NEUROLOGY RESIDENT HANDBOOK

2024-2025

DEPARTMENT OF NEUROLOGY
UNIVERSITY OF ROCHESTER
SCHOOL OF MEDICINE AND DENTISTRY

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FOREWORD

This Neurology Resident Handbook is intended as a handy reference for all Neurology clinical faculty, residents and administrative staff. The handbook is divided into seven

ACGME NEW ACCREDITATION SYSTEM

At its February 1999 meeting, the ACGME endorsed general competencies for residents in the areas of

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

Identification of general competencies is the first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the D F F U H G L W D W L R Q S U R F H V V $ V R I - X O \ W K H $ & * 0 (¶ V 5 H V L G Institutional Review Committees have incorporated the general competencies into their Requirements. The following Neurology Core Competencies were developed by the American Board of Psychiatry and Neurology, and represent what each graduate of the adult neurology residency training program at the University of Rochester is expected to learn by the end of his/her residency. All evaluation instruments are keyed to these six core competencies.

In 2013, the ACGME adopted the New Accreditation System (NAS), effectively replacing the previous system of five-year site visits to residency programs that was focused on process and not outcomes. A key feature of the NAS will be the Milestones, which are a set of competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents and fellows from the beginning of their e /TT1 11.03.995 (byc(t)6.005 (i)5 (t)-4.004 (s)-4.004 (be)2.998 (h)13.007 (at)7.998 (

AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY
NEUROLOGY CORE COMPETENCIES

I. Patient Care and Procedural Skills

A.

2. Pathophysiology and treatment of major psychiatric and neurological disorders and familiarity with the scientific basis of neurology, including:
    a. Neuroanatomy
    b. Neuropathology
    c. Neurochemistry
    d. Neurophysiology
    e. Neuropharmacology
    f. Neuroimmunology/neurovirology
    g. Neurogenetics/molecular neurology and neuroepidemiology
    h. Neuroendocrinology
    i. Neuroimaging
    j. Neuro-ophthalmology
    k. Neuro-otology
    l. Child neurology
    m. Geriatric neurology
    n. Interventional neurology (basic principles only)
3. Neurologic disorders and diseases across the lifespan, including treatment for the following:
    a. Dementia and behavioral neurology disorders
    b. Epilepsy and related disorders
    c. Neuromuscular disorders
    d. Demyelinating and dysmyelinating disorders of the central nervous system
    e. Cerebrovascular disorders
    f. Infectious diseases of the nervous system
    g. Neoplastic disorders and tumors of the nervous system
    h. Nervous system trauma
    i. Toxic and metabolic disorders of the nervous system
    j. Acute, chronic pain
    k. Sleep disorders
    l.

r. Neurologic disorders associated with vitamin deficiency or excess

4. Patient evaluation and treatment selection, including:
   a.

iii. Iatrogenic disorders in psychiatry and neurology, changes in mental status, and movement disorders

iv. Nonpharmacologic treatments and management

6. Employment of principles of quality improvement in practice

III. Interpersonal [illegible]ions Skills

A. Neurol[illegible] shall demo[illegible]e the following competencies:

1. T[illegible]en to and understand patients and to attend to nonverbal c[illegible]unication

2. [illegible]omm[illegible]ctively with patients using verbal, nonverbal, and written a[illegible]prop[illegible]

3. [illegible]velop and main[illegible]therapeutic alliance with patients by instilling [illegible]gs of trust, hones[illegible]enness, rapport, and comfort in the relationship [illegible]hysicians

4. T[illegible]rtner with patient[illegible]evelop an agreed upon healthcare management p[illegible]

5. To [illegible]it inform[illegible] patients in [illegible]r and meaningful fashion

6. 7R X[illegible]WDQG WKH[illegible]SDFW RI SK\VLFLDQV¶ RZQ IHHO does not interfere with appropriate treatment

7. To communicate effectively and work collaboratively with allied healthcare professionals and with other professionals involved in the lives of patients and families

8. To educate patients, their families, and professionals about medical, psychosocial, and behavioral issues

9. To preserve patient confidentiality

B. Neurologists shall demonstrate the ability to obtain, interpret, and evaluate consultations from other medical specialties. This shall include:

1. Knowing when to solicit consultation and having sensitivity to assess the need for consultation

2. Formulating and clearly communicating the consultation question

3. Discussing the consultation findings with the consultant

4. Discussing the consultation findings with the patient and family

C. Neurologists shall serve as an effective consultant to other medical specialists, and community agencies by demonstrating the abilities to:

1. Communicate effectively with the requesting party to refine the consultation question

2. Maintain the role of consultant

3. Communicate clear and specific recommendations

4. Respect the knowledge and expe1(t)-4(i)00912 0 6120 612 792 re W* n BT /F2 11.04 Tf 1 0 0

D.

7. Appropriate education concerning the disorder, its prognosis, and prevention strategies

IV. Practice -Based Learning and Improvement

A. Neurologists shall recognize limitations in their own knowledge base and clinical skills, and understand and address the need for lifelong learning.

B. Neurologists shall demonstrate appropriate skills for obtaining and evaluating up-to-date information from scientific and practice literature and other sources to assist in the quality care of patients. This shall include, but not be limited to:

1. Use of medical libraries
2. Use of information technology, including Internet-based searches and literature databases
3. Use of drug information databases
4. Active participation, as appropriate, in educational courses, conferences, and other organized educational activities both at the local and national levels

C. Neurologists shall evaluate caseload and practice experience in a systematic manner. This may include:

1. Case-based learning
2. Use of best practices through practice guidelines or clinical pathways
3. Review of patient records
4. Obtaining evaluations from patients, e.g., outcomes and patient satisfaction
5. Employment of principles of quality improvement in

4. Demonstration of skills for the practice of ambulatory medicine, including time management, clinical scheduling, and efficient communication with referring physicians
5. Use of appropriate consultation and referral mechanisms for the optimal clinical management of patients with complicated medical illness
6. Demonstration of awareness of the importance of adequate cross-coverage
7. Use of accurate medical data in the communication with and effective management of patients

B. In the community system, neurologists shall:

1. Recognize the limitation of healthcare resources and demonstrate the ability to act as an advocate for patients within their sociocultural and financial constraints
2. Demonstrate knowledge of the legal aspects of neurologic diseases as they impact patients and their families
3. Demonstrate an understanding of risk management.

C. Neurologists shall demonstrate knowledge of different health care systems, including:

1. Working within the system of care to maximize cost effective utilization of

GOALS OF THE NEUROLOGY RESIDENCY TRAINING PROGRAM

Overall Competency -Based Program Goals

Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Residents must demonstrate competency in the [management of outpatients and inpatients with neurological disorders across the lifespan, including those who require emergency and intensive care.

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical,

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
2.

Goals for the Third Year in Neurology

1. To independently evaluate and manage patients presenting with a wide variety of inpatient and outpatient neurological disorders. PC
2. 7R SHUIRUP DQG LQWHUSUHW (0*¶V 1HUYH &RQGXFWLRQ 6WXG testing. PC, MK
3. To supervise junior residents on the inpatient neurology services at Strong Memorial Hospital. PBLI, SBP
4. To participate as a laboratory instructor in the Medical Student Nervous System Course. PBLI

Goals for General Neurology Rotations

1. To develop skills in obtaining complete neurological histories, in performing accurate neurological examinations, and in selecting appropriate therapies on a general neurology consultation service in a tertiary referral center. PC
2. To acquire in-depth knowledge of major categories of neurological disease, with special emphasis on epilepsy, coma and mental status changes, movement disorders, neuromuscular disorders, demyelinating disorders, infections of the nervous system, tumors of the nervous system, head trauma and dementia. MK
3. To gain experience in the appropriate ordering and interpretation of neurodiagnostic tests, including head and spine CT and MR scans, EEG, Evoked Potential Testing,

Goals for Chief Resident Year

1. To become independent in the evaluation and management of patients presenting with a wide variety of inpatient and outpatient neurological disorders. PC
2. To gain experience supervising junior residents on the inpatient neurology services at Strong Memorial Hospital. PBLI, SBP
3. To develop administrative skills with respect to organizing and scheduling teaching conferences for the department of neurology. SBP

Key to Core Competencies:

PK	Patient care
MK	Medical knowledge
PBLI	Practice-based learning and improvement
ICS	Interpersonal and communication skills
P	Professionalism
SBP	Systems-based practice

The ACGME Milestones Project

How will the Milestones be used by the ACGME?
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specific data for the specialty Review Committees to use in assessing the quality of residency and fellowship programs and for facilitating improvements to program curricula and resident performance if and when needed. The Milestones will also be used by the ACGME to demonstrate accountability of the effectiveness of graduate medical education within ACGME-accredited programs in meeting the needs of the public.

Milestone Reporting

Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation.

Patient Care 1: History				
Level 1	Level 2	Level 3	Level 4	Level 5
Obtains a basic	Obtains a complete and	Obtains an organized		

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Patient Care 3: Formulation

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Patient Care 6: Diagnosis and Management of Neurologic Emergencies				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes the typical presentation of	Recognizes when a S D W L H Q W ¶ V S U H	Diagnoses neurologic	Re-appraises diagnostic	Serves as a role model

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Patient Care 7: Determination of Death by Neurologic Criteria				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of medical and legal significance of	Lists the components for determining death by neurologic criteri11802 0 79	Describes supplemental testing used to determine	Accurately performs determination of death	Educates others in the determination of death by

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Patient Care 8: Interpretation of Neuroimaging				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies basic neuroanatomy on brain and vascular anatomy of the head and neck magnetic resonance (MR) and computed tomography (CT)	Identifies major abnormalities of the brain			

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Patient Care 9: Electroencephalogram (EEG)				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies patients for whom EEG is appropriate	Recognizes normal EEG features, including common artifacts, in children and adults	Recognizes patterns of status epilepticus, normal EEG variants, and common abnormalities in children and adults	Interprets common EEG abnormalities and patterns that could represent status epilepticus	Interprets uncommon EEG abnormalities and creates a report
Comments:				

Not Yet Completed Level 1

Not Yet Assessable

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Patient Care 10: Nerve Conduction Study/Electromyogram (NCS/EMG)				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies patients for whom NCS/EMG is appropriate	Identifies NCS/EMG findings for common disorders	Correlates NCS/EMG results to patient presentation, including identification of potential study limitations	Formulates basic NCS/EMG plan and interprets data for common clinical presentations	Performs, interprets, and creates a report for NCS/EMG
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐
				Not Yet Assessable ☐

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Medical Knowledge 1: Localization				
Level 1	Level 2	Level 3	Level 4	

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Systems -Based Practice 1: Patient Safety				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of commonly	Identifies system factors that lead to patient safety	Participates in analysis of patient safety events	Conducts analysis of patient safety events	Actively engages teams and processes to modify

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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	Coordinates care of patients in routine clinical situations effectively using the roles of the			
Performs safe and effective transitions of care/hand-offs in routine clinical situations				

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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, and to incorporate patient preferences and values to care for a routine patient	Articulates clinical questions and elicits patient preferences and values to guide evidence-based care	Locates and applies the best available evidence, integrated with patient preference, to the care of complex patients	Critically appraises and applies evidence, even in the face of uncertainty, and interprets conflicting evidence to guide care, tailored to the individual patient	Coaches others to critically appraise and apply evidence for complex patients, and/or participates in the development of guidelines
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
Not Yet Completed Level 1 ☐				

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Professionalism 1: Professional Behavior and Ethical Principles				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies and describes	Demonstrates insight into	Demonstrates	Intervenes to prevent	Coaches others when

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Interpersonal and Communication Skills 3: Interprofessional and Team Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Respectfully requests a consultation	Confirms understanding of consultant recommendations	Clearly and concisely formulates a consultation request	Coordinates recommendations from different members of the health care team to optimize patient care	Role models and facilitates flexible communication strategies that value input from all health care team members, resolving conflict when needed
Recognizes the role of a neurology consultant	Respectfully accepts a consultation request	Clearly and concisely responds to a consultation request		
Uses language that values all members of the health care team	Communicates information effectively with all health care team members	Uses active listening to adapt communication style to fit team needs	Solicits and communicates feedback to other members of the health care team	
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐

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THE RESIDENCY IN-SERVICE TRAINING EXAM (RITE)

Objective

The American Academy Neurology (AAN) Residency In-service Training Examination (RITE) is a self-assessment tool designed to gauge knowledge of neurology and neuroscience, identify areas for potential growth, and provide references and discussions for each.

Examination Features

- Content outline that aligns with the ABPN Certification Examination in Neurology. View the 2024 topic outline here.
- 400 multiple-choice questions administered in two parts (3.5 hours each) on the same day
- Written and reviewed by a panel of recognized experts to ensure accuracy, clarity, relevance to practice, and topical balance of questions
- Images that include CT scans, MR images, EEGs, and full-color pathologic representations
- Online exam administration via the web-based Surpass platform
- A scoring process conducted by a professional data systems company to ensure the highest quality data collection with an accuracy rate in excess of 99.9%
- A downloadable RITE Discussion and Reference Manual that provides the test questions, explanations of the correct answers, relevant images, and current references to guide independent study

RITE Scores

- Residents will receive an

ABPN CLINICAL SKILLS EVALUATION OF RESIDENTS

The American Board of Psychiatry and Neurology (ABPN) mandates that demonstration of clinical skills competency is a basic requirement in order to apply for certification in the specialties of neurology and neurology with special qualification in child neurology. Competency in these skills should be achieved during residency. The ABPN requires that residents demonstrate competency in the following areas:

- Medical interviewing
- Neurological examination
- Humanistic qualities, professionalism, and counseling skills

Demonstration of competency in evaluating a minimum of five different patients during residency training is required, as follows:

1. Critical care: One critically ill adult patient with neurological disease (may be in either an intensive care unit or emergency department setting or an emergency consultation from another inpatient service)
2. Neuromuscular: One adult patient with a neuromuscular disease (may be in either an inpatient or outpatient setting)
3. Ambulatory: One adult patient with an episodic disorder, such as seizures or migraine (most likely in an outpatient setting)
4. Neurodegenerative: One adult patient with a neurodegenerative disorder, such as dementia, a movement disorder, or multiple sclerosis (most likely in an outpatient setting)
5. Child patient: One child patient with a neurological disorder (most likely in an outpatient setting)

The program coordinator and other administrative staff will schedule the clinical skills examinations during appropriate inpatient or outpatient rotations. If the examination cannot be completed as scheduled (i.e. due resident/faculty illness/emergency or patient cancellation/no-show), please let the Neurology program coordinator know as soon as possible in order to reschedule.

NB:

- The clinical skills evaluation session must be scheduled with the attending in advance and the evaluation form must be completed by and discussed with the attending immediately following the encounter. Retrospective completion of the evaluation form by the attending is not allowed by the ABPN.

MEDICAL STUDENT ASSESSMENT

UR medical students complete evaluation forms on neurology residents using the MedHub system. All neurology residents are evaluated by 3rd year medical students for their teaching efforts during the 3rd year neurology clerkship. In addition, the neurology chief residents are evaluated by the 2nd year medical students for their teaching efforts in the Mind, Brain and Behavior course, where the residents function as laboratory instructors and PBL tutors. The program director reviews this medical student feedback with each resident during the semi-annual evaluation meetings. This feedback is also I L O H G L Q H D F K U H V L G H Q W ¶ V H Y D O X D W L R Q I R O G H U

CHART REVIEW

Chart review can provide evidence about clinical decision-making, follow-through in patient management and preventive health services, and appropriate use of clinical facilities and resources (e.g., appropriate laboratory tests and consultations). These reviews help us satisfy requirements for the ACGME Practice-Based Learning and Improvement and Interpersonal Communication Skills comptetencies.

Each resident will select one new patient consultation or admission note, and one new outpatient clinic note semi-annually and submit these to the supervising attendings for their review. The neurology attendings will complete the form below and will also provide verbal feedback to the resident concerning the written notes.

The following items from each note will be specifically reviewed by the attending:

- Chief complaint or reason for consultation
- History of the Present Illness
- Past medical history
- Neurological examination
- Assessment and differential diagnosis
- Diagnostic and treatment plan

The resident should perform a brief topic review/literature search appropriate for the

Department of Neurology
University of Rochester
Resident Chart Review

Resident	_____	Year in training	_____
Attending physician	_____	Rotation	_____
Patient ID number	_____	Date of review	_____

Each resident will select one new patient consultation or admission note, and one new

RESIDENT CASE LOG

Case logs document each patient encounter by medical conditions seen. Patient case logs involve recording of some number of consecutive cases in a designated time frame.

Logs of types of cases seen are useful for determining the scope of patient care experience. Regular review of logs can be used to help the resident track what cases must be sought out in order to meet residency requirements or specific learning objectives. Patient logs documenting clinical experience for the entire residency can serve as a summative report of that experience; the numbers reported do not necessarily indicate competence.

Residents are encouraged to create a case log of inpatients seen while they are on service in the eRecord system, including:

- ED consultations
- Hospital adult consultations
- Hospital pediatric consultations
- 5-1600 inpatients
- Highland Hospital consultations

Each resident must log the following procedures in MedHub:

- Successful lumbar puncture (5 are required by the end of PGY4)
- NIH Stroke Scale certification, which can be completed via one of the following online resources:
  - BlueCloud (free) https://www.healthcarepoint.com/sign-up-home-page/
  - The American Heart Association ($10 cost associated) https://education.heart.org/productdetails/nih-stroke-scale-test-group-a
- Tenecteplase training

Barnes Jewish bedside dysphagia training must be completed in MyPath, followed by an in-person observation by a member of our Stroke quality team. Once this observation is completed, the resident must attest completion in MyPath

The Program Director will review the case and procedure logs with each resident during his/her/their semi-annual evaluation meeting.

RESIDENT PORTFOLIO

SEMI-ANNUAL EVALUATIONS

Each resident will meet with the Adult Neurology Program Director on a semi-annual basis to review his/her progression through each post-graduate year. Adult Neurology PGY2 residents will have an initial meeting at the three month mark, then semi-annually after that. Topics for discussion include:

- Evaluations from faculty and medical students
- Compliance with program and institutional requirements
- Assessment of wellness
- Performance on clinical skills exams and RITE
- Quality improvement/research project development and progress
-

ACGME Core Competency Project

University of Rochester Neurology Residency Training Program

Methods of Evaluation

Competency	RITE	Clinical Skills Evaluation	Chart Review	Resident Case Log	Attending Global Assessment	360 **q** Evaluation	Resident Portfolio
Patient Care		X	X	X	X		X
Medical Knowledge	X	X	X		X		X
Practice -Based Learning and Improvement					X	X	X
Interpersonal &							

ACGME Core Competency Project

University of Rochester Neurology Residency Training Program

Methods of Instruction - Sites

Competency	Inpatient Neurology Rotation	Inpatient Consultation Rotation	HH Rotation	ED Consultations	Neurology FIRM	Faculty Clinics	Resident Conferences and Rounds
Patient Care	X	X	X	X	X	X	X
Medical Knowledge	X	X	X	X	X	X	X

DEPARTMENT OF NEUROLOGY
RESIDENT MENTORING PROGRAM

The Neurology Resident Mentoring Program is a longitudinal 4-year experience that focuses on guiding residents in 4 key areas:

1. Fellowship and career decisions
2. Structured development of a scholarship project
3. Defining personal and professional career goals
4. Developing leadership skills

YEAR ONE
Residents complete a written assessment to identify goals, career interests, and research interests, and meet individually with the mentorship director to discuss. Residents are then paired with a specific mentor by the end of PGY1. Their mentors are intended to help throughout residency and may also serve as their research, content, and/or subspecialty mentor.

YEAR TWO
Following a kickLangc(l)5TWOFollowa kickLe W* 0 G 4(r)awis14(t)-4(,)6e4(a ki1 Tm 0 t 0 g 0 0 0 1 10ski1 Tm

DEPARTMENT OF NEUROLOGY
RESIDENT AND FELLOW RESEARCH SYMPOSIUM

care. They attend morning huddle at 8:30 a.m. and afternoon huddle at 2:30 p.m. on 516/2:40 p.m. on 536 (if applicable). They take sign out from the Red and Blue teams at 4:30 p.m. and provide cross-coverage until 7:30 PM. At that time, the Neuroscience APPs sign out to the Medicine APPs on call overnight. There is a shared APP stroke list for other team members to look at so the PGY1/2 residents on Red Team know who they do/do not need to see. Patients are placed on the list by the APP at the end of the day. The Neuroscience APP independently evaluates the patient, writes the daily notes, and performs discharge paperwork including the discharge summary. They oversee all stroke patients and assist with their care as needed. They also assist the Blue Team when needed,

Teaching Rounds:

- Teaching Rounds are held every weekday morning from 9:00 am ±12:00 pm. Times are subject to change, depending on census, acuity of the patients, and afternoon responsibilities of the residents on service (i.e. FIRM, didactics).

The goals and objectives for Attending Rounds, as well as guidelines for conducting them, are included elsewhere in this handbook.

Admission Guidelines - Weekdays:

- The Stroke and General Teams accept admissions from General and Stroke consult services based on suspected admission diagnosis each weekday in the morning and throughout the day if the patient arrives to the Neurology floor prior to sign-out rounds at 4:30 p.m.

- Elective admissions: Elective admissions that arrive on the floor by 4:30 p.m. are admitted by the appropriate floor team, either the neurology PGY-

Consult rounds: Each consultation team will round with the Attending usually twice daily at a mutually convenient time (typically in AM and then early PM). All new patient consultations should be formally presented to the Attending on rounds that day. Follow-up patients may be seen by the Attending at the discretion of the PGY-3 neurology resident and the Attending on service.

Transfer notes and orders: The neurology PGY-3s on each consultation service are responsible for writing a transfer accept note for any of their patients who are being transferred to 5-1600 from an ICU other than the NMICU or another service. The transfer/accept notes for patients being called out of the NMICU are written by the appropriate chief or call resident. Transfer orders also need to be written, and may be entered by either the consult resident or the accepting team.

Admission notes and orders: When a patient seen in consultation will be admitted to the Stroke or General floor team, the neurology PGY-3 consult resident is responsible for writing the D G P L V V L R Q Q R W H D Q G R U G H U V I R U W K D W S D W L H Q W- D Q G D G G L Q record. The neurology PGY-3 should then communicate the pertinent information regarding the S D W L H Q W ¶ V S U H V H Q W D W L R Q D Q G S O D Q W R W K H D S S U R S U L D W H

Cross -Coverage: The neurology urgent care (UCEF) resident cross-covers for the Stroke and General neurology consult residents on the afternoons when either of them is in clinic.

Weekend coverage: The neurology PGY-3 consult residents each come in on one day each weekend and will round on both consult teams providing cross coverage of the consult services. If the resident is also on-call and is the primary day float resident, this shift starts at 8am and they must often be on-call and rounding with attendings simultaneously with the back up call resident free to assist in seeing consults by 12 pm. If they are on back-up call on the weekends, they should complete their work by 12 pm to be able to start assisting the day float resident. If the consult resident is not on-call, they are free to leave the hospital once all of their work is completed.

Evening, Night, and Weekend Coverage

- The neurology evening and night float residents are responsible for all adult ED patients triaged to Neurology, as well as adult and pediatric neurology consultations in the hospital, the ED, the R wing, WCC, and the ICUs. They are the primary providers for all admitted SEC patients. In addition, they may be called concerning problems with patients already being followed on the consult services and provide back-up coverage to the APP service cross-covering neurology inpatients on 5-1600.
- On Saturdays and Sundays, the neurology weekend (day float) and night float residents are responsible for all neurology consultations and admissions, including direct admissions to 5-1600.
- There are two residents on call during the day on all weekends from 8 am to 8 pm. The primary call resident is the day float resident and the second resident is the ³ % D-FXNS ´ Z K L F K L V H V V H Q W L D O O \ D V H-FXRSQ G HVDL\ GHORDWW \ 7KLEVD ³EDFKNDV L (floors, chief, consults). The BU is expected to start splitting consults and clinic calls (1:1) with the DF as soon as they complete their inpatient work, and no later than 12pm.

- The UC resident should participate in sign-out rounds at 4:30 pm, taking sign out from the floor teams regarding any active patients or patients in the Neurology step-down unit and will then subsequently provide this information to the Night Float resident.
- During the evening hours (4:30 pm to 10 pm), the UC resident will have the following responsibilities:
    - Work together with evening float (EF) resident in performing inpatient consults. The EF will receive the consult and clinic call pages and will divide these equally with the UC resident. The UC and EF residents should both carry a consult mobile phone to facilitate direct communication.
    - The UC resident should be assigned as covering provider for all SEC inpatients, newly-admitted patients, and step-down patients until 8 pm. They, as well as the EF, will also provide assistance to the covering APPs for the floor patients as needed, particu

Evening and Night float hours:

Night float:	Week 1: Saturday through Friday	8 PM ±8 AM (home by 9:00 AM)
	Week 2: Sunday through Friday	
	Saturday night:	Off
Evening float:	Monday through Friday:	4:30 PM ±8 PM (off by 9:00 PM)
Urgent care:	Monday through Friday:	12 PM ±10 PM
Weekends:	( )] TJ ET Q Q EMC q d9 Tn	

- All patients located in the neurology step-down unit will be covered by the Neurology on-call resident as mentioned above. These patients should not be covered by the APP service.

- All consults seen by the on-call resident should be staffed with either the stroke fellow/attending, chief resident, or general neurology attending. Any general patient who is being admitted to the hospital or is already admitted can be staffed by the chief resident unless the chief feels that attending input is needed. Stroke consults should be staffed with the stroke fellow on call or attending if no fellow is on call. Any patient that is being discharged from the hospital or ED or may be discharged should be staffed with a fellow or attending.

Responsibilities of the Neurology Chief Resident

- General Responsibilities: The Neurology Chief Residents are responsible for the smooth operation of the Neurology Inpatient General and Stroke Services on 5-1600 as well as the consult services. Each chief should closely monitor work-up and management for all patients admitted to Neurology and their respective Stroke/General teams, assist with the evaluation of acutely unstable patients, provide support and give feedback to all 5-1600 house staff. They are also responsible for seeing any NMICU call-outs during the day. They should also be available to help with any tasks for the inpatient teams, such as updating families, helping with discharge summaries, and other tasks as needed.

- Work rounds on 5 -1600: The Stroke and General Chief Residents will attend work rounds at 9:00 AM with their respective teams.

- Support for the on -call Resident: The Chief resident on-call provides primary support for the neurology on-call resident. This is particularly crucial for the neurology PGY-2s, and especially during the first six months of their residency. The Chief Resident should specifically be notified if the on -call resident is more than 4 consults behind and/or has more than 2 acute consults within 30 minutes. Otherwise, on-call residents are expected to call the Chief with any other concerns and the Chief is expected to provide assistance both via phone and in person as necessary. It is also expected that any general neurology patients seen by the call residents, including overnight, who are either being admitted to the hospital or are already admitted to the hospital be staffed with the chief resident on call. Any patients who are being discharged from the hospital or ED should be staffed with an attending or fellow.

- Availability: The Chief Resident who is listed on-call is expected to be available at all times, including overnight.

- Weekends: The Stroke and General Chief will come in on one day each weekend, these are pre-designated in the call-schedule. The intern of their respective team will come in on the same day as the chief. The chief is responsible for all new admissions for their respective team and seeing follow-ups beyond the 10-patient intern cap. The chief is responsible for providing support to all junior residents on the weekends.

- Direct Admissions: The chief resident is responsible for coordinating direct admissions to the Neurology service from the outpatient setting.

- Urgent Outpatient Consultations: The Chief Resident is responsible for arranging to see any outpatients who need to be evaluated urgently and who cannot be scheduled in the Firms within a week. He/she will have a room reserved in the Neurology clinic one afternoon each week for these patients. The General Neurology Attendings are responsible for staffing these patients with the Chief Resident.

- Grand Rounds: One Chief Resident is designated to be in charge of scheduling and emceeing weekly Grand Rounds, with assistance from the Chair of Neurology and Associate Chair for Education.

NEUROLOGY CONFERENCES/TEACHING ROUNDS SCHEDULE

MONDAY
7:30 AM ±8:00 AM: Morning Report
9:00 AM ±12:00 PM: Attending Rounds

TUESDAY
7:30 AM ±8:00 AM: Morning Report
9:00 AM ±12:00 PM: Attending Rounds

WEDNESDAY
9:00 AM ±12:00 PM: Attending Rounds
12:00 PM ±1:00 PM: Department of Neurology Grand Rounds
1:00 PM ±5:00 PM: Neurology Resident Didactics

THURSDAY
7:30 AM ±8:00 AM: Neuroradiology Conference
9:00 AM ±12:00 PM: Attending Rounds

FRIDAY
7:30 AM ±8:00 AM: Morning Report
9:00 AM ±12:00

Sign-out and Coverage Details:
Before being excused for educational conferences, all residents MUST sign-out to the covering team members. They also should make their personal pager unavailable, list their Haiku secure chat status as unavailable (and list the covering provider), and hand off the service pagers. Excused residents must ensure that handoffs and patients lists are updated before leaving for didactics. Neurology PGY1 residents do not attend the Wednesday afternoon educational sessions, unless the inpatient service is very light; in that case, they must remain available by pager/phone/e-record at all times and excuse themselves if required for patient care.

The Blue PGY2 will sign-out to the covering Attending and Blue PGY1.
The Red PGY2 will sign-out to the Neuromedicine APP on the Red Team.

The Stroke consult

INPATIENT ATTENDING PHYSICIAN'S RESPONSIBILITIES

Teaching Responsibilities

1. The primary responsibility of the Stroke and General Neurology Attending Physicians is to teach the House Staff on the inpatient and consultation services. A focal point of this teaching are the Attending Rounds, which occur daily according to the schedule below. However, Attending Physicians may elect to start rounding earlier, depending on the needs of the team on a given day.

Monday	9:00 am - 12:00 pm	Attending Rounds
Tuesday	9:00 am - 12:00 pm	Attending Rounds
Wednesday	9:00 am - 12:00 pm 12:00 pm - 1:00 pm	Attending Rounds Neurology Grand Rounds
Thursday	9:00 am - 12:00 pm	Attending Rounds
Friday	9:00 am - 12:00 pm	Attending Rounds

2. Residents are asked to be well prepared for Attending Rounds and to meet promptly at the appointed hour. Each resident is expected to be at Rounds unless an acutely ill patient needs immediate attention.

3. Rounds should be built around the patient's central problem with teaching directed primarily at the first year neurology residents. Patient presentations should take place at the bedside, when possible.

4. Attending Rounds will include formal case presentations by the intern or medical student, bedside teaching by the attendings, and management discussions with the team.

5. Interruption of Rounds should be kept to a minimum. Where there is an acute problem needing attention, the chief resident should excuse him or herself and see the patient allowing the PGY-1 and PGY-2 to remain at Rounds. Attendings should pay particular attention to time on Wednesdays, in order to complete morning work in time for residents to be released to attend Grand Rounds followed by Wednesday afternoon didactics.

6. Attending Rounds should be directed actively by the Attending with appropriate cding

Evaluation Responsibilities

1. The Residency Program Director is required to certify that each resident, at the end of his or her residency training, is clinically competent in each of the six ACGME Core Competencies in order to be qualified to sit for the ABPN Certifying Examinations. Ongoing evaluation is required of faculty members who teach and supervise residents.

2. Global Assessment Forms evaluating all six ACGME Core Competencies and a subset of the Milestones are available through the MedHub system and must be filled out by the Attending for each resident with whom he/she has worked for at least one week. It is important to write at least 2 or 3 sentences in the text box summarizing the resident's performance. In order to provide more accurate evaluations, the attending should keep notes on the performance of each resident throughout the attending period.

3. The attending should direct teaching not only to enhance medical knowledge and clinical judgment, but also to improve individual clinical skills. During the attending period, the PGY-1 or PGY-

Evaluation of Attendings

Each resident is asked to evaluate the attending on the following 10 areas:

	Low 1 2 3 4 High 5
1. Interest in Teaching	
2. Ability to Teach Outside Own Specialty	
3. Demonstrating Appropriate Physician Attitudes	
4. Bedside Teaching of Interview and Physical Dx	
5. Basic Science Correlation	
6. Teaching Diagnostic Reasoning	
7. Teaching Medical Facts	
8. Appropriate Involvement of all on Rounds	
9. Stimulating Acquisition of New Knowledge	
10. Review of Medical Records with Comments	
OVERALL RATING	

Attendings are encouraged to review their own evaluation file kept in the Chair's office.

HIGHLAND HOSPITAL
1st YEAR NEUROLOGY RESIDENT ROTATION

Highland Hospital
1000 South Avenue
Rochester, NY 14620

Highland Hospital is a 261-bed, full service hospital established in 1889. It became part of the University of Rochester Medical Center in 1997, and has developed centers of excellence in

CHILD NEUROLOGY RESIDENT ROTATION

Objectives

The overall goal for the three-month rotation in Child Neurology is for the neurology resident to be proficient in obtaining histories and performing neurologic examinations on infants and children. Additional goals include learning about normal growth and development and understanding the interrelationship between development and abnormalities of the nervous system.

In order to achieve these goals, the resident should be involved in the work-up and management of infants and children of various ages in both the inpatient and outpatient settings. Furthermore, the resident should have an opportunity to discuss and read about the problems he/she is seeing.

The common neurologic problems of childhood are to be emphasized. These include:

1. Perinatal Problems in Premature and Full Term Infants
    - Perinatal asphyxia
    - Intracranial hemorrhage and hydrocephalus
    - Hypotonia
    - Seizures
    - Birth injuries to the nervous system (including to the brachial plexus)

2. Developmental Delay and Intellectual Disability
    - Global Developmental Delay
    - Delayed motor development (including cerebral palsy)
    - Delayed speech/language development
    - Delayed cognitive development
    - Abnormal social development (including autism)

3. Childhood Seizures
    - Neonatal Seizures
    - Febrile Seizures
    - Idiopathic Generalized Epilepsies (including childhood absence and juvenile myoclonic)
    - Idiopathic and Symptomatic Focal Epilepsies (including Benign Rolandic)
    - Infantile Spasms (West Syndrome)
    - Lennox-Gastaut syndrome

4. Headaches
    - Migraine and variants in childhood including:
        - Benign paroxysmal torticollis
        - Benign paroxysmal vertigo of childhood
        - Hemiplegic migraine
        - Abdominal migraine / cyclic vomiting
        - Ophthalmoplegic migraine

- x Idiopathic Intracranial Hypertension

5. Learning, Attention, and Behavioral Disorders
   - x Attention Deficit Hyperactivity Disorder
   - x Learning disabilities (including dyslexia)

6. Movement Disorders
   - x Tics
   - x Dystonia/Chorea
   - x Ataxia

7. Head injuries
   - x Acute and subacute care
   - x Sequelae and rehabilitation

8. Neurogenetics
   - x Genetic considerations in developmental disability, CNS malformation, and epilepsy
   - x Chromoso

- The neurology resident will be expected to read about the problems they are seeing, both in the standard pediatric neurology texts and in the literature. A suggested reading list with links to articles is available on the Neurology intranet page under Pediatric Neurology at http://intranet.urmc-sh.rochester.edu/depts/neurology/peds/.
- Typically, the neurology resident will be assigned 4 weeks on the inpatient service, 2 weeks on the consult & call rotation, and 6 weeks on the outpatient service.

Responsibilities of the Adult Neurology Resident

- Please refer to the University of Rochester Child Neurology resident handbook for current guidelines and resident responsibilities for each child neurology rotation.

NEUROLOGY ED NINJA ROTATION

Description:
The Neurology ED Ninja role was created to enable senior residents to improve their acute care and patient triage skills, as well as to offload the busy inpatient consultation services to maintain duty hours restrictions and improve wellness among residents.

Objectives:
1. To evaluate acute, undifferentiated neurologic patients in the SMH emergency department.

2. To initiate appropriate urgent management as required.

3. To triage evaluated patients for either discharge or admission to the most appropriate inpatient medical or surgical service.

4. To communicate treatment and disposition decisions effectively to emergency room and inpatient personnel (including inpatient Neurology services if applicable).

RESPONSIBILITIES OF NEURO ED NINJA RESID ENT

HOURS: 7 AM - 4:30 PM, Monday-Friday

The Ninja is responsible for seeing all NON STROKE

PSYCHIATRY ROTATION
For Neurology Residents

PSYCHIATRY CONSULTATION / LIAISON SERVICE (PCLS)

The four-week psychiatry rotation for neurology residents is designed to teach fundamentals of psychiatry that are beneficial for the practice of neurology. This rotation was established as a result of the Neurology RRC guidelines, which mandate a one-month rotation in Psychiatry, under the direction of a board-certified psychiatrist.

Rotation Director - Jennifer Richman, MD - Medical Director, PCLS

Phone: 275-3592 (Constance Smith, Division Secretary)

Faculty: Jennifer Richman, MD; Aspen Ainsworth, MD; Paul Geha, MD; Mark Oldham, MD; Greg Sherman, MD;

Clinical Coordinator: Barbara Olesko, MS, RN, CS, NP (Pager number 3858)

First day of service: Report to the PCLS office, Room 1-8129 at 8:45 am.

Program Description

The Psychiatric Consultation ±Liaison Service provides evaluation and assistance with the management of psychiatric disorders occurring in medically ill inpatients throughout SMH. During their C/L rotation, PGY-4 residents will develop skills in the assessment of psychiatric problems in a medical setting, master the understanding of the interaction and medical and neurological conditions with psychiatric disorders, and begin to develop the skills of a specialty consultant.

A wide variety of neuropsychiatric, forensic and psychosomatic problems are frequently encountered on the C/L Service, including:

- Acute confusional states and delirium
- Dementing disorders
- Depression in the elderly or medically ill
- Capacity to make informed decisions
- Suicide attempts and suicidality on the medical floors
- Somatoform and factitious disorders
- Psychogenic nonepileptic attacks (PNEA)
- Anxiety/agitation in the medically ill
- Secondary anxiety, mood and psychotic disorders
- AIDS-related secondary mental disorders
- Substance abuse

Training Objectives

Medical Knowledge

1. Develop knowledge base of psychiatric and neurologic aspects of psychiatry, psychosomatic disorders, delirium, depression and anxiety in the elderly and the medically ill patient.
2. Management of primary mental disorders and mental disorders secondary to medical conditions in the medical setting.
3. Understand potential risks/benefits of using psychotropic medications in the medically ill and geriatric patient.
4. Assessment of suicide risk and management on medical floor.

Patient Care

1. Conduct comprehensive and accurate psychiatric interviews and review of data.
2. Formulate a comprehensive differential diagnosis, case formulation, and treatment recommendation.
3. Develop and sustain effective therapeutic and ethnically sound relationships with patients.

Mentorship	
x Be familiar with the training objectives and expectations of this clinical rotation.	x Review the training objectives and the site expectations herein with the resident at the beginning of the rotation.
x Complete readings as clinically indicated and assigned.	x Provide readings to resident as clinically indicated.
x Meet with the attending supervisor or responsible person one half hour weekly for supervision in addition to bedside teaching.	x Meet one half hour per week with resident for individual supervision in addition to bedside teaching.
Clinical Responsibilities	
x Complete new consults as assigned daily, approximately 2-3 consults per day	

NEUROMEDICINE INTENSIVE CARE ROTATION
For PGY-2 and PGY-3 Neurology Residents

Medical Director: Debra Roberts, MD, PhD
Surgical Co-Director: Thomas Mattingly, MD
Nurse Manager: Sarah Gantz, RN, MSN
Lead Advance Practice Practitioner/Scheduler: Jeanette McCorry MS, PA-C

NMICU Intensivists :

- Neuro Critical Care: Imad Khan MD; Ben George MD, Remi Okwechime MD
- Anesthesia Critical Care: Peter Papadakos MD

Advance Practice Providers :

- Jeanette McCorry, PA-C, NMICU Lead APP
- Samantha Deland, PA-C
- Sara Finney, PA-C
- Jenna Gonillo-Davis MS, ACNPC-AG, CCRN
- Abby Judd, PA-C
- Kelli Outlaw-Wilder, ACNP
- Jamie Pica, ACNP
- Christina Skifstad, ACNP
- Andrew Tsavaris, ACNP

For schedule questions please contact: Pam Marks, Pamela_marks@urmc.rochester.edu.
585-275-9238.

Mission Statement

The NeuroMedicine , Q W H Q V L Y H & D U H 8 Q L W ¶ V P L V V L R Q L V W R S U R Y L G H V critically ill neurosurgical and neurological patients.

Patient Population tion

procedures and keeping the attending informed of any emergent situations. They also assist with resident education when time allows.

Depending on the census, the APP may pick up patients. However, this will mainly fall to the residents as the APP chief responsibilities will be to carry the primary phone for the unit (x44569), attend to acute issues that arise with patients throughout the day and cover the fellow responsibilities when the fellow is not on the schedule or has educational requirements.

NeuroMedicine ICU Residents

meetings. The fellow may lead daily rounds, as appropriate and to be determined by the attending on service.

Because of the full time presence of the APPs in the NMICU, off-service fellows should utilize the APPs as a resource for learning Neuro-critical care procedure and treatment algorithms. The APPs will cover the fellow responsibilities when the fellow is not on the schedule or has educational requirements (i.e. conference) that will not allow the fellow presence in the ICU and vice versa.

When the fellow leaves the unit for the conference they must inform the APP and charge nurse of when they plan to return. The fellow will be expected to answer the pager for patient questions when on duty. The fellow will sign their patients out to the appropriate APP when finishing the shift. Sign out occurs on the unit at 1800.

Evening Sign -out ±1800 Daily

The night provider(s) arrive at 18:00. Evening sign-

- Active issues/diagnosis only in a System by System format ±This is NOT THE CARE PLAN . This is basically a fast reference for the overnight team if they need to N Q R Z L I ³ V R P H W K L Q J L V

x To Do:
  - All orders, plan changes and items that require follow up which were discussed on rounds are to be documented as a checklist
  - DO NOT delete items when completed, check them off so night providers know what has occurred and what needs follow-up.
  - 7 K H O L V W V K R X O G E H G H O H W H G W K H Q H [W P R U Q L Q J R Q U updated.

x Anticipatory Guidance:
  - Include important high risk events to watch for and/or ongoing follow up items
  - This section is also where the night team puts in any events or changes that happen overnight

Consulting Services

The Neuromedicine ICU is a closed unit but communication among the ICU staff and consulting services is absolutely essential to the smooth function of the unit. The quality of patient care depends on the lines of communication being open and used frequently.

While admitted to the unit, the NMICU will act as the primary provider team. Consulting services can make recommendations, but orders must be placed by the NMICU and approved by the 1 H X U R 0 H G L F L Q H $ W W H Q G L Q J 6 L J Q L I L F D Q W F K D Q J H V L Q F D U H S C
Want and/or their level of status should be communicated as soon as possible. Anticipated discharge of a patient from the ICU must be communicated in a timely fashion. Emergent admissions or discharges will be handled as judiciously as possible.

Any conflicts in the management of patients between the consulting services and the critical care team that cannot be resolved in a timely fashion should be brought to the attention of the

Unit Meetings

- NMICU provider meetings: first Thursday of the month at 5:00 pm ±7:00 pm
  - Teaching Lectures/Case Conference
  - Unit Business Meetings
  - Research Meeting
  - Mortality and Morbidity
- Neurocritical Care Journal Club: 1 hour weekly, day of week varies based on schedules
  - Residents will be assigned a paper to present and will be discussed by the group
- Critical Care Teaching sessions: Monday-Friday 3-4 pm
  - Rotating sessions giving by faculty from all of the ICUs, Pharmacy and Ethics focusing on high yield critical care topics, given at the resident level.

Research

A number of clinical trials are in the works. In addition considerable effort is going into the creating and maintenance of a comprehensive neuro-critical care research database in order to facilitate future research efforts. The residents/fellows and APPs are welcome to discuss research opportunities.

Recommended Reading

1. Jose I. Suarez: Critical Care Neurology and Neurosurgery. Springer 2010.

Anatomy of the Presentation:

Introduction:

Provider

1. Patient introduction
2. Events since rounds the prior day
3. 24hr pertinent data
4. Imaging since evening sign out

6. Neuro exam

Nursing

5. Additional 24hr information

7. Neuro exam
8. Rates of current infusion

Body systems data:

This is a list of the most commonly seen data points we look for in each system. Not all data will exist for each patient and there may be relevant information not mentioned below. Please use your clinical judgment when deciding what needs to be presented.

1. Neuro

- x Examination :
  - o Level of Consciousness
  - o Cranial Nerves / pupils
  - o Language
  - o Motor
  - o Sensory
  - o Tone / Reflexes
  - o Coordination / Gait
- x 24-hour data
  - o EVD (level, output)
  - o ICP Range
  - o CPP Range
  - o ICP Waveform
  - o Pbt O_2 range
  - o Brain temp range
  - o CSF results
  - o AED levels
  - o Sedatives / analgesics / Anti-psychotic PRNs
  - o Shivering meds
  - o TCDs
  - o EEG results
  - o Neuroimaging

2. Pulmonary

- x Examination :
  - o secretions
  - o breath sounds
- x 24-hour data
  - o Vent or noninvasive O_2 needs
    - o Tidal volume, PEEP RSBI, RR, FiO_2
  - o $EtCO_2$
  - o SpO_2
  - o ABG (with FiO_2 and Vent settings when drawn)
  - o CXR
  - o Bedside (ICU) Lung U/S
  - o Respiratory / Secretion PRN Meds

3. Cardiovascular

- x 24-hour data
  - o Rhythm, HR
  - o BP/MAP range
  - o Cardiac gtt requirements
  - o BP PRNs given

4. Renal/ Fluids/ Electrolytes

- x 24-hour data
  - o IVF (type, rate)
  - o Tube Feeds (type, rate)
  - o U/O (mL/kg/hr)
  - o Net I/O over 24hrs

CLINICAL NEUROPHYSIOLOGY and EPILEPSY ROTATIONS FOR 1st, 2nd and 3rd YEAR NEUROLOGY RESIDENTS

Faculty:
Derek Bauer, M.D.
Michel Berg, M.D.
Evelyn Berman, M.D.
Gretchen Birbeck, M.D., M.P.H.
Deana Bonno, MD
Michael Chilungu, M.D.
Robert Gross, M.D., Ph.D.
Inna Hughes, M.D., Ph.D.
Laurie Seltzer, D.O.
Trenton Tollefson, M.D
Thomas Wychowski, MD

Psychosocial Faculty:
Dalin Pulsipher, Ph.D.
William Watson, Ph.D.
Kelly Nye, Ph.D.
Adrianna Hutchinson, M.D.

The Clinical (central) Neurophysiology Laboratory is part of the epilepsy unit and is under the leadership of Michel Berg, MD. The laboratory structure is highly integrated with the clinical operation. The neurophysiology laboratory includes out-patient and in-patient EEG and EP laboratories, intraoperative monitoring and long term EEG monitoring services. The epilepsy unit is divided into the adult and pediatric teams. Lynn Liu, MD supervises the fellow and residency training.

Epilepsy Monitoring Unit (EMU) Resident Rotations: General Guidelines

Each of the PGY-2 and PGY-3 neurology residents spend a two-week block on the inpatient EMU service. One week will be on the adult service and the other week will be on the pediatric service.

Description:

5. Participate in the diagnosis and treatment of psychogenic events (conversion disorders), by learning the etiologies, psychosocial dynamics, and approaches to interactions.

6. By the end of the rotation, be competently able to formulate and implement treatment plans for patients with seizures, epilepsy and the differential diagnoses of paroxysmal events.

Assessment:
Performance is evaluated at the end of each resident rotation by the supervising attending, based on the direct observation of the resident to achieve the goals of the rotation.

Responsibilities:

Daily Management of EMU inpatients:

- Pre-round around 8:30 - 9:00 AM to assess how the patient has done overnight and if there have been any episodes.

- Sign-in rounds (LTM Room 5-

- Then assign a covering provider evening and night float residents:
- Neurology First call: evening 4-8 PM and nights 8 PM-8

3) Graeme J. Sills, Michael A. Rogawski, Mechanisms of action of currently used antiseizure drugs, Neuropharmacology, Volume 168, 2020, 107966, https://doi.org/10.1016/j.neuropharm.2020.107966. https://www.sciencedirect.com/science/article/pii/S0028390820300320

4) Jette N, Reid AY, Wiebe S. Surgical management of epilepsy. CMAJ. 2014 Sep 16;186(13):997-1004. doi: 10.1503/cmaj.121291. Epub 2014 Jun 9. PMID: 24914117; PMCID: PMC4162780. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4162780/pdf/1860997.pdf

3. Weekly EMG conference - Friday 10 or 11 AM - 1 hour didactic teaching in EMG

4. Sign out conference in the EMG lab - daily 5 PM. (Applicable when resident is scheduled in EMG for the afternoon)

5. To document improvement in knowledge base, two brief written examinations are given at the beginning and end of the rotation for PGY-4 residents.

6. Continuity experience:

    a. Residents who rotate through neuromuscular/MDA and Peripheral Neuropathy clinics will participate in and perform electromyography studies on their clinic patients (from the morning), the same afternoon where possible.

    b. Residents will interact with many members of the neuromuscular faculty both in neuromuscular clinic and EMG during their rotations.

Overall Goals of the Neuromuscular/EMG Rotation

1. To learn the clinical presentation of the major neuromuscular diseases, and to perform a neuromuscular history and examination.

2. To learn the detailed spatial anatomy of the peripheral nervous system with reference to surface landmarks.

3. To localize peripheral nerve lesions precisely, and to determine their pathophysiology, severity and prognosis.

4. To gain a basic understanding of the electrical signature of the various neuromuscular diseases affecting anterior horn cell, nerve, neuromuscular junction, and muscle.

PGY-4 level goals

dim

b. Disorder of muscle membrane

2. Read chapter 8: Artifacts and Technical factors.

3. Read Chapter 11: Routine Lower Extremity Nerve Conduction Techniques.

4. Perform median, ulnar, peroneal, and tibial nerve conduction studies with supervision in patients with carpal tunnel syndrome, ulnar neuropathy, cervical radiculopathy, peripheral neuropathy, and lumbosacral radiculopathy.

5. Read relevant chapters in Preston & Shapiro on each patient seen.

Third Week

1. Continue to practice and perform routine nerve conduction studies.

2.

When possible, residents will also be involved in any electrodiagnostic testing that is conducted on these patients during the rotation. Residents will be responsible for following up on patients seen during the rotation under the supervision of a neuromuscular attending.

Learning Objectives of the Neuromuscular Clinic and Muscle/Nerve Pathology Component

1.

Basic EEG Rotation

Each of the PGY2 Adult Neurology residents spend a 2 week block on the EEG service. The resident is directly supervised by the clinical neurophysiology fellow and EEG attending of the day.

Description:

The purpose of the EEG elective is to provide an introduction to EEG and other neurophysiological procedures.

While on the EEG service the residents have no other epilepsy service clinical responsibilities (specifically they have no outpatient or in-

- Receive feedback on each report from an EEG attending
- Read about the EEG finding and associated epilepsy syndrome or clinical

Recommended reading list:

GUIDELINES FOR THE RESIDENT FIRMS

Director: Colleen Tomcik, MD
Clinic Nurse: & K D U O H V ³ & R G \ ´ + H Q G H U V R Q 5 1

Philosophy of the FIRMS

The neurology resident FIRMS were established in 1987 to provide the best possible patient care and resident education in a hospital-based neurology continuity clinic. The FIRMS were set up in such a way as to simulate, as much as possible, a private-prac

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business day. If paged regarding an outpatient issue, this call must be returned immediately.

Phone Numbers

The patient appointment number is: 585-275-1200.

Other useful numbers:

Support staff/schedulers	1-7450
Direct line to secretaries (not for patient use)	1-7450
Check-in	5-1247 / 5-7198
Check-out	5-1247 / 5-7198
Administrator	1-7429 or 764-9038
Nurse manager	5-8796
Staffing room	5-1202 5-7199
Fax	756-5189

Correspondence/Forms

All mail (in-house and out-of-hospital) should be placed in the mail bin located in the front office. All inter-office mail should go in a blue envelope or in a large tan interoffice mail envelope. Please do not use pre-stamped envelopes for inter-office mail.

Please complete all forms (DMV, Disability, etc.) within 7-10 business days, sooner if considered time- V H Q V L W L Y H) R U P V D Z D L W L Q J F R P S O H W L R Q D U H X S O R D % 2 ; 2 Q F H F R P S O H W H G S O H D V H P R Y H W K H I efolder in Box W K H D S S U R cosignature is required; if not, please move the form to the Completed Files-all providers efolder in Box. A copy of the completed form will be faxed, mailed and scanned into the record by the support staff, as applicable.

There are various consent/ release of information forms L H K R V S L W D O W R S D W L H Q W office to hospital, etc.) Be sure that you are using the correct form for a timely response to the request.

All patient notes must be entered electronically into the medical record using e-record. The HPI and Assessment and Plan should be complete, organized and typed in prose into the electronic patient record. The medications, allergies, and PMH must also be reconciled in e-record for all new patients and should be updated at each visit.

Medication reconciliation: Medication reconciliation is a hospital and Joint Commission requirement. The purpose of medication reconciliation is to avoid medication errors, which include errors of omission, duplication of therapy, and drug-drug and drug-disease interactions. Medication lists in e-record should be reviewed by the resident to ensure that they are correct and that all medications prescribed are appropriate (patients will get a print-out of their meds on arrival to the clinic to make any changes so the provider or medical technician can enter these into the record)3(s6)-4( )-4(T)13(he)3( )6(m)-3(ed)3(i)5(cat66.7911.04 Tf 1 0 0 1 438.46 334.01 Tm 0 G [(-)] T

patient at the completion of the visit. These lists will be audited and the resident will be notified if the lists are incomplete. Whenever any new medication is prescribed, appropriate patient counseling should be performed and documented in the visit note.
Problem List: It is a hospital and Joint Commission requirement for ambulatory care areas to maintain an updated problem list for each patient that contains significant medical diagnoses, and operative and invasive procedures. Please review and update this list at each visit.

Allergies: All allergies need to be documented and verified in the medical record and reconciled at every visit.

Visit Navigator:
Patient Instructions : This area of the visit navigator should be completed prior to the patient leaving so that these can be provided on the AVS.
LOS and Follow Up : Resident must assign a visit diagnosis and a level of service in the visit navigator prior to the patient leaving the office.

Imaging

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Vacations and Cancellation of Clinic

According to department policy, residents receive four weeks of vacation per year. All vacations must be scheduled annually in advance, and all vacation requests must be approved by the Program Director. Vacations may not be taken during the first year SMH inpatient rotations, second year general neurology, stroke, pediatric neurology or psychiatry rotations, or during the third year acting chief resident or MBB rotations.

A resident's clinic should only be canceled in the event of an emergency. If a resident requests that his/her/their clinic be rescheduled for any reason other than a true emergency, the residency program director must be notified and must approve the schedule change. The resident needs to take an active part in rescheduling the patients, working collaboratively with

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Scheduling Errors

A scheduling error may occur on occasion, resulting in a patient arriving in clinic without an appointment. If this occurs, the patient will be informed of the error and will be given the option of rescheduling the appointment or being seen later that afternoon by a resident as soon as a time slot is available. The clinic chief and FIRM attending will decide which resident will see that patient. They will decide the best way to accommodate the patient.

Policy for Providers when Patients Arrive Late for Appointment

Patients who arrive within 20 minutes of their scheduled new patient OR follow up appointment will be given the opportunity to be seen by their provider. If the patient arrives twenty minutes or longer after their appointment time, the patient will be given the option to be worked in at a different time if possible or to be rescheduled to a different date.

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who travel from a distance will also be given special consideration. If at all possible the provider

AMBULATORY SUBSPECIALTY BLOCKS FOR RESIDENTS 2024-2025

Description:
Each Adult Neurology resident will rotate through six required ambulatory subspecialty blocks

Epilepsy/Sleep Medicine
Directors: Inna Hughes, MD, PhD/Michael Yurcheshen, MD
Coordinators: Sarah Emond (Epilepsy), Michael Yurcheshen, MD (Sleep)

Location: Clinton Crossings, 919 Westfall Road, Building C, Suite 220 (Epilepsy)
South Clinton Sleep Clinic, 2337 South Clinton Avenue (Sleep)

Neuro-Oncology/Stroke
Directors: Lauryn Hemminger, MD (Neuro-Oncology)/Curt Benesch, MD, MPH (Stroke)
Coordinators: Amy Dodge (Neuro-Oncology)/Karen Sukert (Stroke)

Location: Wilmot Cancer Center at Strong Memorial Hospital (Neuro-Oncology)
Clinton Crossings, 2400 South Clinton Avenue, Building F

Neuro-Immunology
Directors: Megan Hyland, MD (NI)
Coordinators: Amy Dodge (NI)

Location: Strong Memorial Hospital, AC-1 Neuroimmunology clinic
Clinton Crossings, 919 Westfall Road, Building C, Suite 220 (NI)

Movement Disorders/Memory Care
Directors: Jamie Adams, MD (Movement)/Fred Marshall, MD (Memory Care)
Coordinators: Anthony Minervino (Movement)/Judy Shafer (Memory Care)

Location: Clinton Crossings, Building C, Suite 100 (Movement)
Science Park, 315 Science Parkway, Entrance B, Suite 200
(Memory Care- Dr. Marshall)
UR Batavia, 7995 Call Parkway, Batavia NY 14020
(Memory Care- Dr. Gill)

ELECTIVES FOR NEUROLOGY RESIDENTS 2024-2025

Description:
Neurology residents at the University of Rochester have several months of elective time during residency to more fully pursue their specific interests within Neurology and/or related
V S H F L D O W L H V D U H D V : H R I I H U V H Y H U D O G F ³ D L G Y L D Q F H H G O H O H W L H Y H V
many subspecialties. Basic electives primarily involve more straightforward patient evaluation and management, while advanced electives allow for evaluation and management of more complicated patients as well as more unique opportunities to observe specialized procedures relevant to the specialty. In general, residents should successfully complete a basic elective (or other pre-requisites) before doing an advanced elective. Please note that not all basic and/or advanced electives are available for each block, as it depends on faculty and service/facility availability and on the presence/absence of other rotating residents/students.

We also have research, educational, and special electives (with approval of the Neurology Residency Program Director) to allow residents time to create and implement scholarly and other types of projects.

Objectives:

1. To gain a deeper understanding of the major neurological subspecialties and/or types of fellowship/career paths available to neurologists

2. To allow for varying levels of care of both straightforward as well as more complex
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particular interests.

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HEADACHE ELECTIVE
For 2nd and 3rd year Neurology Residents

Faculty

- Caren Douenias, MD
- Jerry Kong, DO
- Heidi Schwarz, MD
- Raissa Villanueva, MD
- Alexander Yoo, MD

Description

Headaches of all types, both primary and secondary, play an important role in the practice of general neurology. A solid understanding of the primary headache disorders and some of the more common secondary headache disorders and their treatments is an invaluable skill for any neurologist planning to practice clinical neurology.

The goal of this rotation is to teach residents how to effectively diagnose and treat various headache disorders and to learn about the underlying pathophysiology of these disorders.

Resident Responsibilities

1. The resident will attend clinic at the URMC Headache Center. Half-day sessions will occur on Mondays, Tuesdays and Thursdays with procedure days on Monday afternoons and Fridays. Clinic hours are from 8am to 12 noon and 1pm to 5pm for half-day sessions.

2. Call Schedule: There is no call on this rotation.

Evaluation

Your evaluation will be completed on the standard form provided by the Department of Neurology, and will be heavily weighted upon your level of interest and involvement and your ability to demonstrate knowledge in headache specialty care.

Required Reading

1) : R O I I ¶ V + H D G D F K H 6 L O E Dodick. D u l v W H L Q / L S W R Q D Q G
2) International Headache Society Classification of Headache Disorders version 3- ICHD-3
3) Comprehensive Review of Headache Medicine. Morris Levin.
4) Journal articles to be decided during the rotation depending up on the interests of the resident

MOVEMENT DISORDER ELECTIVE
For 1st, 2nd and 3rd Year Neurology Residents

Faculty

- Jamie Adams, MD
- Richard Barbano, MD, PhD
- Karlo J. Lizárraga, MD, MS
- Frederick Marshall, MD
- Peter Morrison, DO
- Irene Richard, MD
- Ruth Schneider, MD
- Benzi Kluger, MD
- Christopher Tarolli, MD, MHPE
- Blanca Valdovinos, MD
- Melanie Braun, MD
- David Sell, DO
- Miriam Weber, PhD

Overview of Movement Disorders

7KH WHUP ³PRYHPHQW GLVRUGHUV´ FDQ UHIHU WR V\PSWRPV H
or postures), physical signs (e.g. bradykinesia, tremor, myoclonus or dystonia), syndromes (e.g.
Parkinsonism, myoclonus-dystonia syndrome) or the specific etiologies associated with
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not necessarily due to dysfunction of the basal ganglia (e.g. slowness due to arthrosis, twitches
due to fasciculations or seizures). Similarly, basal ganglia dysfunction may be associated with
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disease or essential tremor) and many diseases may be associated with more than one type of
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dystonic features in essential tremor). Movement disorders are typically conceptualized as
either hypokinetic (paucity of voluntary and automatic movements) or hyperkinetic (excessive
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necessarily be excessive. However, the terms hyperkinesia and dyskinesia are usually
interchangeable.

The differential diagnosis for a patient with abnormal movements requires careful observation.
Here is a suggested approach with three steps:

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brain stimulation. Appropriately refer a movement disorder patient for a surgical evaluation or other interventional therapies (ACGME level 4).

5. Become familiar with other motor and non-motor areas of impairment experienced by patients with movement disorders (e.g. psychiatric, cognitive, gait/posture/balance, speech/swallowing) and when to refer for further evaluation and treatment (e.g. neuropsychological evaluation, physical therapy, speech therapy).

6. Become familiar with advanced diagnostic options for patients with movement disorders, including neuropsychological testing, nuclear imaging (e.g. DATSCAN), electrophysiology and gait analysis.

7. Identify (ACGME level 3) and manage (ACGME level 4) movement disorders emergencies such as neuroleptic malignant syndrome, serotoninergic syndrome, malignant catatonia and status dystonicus.

Resident Responsibilities

Most of the clinical activity during the movement disorders elective will take place in the outpatient setting at 919 Westfall Road, Building C, Suite 100. Residents are welcome to observe inpatient movement disorders consultations but there are generally no inpatient activities and there will be no call responsibilities. Rotating residents are also welcome to attend educational activities of the division (video rounds, lectures and journal club). These are generally scheduled on Fridays at noon (except for the first Friday of the month when we have division administrative meeting).

Clinic

- Movement disorder clinics currently take place Monday, Tuesday, Wednesday, Thursday and some Fridays. Residents are scheduled for 6-7 clinics each week and are not scheduled during Wednesday afternoon or the afternoon of their own FIRM. Residents will receive a ³welcome´ email the Friday before his/her elective begins with information pertinent to the elective(ni)6(cs)-4(cur)9(r)-3(en)3(t)-4(l)5(y)11( )-4(t)-4(ake)14( )-4(pl)6(ace)3(u7

implanted stimulators. The resident may also observe a deep brain stimulation surgery if one

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Resident Responsibilities

Inpatient: Residents will see new inpatient and ED consults during the day (8am-4pm), and Resident Responsibilitstaff them with the neuro-oncology attending on-service. They will also see follow-up consults as needed.

Outpatient: The resident will attend neuro-oncology clinic on Tuesdays and Wednesdays at the James P. Wilmot Cancer Center. Priority will be given to seeing new patients or follow-up patients with active problems and unique diagnoses.

Call Schedule: There is no evening, weekend or overnight call on this rotation.

Conferences: Residents will attend the weekly multi-disciplinary Brain Metastases Conference on Wednesdays at 7:30 and the Brain Tumor Conference on Thursday mornings at 8:00 am. They are also encouraged to attend the academic conferences 12PM on Thursdays.

Readings: There will be assigned readings covering major topics and particular interests of the residents. These will be discussed weekly with the attending physician.

Evaluation

Your evaluation will be completed on the standard form provided by the Department of Neurology, and will be heavily weighted upon your level of interest and involvement.

Suggested Reading

Glioblastoma Multiforme

1. Stupp R. Chemoradiotherapy in malignant glioma: Standard of care and future directions. Journal of clinical oncology. 2007;25(26):4127.
2. Stupp R. Radiotherapy plus concomitant and adjuvant temozolomide for glioblastoma. New England Journal of Medicine, The. 2005;352(10):987.
3. Hegi ME. MGMT gene silencing and benefit from temozolomide in glioblastoma. New England Journal of Medicine, The. 2005;352(10):997.
4. Keime-Guibert F. Radiotherapy for glioblastoma in the elderly. New England Journal of Medicine, The. 2007;356(15):1527.
5. Brandsma D. Molecular targeted therapies and chemotherapy in malignant gliomas. Current opinion in oncology. 2007;19(6):598.
6. Stupp R. Maintenance Therapy with Tumor-Treating Fields Plus Temozolomide vs. Temozolomide alone for Glioblastoma. JAMA 2015; 314(23):2535-2543

Anaplastic Oligodendroglioma and Low grade Gliomas

7. van den Bent, Martin J. Adjuvant procarbazine, lomustine, and vincristine improves progression-free survival but not overall survival in newly diagnosed anaplastic oligodendrogliomas and oligoastrocytomas: A randomized European organisation for

research and treatment of cancer phase III trial. Journal of clinical oncology. 2006;24(18):2715.

8. Cairncross G. Phase III trial of chemotherapy plus radiotherapy compared with radiotherapy alone for pure and mixed anaplastic oligodendroglioma: Intergroup radiation therapy oncology group trial 9402. Journal of clinical oncology. 2006;24(18):2707.

9. Macdonald DR. Successful chemotherapy for newly diagnosed aggressive oligodendroglioma. Annals of neurology. 1990;27(5):573.

10. Jakola, AS et al. Comparison of a Strategy Favoring Early Surgical Resection vs. a Strategy Favoring Watchful Waiting in Low-Grade Gliomas. JAMA 2012; 308(18); 18881-1888

11. Buckner, J et al. Radiation plus Procarbazine, CCNu and Vincristine in Low Grade Glioma. New Eng J Med 2016; 374:1344-1355

12. The Cancer Genome Atlas Research Network. Comprehensive, Integrative Genomic Analysis of Diffuse Lower-Grade Gliomas. N Engl J Med 2015;372;2481-2498

Brain Metastases

13.

Learning Objectives

1. Perform a neuro-ophthalmic history and examination, focusing on examination techniques that are useful in a general neurologic practice (rather than emphasizing the use of ophthalmic equipment that is generally unavailable to neurologists).
2. Learn to differentiate optic nerve disease from other ophthalmic causes of visual loss based on the history and exam.
3. Become proficient in identifying normal optic nerve anatomy, optic disc edema, and optic atrophy.
4. Become familiar with ophthalmic terminology and

The resident should plan to read one of the following recommended textbooks while on service:

1. Miller NR, Newman NJ, Biousse V, Kerrison JB. : D O V K D Q G + R \ W ¶ V - & O L Q L F D O 1 H Ophthalmology : The Essentials. 2nd ed., Lippincott Williams & Wilkins, 2008.

2. Leigh J and Zee D, The Neurology of Eye Movements. 4th ed., Oxford University Press, New York, 2006.

3. Pane A, Burdon M, Miller NR. The Neuro-Ophthalmology Survival Guide, Mosby, 2006.

A Manual for the Beginning Ophthalmology Resident, published by the American Academy of Ophthalmology, is also helpful for understanding various ophthalmic procedures and examination techniques that will be encountered on service.

Other reading material, including journal articles, will be incorporated as relevant to patient exposure.

Evaluation

NEURORADIOLOGY ELECTIVE

Neuroradiology Faculty

- Jeevak Almast, M.D.
- Shehanaz Ellika, M.D.
- Ali Hussain, M.D.
- Alex Kessler M.D.
- Ed Lin, M.D.
- Anthony Portanova, M.D.
- Michael Potchen, M.D.
- Akm Rahman, D.O.
- Henry Z. Wang, M.D., Ph.D.

The administrator for the neurology elective in neuroradiology is the neuroradiology division

Bibliography

http://www.amazon.com/Neuroradiology-Requisites-3e-Radiology/dp/0323045219/ref=sr_1_1?s=books&ie=UTF8&qid=1369163124&sr=1-1&keywords=neuroradiology+requisites

http://www.amazon.com/Pediatric-Neuroimaging-Barkovich/dp/1605477141/ref=sr_1_1?s=books&ie=UTF8&qid=1369163198&sr=1-1&keywords=barkovich+pediatric+neuroimaging

PAIN MANAGEMENT ELECTIVE
For 2nd and 3rd year Neurology Residents

Director:		Faculty:
Joseph Poli, MD	242-1300	Joel Kent, MD Rajbala Thakur, MD Annie PhiD

4. Kalso E. Edwards JE. Moore RA. McQuay HJ. Opioids in chronic non-cancer pain: systematic review of efficacy and safety. Pain. 112(3):372-80, 2004

5. Rowbotham MC. Twilling L. Davies PS. Reisner L. Taylor K. Mohr D. Oral opioid therapy for chronic peripheral and central neuropathic pain. New England Journal of Medicine. 348(13):1223-32, 2003 Mar 27.

6. North RB. Kidd DH. Zahurak M. James CS. Long DM. Spinal cord stimulation for chronic, intractable pain: experience over two decades. Neurosurgery. 32(3):384-94; discussion 394-5, 1993 Mar.

7. Woolf CJ. American College of Physicians. American Physiological Society. Pain: moving from symptom control toward mechanism-specific pharmacologic management. Annals of Internal Medicine. 140(6):441-51, 2004 Mar 16

PALLIATIVE CARE INPATIENT ELECTIVE
For 2nd and 3rd year Neurology Residents
2021-2022

Palliative Care Division, Department of Medicine
Room 1-6305, URMC (near Miner Library)
Phone: (585) 273-1154
Fax: (585) 275-7403
www.urmc.rochester.edu/palliative

URMC-Strong Memorial Hospital Inpatient Palliative Care Program Providers

Physicians
Rob Horowitz, MD, Chief
Tom Carroll, MD
Erin Denney-Koelsch, MD
Carly Dennis, MD
Rachel Diamond, MD
Ron Epstein, MD
Bob Holloway, MD
Anna Kenney, DO
Joel Kent, MD
Benzi Kluger, MD, MS (Adult Pal Care)
Andrew Huang, MD
Rajbala Thakur, MD
Paul Vermilion, MD (Peds Pal Care)
Aaron Lampkin, MD
Jefferson Svengsouk, MD

Advanced Practice Providers
Judy Brustein, NP
Christy Dillon, NP
Lorraine Kirchhoff, NP
Jess Luciano, NP
Ann Syrett, NP
Elaine Townsend, NP

ACGME Competencies for Palliative Care Rotation
Learning Objectives and Assessment Methodologies

Prior to completion of this rotation, the resident will:

Principle Educational Objective	Assessment Methods
Patient Care: x	- Demonstration of competence and case discussion on daily rounds - Review completion of eRecord template by PC attending - Demonstration of competence with elements of neuropalliative care checklist including advance care planning - End of rotation evaluation

For session 2 please review the Primer chapters 5-9, with

Responsibilities of the Resident

1. Initial participation as an observer in the outpatient clinic. This should progress to independent outpatient assessment as deemed appropriate by the clinical faculty.

2. Directed review of polysomnographic studies, progressing to sleep scoring and interpretation as deemed appropriate by the clinic faculty.

General Guidelines

The rotation is intended to be two weeks in duration, and should include time with each of the faculty, in order to ensure a sufficiently broad clinical exposure. Your reading should include a review of summary journal articles provided at the st8 e a

An update on the dopaminergic treatment of restless legs syndrome and periodic limb movement disorder. Sleep 2004;27:560-83.

3. Schutte-Rodin S, Broch L, Buysse D, Dorsey C, Sateia M. Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults. J Clin Sleep Med. 2008; 15: 487-504.

4. Kushida CA, Littner MR, Hirshkowitz M, et al. Practice parameters for the use of continuous and bilevel positive airway pressure devices to treat adult patients with sleep-related breathing disorders. Sleep 2006;29:375-80.

5. Ramar K, Dort L, Katz S et al. Practice parameters for the treatment of snoring and Obstructive Sleep Apnea with oral appliances: an update for 2015. Journal of Clinical Sleep Medicine 2015;11:773-827.

6. Morgenthaler TI, Kapen S, Lee-Chiong T, et al. Practice parameters for the medical therapy of obstructive sleep apnea. Sleep 2006;29:1031-5.

7. Schenck CH, Mahowald MW. REM sleep behavior disorder: clinical, developmental, and neuroscience perspectives 16 years after its formal identification in SLEEP. Sleep 2002;25:120-38.

8. Aurora RN1 0 0 1 154.94 456gAzk f1.04 Tf 1 0 092 re esb(L,) 1 81.144 431.47 Tm 0 g 0 G [( )] TJ ET Q

University of Rochester
Anti -Discrimination and Anti -Harassment Policy

The University prohibits discrimination and harassment on the basis of age, color, disability, domestic violence victim status, ethnicity, gender identity or expression including transgender and gender expansive identities, genetic information, marital status, familial status or an L Q G L Y L G X D O ¶ V U H S U R G X F L Q J P L O L W D U \ Y H W H U D Q V W D W X V Q D W L R Q D O R U L J L Q race (including hair style), religion/creed (including religious attire and facial hair), sex, sexual orientation, citizenship status, arrest or conviction record, or any other status protected by law K H U H D I W H U H D F K R I W K H V H Z L O O E H U H I H U U H G W R D V D ³ 3 U R W H harassment based on a Protected Class will not be tolerated, and is considered misconduct that will be subject to discipline. The Department of Neurology fully supports this policy at all times for ALL faculty, trainees, students, and staff. If you see something, say something!

Also see PADH: Policy Against Discrimination, Harassment and Discriminatory Employment/Service Practices at

Department of Neurology Policy on Selection of Residents

Graduates of LCME-accredited US or Canadian medical schools applying for a Neurology residency at the University of Rochester are selected on the basis of the following:

- Performance in medical school, as evidenced by their official transcript
- Performance in the basic and clinical science years, as evidenced by the Medical Student Performance Evaluation (MSPE)
- Performance on the USMLE Step 1 and Step 2 examinations
- 3-4 letters of recommendation
- Personal and professional traits, based on interviews with the Program Director and several other faculty and residents in the Department of Neurology at the University of Rochester.

International Medical Graduates applying for a Neurology residency at the University of Rochester are selected on the basis of the same criteria as above. In addition, they must have the following:

- ECFMG certification at the time of application to the residency program
- Only J-1 visas are accepted for training

The Neurology Residency Selection Committee, consisting of the Residency Program Director, the Associate Residency Program Director, 1-2 Neurology Chief Residents and two ad-hoc faculty members, reviews all information on candidates and constructs the Match list, subject to approval by the Department Chair.

- x Oversight ±The supervising physician is available to provide review of procedures / encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a

Department of Neurology
Policy on Progressive Responsibility for Patient Management

Neurology residents assume progressive responsibility for patient care as they progress through the residency program due to the structure of the program:

- PGY-2 residents primarily work in a supervised inpatient setting.
- PGY-3 residents primarily work on the consultation services, where they have more autonomy.
- PGY-4 residents serve as chief residents, overseeing the inpatient teams and the more junior residents, and also coordinate medical student

Department of Neurology
Policy on Hand -offs

Inpatient Teams:

All sign-outs in the EMR for neurology inpatients should include the following components:

1. Summary: A brief summary of the patient, including the reason for admission and important details of the PMH.
2. Baseline examination: Current neurological exam including any neurological deficits or pertinent negatives.
3. Active Issues: Active hospital issues undergoing treatment. Brief bullet points by problem and summary of work

Triaging consults prior to change to change of shift:

- Consult residents (general, stroke, peds) are expected to triage consults that come late in the day prior to change of shift, which generally refers to consults that come in between 4:00 pm and 4:30 pm.
- The consults should be called back by the day consult resident in order to triage acuity
- Consults that are urgent (ie stroke alert, status) need to be seen by the day consult resident
- Non-urgent consults can be passed off to evening shift residents along with information about how to contact the consultant, in general, this should not exceed more than 2 passed off consults total per shift
- Rarely there are very non-urgent consults that can be seen the following day by

- Floor patients: 51600 and 53600 floor patients are assigned to the neuroscience APP from 4:30 until 7:30 pm currently Monday-Saturday. There are plans to expand this to include Sundays as well. The neuroscience APP will then sign the patients out to the medicine APP who will continue to cover the patients overnight until am sign out.
- 51600 and 53600 step down patients are assigned to the UCEF resident and night float at the start of each shift
- Newly admitted patients: Assigned to on-call resident until arrival on 51600 and taken over by inpatient team

- A resident who is deemed unqualified to advance to the next year of training, based upon not meeting the specific objectives noted above, will be given a program of remediation. If remediation is unsuccessful in the allotted period of time, the resident may be asked to repeat the year.
- The Department Chair meets with each resident at least annually to review progress and to provide career planning.

Department of Neurology
Policy on Breastfeeding, Chestfeeding, and Pumping Milk at Work

- The Department of Neurology fully supports its trainees who are currently breastfeeding or chestfeeding. We strictly adhere to NYS law and URMC GME policies regarding pumping milk at work at all times, on all rotations , at all clinical sites .
- 7 K H S U R J U D P P X V W S U R Y L G H D E U H D N R I D W O H D V W P L Q X W I hours for pumping. This must be provided for up to three years following the birth of the U H V L G H Q W ¶ V F K L O G
- Residents are responsible for providing their own pump and supplies at work.
- Residents are welcome

Department of Neurology
Policy on Moonlighting

Professional activities outside the neurology training program are prohibited to the extent that they may interfere with training program responsibilities.

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- Combined night-call duty may not occur more frequently than an average of every third night.
- Total working hours per week may not exceed an average of 80 hours.
- Each resident must have at least 10 hours off between

Department of Neurology
Program Evaluation Committee

x

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Basic Sciences

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18. Kandel ER, Schwartz JH, Jessell TM: Principles of Neural Science (4th ed.), New York: McGraw Hill, 2000

EEG

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Multiple Sclerosis

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Neuro-Critical Care

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Neuromuscular Disorders

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NEUROLOGY RESIDENT
MASTER BLOCK SCHEDULES 2024-25

Please consult Qgenda or Notion for the most up-to-

AMBULATORY BLOCK ROTATIONS FOR NEUROLOGY RESIDENTS 2024-25

Headache Clinic / Neuro -Ophthalmology Block

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	HA OR Neuro-Ophtho	HA OR Neuro-Ophtho	Headache	Headache	Flex time/LP clinic
PM	HA OR Neuro-Ophtho	HA OR Neuro-Ophtho	Academic Half-Day	Headache	Headache- Botox

Headache Clinic is located at Clinton Crossings Building C 919 Westfall Road. Neuro-ophthalmology is located at AC3 Ophthalmology (close to green elevators).

Headache faculty: Raissa Villanueva, Kathleen Sellick, Nathalia Figeureido
Neuro-Ophthalmology faculty: Zoe Williams, Bayan Al Othman- LIMITED AVAILABILITY, WILL BE SCHEDULED AS THEIR SCHEDULE ALLOWS

- Check the Erecord department schedules . While faculty schedules have some patterns, they are not always consistent week to week, making it difficult to reliably schedule clinics for residents to join. We encourage you to examine the Erecord schedule tab under the specialty departments for your weeks to view the schedule, decide which clinics you would like to join, and reach out to the attendings > 24 hours before the clinic to confirm attendance.
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AMBULATORY BLOCK ROTATIONS FOR NEUROLOGY RESIDENTS 2024-25

Neuro -Immunology Clinic

AMBULATORY BLOCK ROTATIONS FOR NEUROLOGY RESIDENTS 2024-25

Movement Clinic / Memory Care Block

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Firm	Attendings	Residents	