Hopkins and/or the community
2. The following services are available to administrators, managers and supervisors:
   a. Managerial consultation and coaching
   b. Risk assessments
   c. Educational workshops and programs
   d. Organizational group interventions

C. Reporting

1. All faculty and residents/fellows possess a duty to report to an appropriate supervisor, in confidence, concerns about possible impairment both in themselves and in others.
2. If a resident/fellow is observed and/or suspected to be impaired while engaged in the performance of his or her duties, the following actions shall occur:
   1. The observer shall report his/her concern to a responsible supervisor, ultimately the residency/fellowship Program Director. The individual making the report does not need to have proof of the impairment, but must state the facts leading to suspicions.
   2. The person to whom the report is made shall report the concern to the Program Director. The Program Director or his/her designee will investigate the matter, in a confidential process.

3. If it is determined that a resident/fellow may have an impairment problem, the Program Director is responsible to refer the resident/fellow to a counseling and treatment, such as that offered by JHEAP.

3. Failure of the resident/fellow to accept referral to counseling or to abide by the treatment program is considered grounds for disciplinary action and may result in suspension or dismissal from the program.

D. Self-Reporting

1. The University is eager to assist residents/fellows with impairment problems and encourages any resident/fellows with impairment problems to contact his or her Program Director or his hospitals counseling resources for assistance. Residents/fellows shall not be subject to punitive actions for voluntarily acknowledging an impairment problem. (Note, however, that this will not excuse violations of other policies for which the resident/fellow is subject to disciplinary action.)

E. Continuation of Training

1. In order for a resident/fellow to resume training after a referral, there shall be satisfactory evidence of the successful completion of or participation in an appropriate treatment program. Further, the resident/fellow shall agree to a provisional period during which time the resident may be monitored and/or tested periodically.

F. Confidentiality

1. The identification, counseling and treatment of an impaired resident/fellow are deemed confidential, except as needed to carry out the policies of the GMEC or University and as required by law.

Resident Supervision and Clinical Responsibility

I. LEVELS OF SUPERVISION

To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized:

1. **Direct Supervision** – the supervising physician is physically present with the resident and patient.

2. **Indirect Supervision**:

   a) **with direct supervision immediately available** – the supervising physician is physically in the emergency department and is immediately available to provide Direct Supervision.

   b) **with direct supervision available** – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities and is available to come to the site of care in order to provide Direct Supervision. This is applicable for non-emergency medicine rotations ONLY.

   c) **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. This is applicable for non-emergency medicine rotations ONLY.

II. CLINICAL RESPONSIBILITIES AND SUPERVISION

Each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for the patient's care and for the supervision of residents involved in the care of the patient.

Clinical responsibilities for residents will be conducted in an appropriately graduated manner, in accordance with residents' education, ability and experience. The attending may specifically delegate portions of care to residents based on the needs of the patient and the skills of the residents and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of junior residents to senior residents, but the attending must assure the competence of the senior resident before supervisory responsibility is delegated. Over time, the senior resident is expected to assume an increasingly larger role in patient care decision making. The attending remains responsible for ensuring that appropriate supervision is occurring and is ultimately responsible for the patient's care. Residents and attendings should inform patients of their respective roles in each patient's care.

Residents MUST communicate with the supervising attending of record:

1) When there is a change in the patient's clinical status, if the patient wishes to leave the department against medical advice (prior to the patient departing the ED), or if the patient elopes
2) When a patient requires sedation or restraint for patient or staff safety

3) When there is a circumstance that changes the plan of care or disposition
4) Prior to discharging a patient from the emergency department
5) Prior to performing any invasive procedure
6) When discussions regarding end-of-life care are taking place
7) If the resident has any questions or uncertainty regarding clinical management or diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care, that cannot be appropriately addressed by a senior resident

The following is a guide to the specific patient care responsibilities by year of clinical training. Resident responsibilities may vary based upon individual patient needs and the discretion of the attending physician.

The guidelines below describe clinical responsibilities and supervision when residents are in the emergency department, where an attending physician is on-site 24 hours per day (Johns Hopkins Adult and Pediatric Emergency Department, Bayview Emergency Department, Howard County Adult and Pediatric Emergency Departments)

When rotating outside of the emergency department, residents must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director. Unless otherwise stated, while residents are rotating on inpatient services, clinics and consultation services, intensive care units, and operating suites, they are subject to the faculty supervision requirements as detailed by the Johns Hopkins Graduate Medical Education Committee's Supervision of Postdoctoral Trainees Policy.

When rotating in other departments, residents may also be supervised by a clinical fellow to provide guidance for medical care delivery. Although the fellow may have significant decision-making capabilities for the service, there will be an attending physician who will ultimately be responsible for all medical decisions.

On all rotations, the circumstances listed below require a call to your attending physician. The call should take place as soon as is possible given the clinical situation.

1. Patient death
2. Code blue/cardiac or respiratory arrest
3. Transfer to a higher level of care and/or Rapid Response called
4. New consults (the rotation may specify if only certain consults require immediate call)
5. Medical error which has resulted in an adverse outcome or patient harm or near-miss
6. Patient's desire to sign out/sign out against medical advice (or if patient has already eloped)
7. Any other critical change in patient condition
8. Any time a clinician involved in the patient's care (e.g. physician, nurse, advanced practice provider, pharmacist) requests to speak with the attending
9. Any time a patient or family member has threatened or physically assaulted a member of the medical team
10. Any time you are unable to continue to work safely (for example, if you have significant fatigue, or are physically or mentally unwell). Please notify both the attending and the Emergency Medicine Chief Residents, if this occurs.
11. Any time there is a significant conflict regarding patient management

Note: Depending on individual circumstances, some calls could be made to a designated clinical fellow or chief resident. This must be specified by the rotation.

IIA. PGY1

Level of supervision

EM1 residents are primarily responsible for the care of patients under the close supervision of the attending physician or EM4 residents. They may also seek guidance from the EM2s and 3s. EM1 residents are initially directly supervised. When merited, at the discretion of the attending, unless otherwise stated by the program leadership, they will progress to being indirectly supervised with direct supervision immediately available by an attending or senior resident when appropriate.

EM1s present patients to the attending or EM4 after evaluation and prior to making a disposition decision or ordering significant diagnostic testing. Final disposition decisions must be approved by an attending physician.

Clinical responsibilities

EM1s will provide comprehensive care to non-critically ill patients in the emergency department. They will be expected to participate in major resuscitations and the care of critically ill patients as part of the greater team providing support as directed by the EM3, EM4, or attending physician. EM1s will develop the fundamental skills of practice of emergency medicine, and are expected to perform an appropriate focused history and exam, develop an appropriate differential of consequence, develop and implement basic treatment plans through admission or discharge, contribute to the healthcare team, gain experience with the management of critically and moderately ill patients, and work on managing patients in a time sensitive-manner.

IIB. PGY2

Level of supervision

EM2 residents are directly or indirectly supervised (with direct supervision immediately available) by an attending physician or EM4 but will provide all services under supervision. They may also seek guidance from EM3 residents. They may assist in supervising EM1 residents and may supervise medical students; however, the attending physician is ultimately responsible for the care of the patient. Final disposition decisions must be approved by an attending physician.

Clinical responsibilities

The EM2 year is geared to allow residents to continue to develop their efficiency, medical knowledge, and clinical skills; during this year, they will manage larger numbers of patients and be expected to care for critically ill patients.

Teaching responsibilities for EM2s in the clinical area are limited to teaching and assisting EM1s and medical students in minor procedures such as IV access and placement of foley catheters.

EM2s will develop an advanced capability in the practice of emergency medicine. They will develop skills in efficiency and are expected to perform an appropriate, timely, and focused history and physical, develop a differential of consequence for multiple patients, demonstrate leadership by being a resident supervisor of a healthcare team, develop proficiency in multi-tasking, develop and institute complex treatment plans for a variety of patients simultaneously, gain experience with the management of critically ill patients, develop and hone resuscitation skills, and provide rapid and appropriate care in the treatment of all emergency department patients in time sensitive manner, including low-acuity patients.

IIC. PGY3

Level of supervision

EM3 residents are directly or indirectly supervised (with direct supervision immediately available) by an attending physician or EM4 but will provide all services under supervision. They may supervise EM1 and EM2 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient. Final disposition decisions must be approved by an attending physician.

Clinical responsibilities

The PGY3 year permits residents to continue to hone their efficiency and clinical skills, while developing their own practice. EM3s routinely plan and begin to carry out diagnostic evaluations and treatment before presenting their patients to an emergency medicine trained-attending. Teaching responsibilities for EM3 residents include teaching and assisting EM1s, 2s, and medical students in procedures such as central line placement

EM3s will develop overall clinical competence in the practice of emergency medicine. They are expected to perform an appropriate, timely, and focused history and physical, develop a differential of consequence for multiple patients, demonstrate leadership by consistently serving as the resident supervisor of a healthcare team, develop proficiency in multi-tasking and interpersonal negotiations, develop and institute complex treatment plans for a variety of patients simultaneously, manage critically ill patients while overseeing the critical care team, develop and hone resuscitation skills, provide rapid and appropriate care in the treatment of all emergency department patients in time sensitive manner, including low-acuity patients, acquire necessary administrative skills, demonstrate supervisory and teaching skills, and develop overall competence in the practice of emergency medicine.

IID. PGY4

Level of supervision

PGY4s are directly supervised or indirectly supervised (with direct supervision immediately available) by attending physicians. They may provide direct patient care or supervisory care, with progressive graded responsibilities as merited. They must provide all services ultimately under the supervision of an attending physician. Senior residents should serve in a supervisory role of medical students, junior and intermediate residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior resident; however, the attending physician is ultimately responsible for the care of the patient.

Clinical responsibilities

The focus on the EM4 year is to demonstrate skill in the full spectrum of activities common to emergency physicians practicing in any clinical setting while still being supervised. This includes the direct provision of clinical care, supervision of the care provided by junior house officers, clinical and didactic teaching, and serving as a resource to handle administrative issues. EM4s will be assigned responsibility for supervising and teaching junior house officers. They will present all cases to emergency medicine trained faculty prior to disposition or at any earlier time, if they desire faculty guidance.

EM4s will develop overall independent and supervisory clinical competence in the practice of emergency medicine. They are expected to perform highly focused and expeditious history and

physical exams in a calm, deliberate, and caring manner, succinctly verbalize and document management plans including relevant differential of consequence for multiple patients, demonstrate leadership by supervising residents and managing multiple resident care teams, as well as providing education to residents and medical students. They will demonstrate leadership by serving as faculty and resident liaisons and serving as key negotiators among nursing staff, develop excellence in multi-tasking, hone skills in interpersonal communication and negotiation, develop and institute complex treatment plans for a variety of patients, including those with severe injury and minor illness simultaneously, oversee the management of critically ill patient while acting as a clinical and education resource for the team, demonstrate excellence in resuscitation, provide rapid and appropriate care in the treatment of all emergency department patients in time sensitive manner, including low-acuity patients, acquire necessary administrative skills, demonstrate excellence in supervision and teaching, and demonstrate outstanding clinical competence in the practice of emergency medicine.

III. SUPERVISION FOR PROCEDURES

Procedures considered within the scope of practice of an emergency medicine resident are listed below. Within the ED, residents will be able to complete these procedures with indirect supervision for non-critical portions and direct supervision for critical portions ONLY AFTER logging the corresponding minimum number of procedures which have been supervised directly by an attending physician or senior resident.

Procedural competency will be assessed via 1) assessment of satisfactory completion of key steps on procedure checklists and 2) procedure logs maintained by residents and approved by the attending of record for those procedures.

IV. FEEDBACK AND ASSESSMENT OF COMPETENCY

Feedback shall be verbally provided to each resident by a senior resident or faculty member at the conclusion of each shift, or, if a team is working multiple shifts together consecutively, also at the end of the stretch of shifts. Written feedback will be provided via faculty or senior resident evaluation of residents (on all rotations, mid- and end-block evaluations should be assigned to faculty, fellows or senior residents, as appropriate; on rotations in the Johns Hopkins or Bayview Emergency Departments, end-shift rotations should be assigned at each shift). Residents also receive feedback on their performance on a semi-annual basis from program leadership. Any significant issues about clinical performance, degree of supervision, or supervisory capacity are to be brought to the attention of the program leadership immediately and will be addressed immediately.

Resident competence will be assessed during clinical shifts by senior residents and attending physicians. Individual resident competence is also discussed quarterly by the CCC based upon faculty evaluations and milestone progress. (*refer to CCC policy)*

Patient Care Transitions

All residents are expected to participate in both formal and informal transitions of care. Formal team handoff, with attending supervision, takes place at dedicated times in the ED and residents are expected to adhere to pre-determined formats for handover of their patients.

When patient care transitions/shift changes occur at times other than dedicated team handoff times, it is expected that residents will provide complete verbal handovers of all patients, either with or without attending supervision.

Hand-off notes should be written by oncoming residents using templates available in EPIC.

Johns Hopkins Transfer of Patient Care during ED Shifts

EM PASS FORMAT

Illness Severity

- Includes illness severity (stable, unstable, watch) / working diagnosis
- Disposition
- Vital signs

Patient Summary

- Pertinent past med hx
- H&P – pertinent
- Labs / radiology initial

Action List

- Interventions
- Outcomes (corrected vital signs, new lab values)
- Active issues

Situational Awareness / Contingency Plan

- Current plan
- Active issues that require follow up
- Contingency plan (BP does not respond to appropriate IVF resus, start pressors)

Synthesis by the Receiver

Fatigue Mitigation

Fatigue is a challenging and significant concern during residency. We understand that managing fatigue is crucial for both your well-being and the safety of our patients.

As part of your orientation, we will provide formal training on fatigue mitigation. This training is designed to help you recognize and manage fatigue effectively. It's important to prioritize getting adequate rest before starting your shift to ensure you are ready to provide the best care possible.

If you ever feel too fatigued to perform your clinical duties safely, please notify your supervising physician immediately. Your safety and the quality of patient care are our top priorities, and we are here to support you in managing these situations.

At the end of your shift, if you feel too tired to drive home safely, you have options available. You can rest in the resident call room or request a car service to ensure you get home safely. The car service charge will be fully reimbursed (please contact Brittney or Christina for further details). Additionally, Hopkins offers an on-call shuttle for those living in close proximity to the hospital. Additionally, if you need an escort to your car, a request can be made with any security officer.

Your well-being is important to us, and we encourage you to take these steps if needed.

Patient Safety and Reporting

Patient safety and the ability to bring concerns regarding issues that may negatively affect the safety of our patients and staff ability to care for them is a top priority for our department.

Training
All residents, as part of emergency medicine intern orientation, receive instruction from nursing leadership, with the nursing Safety Officer and the co-chair of the CUSP team (Comprehensive Unit Based Safety Program). This covers requirements for reporting and consequences of reporting patient safety events.

Reporting
Johns Hopkins utilizes an online reporting system, the HERO portal, (Hopkins Events Reporting Online) for centralized reporting. The Safety Officer provides instructions for accessing the HERO portal, which allows for reporting of patient safety events and near misses. Additionally, residents receive instructions on how to utilize the Emergency Department's EB Guideline feature of the EPIC electronic health record to report cases to the clinical leadership team for potential morbidity and mortality presentations. These flagged cases are also reviewed by the appropriate hospital safety committee.

Discussion and Group Work
As part of the residency conference program, residents participate in and present M&M cases that are selected by the ED Safety Committee in collaboration with the residents themselves. The residents also receive education on how to approach an M&M including different methodological approaches and are assigned a faculty mentor to help them review and analyze cases. Ultimately, as part of the M&M the goal is to identify, when present, safety defects that may have contributed to bad outcomes. These defects are referred to the ED Safety Committee and Clinical Operations Committee and are managed as a priority. The residency didactic conference includes periodic administrative update sessions where residents and others in the department are updated on the progress on safety defects and safety action items from prior M&M's as well as any other Safety and Quality improvement projects. These sessions highlight quality and safety action items as well as follow-up form prior M&M's and quality/safety improvement projects. These meetings also include a discussion of the importance of safety reporting and the different mechanisms to do so – including HERO and emailing to the clinical affairs leadership. Residents are also frequently reminded that they are welcome to become part of our CUSP team and or attend the CUSP sessions or clinical operations meetings during which they may raise safety concerns.

The clinical faculty receive similar orientation to safety reporting systems and requirements for reporting at new faculty orientation. And at faculty meetings, providers are similarly given updates on important safety cases and the importance of safety reporting and the different mechanisms to do so, including HERO and emailing the clinical affairs leadership are reaffirmed at these meetings.

CUSP meetings are open to all faculty members and residents. This validated Safety Program gives the department an open forum to bring up safety cases and concerns. Dr. Redonda Miller (the president of the hospital) attends these meetings as our assigned CUSP executive. During CUSP meetings, we intermittently complete safety rounds and reach out to providers to solicit their input and to reaffirm important details about our safety infrastructure.

Raising Concerns Policy

All residents are encouraged and expected to share all concerns that may arise to allow for appropriate action to be undertaken.

To this end, residents may contact the Chief Residents or any of the Residency Program Directors or Administrators at any time without fear for retribution.

Alternatively, residents may contact the Residency Ombudspeople, Dr. Nate Irvin and/or Dr. Julie Rice, if, at any time, they have a concern that they feel unable to bring to the Chiefs or the Program Leadership.

If residents wish to remain anonymous, they may write and submit anonymous comments to the locked Comments Box that is located in the JHH ED Resident Lounge, which will be checked monthly by the Chief Residents for submissions or via the anonymous link run by the PD.

If residents have concerns regarding discrimination or harassment that they would prefer to not bring to the Residency Leadership, they may contact the Johns Hopkins University Office of Institutional Equity (OIE) directly at oie.jhu.edu and/or 410-516-8075 or the DIO, Dr. Jessica Bienstock at jbienst@jhmi.edu

Residents as Patients in the ED Policy

If an EM resident presents for care as a patient at any of the Emergency Departments in which their co-residents work clinically, and their clinical stability allows, the resident:

- Will not be expected to have any co-residents on their care team
- Will have only EM faculty (ideally of their choosing to avoid APD or PD involvement) and/or APPs care for them

If an EM resident requires care at any Johns Hopkins entity that may involve worker's compensation (eg, if injured during work), the resident will notify the Program Director as soon as possible, without disclosing protected health information, so that the Program Director may notify the Department of Emergency Medicine Administrator to assist with processing worker's compensation paperwork which may include:

- Receiving a bill for services rendered
- Forwarding that bill to the Office of Worker's Compensation for payment of services rendered:

Johns Hopkins Worker's Compensation
2024 East Monument Street,
Suite 1-300
Baltimore, MD 21205
Phone: 410-955-4800
Fax: 410-614-2995

If an EM resident requires care at any Johns Hopkins entity that does not involve worker's compensation, but requires assistance with post-care processes, the resident may notify the Program Director, without disclosing protected health information, so that the Program Director may assist with connecting the resident to appropriate resources, as needed.

RESIDENT RETREAT POLICY

The residency administration recognizes the importance of strong, supportive relationships among residents and their classmates. Retreats offer an opportunity for residents to have a common experience together and bolster these relationships. The residency administration fully supports an all-residency retreat and individual resident class retreats but recognizes the impact on clinical coverage both in the emergency department and on off-service rotations. Parameters to ensure adequate awareness, parity and coverage during retreats are outlined as follows:

1. **Retreat allotment**

   All-resident retreat: One per year, held in late May or June to close out the academic year. This is a one-day retreat. Residents are excused from clinical responsibilities from 7am-3pm.

   Individual resident class retreats: In addition to the all-resident retreat noted above, individual resident classes can organize (optional) retreats that may be funded in part by the residency program, if available. Funds available for retreats are evaluated on an annual basis and may include funding anything from a 24-hour to a maximum 48-hour retreat. Priority for class funding is as follows: 1. PGY4; 2. PGY2; 3. PGY3

   Any class that chooses to self-fund a retreat must have at least 75% of the class participating to qualify for residency approved clinical coverage. The Program Director must approve all residency class retreats in advance.

   PGY-1: Held during the 1st block (intern orientation) on a date prior to integration into the ED clinical schedule. This is a maximum one-day retreat.

   PGY-2: Ideally held the weekend prior to SAEM, with other options available, but cannot occur during the same block as CORD. In coordination with the Chiefs, the retreat date must be selected before PGY2-3 schedule generation for JHH ED and BV ED occurs. This is a maximum two-day retreat.

   PGY-3: Ideally held the weekend prior to CORD, with other options available, but cannot occur during the same block as SAEM. In coordination with the Chiefs, the retreat date must be selected before PGY2-3 schedule generation for JHH ED and BV ED occurs. This is a maximum two-day retreat.

   PGY-4: Held in the last block of the PGY-4 year. In coordination with the Chiefs, the retreat date must be selected before PGY2-3 schedule generation for JHH ED and BV ED occurs. This is a maximum two-day retreat.

Please note that weekend days over holidays or national conferences are unavailable for any retreats due to staffing requirements.

2. **Funding**

   Retreat funding sources are as follows:

   All-resident Retreat: will be paid for with residency funds.

Individual PGY retreats: expenses will be paid for by the individuals of the particular PGY class. If resident wellness funds are available, they will be allotted in the priority list described above (PGY4>PGY2>PGY3).

3. Clinical Coverage

Adequate clinical coverage must be maintained during all residency retreats. In general, classes above cover for classes below (i.e., PGY3 covers PGY2), however, PGY4s can be covered by PGY3s, and PGY3s can be covered by PGY2s in the final two blocks of the academic year with approval by the residency leadership. In coordination with the Chiefs, retreat dates must be selected before PGY2-3 schedule generation for JHH ED and BV ED occurs.

Scheduling Policy

I. Clinical Hours Scheduled

Maximum allowable clinical hours per week while on ED rotations **(includes Peds ED): 60 hours per week**

Typical ED clinical hours scheduled by year:

PGY-I	50-60 hours per week
PGY-II	40-50 hours per week
PGY-III	30-40 hours per week
PGY-IV	1080 clinical hours per year

1. Hours may be adjusted on a per block basis.
    a. If a resident's clinical hours exceed the maximum hours per week or violate any other duty hour's rules, a review by Program Director will occur.
    b. The schedule will consist of 13 four-week blocks.
    c. Schedule changes may be arranged by individual residents but must not violate duty hour regulations and must be submitted in ShiftAdmin and approved by the Scheduling Chief.
        1. Residents may only switch shifts within their own PGY year unless approved by the Chiefs.
        2. Partial shift exchanges are not permitted unless the exchange does not increase the number of patient care handoffs that must occur for appropriate care transitions
            i. For example, resident A is scheduled from 7AM-3PM and may request that resident B who is scheduled from 3PM-11PM come in at 2PM to take signout 1 hour early. In the above example, resident A may not split their shift and request that resident C work from 11AM-3PM before signing out to resident B at 3PM.
        3. Longitudinal PGY2 and 3 Peds ED shifts cannot be traded away unless they are 1:1 for another PED shift within the same block.
            i. Reasoning: The ACGME requires 5 full months of pediatric experience. Our curriculum is set up for 4.5 months of dedicated pediatric rotations plus the equivalent of 2 weeks of PED time spread longitudinally over PGY2-3.

II. PGY-4 Teaching Shifts

1. PGY-4 residents must self-select dedicated Teaching Shifts to meet their clinical hourly obligation as directed by the PGY-4 Scheduler.
2. These shifts must adhere to all ACGME duty hour regulations.
3. These shifts may be scheduled on days for which the PGY-4 resident is assigned jeopardy, however, the teaching shift length cannot exceed 4 hours so that the resident is available for any 8-hour shift that might require jeopardy activation
4. Teaching shifts should ideally be maximized at the beginning of the academic year, as permitting, to allow for additional assistance in the department during transitions to new roles.

II. Minimum Resident Schedule Requirements

1. A PGY3 and PGY4 resident must be scheduled in the department at all times (except during SAEM when PGY3 residents are attending this conference and

during the 48-hour period when PGY4 residents have their annual retreat)

2. At no time can there be fewer than three non-intern EM level (must be EM4, EM3 and EM2) residents in the department unless approved by the residency leadership.
3. A resident must have 24 hours FREE from clinical responsibility per seven-day period (measured from 7AM on switch day to 7AM seven days later [e.g. if switch day is Thursday, the 7-day period is defined as 7AM Thursday to 7AM Thursday]). This cannot be averaged.
    - Friday morning conference does not count toward this time so you must have an 24 consecutive hours off each week, not including Friday morning from 7am-12pm.
4. A resident must have an equal number of hours FREE from clinical or conference responsibility after a shift. For example, if you work a 10-hour shift, you must have 10 consecutive hours free before returning to a clinical shift.
    - Friday morning conference does not count toward this time so you must have an equal number of consecutive hours off before or after attending an educational activity before returning to work.
5. ANY deviation from the above guidelines must be approved by the Program Director.

III. Chief Resident Scheduling Allowance

Chiefs will be allowed one additional scheduled shift off per month beyond the non-Chief PGY3 mean shift assignment to perform Chief Resident tasks, including scheduling, etc.

Vacation Policy

Inclusive vacations dates are:

1. Interns will have three weeks of vacation per academic year.
2. PGY-2, PGY-3, and PGY-4 residents will have four weeks of vacation per academic year.
3. All attempts will be made to allow each resident to have five days clear from any clinical duties during the Holiday break. However, due to variability in off-service schedules, this may not be possible. If a resident does have five days off, it is also expected that the resident will work five days during the holiday break. (Holiday break = Dec 23rd-Jan 1st)
4. Should vacation time fall during any major EM conferences, the resident can either attend or not attend the conference. No additional conferences will be offered in place of this, except if the resident is presenting their work.
5. Parental leave may or may not include vacation time, with close attention paid to the ABEM parental leave policy limitations listed above (ABEM Policy on Leave for Residents).

Technology (Pager/Phone) Policy

Pagers

All residents are currently required to carry pagers until they have completed their Bayview Burn ICU and the Howard County Hospital MICU rotations in their PGY3 year. It is still the institutional opinion, as well as that of the Pediatrics and Surgery departments, that residents who may be on critical rotations such as ICUs or in locations where they could be in the OR, must still have access to a pager. There are still many locations in the hospital that cell reception is poor.

Phones

All EM residents will receive either 1) a $300 annual stipend for the use of your phone for work purposes or 2) a departmentally-issued iPhone that you are responsible for during residency. While some of you may choose to simply use your personal phone, others may choose to use the stipend to purchase a Wi-Fi enabled phone that you use only for work.

- Apps required (to be downloaded from the InTune Portal after you have registered your phone with Hopkins)
  - Haiku
  - Jabber

Also, there are new medical apps that may be helpful to you also available for download.

1. Stipend:
   i. You will be asked to sign a user agreement in New Innovations to receive this stipend which is for your use of your phone as a phone for work. In addition, for all other (non-ED) services you are on, you will be expected to use your personal phone or a phone you choose to purchase with the funds below for the purposes of work
   ii. The total stipend that will be provided to each resident is $300 yearly. This is enough to purchase a phone with Wi-Fi capability that can accommodate the apps you need at work, should you wish to not use your personal phone. If you use your personal phone, you can use this stipend towards your monthly bill.

   iii. How to receive the stipend:
   Residents will need to sign a user agreement prior to receiving the stipend. This form has been assigned to you as an "Advancement checklist" in New Innovations. There are 2 steps in the checklist (downloading a blank form and uploading a completed form); you will need to mark each step as complete (click the checkbox) when you are finished. If you do not submit the forms prior to this, your stipend will be delayed.

3. Departmentally Issued phone
   1. You will be asked to sign an agreement with the department for a departmentally issued iPhone. You can use this phone on the Hopkins network for any service you work on at any of the Hopkins campuses.

TERMS OF USAGE:

1. I agree to keep the phone charged and accessible while on duty · I understand that apps on the InTune portal will be periodically updated · I agree to comply with all HIPAA regulations regarding Protected Health Information (PHI) and will not transmit anything via the phone that would violate HIPAA regulations
2. I will be responsible for the security of the phone and am responsible

for replacement if it is lost or damaged by misuse. Phones damaged during routine clinical work will be repaired or replaced by the department, but must be returned to the departmental clinical communications team (Currently, Heather Gardner or Daniel Swedien)

3. The phone will be returned to Christina Tarleton at the end of your residency upon graduation

Meal Cards – Transition to GrubHub app

Effective 7/1/2023

- JHH beginning implementation of Grubhub mobile ordering.
- Residents' meal program will be enabled in the Grubhub platform – specific to JHU locations only.
- JHH at Grubhub lunch will phase away use of Dome Pay Pass for residents' meals.

Here's an important message from the JHH Culinary Services Team managing the transition from Dome Passes to the Grub Hub app:

Kindly take note that all funds must be utilized within the new academic year. There will be no provision for carrying over funds to the subsequent academic year beyond June 2024.

JHMI
Policies

JHMI Institutional Policies

All institutional policies can be found at the website listed below:

https://www.hopkinsmedicine.org/som/gme/residents-fellows#contracts-policies

Residents/Fellows

1. **Sample Resident Contract**
2. **Residents Benefits Summary**
    - **Vacation Policy and Stipend for Residents**

Contract Attachments

3. **Equal Opportunity Policy (JHU)**
4. **Discrimination and Harassment Policy and Procedures (JHU)**
5. **Teacher Learner Policy (SOM)**
6. **Code of Conduct (JHH)**
7. **Remediation, Probation, Suspension and Dismissal of Residents/Clinical Fellows (GMEC)**
8. **Grievance Procedure for Faculty, Fellows and the Student Body (SOM)**
9. **Policy on Alcohol and Drug Abuse and Drug-Free Environment (JHU)**
10. **Physician Impairment (GMEC)**
11. **Disability Services Guidelines (JHU)**
12. **Duty Hours Policy and Procedure (GMEC)**
13. **Moonlighting of Residents and Fellows in ACGME and ABMS Accredited Programs (GMEC)**
    - **Moonlighting Exception Request Form**
14. **Professional Fee Billing (GMEC) - Residents**
15. **Health Care and Sick Leave Policy for Postdoctoral Trainees (SOM)**
16. **New Child Accommodations for Full-time Graduate Students and Postdoctoral Trainees (JHU)**
17. **Non-Medical Leave of Absence for Postdoctoral Trainees (GMEC)**
18. **Professional Liability Insurance (GMEC)**
19. **Criminal Background Investigation Policy (SOM)**
20. **Maryland Licensure and Registration (GMEC)**
21. **Records Retention Policy (GMEC)**
22. **Policy on Mandatory Immunizations/Vaccination (GMEC)**

Additional Policies and Resources

- **Johns Hopkins Compliance Line**
- **Disability Policy for Faculty, Staff (Including Postdoctoral Trainees) or Members of the Public**
- **Statement on Diversity and Inclusion**
- **East Baltimore Blue Jay Shuttle Service**
- **Equal Opportunity and Title IX Notice for Students, Faculty, Staff and Applicants**
- **Equity Compliance Complaint Form**
- **Faculty and Staff Accommodation Form**
- **Guidelines for Patient Handoffs (GMEC)**
- **Closure/Reduction of Training Programs (GMEC)**
- **External Funding of Residents and Clinical Fellows**
- **Extracurricular Activities of Postdoctoral Trainees (GMEC)**
- **Non-clinical Extracurricular (Moonlighting) Activity Request Form**
- **FICA Refund Project**
- **Office of International Services**
- **GMEC Oversight of Training Programs Policy (GMEC)**
- **Lactation Policy (JHU)**
- **Policy on Evaluation, Promotion and Non-Renewal of Residents/Clinical Fellows (GMEC)**
- **Policy on Interaction with Industry**
- **Policy on Recruitment, Eligibility, and Appointment of Residents and Clinical Fellows to ACGME- and ABMS-Accredited Programs (GMEC)**
- **Service and Assistance Animal Policy**
- **Sexual Misconduct Policy and Procedures**
- **Statement on Principles on Academic Freedom**
- **Supervision of Postdoctoral Trainees (GMEC)**
- **Visa Sponsorship for Clinical Training**
- **Personal Relationships Policy**
- **JHU SOM Learner Mistreatment, Harassment, and Discrimination – Responsibilities and Expectations of Learners**
- **Additional Shifts Approval Form**
- **Telemedicine and Tele-Supervision Policy**
- **University Statement on Supporting Preferred Names**

Updated 7/1/2024

Appendix

ELECTIVE ROTATION FORM

This is a request for a John Hopkins Medical System elective. This form should be completed for each elective block while at one of the Johns Hopkins Institutions.

If you are requesting an elective for outside of the Hopkins system, you will need to complete the Away elective form.

Resident _____

Elective Block _____

Name of Rotation _____

Preceptor During Rotation _____

Preceptors Phone Number _____

Preceptors Email _____

Patient Care Contact YES NO

Goals and Objectives of Rotation
(Please list as least one objective per ACGME competency. Every box in the chart on page 2 must be filled.)

Name Preceptor: _____ Date: _____

Preceptor Approval: _____

Training Program Director Approval: _____ Date: _____

Return the completed form to Christina Tarleton (christina.tarleton@jhmi.edu)

List objective(s) under each competency heading	List the method for accomplishing the objective	List the evaluation method for assessing competence
Patient Care		
Medical Knowledge		
Practice-based learning and improvement		
Interpersonal and Communication Skills		
Professionalism		
Systems-based Practice		

THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF GRADUATE MEDICAL EDUCATION

REQUEST FOR ELECTIVE ROTATION
OUTSIDE OF TRAINING PROGRAM'S STANDARD ROTATIONS
(RESIDENTS AND CLINICAL FELLOWS)

This form should be completed for each outside elective rotation which is not part of the training program's standard rotations. THIS FORM MUST BE TYPED.

The completed form must be signed by the resident/clinical fellow, the JHU Program Director, and the representatives at the Host Institution, and sent with the required documentation to GMEOffice@jhmi.edu for final approval by the Sr. Associate Dean for Graduate Medical Education / DIO.

Host Institution: (Name and full mailing address of location)		
Specialty Rotation at Host Institution:		
Preceptor at Host Institution and preceptor's email address and phone number:		
Period of Rotation: (Specific dates-mm/dd/yy)	From:	To:
Name of Hopkins Resident/Clinical Fellow:		
Johns Hopkins Department:		
Johns Hopkins Program Director:		
Year in Johns Hopkins Training Program:		

For out-of-state rotations, provide evidence that the appropriate out-of-state licensure has been obtained.
_____ Attached _____ Not applicable

Indicate the responsible institution for the following:
1. Professional liability insurance (Minimum requirements: $1 Million per incident/$3 Million aggregate): will be provided by:
_____Johns Hopkins _____Host Institution
* If provided by Johns Hopkins, Certificate of Insurance shall be sent to: (provide mailing address, e-mail and phone number)

2. Salary and Fringe Benefit Payments to be made by: _____Johns Hopkins _____Host Institution

3. Reimbursements
_____There are no reimbursements to be made.
__ __There is an agreement for reimbursement to be made between institutions; please attach a copy of the reimbursement agreement.

4. Research Performed During Rotation:
If the resident or fellow participates in a research project during the course of the elective, this work will require approval from the Host Institution's Institutional Review Board.

_____ I, _____(resident/fellow name) understand that I must comply with the Host Institution requirements for Institutional Review Board approval. I also understand that, if any research I do at the Host Institution extends beyond the length of this elective rotation, I must submit a request to the JHM IRB to either have the JHM IRB review the research or to request an IRB Reliance Agreement.
_____ I will not be participating in any research project during my elective.

5. Host Institution Responsibilities for Rotation:

a. Host Institution recognizes that the Program Director of the Johns Hopkins Training Program has the responsibility for the overall administration of the Training Program for the resident/clinical fellow.

b. The Host Institution Preceptor will evaluate the resident/clinical fellow upon completion of the rotation.

c. The Host Institution will distribute to the resident/clinical fellow copies of Host Institution's policies, rules and regulations that will be applicable to the resident/clinical fellow.

d. The Host Institution Preceptor will be responsible for coordinating and administering the rotation and will report all issues relating to the resident/clinical fellow to the Johns Hopkins Training Program Director.

e. The Host Institution will provide to the resident/clinical fellow the equipment, resources, facilities and professional/technical/clerical personnel necessary for the rotation.

f. Any removal or discipline of the resident/clinical fellow by the Host Institution will be discussed with the Johns Hopkins Training Program Director prior to action; provided, however, Host Institution may take action when, in its opinion, the resident/clinical fellow pose an imminent threat to patient safety or welfare.

g. If the Host Institution is subject to accreditation by the Joint Commission or any other applicable accrediting agency, the Host Institution shall maintain such accreditation.

h. Pursuant to Section 952 of the Omnibus Reconciliation Act of 1980, Public Law No. 96-499 (the "Act"), the parties agree as follows: until the expiration of four years after the furnishing of the services provided under this Request, the parties will make available to the Secretary, U.S. Department of Health and Human Services, the U.S. Comptroller General, and their representatives, this Request and all books, documents, and records necessary to certify the nature and extent of the costs of those services. If a party carries out the duties of this Request through a subcontract worth $10,000 or more over a 12-month period with a related organization as defined in the Act, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General, and their representatives to the related organization's books and records.

i. The Host Institution agrees to indemnify, defend and hold harmless Johns Hopkins University and its affiliates (and their respective employees, agents, trustees, officers and directors) (collectively, "Indemnitees") from and against any and all claims, losses, damages, suits, and costs (including attorneys' fees and defense costs), regardless of the outcome of such claims or actions, arising out of or relating to any allegedly negligent or intentional act or omission of the Host Institution, its officers, employees, or agents, including but not limited to, any violation or breach of duty owed to any third party, or any failure to perform any other covenant of this Agreement. The indemnification obligations herein shall not be limited by any insurance, or lack of insurance, maintained by the Host Institution. This indemnification provision shall survive termination or expiration of this Agreement.

6. Miscellaneous.

a. This Request shall be governed and construed according to the laws of the State of Maryland.

b. It is expressly understood that the parties hereto are independent contractors.

7. Overall Goal for this Rotation; Complete specific goals & objectives on the next page.

_____Date_____
Signature – Resident/Clinical Fellow

THE JOHNS HOPKINS UNIVERSITY

_____Date_____
Signature – Training Program Director

_____
(Print Name)

_____ Date_____
Signature - Sr. Associate Dean for Graduate Medical Education and DIO
Jessica L. Bienstock, MD, MPH

HOST INSTITUTION

_____Date_____
Signature – Preceptor at Host Institution

_____
(Print Name)

_____Date_____
Signature – Official at Host Institution

_____
(Print Name and Title)

8. Objectives for this Rotation (please list at least one objective per ACGME Competency; attach additional page(s) if necessary). Every box in this chart needs to be filled.

List objective(s) under each competency heading	List the method for accomplishing the objective	List the evaluation method for assessing competence
Patient Care		
Medical Knowledge		
Practice-based learning and improvement		
Interpersonal and Communication Skills		
Professionalism		
Systems-based Practice		

Elective Rotation – Addendum

Complete this form for any international elective rotation and attach to the Elective Rotation Request form.

Resident/Fellow Name: _____

Country of Travel: _____

In 250 words, or less, please describe how this international elective experience will provide a real and tangible impact to your career advancement, as well as why other options to accomplish this goal are not feasible.

_____

Resident/Fellow Signature

We have reviewed the above justification, discussed with the resident/fellow the risks and benefits to themselves of this experience, and support their request to participate in this international elective.

_____

Training Program Director Signature & Date

_____

Department Director Signature & Date

Elective Options

Your elective block is designed to enhance and refine skills vital to emergency medicine physicians that are often overlooked or underemphasized. Options for EM3 residents for their elective time include, but are not limited to:

Anesthesia at Sinai Hospital
Contact: Dr. Tom Suarez
Director of Education, Department of Anesthesia
Sinai Hospital of Baltimore
410-963-8462
toms1636@gmail.com

Regional Anesthesia Elective for Emergency Medicine Residents

Where: Anesthesiology/Critical Care Med in Regional Anesthesia at JHH and Bayview Med Ctr (see elective information page for specifics and the goals and objectives for details)

All requests for this elective should be sent to Drs. Tiffany Fong for approval. Max residents for the year will be 4.

Contacts: Drs. Tiffany Fong, tfong3@jhmi.edu
Preceptor: Dr. Jason Brookman, jbrokman@jhmi.edu, Cell 617-777-4147, Work - 410-955-5608
Dr. Vineesh Mathur, mathur@jhmi.edu, Cell 443-845-4082, Work - 410-955-7609

Cardiology
Contact: Lauren Rodgers
lmodica1@jhmi.edu or 410-955-5999
***requires at least a 3-week rotation minimum

Community Emergency Medicine at Sibley Memorial Hospital
Contact: Nadia Eltaki, MD FACEP
Chair and Medical Director
Department of Emergency Medicine
Sibley Memorial Hospital
202-660-5193 (office)
202-537-4080 (ED)
neltaki1@jhmi.edu
Where: Sibley Memorial Hospital Emergency Department

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Dental Clinic at University of Maryland
Contact: 410-706-7101
Where: University of Maryland
666 W. Baltimore St

Dermatology
Contact: 955-4940
Where: Outpatient Center 6th floor
Goals: Recognize the dermatological manifestations of internal disease
Learn how to recognize and manage true dermatological emergencies Recognition and management of common dermatological disorders

ECG
Contact: Logan Weygandt (lweygandt@jhmi.edu)
Where: virtual/asynchronous
Goals: to develop advanced skills in ECG interpretation, to prepare to apply those skills for daily ECG interpretation, and to create a deliverable (presentation/poster/publication) on an advanced ECG topic
Note: requests must be made at least 3 months in advance in order to guarantee acceptance to this rotation

ENT (Otolaryngology)
Contact: Donna Riley donna.riley@jhmi.edu or 410-955-1932
Where: JHOC 6

ENT (Laryngology)
Where: JHOC 6th floor
Goal: Competence with NP flexible scopes, improved recognition and management of ENT disorders. Attend Laryngology clinic, follow ENT consult pager

Ophthalmology
Contact: 955-5700; Point of Contact is Sherveen Salek (ssalek1@jhmi.edu) resident
Where: Wilmer 2nd floor
Contact: In the GES clinic, they'd be with one of our residents and Chief is Dr. Eric Singman
Contact: The day ER coverage
Goals: Learn how to identify true Ophthalmologic emergencies
Basic slit lamp eye exam
Funduscopic eye exam
How to manage basic eye infections, corneal abrasions, ocular trauma
Location: JHED
Staffing: Work with Ophtho resident or PA on consults
Schedule: As many shifts as needed to feel proficient at slit lamp and eye exam
Responsibilities: Assist the Ophtho resident on call in the ED and see patients with them
Useful things to review: Ophtho section of textbook of your choice
Attire: Scrubs and Coat

Karen Shafer
Clinic Manager - General Eye, Low Vision and Rehabilitation Services
The Wilmer Eye Institute
600 North Wolfe St., B1-65

Baltimore, MD 21287
410-955-2350
kshafer3@jhmi.edu

Orthopedic Surgery/Fracture Clinic

Contact: 955-2617
Where: BV Clinic or JHH
Goals: Learn correct splinting and casting technique
Identify which injuries require operative us non-operative management
Correct management of minor orthopedic trauma
Refine orthopedic physical exam skills

Orthopedics at Johns Hopkins Hospital

CHIEF RESIDENT**:** Dr. Dawn Laporte
Professor, SOM Ortho Hand Division
JHOC 5252
Office: 410-955-3134/410-955-8344
Email: dlaport1@jhmi.edu

Orthopedic at Union Memorial

Contacts: Dr. Russ Matthews who is the PD at UM for Ortho
Coordinator: Kathy Lind
410-554-2857
Kathy.lind@medstar.net
Where: Union Memorial Hospital, Clinic
201 East University Pkwy, Balto MD 21218

An affiliation agreement would be needed for residents to do an elective at Union Memorial

Orthopedic at University of Maryland (not shock trauma)

410-328-8915 Stacy Santiago (coordinator)
University of Maryland Orthopedic Dept.
Contact is Stacy Santiago (coordinator), 410-328-8915, ssantiago@umoa.umm.edu
(She is with the Orthopedic residency program where our residents have rotated in the past)

Pain Clinic

Contact: 410-955-5078
Where: Outpatient Center
Goals: Rotate and round with the pain service and attend pain clinic. Learn how to manage patients with chronic pain using oral medications, patches, nerve blocks, etc.

Palliative Care

Contact: 410-955-8305
Danielle J. Doberman, MD, MPH, HMDC

Medical Director, Palliative Medicine
Johns Hopkins Hospital
600 North Wolfe St, **Blalock 371**
Baltimore, MD 21287
(T) 410-955-8305
ddoberm1@jhmi.edu

Options for:

- Palliative Medicine, 2 weeks or 4 weeks
- Hospice & Palliative Medicine, 2 weeks or 4 weeks
- Geriatrics, Palliative Medicine and Hospice: 4 week elective only

JHH Radiology

Where: JHH or BV
JHH Contact: 955-5784 or 955-6500
Contact: Dr. Donna Magid and Margaret Sturgill both
Margaret Sturgill 410-955-8193, msturgi2@jhmi.edu

Donna Magid, MD, M.Ed www.TeamRads.com<http://www.teamrads.com/>
Associate Professor of Radiology, Russell H. Morgan Department of Radiology and Radiological Science Associate Professor of Orthopaedic Surgery Associate Professor of Functional Anatomy and Evolution
Director, Undergraduate Medical Student Education in Radiology
Director, JHU SOM Horizontal Strand in Diagnostic Imaging Director,
JHU SOM Radiology Elective Education Director, MSK Imaging Fellowship
switchboard 410 955 6501, cell 410 428 5530
dmagid1@jhmi.edu

SICU

Contact: Pamela Lipsett, Surgical co-director
Where: JHH
Goals: Work and round with the SICU team. Learn how to manage surgical patients

Toxicology/Maryland Poison Control Center

Contact: Wendy Klein-Schwartz, PharmD, MPH
Where: Participating Institution: Maryland Poison Center
220 Arch St, Office Level 1
Baltimore MD 21201
Phone: 410-706-7604 or 410-563-5581

Toxicology/ New York Poison Control Center

Contact: Dr. Mark Su
nycpcc@yahoo.com or nyccctoxrotation@health.nyc.gov
212-447-8150
Where: New York City, 455 First Ave, Rm 123, NY, NY 10016
Goals: in file

Mark K. Su, MD, MPH
Director, New York City Poison Control Center
Email: msu3@health.nyc.gov
Catherine Castro
Community Coordinator

New York City Poison Control Center
455 1st Avenue Room 114
New York City, NY 10016
Ccastro2@health.nyc.gov
(212) 671-5766

Tropical Medicine with Dr. Karen Schneider RSM, MD

Contact: Dr. Karen Schneider in Pediatric Emergency Med/CMSC 144, 410-955-6143
Email: karenrsmmd@gmail.com
Where: various oversea locations
Goals: in file

Ultrasound with Division Director

Contact: Dr. Tiffany Fong tfong3@jhmi.edu
Where: JHH
Goals: in file

Wilderness Medicine: Jackson Hole, Wyoming

Contact: Albert R. Wheeler III, M.D. wheelerdoc@mac.com
Emergency Medicine of Jackson Hole Wyoming
Medical Director Grand Teton National Park EMS
Medical Director Teton County SAR
Director of Trauma Services
P.O. Box 7890
Jackson, WY 83002
Cell 307-699-2287
Home 307-734-1745

Amanda Meekins, CPCS
Medical Staff Services Manager
Ph: 307-739-7514
Fx: 307-739-7513
Cell: 307-203-6885

Where: St. Johns Medical Center
PO Box 428
625 East Broadway
Jackson, WY 83001
Goals: in file

Organizations and Committees for 2024-2025

Full descriptions of the committees can be found here:
https://docs.google.com/document/d/1PniMwsD97nelr-0WzYpsKAaOj8mQ6aOpF7pEHtjWd9g/edit?usp=sharing
https://docs.google.com/document/d/1Ftk4ovjtGgNxKMizIabFXsVcPJDd23Ch15VcY5t9H8U/edit?usp=sharing

- AAEM
- Central Hospital House Staff Patient Safety and Quality Council (HPSQC)
- Education Committee
- EMRA Representative
- Housestaff Council
- Housestaff diversity council
- Bayview Housestaff council
- Informatics Committee
- Maryland ACEP
- Recruitment Committee
- Resident Patient Safety Liaison (CUSP)
- Resident Research Operations Liaison
- Social Emergency Medicine, Community Service and Humanities Committee
- The Trauma and Critical Care Committee (TCCC)
- Wellness Committee

Resources

RESOURCES ON WELL-BEING

Repository of wellness programs, resources, and information available at:
http://wellness.som.jhu.edu/

Mental health services are available to you as an important benefit for you to use, when needed, to support your well-being.

Mental Health Services, Summarized:

Are you or a colleague in crisis? We have THREE separate services available to you:

I. **JHU Mental Health at University Health Services**

Help is available 24 hours a day, 7 days a week
Phone: **410-955-1892**
After hours press "0" and ask to speak to the University Health Services Mental Health psychiatrist on call. (more information below)

II. **Johns Hopkins Employee Assistance Program (JHEAP)**,

Access to confidential counseling and referral services. JHEAP will provide referrals to licensed clinicians OR you can opt for an in-person appointment located on various campus. Your first five counseling sessions are free and won't require use of your insurance.
Phone: 888-978-1262. 24/7/365
https://www.hopkinsmedicine.org/human-resources/benefits/jh-worklife-programs/worklife-support-programs

III. **RISE (Resilience in Stressful Events)**

Need to debrief about a difficult patient event? Unburden your frustrations to another provider. It's like calling your best friend, if your best friend understood all that jargon you use.

https://www.hopkinsmedicine.org/armstrong-institute/training-services/caring-for-the-caregiver

JHHpage 410-283-3953
Bayview: Pager: 410-283-0365
CORUS: JHBMC RISE Team

Is this a mental health emergency? Please use the national free crisis resource: National Suicide Prevention Lifeline
Phone: **988**

Mental Health Services, In Detail

I. University Mental Health Services (UHS) [a benefit of being a trainee here]

Talk to a clinician at University Health Services.
Phone: 410-955-1892
Website: https://wellbeing.jhu.edu/MentalHealthServices/

Urgent Care After Hour Numbers: 410-955-1892, press "0" to connect to JHH operator and request the UHS Mental Health psychiatrist on call
Location: 933 N. Wolfe Street, Baltimore, MD 21205
Hours of operation: Monday-Friday, 8:00a-5:00p
Appointments outside of normal hours can be arranged if necessary.

Details:
University Health Services Mental Health is a confidential diagnostic and treatment program for medical learners – including residents and clinical fellows - seeking mental health treatment from psychiatrists or other mental health clinicians.

UHS Mental Health services are available for mental health conditions include depression, anxiety, and stress. Psychiatric assessment and treatment, including medication therapy if appropriate, is offered. Treatment providers at UHS Mental Health include psychiatrists and therapists, including a psychologist and licensed clinical social workers.

UHS Mental Health Services Offered:

- Psychiatric assessment, diagnosis and treatment for mental health conditions
- Counseling services
- For after- hours urgent care, please call 410-955-1892, press "0" and ask for the UHS mental Health Psychiatrist on call to be paged

Residents and fellows can access UHS Mental Health providers at no cost. If care is received outside UHS-Mental Health, residents and fellows would utilize their insurance. Details can be found under Resident or Fellow Benefits Summary.

II. Johns Hopkins Employee Assistance Program (JHEAP) [a benefit of being an employee here]

Talk to a clinician about yourself or a colleague. Available for your immediate family too.
Phone: 443-997-7000
Website: https://hr.jhu.edu/benefits-worklife/support-programs/
Locations at

- East Baltimore campus, 550 North Broadway, Suite 507
- Johns Hopkins at Eastern, 1101 E. 33rd St., Suite D-200
- Homewood: Wyman Park Building: Room S-703

Details:
JHEAP On-Site Clinical Team offers in-person appointments from 9 a.m. to 5 p.m., Monday through Friday.
Callers can speak to a licensed clinician 24/7/365 by calling JHEAP's number: 888-978-1262 .

JHEAP is the employee assistance program of the Johns Hopkins University, Johns Hopkins Medicine, and Community Physicians. JHEAP provides confidential services. JHEAP clinical staff members are licensed mental health clinicians (licensed certified professional counselors and licensed clinical social workers) and will refer clients to outside mental health treatment

providers as appropriate, including those at University Health Services Mental Health.

JHEAP services include an assessment of emotional wellbeing and current stressors, and short-term counseling during times of grief, loss, stress, challenge, and transition. JHEAP clinicians provide referral to mental health treatment providers when necessary for treatment of clinical depression, anxiety disorders, and substance use disorders.

- ∉ JHEAP provides assistance with the following: Stress and worry
- ∉ Concern about their own or someone else's unhealthy use of alcohol or drugs
- ∉ Challenging life transitions
- ∉ Problems with interpersonal relationships
- ∉ Difficulties with co-workers
- ∉ Problems with work performance and productivity
- ∉ Concern for family members' and colleagues' well-being
- ∉ Grief and loss
- ∉ Problems with low mood, low energy, or anxiety
- ∉ Financial problems
- ∉ Legal concerns

JHEAP referral as a condition of employment or as a facilitated referral

If a trainee's ability to function effectively is impaired (e.g., mental health concerns, emotional problems, substance abuse, or behavioral concerns), a referral may be made as a facilitated referral or as a condition of employment. In both cases, it is important that the program director or other faculty member contact FASAP to identify the trainee in question and to describe the reason for the referral. In cases of facilitated referral, reports to the program director will be contingent upon the trainee approving disclosure of that information. When referral is a condition of employment, compliance with and progress with recommended interventions are provided to the program director as part of the condition of employment. Documentation of the reason for referral is extremely important in both facilitated referrals and in referrals as a condition of employment.

III. RISE – Resilience In Stressful Events Program: Caring for the Caregiver

The RISE (Resilience in Stressful Events) team provides confidential peer-to-peer support to Johns Hopkins Hospital employees who have experienced a stressful, patient-related incident.
Website: https://livejohnshopkins.sharepoint.com/sites/inside-rise/SitePages/home.aspx
Phone Number, by Campus:

Johns Hopkins All Children's Hospital 727-767-RISE (7473)	**Johns Hopkins Bayview Medical Center** Pager: 410-283-0365 CORUS: JHBMC RISE Team
The Johns Hopkins Hospital Click here for support or Page 410-283-3953	**Johns Hopkins Howard County Medical Center** Phone: 888-978-1262 Online: www.myccaonline.com (Company Code: JHEAP)

	Mobile App: CCA@YourService | Access Code: JHEAP

Details:
An adverse patient event can have a profound impact on care providers, any of whom may become a "second victim" who is traumatized by the stressful situation. The RISE team provides trained responders—including physicians, nurses, respiratory therapists, social workers and chaplains—who can deliver emotional first aid to peers in a confidential, nonjudgmental environment. Every RISE responder has been trained in psychological first aid and has demonstrated a high level of competence in assisting second victims.
Johns Hopkins Hospital employees, supervisors and colleagues are encouraged to request the RISE team's free services to help cope with any stress-producing patient-related event. These incidents include but are not limited to:

- Medical errors
- Unexpected patient death or injury
- Preventable complications
- Unplanned transfer to a higher level of care
- "Near-misses"
- Breach of patient privacy
- Any particularly troubling patient case that makes you feel uneasy, even when care delivery is excellent. This includes troubling or difficult care decisions, communication issues and complex situations.

JOHNS HOPKINS
UNIVERSITY & HEALTH SYSTEM

FASAP
The Faculty and Staff Assistance Program

The Faculty and Staff Assistance Program (FASAP): A Resource for Faculty

Frances Callahan, LCSW-C

Assistant Director

Faculty and Staff Assistance Program

fcallah1@jhmi.edu

443.997.7000

http://www.fasap.org/

JOHNS HOPKINS
UNIVERSITY & HEALTH SYSTEM

FASAP
The Faculty and Staff Assistance Program

FASAP Facts

Free, confidential, and professional support services for problems of daily living and emotional well-being

Assessment, **short term counseling** when appropriate, and **targeted referrals** to community services and resources when appropriate.

Eligibility: benefited faculty and staff and their families (referrals for children under 16)

Clinical team: 11 licensed, master's level mental health professionals

Hours: 24/7/365 access to support; FASAP clinicians see clients and take on-call between 9 and 7 on weekdays.

Locations: East Baltimore, JH@Eastern, Bayview, Columbia, Washington, DC

Call: 443.997.7000, 24/7/365; Website: www.FASAP.org.

JOHNS HOPKINS
UNIVERSITY & HEALTH SYSTEM

FASAP
The Faculty and Staff Assistance Program

How FASAP Helps Individuals

- In-person sessions include thorough bio-psycho-social assessment.
- In-person, short-term, solution-focused counseling for individuals and couples.
- Targeted referrals to community providers and resources when necessary.
- Telephone access, 24/7/365: telephonic triage and assessment by licensed clinicians and direct referral to mental health and community resources when needed.
- Video consultations when in-person sessions are not possible.
- Consultation to leaders and managers concerned about a team member.
- No limit to how often clients use FASAP services.
- FASAP services are free and confidential.

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UNIVERSITY & HEALTH SYSTEM

FASAP
The Faculty and Staff Assistance Program

How FASAP Helps Teams

- Crisis response services
- Customized presentations and workshops, upon request. Recent and upcoming topics include
  - Recognizing and responding to depression in the workplace
  - Developing mindfulness skills
  - Stress management strategies
  - Substance abuse in the workplace
  - Juggling parenting and medical residency
- Facilitated group conversations following loss and disruption
- Assistance to teams and individuals following a reduction in force

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UNIVERSITY & HEALTH SYSTEM

FASAP
The Faculty and Staff Assistance Program

How FASAP Helps Managers

Consultations: We encourage managers to call FASAP to consult when they are concerned about a team member or their team as a whole.

Referrals to FASAP:

Voluntary options:

- Regularly remind entire team about FASAP services
- Make supportive suggestion to individual
- **Facilitated Management Referral:** aims to address concerns about inappropriate workplace behavior and communication; allows managers to convey their concerns to FASAP and to receive updates, and allows FASAP to communicate attendance and engagement to manager.

JOHNS HOPKINS
UNIVERSITY & HEALTH SYSTEM

FASAP
The Faculty and Staff Assistance Program

How FASAP Helps Managers

Mandated referrals:

- **Fitness for Duty Assessment**: appropriate when there are concerns about safety or impairment; employee is off duty pending completion of assessment; requires prior consultation with department leadership (for faculty), human resources (for staff), and FASAP
- **Condition of Employment:** instituted by HR and departments and implemented by Occupational Health and FASAP; most often, used to support and monitor clients who have tested positive for drugs or alcohol at work.
- **Pre-employment** and **Return to Duty Assessments** for individuals referred to FASAP by Occupational Health Services.

JOHNS HOPKINS
UNIVERSITY & HEALTH SYSTEM

FASAP
The Faculty and Staff Assistance Program

Mental Health Services for Students at the Schools of Medicine, Nursing, and Public Health

JHSAP: 443.997.7000; www.JHSAP.org

- Shares a clinical and call-center team with FASAP; close coordination with FASAP.
- Assessment, short-term counseling, and referrals to treatment providers as appropriate.
- A 24/7/365 on-call line for urgent concerns; calls are triaged by a licensed counselor.
- Consultations for faculty and staff who are concerned about a student's mental health.

University Health Services, Mental Health: 410-955-1892

https://www.hopkinsmedicine.org/uhs/university_mental_health.html

- Therapy, when clinically indicated, psychiatric evaluation, and medication management.
- Documentation for Disability Support Services for active patients needing accommodations due to mental health diagnosis.
- On-Call clinician for urgent concerns for active patients.

Welch Library Resources

Accessing resources are on the home page of the Welch Library website, in the middle under the slideshow. If you are off-campus, you will be prompted to enter your JHED ID and password before you can access the book. If you are on-campus using the Hopkins network or a desktop, you may not be prompted for a password.

http://welch.jhmi.edu/welchone/search_eresources_results&r=t&term=&type=All

OR

https://catalyst.library.jhu.edu/

Some resources available online include:

- Clinical Practice of Emergency Medicine – Harwood Nuss
- Tintinalli's Emergency Medicine – Judith Tintinalli
- Clinical Procedures in Emergency Medicine – Roberts & Hedges
- Emergency Ultrasound – O. John Ma
- Manual of Emergency and Critical Care Ultrasound – Vicki Noble
- Atlas of Emergency Ultrasound – John C. Fox
- Feigenbaum's Echocardiography – William Armstrong
- Diagnostic Ultrasound Textbook – Carol Rumack
- Introduction to Vascular Ultrasonography – Pellerito
- Opthalmic Ultrasonography – Singh

Spiritual Care

The Johns Hopkins Hospital Department of Spiritual Care and Chaplaincy
1800 Orleans St, Osler 101
Baltimore, MD 21287-0019

Mission of Johns Hopkins Spiritual Care & Chaplaincy

- To provide excellent and effective spiritual care and chaplaincy support which attends to the spiritual needs of the patients, their families, staff and personnel of The Johns Hopkins Hospital.
- To provide opportunities for the discussion of the religious, spiritual and ethical dimensions of health care for clergy, health care professionals and interested laity.
- To engage in partnership with the religious community in Baltimore to promote health and wholeness.

Contact Information: 24x7 availability

(410) 955-5843 (8:30 am – 5:00 pm, Monday – Friday)
After 5:00 p.m., and on weekends and holidays, patients or visitors may ask a nurse or other staff member to contact the JHH On-Call Chaplain. Staff can also call the main hospital operator and ask for the JHH On-Call Chaplain (Evening, Weekends and Holidays) or contact the On-Call Pager at **(410) 434-0909 or #4-0909** (JHH On-Call Chaplain is also in CORUS)

Continuum of Care:
Pastoral Visitations & Interfaith Ministries

Pre/Post Surgery Prayers
Goals of Care Consultation
Lifestyle Changes
Anointing of the Sick
Confession and Absolution
Nurture/Emotional Support
End of Life Concerns
Ethics Consultations
Crisis Intervention
Short-term Pastoral Counseling
Religious and Cultural Diversity
Liaison to Community Clergy
Family Support
Spiritual Crisis
Blessing or Naming Services
Religious Education and Resources
Family Advocacy
Advance Directives
Family Conflict Resolution
Patient/Staff Resolution
Stress Management
Death, Bereavement
Grief Counseling
Memorial Services

Religious Services

Regularly take place at the Johns Hopkins Hospital, such as Catholic Mass, Protestant Worship, Jewish Minyan, and Muslim Prayer. For more information, times and locations, please contact:

Department of Spiritual Care and Chaplaincy
1800 Orleans St, Osler 101
Baltimore, MD 21287-0019
410-955-5843

Policy and Procedure Acknowledgement Record

The following policies have been reviewed with me and I agree to abide by them (please initial beside each policy or procedure as an acknowledgement of receipt and review):

Residency Requirements:

Chart Reviews and Patient Follow-Ups _____

Procedure Logs _____

Resident Conference (Attendance, Lecture Requirements) _____

Biannual Reviews/End of Residency Requirements _____

Longitudinal US Scanning Requirements _____

Simulation _____

Documentation Requirements _____

USMLE Examination Requirements _____

Residency Policies:

Academic Alert/Probation/Suspension & Dismissal _____

Non-Renewal/Non-Promotion _____

Individual Development Plans _____

Dress Code _____

Duty Hours Policy _____

Duty Hours Reporting _____

Moonlighting and Additional Shift Policy _____

Moonlighting in the PGY4 Year _____

Elective Policy _____

Code of Conduct _____

Jeopardy Policy _____

Disaster Deployment Plan _____

Parental Leave Policy _____

Leave for Residents _____

National Conference Attendance Policy _____

Professionalism _____

Physician Impairment Policy _____

Resident Supervision and Clinical Responsibility _____

Patient Care Transitions _____

Fatigue Mitigation _____

Patient Safety and Reporting _____

Raising Concerns Policy _____

Resident Retreat Policy _____

Scheduling Policy _____

Vacation Policy _____

Technology Policy _____

Meal Funds/Grubhub _____

I have received the following policies and will review and abide by them (please initial as acknowledgement of receipt):

JHMI Institutional Policies _____
All institutional policies can be found at the website listed below:
https://www.hopkinsmedicine.org/som/gme/residents-fellows#contracts-policies

Signature_____ Date _____