Denver Health Residency in Emergency Medicine
Clinical Rotation Summary
Handbook

Last Revised: April 2019

Document Type:	**Clinical Rotation Summary**
Rotation:	**Anesthesia**
Institutions:	**Denver Health Medical Center** **University of Colorado Hospital** **Children's Hospital Colorado**
Rotational Service Directors:	**Howard Miller, MD (DHMC)** **John Armstrong, MD (UCH)**
Year of Training:	**EM-1**
Length of Rotation:	**2 weeks**
Last Revised:	**8/2018**

The goal of the *Anesthesia* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to learn to assess and control patient airways in a safe and efficient manner. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Learn the normal anatomy and physiology of the airway and pulmonary system (PC, MK)
2. Exposure and experience in management of the scheduled operating room airway (PC, MK)
3. Exposure to and experience in assessing the airway for risk of difficult intubation (LEMON)(PC, MK)
4. Exposure to and experience with a variety of airway management devices (PC, MK, PBL, SBP)
    a. oral intubation equipment
    b. bag-valve mask ventilation systems
    c. laryngeal mask airway
    d. video laryngoscope
    e. fiberoptic laryngoscope
5. Exposure to and experience with a variety of pharmacologic anesthetic agents (PC, MK, PBL, SBP)
    a. Sedative-hypnotics
    b. neuromuscular relaxants
    c. regional anesthetics
6. Specific experience and training in:
    a. taking a history (PC)
    b. physical examination of the airway (PC, MK, ICS, PBL)
    c. understanding the indications and interpretation of ancillary laboratory and imaging techniques (PC, MK)
7. Experience in (but not limited to) the following procedures (PC, MK):
    a. oral intubation
    b. bag-valve mask ventilation

c. laryngeal mask airway
d. video laryngoscopy
e. fiberoptic laryngoscopy
f. arterial line placement
g. venous access

8. Exposure to and experience in the management of the difficult airway (PC, MK, PBL, ICS, SBP)
9. Exposure to and experience in operative sedation principles (PC, MK)
10. Develop and maintain interpersonal skills essential to interactions with patients and staff (ICS, PF)
11. Practice medicine in a fashion that displays competence, consideration and integrity (PC, MK, PBL, ICS, PF, SBP)
12. Maintain personal wellness and assist colleagues in time of crisis (ICS, PF, SBP)

Corresponding ACGME core competencies identified in ( ):

PC Patient Care
MK Medical Knowledge
PBL Practice Based Learning and Improvement
ICS Interpersonal and Communication Skills
PF Professionalism
SBP Systems Based Practice

Description of Clinical Experiences:

The EM1 resident will rotate for a two-week period and function as the airway manager for a scheduled outpatient and/or inpatient surgical population under the supervision of faculty anesthesiologists. The resident will have exposure to a wide variety of both adult and pediatric patients, including but not limited to those with cardiovascular, orthopedic, otolaryngological and gastrointestinal issues. Resident work hours are based off a rotating work schedule in compliance with the ACGME duty hours.

Supervisory lines of responsibility for the care of patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM
2. Attend and participate in the mandatory weekly EM residency program didactic activities.

3. Continue to complete their scheduled assigned readings, self-study questions and EM tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 3pm the day of the exam

Duty Hours:

Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Evaluation Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies and resident Milestones. The completed evaluation will be forwarded to the resident for review. All resident evaluations will be reviewed semi-annually in the PGY-specific Clinical Competency Committee. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter and is reviewed with the resident in their semi-annual meeting with the appointed Associate Program Director.

Other means of resident evaluation include oral examinations, Rosh Review tests, end of shift Milestone evaluations, and annual ABEM In-Training Examination.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director and residency leadership team. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed Associate Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director and EM leadership team as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee and residency leadership-run class meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Program Evaluation & Advisory) for further discussion. Completely anonymous feedback may be given to Abraham Nussbaum MD, Psychiatry, and Chief Education Officer at Denver Health or submitted electronically via a Confidential Survey link available to all residents.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, faculty consultation, faculty supervision) and academic (administrative offices, library, faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Burn ICU**
Institution:	**University of Colorado Hospital**
Rotational Service Director:	**Anne Wagner, MD**

Year of Training: **EM-2**

Length of Rotation: **3 weeks**

Last Revised: **8/2018**

Goal:

The goal of the Burn ICU rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to develop an understanding of the current concepts of burn and inhalation injury pathophysiology and apply this information in the evaluation, resuscitation, clinical management and rehabilitation of these critically ill patients. This is to serve as one of the primary venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of *surgical and burn patients*. Such competencies must extend across the range of patients presenting with critical disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives with respect to burn injury, inhalation injury and resuscitation as outlined in the DHREM Curriculum (1) for: (PC, MK, PBL, ICS, PF, SBP)
    a. Environmental Illness (as applicable)
    b. Pediatrics (as applicable)
    c. Resuscitation (as applicable)
    d. Trauma (as applicable)
    e. Wound Management (as applicable)
2. Perform primary assessments and appropriate emergent stabilization and treatment of patients with burn or inhalation injury. (PC, MK, PBL, SBP)
3. Perform focused histories and physical examinations of patients with burn or inhalation related complaints with particular attention to communicating effectively to interpret and evaluate the patient's symptoms and history; identifying pertinent risk factors in the patient's history; appropriately interpreting patient appearance, vital signs and condition; recognizing pertinent physical findings and performing proper maneuvers and techniques necessary for conducting the exam. (PC, MK, PBL, SBP)
4. Recognize age, gender, ethnicity, barriers to communication, socioeconomic status, underlying disease, and other factors that may affect the management of burn or inhalation injury. (PC, PBL, ICS, PF)
5. Understand and apply the principles of professionalism, ethics, and legal concepts pertinent to the management of patients with burn or inhalation injury. (PBL, ICS, PF, SBP)
6. Select, perform, and interpret diagnostic studies most appropriate to the presenting burn or inhalation injured patient. (PC, MK, PBL)
7. Develop a differential diagnosis for patients presenting with burn or inhalation related complaints and the establishment of the most likely diagnosis in light of the history, physical, intervention, and test results. (PC, MK, PBL)
8. Perform procedures pertinent to burn or inhalation injury that include but are not limited to pain management (local anesthesia, and sedation/pharmacologic analgesia), airway management, vascular access, escharotomies, wound debridement and management techniques. (PC, MK)
9. Evaluate and treat burn or inhalation injury. (PC, MK)
10. Select appropriate pharmacotherapy for burn or inhalation injury diseases and any pain resulting thereof, the recognition of pharmacokinetic properties, and the anticipation of drug interactions and adverse effects. (PC, MK)
11. Evaluate and reassess the effectiveness of treatment for burn or inhalation injury, including addressing complications and potential errors, as well as monitoring, managing, and maintaining the stability of one or more burn or inhalation injured patients. (PC, MK, PF, SBP)

12. Function as a burn or inhalation injury consultant to the emergency department and the urgent care clinics. (PC, MK, PBL, ICS, PF, SBP)
13. Collaborate with physicians and other professionals to evaluate and treat patients with burn or inhalation injury, arrange appropriate patient placement and follow-up, and communicate effectively regarding treatment plans with patients, family, and involved health care members. (PBL, ICS, PF, SBP)
14. Demonstrate and apply medical knowledge and epidemiology information to identify patients at risk for burn or inhalation injury, educating patients regarding their condition, and selecting appropriate disease and injury prevention techniques. (PC, MK, PBL, SBP)
15. Document patient care for burn or inhalation injury in a concise manner that facilitates quality care and coding. (PBL, PF, SBP)
16. Multitask effectively through the prioritization of multiple patients with burn or inhalation injury in order to provide optimal patient care while maintaining effective interaction, coordination, education, and supervision of all members of the patient management team. (PC, MK, PBL, ICS, PF, SBP)
17. Understand the policies within the state and patient need for transfer to a hospital with a Burn Unit. (PC, SBP)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The EM2 resident will be integrated into the burn service, rotating in the call schedule. The EM2 resident will provide ongoing primary patient care to admitted patients, performing history and physicals, daily rounds, and pre/post operative care. The EM2 may provide operative assistance.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities as clinical duties allow.
3. Continue to complete their scheduled EM readings and Rosh Review tests.
4. Complete supplemental procedural readings in the most recent edition of Clinical Procedures in Emergency Medicine, editors Roberts and Hedges.
5. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**COPIC/Administration**
Institution:	**COPIC Insurance Corporation** **University of Colorado Hospital** **Denver Health Medical Center**
Rotational Service Director:	**Jennie Buchanan, MD**
Year of Training:	**EM-4**
Length of Rotation:	**1 week**

Last Revised: **8/2018**

Goal:

The goal of the *COPIC/Administration* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to develop an understanding of quality assurance, risk management, and malpractice litigation as it applies to emergency medicine. Additionally, the residents will gain experience with billing and coding, variable triage systems, and practice improvement. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages. At the end of this rotation, residents will have a better understanding of the skills and abilities required to be an effective administrator.

Specific Educational Rotation Objectives:

1. Upon completion of all rotational time, the resident will be expected to have achieved demonstrable competence/compliance in the below areas: (PC, MK, PBL, ICS, PF, SBP)
    a. Administration
    b. Ethics
2. Develop an understanding of the concepts of risk management in emergency medicine. (PBL, ICS, PF, SBP)
3. Develop effective documentation skills. (PBL, ICS, PF, SBP)
4. Understand the factors leading to a malpractice suit. (PBL, ICS, PF, SBP)
5. Understand strategies and principles of practice that decrease the emergency physician's risk of a malpractice suit. (PC, MK, PBL, ICS, PF, SBP)
6. Develop and maintain interpersonal skills essential to interactions with patients and staff. (PBL, ICS, PF, SBP)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:

The rotation is split between three sites. Part of the resident's time is spent at the office of a medical liability insurance company. By examining current cases involving complaints or lawsuits, the resident learns about the important factors in risk management, gaining a heightened appreciation for quality patient care, adequate documentation, and the importance of good communication. The administrative portion of the rotation is split between University of Colorado Hospital and Denver Health. Residents will spend time with coders and billers, rotate through each hospital's triage area, perform patient call backs and answer patient complaints, participate in administrative rounding and meet and be mentored by administrative leadership. Part of the curriculum will include reading material and assignments to evaluate knowledge in this area. Resident work hours are in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities.
3. Continue to complete their assigned reading and ROSH review tests.

4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
There is minimal direct patient care associated with this rotation. The staff of COPIC Insurance Corporation will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director. Our administrative team including Jeffrey Sankoff and Christopher McStay will provide supervision during the rotation for the administrative portions of the curriculum at the specific hospitals.

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the Residency Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Cardiology**
Institution:	**Exempla Saint Joseph Hospital**
Rotational Service Director:	**Michael Fisher, MD**
Year of Training:	**EM-1**
Length of Rotation:	**2 weeks**
Last Revised:	**8/2018**

Goal:

The goal of the *Emergency Cardiology* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the primary venues by which residents will gain the competency expected of board-certified emergency physicians in the interpretation of ECGs for patients presenting with a wide range of complaints and medical conditions. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for Cardiology (PC, MK, PBL, ICS, PF, SBP)
2. Acquire the knowledge and skills in the interpretation of ECGs.
3. Describe typical ECG findings for patients presenting with STEMI, NSTEMI, electrolyte abnormalities, dysrhythmias and toxic ingestions.
4. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS)
5. Maintain personal wellness and assist colleagues in time of crisis. (PF)

Corresponding ACGME core competencies identified in ( ).

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:

The residents will spend two weeks with Cardiology faculty at Exempla Saint Joseph Hospital in an intensive EKG reading course. The rotation includes a comprehensive review of all major ECG topics including dysrhythmias, bundle branch blocks, STEMI/NSTEM, electrolyte abnormalities and toxic ingestions with correlation to appropriate diagnosis and treatment of findings. Resident work hours are based off of a rotating work schedule in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Residents are excused from 2 didactic days to attend the EKG course which counts for conference credit as part of the EM1 curriculum.
3. Continue to complete their scheduled assigned readings, and Rosh Review tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:

Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Medicine – Denver Health EM-1**
Institution:	**Denver Health Medical Center**
Rotational Service Director:	**Barbara Blok, MD**
Year of Training:	**EM-1**
Length of Rotation:	**Four weeks**
Last Revised:	**8/2018**

Goal:

The goal of this Academic Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment

of patients presenting to a county emergency department. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Dermatology
    d. Emergency Medical Services
    e. Environmental Illness
    f. Ethics
    g. General Medicine
    h. General Surgery
    i. Geriatrics
    j. Neurology
    k. Neurosurgery
    l. Obstetrics/Gynecology
    m. Orthopedics
    n. Ophthalmology
    o. Otolaryngology
    p. Pediatrics
    q. Psychiatry
    r. Resuscitation
    s. Toxicology
    t. Trauma
    u. Ultrasound
    v. Urology
    w. Physician Wellness
    x. Wound Management
2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)
3. Evaluate and treat all medical and trauma patients presenting with a wide variety of complaints. (PC, MK, PBL, ICS, PF, SBP). Particularly:
    a. Patients presenting with cardiac symptomatology
    b. Major and minor general adult and pediatric trauma patients
    c. Major and minor orthopedic trauma patients
    d. Major and minor neurosurgical trauma patients
    e. Major and minor vascular trauma patients
    f. Patients presenting with gynecologic complaints
    g. Patients presenting with respiratory complaints
    h. Patients with substance abuse and addictions related complaints
    i. Victims of domestic violence and sexual assault
    j. Issues and conditions unique to patients with a lack of domicile

k. Issues and conditions unique to patients of non-American ethnicity and culture
l. Issues and conditions unique to patients presenting to a large county

4. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions. (PC, MK, PBL, ICS, PF, SBP)
5. Become proficient at understanding and identifying the indications from admission, in-hospital observation, and ED observation. (PC, MK, PBL, SBP)
6. Gain exposure in the management of multiple patients. (PC, MK, ICS, PBL, SBP)
7. Gain exposure in essential procedural skills. (MK, PC)
8. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
9. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
10. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF)
11. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting. (PBL, IC, PF, SBP)
12. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine. (MK)
13. Practice emergency medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
14. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:

The resident rotates for a 4 week block and functions as a primary caregiver in Denver Health Medical Center Emergency Department, reporting directly to the supervising attending EM physician and Denver Health EM Senior Resident. Denver Health Emergency Department is a large city and county based level I trauma center, which sees a large trauma, medical, cardiac, gynecological, homeless, and substance abuse population. It is directed by the Department of Emergency Medicine at Denver Health. All core faculty have academic appointment at the University of Colorado School of Medicine. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents to the resuscitation rooms and the minor injury rooms, providing the typical academic and county emergency medicine experience. Residents work 4-6 rotating 8-hour shifts per week that are in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities except those didactics that occur after an overnight shift.
3. Continue to complete their scheduled assigned readings, weekly quizzes and EM tests.

4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Emergency Medicine. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory Lines of Responsibility for the Care of Patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Evaluation Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty and residents will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies and EM Milestones. The completed evaluation will be forwarded to the resident for review. All interval evaluations will be reviewed each 6 months by the Intern Clinical Competence Committee consisting of nurses, EM faculty, the intern Associate Program Director and the Program Director with an eye towards establishing a level of competency and providing constructive feedback for clinical growth. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter and reviewed in person with the resident. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, ROSH review questions, end of shift competency evaluations and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director and DHREM Education Committee. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to oral and written feedback provided by supervising faculty and residents. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the Intern Associate Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Program Evaluation & Advisory) for further discussion. Completely anonymous feedback may be given Abraham Nussbaum, MD, Psychiatry, and Chief Education Officer at Denver Health or submitted electronically via a Confidential Survey link available to all residents.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policies

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Medicine - Denver Health Junior**
Institution:	**Denver Health Medical Center**
Rotational Service Director:	**Bonnie Kaplan, MD**
Year of Training:	**EM-3**
Length of Rotation:	**EM-2 4 weeks; EM-3 10-14 weeks**
Last Revised:	**8/2018**

Goal:
The goal of this Academic Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients presenting to a county emergency room. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Dermatology
    d. Emergency Medical Services
    e. Environmental Illness
    f. Ethics
    g. General Medicine
    h. General Surgery
    i. Geriatrics
    j. Neurology
    k. Neurosurgery
    l. Obstetrics/Gynecology
    m. Orthopedics
    n. Ophthalmology
    o. Otolaryngology
    p. Pediatrics
    q. Psychiatry
    r. Resuscitation
    s. Toxicology
    t. Trauma
    u. Ultrasound
    v. Urology
    w. Physician Wellness
    x. Wound Management
2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)
3. Evaluate and treat all medical and trauma patients presenting with a wide variety of complaints. (PC, MK, PBL, ICS, PF, SBP). Particularly:
    a. Patients presenting with cardiac symptomatology in particular in the setting when cardiac catheterization facilities are not in-hospital (PC, MK, PBL, SBP)
    b. Major and minor general trauma patients (PC, MK, PBL, SBP)
    c. Major and minor orthopedic trauma patients (PC, MK, PBL, SBP)
    d. Major and minor neurosurgical trauma patients (PC, MK, PBL, SBP)
    e. Major and minor vascular trauma patients (PC, MK, PBL, SBP)
    f. Patients with substance abuse and addiction related complaints (PC, MK, PBL, SBP)
    g. Victims of domestic violence (PC, MK, PBL, SBP)
    h. Issues and conditions unique to homeless patients (PC, MK, PBL, SBP)
    i. Issues and conditions unique to patients of non-American ethnicity and culture (PC, MK, PBL, SBP)
    j. Issues and conditions unique to patients presenting to a large county hospital (PC, MK, PBL, SBP)
4. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions (PC, MK, PBL, ICS, PF, SBP)
5. Become proficient at understanding and identifying the indications from admission, in-hospital observation, and ED observation (PC, MK, PBL, SBP)
6. Establish the ability to prioritize the management of multiple patients (PC, MK, PBL, ICS, PF, SBP)

7. Provide rapid assessment and stabilization of critically ill medical and trauma patients (PC, MK, PBL, ICS, PF, SBP)
8. Become expert in essential procedural skill. (PC, MK)
9. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
10. Demonstrate sound charting practices and expertise in quality assurance methodology (PBL, PF, SBP)
11. Develop and maintain interpersonal skills essential to interactions with patients and staff (ICS, PF)
12. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting (PBL, ICS, PF, SBP)
13. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine (MK)
14. Practice emergency medicine in a fashion that displays competence, consideration and integrity (PC, ICS, PF)
15. Maintain personal wellness and assist colleagues in time of crisis (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The resident rotates for 4 week blocks and functions as a primary caregiver on the major resuscitation and minor injury side of Denver Health's emergency department reporting directly to their supervising attending EM physician and Denver Health EM Senior Resident. The Denver Health emergency department is a large city and county based level I trauma center, which sees a large trauma, medical, cardiac, gynecological, homeless, and substance abuse population. It is directed by the Department of Emergency Medicine at Denver Health. All core faculty have academic appointment at the University of Colorado School of Medicine through the Department of Emergency Medicine at the University of Colorado Health Science Center. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents to the resuscitation rooms and the minor injury rooms, providing the typical academic and county emergency medicine experience. Residents work 5-6 rotating 8-hour shifts per week that are in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities.
3. Continue to complete their scheduled assigned readings, and Rosh Review tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to the written assessment provided by the supervising faculty. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via an anonymous comment box on the DHREM website. In addition, an ombudsman is being recruited to be available to mediate issues in a confidential format.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Medicine - Denver Health Pullback**
Institution:	**Denver Health Medical Center**
Rotational Service Director:	**W. Gannon Sungar, DO**
Year of Training:	**EM-2**
Length of Rotation:	**Variable (approximately 12 weeks)**
Last Revised:	**8/2018**

Goal:

The goal of this Academic Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients presenting to a county emergency room. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology

c. Dermatology
d. Emergency Medical Services
e. Environmental Illness
f. Ethics
g. General Medicine
h. General Surgery
i. Geriatrics
j. Neurology
k. Neurosurgery
l. Obstetrics/Gynecology
m. Orthopedics
n. Ophthalmology
o. Otolaryngology
p. Pediatrics
q. Psychiatry
r. Resuscitation
s. Toxicology
t. Trauma
u. Ultrasound
v. Urology
w. Physician Wellness
x. Wound Management

2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)

3. Evaluate and treat medical patients presenting with a wide variety of complaints. (PC, MK, PBL, ICS, PF, SBP). Particularly:

a. Patients presenting with cardiac symptomatology in particular in the setting when cardiac catheterization facilities are not in-hospital (PC, MK, PBL, SBP)
b. Evaluate and treat patients presenting with respiratory complaints (PC, MK, PBL, SBP)
c. Patients with substance abuse and addictions related complaints (PC, MK, PBL, SBP)
d. Victims of domestic violence and sexual assault (PC, MK, PBL, SBP)
e. Issues and conditions unique to homeless patients (PC, MK, PBL, SBP)
f. Issues and conditions unique to patients of non-American ethnicity and culture (PC, MK, PBL, SBP)
g. Issues and conditions unique to patients presenting to a large county hospital (PC, MK, PBL, SBP)

4. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions. (PC, MK, PBL, ICS, PF, SBP)

5. Establish the ability to prioritize the management of multiple patients. (PC, MK, PBL, ICS, PF, SBP)

6. Provide rapid assessment and stabilization of critically ill medical and trauma patients. (PC, MK, PBL, ICS, PF, SBP)

7. Become proficient at understanding and identifying the indications from admission, in-hospital observation, and ED observation. (PC, MK, PBL, SBP)

8. Become expert in essential procedural skills. (PC, MK)

9. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)

10. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)

11. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF)

12. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting. (PBL, ICS, PF, SBP)

13. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine. (MK)
14. Practice emergency medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
15. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The resident rotates for 2-4 week blocks and functions as a primary caregiver on the medical side of Denver Health's emergency department reporting directly to their supervising attending EM physician and Denver Health EM Senior Resident. The Denver Health emergency department is a large city and county based level I trauma center, which sees a large trauma, medical, cardiac, gynecological, homeless, and substance abuse population. It is directed by the Department of Emergency Medicine at Denver Health. All core faculty have academic appointment at the University of Colorado School of Medicine through the Department of Emergency Medicine at the University of Colorado Health Science Center. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents to the resuscitation rooms and the minor injury rooms, providing the typical academic and county emergency medicine experience. Residents work 5-6 rotating 8-hour shifts per week that are in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities.
3. Continue to complete their scheduled assigned readings.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to the written assessment provided by the supervising faculty. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

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Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Medicine - Denver Health Senior**
Institution:	**Denver Health Medical Center**
Rotational Service Director:	**Jennie Buchanan, MD**
Year of Training:	**EM-4**
Length of Rotation:	**Approximately 15 weeks**
Last Revised:	**8/2018**

Goal:
The goal of this academic Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients presenting to an academic and county emergency room. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:
1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Dermatology
    d. Emergency Medical Services
    e. Environmental Illness
    f. Ethics
    g. General Medicine
    h. General Surgery
    i. Geriatrics

j. Neurology
k. Neurosurgery
l. Obstetrics/Gynecology
m. Orthopedics
n. Ophthalmology
o. Otolaryngology
p. Pediatrics
q. Psychiatry
r. Resuscitation
s. Toxicology
t. Trauma
u. Ultrasound
v. Urology
w. Physician Wellness
x. Wound Management

2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)

3. Evaluate and supervise the treatment of medical patients presenting with a wide variety of complaints. (PC, MK, PBL, ICS, PF, SBP). Particularly:

a. Patients presenting with cardiac symptomatology in particular in the setting when cardiac catheterization facilities are not in-hospital (PC, MK, PBL, SBP)
b. Major and minor general adult and pediatric trauma patients (PC, MK, PBL, SBP)
c. Major and minor orthopedic trauma patients (PC, MK, PBL, SBP)
d. Major and minor neurosurgical trauma patient. (PC, MK, PBL, SBP)
e. Major and minor vascular trauma patients. (PC, MK, PBL, SBP)
f. Patients with substance abuse and addiction related complaints (PC, MK, PBL, SBP)
g. Issues and conditions unique to patients of non-American ethnicity and culture (PC, MK, PBL, SBP)
h. Patients presenting with gynecologic complaints (PC, MK, PBL, SBP)
i. Patients presenting with respiratory complaints (PC, MK, PBL, SBP)
j. Victims of domestic violence and sexual assault (PC, MK, PBL, SBP)
k. Issues and conditions unique to homeless patients (PC, MK, PBL, SBP)
l. Issues and conditions unique to patients presenting to a large county hospital (PC, MK, PBL, SBP)

4. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions. (PC, MK, PBL, ICS, PF, SBP)

5. Establish the ability to prioritize the management of multiple patients. (PC, MK, PBL, ICS, PF, SBP)

6. Provide rapid assessment and stabilization of critically ill medical and trauma patients. (PC, MK, PBL, ICS, PF, SBP)

7. Become expert in essential procedural skills. (PC, MK)

8. Establish the ability to direct patient flow through supervision of housestaff, interaction with consultants, and communication to the entire emergency department team. (PC, MK, PBL, ICS, PF, SBP)

9. Direct a medical arrest resuscitation. (PC, MK, PBL, ICS, PF, SBP)

10. Direct a trauma team during complex resuscitations. (PC, MK, PBL, ICS, PF, SBP)

11. Direct a trauma arrest. (PC, MK, PBL, ICS, PF, SBP)

12. Demonstrate the ability to supervise medical students, interns, and junior EM residents. (PC, MK, PBL, ICS, PF, SBP)

13. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)

14. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)

15. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF)
16. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting. (PBL, ICS, PF, SBP)
17. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine. (MK)
18. Practice emergency medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
19. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The resident rotates for 2 to 4 week blocks and functions primarily as the supervising resident for the Denver Health EM junior resident, the Denver Health EM pullback resident, the DH EM intern, any off-service rotating interns, mid-level providers and any rotating medical students. Additionally, the resident will provide primary care to assist with patient flow and EMS direction. In the Denver Health Emergency Department, the Denver Health Senior resident reports directly to the supervising emergency medicine attending physician. The Denver Health emergency department is a large city and county based level I trauma center, which sees a large trauma, medical, cardiac, gynecological, homeless, and substance abuse population. It is directed by the Department of Emergency Medicine at Denver Health. All core faculty have academic appointment at the University of Colorado School of Medicine through the Department of Emergency Medicine at the University of Colorado Health Science Center. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents to the resuscitation rooms and the minor injury rooms, providing the typical academic and county emergency medicine experience. Residents work 5-6 rotating 8-hour shifts per week that are in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities except those didactics that occur after an overnight shift.
3. Continue to complete their scheduled assigned readings, Rosh Review tests and other EM assignments.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, ROSH review questions, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the supervising faculty. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given online (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Pediatric Emergency Department & Urgent Care (PEDUC)**
Institution:	**Denver Health Medical Center**
Rotational Service Director:	**Genie Roosevelt, MD**
Year of Training:	**EM-1, EM-2, EM-4**
Length of Rotation:	**15 weeks (EM-1 6wks; EM-2 3 wks; EM-4 6wks)**
Last Revised:	**8/2018**

Goal:
The goal of the *Pediatric Emergency Department & Urgent Care (PEDUC)* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the primary venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, urgent and emergent stabilization, and effective and compassionate treatment of *pediatric patients*. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all pediatric ages (0 – 18 years).

Specific Educational Rotation Objectives:
Upon completion of all rotational time, the resident will be expected to have achieved demonstrable competence/compliance in the below areas:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (SBP, MK, PC, ICS, PF)
    a. Pediatrics
    b. Dermatology (as applicable)
    c. Neurosurgery (as applicable)
    d. Orthopedics (as applicable)
    e. Ophthalmology (as applicable)
    f. Otolaryngology (as applicable)
    g. Resuscitation (as applicable)
    h. Toxicology (as applicable)
2. Perform histories and physical examinations on children of different ages, and recognize normal and abnormal physical findings. (PC, MK, ICS, PF)
3. Develop the ability to assess the seriously ill child, with an emphasis on recognizing early signs and symptoms before further deterioration can occur. (PC, MK, ICS, PF, SBP)
4. Master the initial evaluation and management of the ill or injured child. (PC, MK, ICS, PF, SBP, PBL)

5. Perform intraosseous access and infusion, intravenous access and infusion, and lumbar punctures. (PC, MK, PF, PBL, ICS, SBP)
6. Develop an approach to the management and disposition of the febrile child, considering such factors as age, source and severity of illness. (PC, MK, PF, PBL, ICS, SBP)
7. Learn an approach to the pediatric patient with respiratory illness, gastrointestinal disorders, neurologic complaints, gynecologic disorders, cardiovascular disorders, painful conditions, and the poisoned patient utilizing history, physical examination and ancillary studies to arrive at a diagnosis allowing appropriate treatment and disposition. (PC, MK, PF, PBL, ICS, SBP)
8. Develop an appropriate level of awareness of child abuse; learn in what circumstance child abuse occurs and how it may present. Evaluate the patient with suspected child abuse including sexual abuse. Learn the legal requirements and appropriate documentation. Understand the emotional factors affecting the patient and family. Understand the relative role of law enforcement, health care provider, and physicians. (PC, MK, PF, PBL, ICS, SBP)
9. Recognize the indications for admission in the ill or injured child. (SBP, MK, PC, ICS, PF)
10. Recognize the signs and symptoms of shock in a pediatric patient. (MK, PC)
11. Differentiate between compensated, uncompensated and terminal shock. (MK, PC)
12. Perform resuscitation of seriously ill child, including resuscitation of hypovolemic and septic shock. (PC, MK, ICS, SBP, PBL, PF)
13. Recognize the child in respiratory distress. (PC, MK)
14. Learn the indications for and methods of airway management in children. (PC, MK)
15. Perform arterial puncture for blood gas examination in children. (PC)
16. Recognize the child with inspiratory stridor, and state the differential diagnosis of stridor. (PC, MK)
17. Compare and contrast the presentation, evaluation and treatment of patients with croup, epiglottitis, and upper airway foreign bodies. (PC, MK, PBL, ICS, SBP)
18. Learn indications for hospitalization of children with croup. (PC, MK, PBL, ICS, SBP)
19. Learn the differential diagnosis of wheezing in children. (PC, MK)
20. Learn the indications for hospitalization of children with wheezing. (PC, MK, PBL, ICS, SBP)
21. Manage patients with respiratory failure of various etiologies. (PC, MK, PBL, PF, SBP)
22. Compare and contrast clinical presentations and management of different types of congenital heart disease. (PC, MK, PBL, ICS, SBP)
23. Recognize the cyanotic child, and state causes of cyanosis in children. (PC, MK, PBL, ICS, PF, SBP)
24. Recognize the child in congestive heart failure. (PC, MK, PBL, ICS, PF, SBP)
25. State the clinical manifestations of bacteremia, sepsis, meningitis, and pneumonia in children. (PC, MK)
26. Select appropriate antibiotic therapy for sepsis, meningitis, and pneumonia in children of different ages. (PC, MK, SBP)
27. Learn the differential diagnosis and appropriate workup of petechiae in children. (PC, MK, PBL, ICS, PF, SBP)
28. Learn the differential diagnosis of altered mental status or altered consciousness in children, and select appropriate diagnostic tests. (PC, MK, PBL, ICS, PF, SBP)
29. Perform lumbar puncture in children. (PC, ICS, PF)
30. Recognize the signs and symptoms of increased intracranial pressure in children. (PC, MK, PBL, ICS, PF, SBP)
31. Learn the differential diagnosis of seizures in children, and select appropriate therapy for the acute management of the child with seizure. (PC, MK, PBL, ICS, PF, SBP)
32. Learn the indications for hospitalization of traumatized pediatric patients. (PC, MK, PBL, ICS, PF, SBP)
33. Perform venipuncture and intravenous access techniques on ill and injured children. (PC, ICS, PF)
34. Diagnose and provide initial management of fluid / electrolyte and acid-base disorders in children. (PC, MK, PBL, ICS, PF, SBP)
35. Select appropriate medications for analgesia and sedation for children with pain and anxiety. (PC, MK, PBL, ICS, PF, SBP)

36. Become expert in essential pediatric procedural skills. (PC, ICS, PF)
37. Understand and encourage the practice of continuity of care. (SBP)
38. Demonstrate sound charting practices and expertise in quality assurance methodology. (PF, SBP)
39. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS)
40. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
41. Maintain personal wellness and assist colleagues in time of crisis. (PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The residents rotate for 2 to 4 week intervals and function as a primary care giver in the PEDUC at Denver Health. The PEDUC provides all emergent and urgent care for all pediatric patients presenting to Denver Health. The PEDUC is directed by Genie Roosevelt, MD who is subspecialty board certified in Pediatric Emergency Medicine. The EM residents are responsible for the rapid evaluation, diagnosis, and treatment of a variety of pediatric patients with medical complaints, both first presentations and acute exacerbation of chronic illnesses. In the EM4 year, the residents also supervise interns and students. The PEDUC is a 24/7 facility and residents provide shift coverage distributed based off of patient census and coverage needs. Resident work hours are in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities.
3. Continue to complete their scheduled assigned readings and Rosh Review tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly assignments, patient simulation, oral examinations, ROSH review, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the supervising faculty. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given online (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Document Type:	**Clinical Rotation Summary**
Rotation:	**Private Emergency Medicine**
Institution:	**Exempla Saint Joseph Hospital**
Rotational Service Director:	**Ryan Patterson, MD**
Year of Training:	**EM-2, EM-3 and EM-4**
Length of Rotation:	**3 wks (EM2), 2 wks (EM-3), 10 weeks (EM-4)**
Last Revised:	**8/2018**

Goal:

The goal of this Private Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients presenting to an emergency room. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the DHREM Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Dermatology
    d. Emergency Medical Services
    e. Environmental Illness
    f. Ethics
    g. General Medicine
    h. General Surgery
    i. Geriatrics
    j. Neurology
    k. Neurosurgery
    l. Obstetrics/Gynecology
    m. Orthopedics
    n. Ophthalmology
    o. Otolaryngology
    p. Pediatrics
    q. Psychiatry
    r. Resuscitation
    s. Toxicology
    t. Trauma
    u. Ultrasound
    v. Urology
    w. Physician Wellness

x. Wound Management

2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)
3. Evaluate and treat geriatric patients with a variety of medical complaints. (PC, MK, PBL, ICS, PF, SBP)
4. Evaluate, treat, and appropriately refer work related injuries. (PC, MK, PBL, ICS, PF, SBP)
5. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions. (PC, MK, PBL, ICS, PF, SBP)
6. Establish the ability to prioritize the management of multiple patients. (PC, MK, PBL, ICS, PF, SBP)
7. Provide rapid assessment and stabilization of critically ill medical patients. (PC, MK, PBL, ICS, PF, SBP)
8. Become expert in essential procedural skills. (PC, MK)
9. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
10. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
11. Develop and maintain interpersonal skills essential to interactions with patients and staff. (PC, ICS, PF)
12. Understand the role of the emergency medical specialist within the setting of a large managed care organization.
13. Evaluate, treat, and refer patients within the setting of a managed care organization.
14. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting. (PBL, ICS, PF, SBP)
15. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine. (MK)
16. Practice emergency medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
17. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:

The resident rotates for 1 - 4 week blocks and functions as a primary care giver in Exempla Saint Joseph Hospital (ESJH) Emergency Department reporting directly to their supervising attending EM physician. Total rotational time is dependent on the EM level of training (*Estimates*: EM1: 0 weeks; EM2: 3 weeks; EM3: 2 weeks; EM4: 10 weeks). ESJH emergency department is a private community-based emergency department that serves a large number of managed care patients and workman's compensation injuries. It is a level III trauma center, and as such primarily sees a medical population. It is directed by the Department of Emergency Medicine at ESJH. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents, providing the typical community emergency medicine experience. Resident work hours are 3-4 12-hour shifts per week and are in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities.
3. Continue to complete their scheduled assigned readings and Rosh Review tests.

4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the examination.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly assignments, patient simulation, oral examinations, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis

during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given online (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type: **Clinical Rotation Summary**

Rotation: **Pediatric Emergency Medicine**

Institution: **Children's Hospital Colorado**

Rotational Service Director: **Patrick Mahar, MD**

Year of Training: **EM-2 and EM-3**

Length of Rotation: **7 weeks (EM-2 3wks; EM-3 4wks)**

Last Revised: **8/2018**

Goal:

The goal of the *Pediatric Emergency Medicine* rotation of the Denver Health Residency in Emergency Medicine (DHREM) (REM) is to serve as one of the primary venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of *pediatric patients*. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity musculoskeletal disease or injury, and they must apply to patients of all pediatric ages (0 – 18 years).

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum for: (SBP, MK, PC, ICS, PF)
    a. Pediatrics
    b. Dermatology (as applicable)
    c. Neurosurgery (as applicable)
    d. Orthopedics (as applicable)
    e. Ophthalmology (as applicable)
    f. Otolaryngology (as applicable)
    g. Resuscitation (as applicable)
    h. Toxicology (as applicable)
    i. Trauma (as applicable)
    j. Wound Care (as applicable)
2. Perform histories and physical examinations on children of different ages, and recognize normal and abnormal physical findings. (PC, MK, ICS, PF)
3. Develop the ability to assess the seriously ill child, with an emphasis on recognizing early signs and symptoms before further deterioration can occur. (PC, MK, ICS, PF, SBP)
4. Master the initial evaluation and management of the critically ill or injured child during resuscitation. (PC, MK, ICS, PF, SBP, PBL)
5. Direct and participate in the pediatric trauma resuscitations. (PC, MK, ICS, PF, SBP, PBL)
6. Direct and participate in the pediatric medical resuscitations. (PC, MK, ICS, PF, SBP, PBL)
7. Perform intraosseous access and infusion, venous cutdown access and infusion, and lumbar punctures. (PC, MK, PF, PBL, ICS, SBP)
8. Develop an approach to the management and disposition of the febrile child, considering such factors as age, source and severity of illness. (PC, MK, PF, PBL, ICS, SBP)
9. Learn an approach to the pediatric patient with respiratory illness, gastrointestinal disorders, neurologic complaints, gynecologic disorders, cardiovascular disorders, painful conditions, and the poisoned patient utilizing history, physical examination and ancillary studies to arrive at a diagnosis allowing appropriate treatment and disposition. (PC, MK, PF, PBL, ICS, SBP)
10. Develop an appropriate level of awareness of child abuse; learn in what circumstance child abuse occurs and how it may present. Evaluate the patient with suspected child abuse including sexual abuse. Learn the legal

requirements and appropriate documentation. Understand the emotional factors affecting the patient and family. Understand the relative role of law enforcement, health care provider, and physicians. (PC, MK, PF, PBL, ICS, SBP)

11. Recognize the indications for the seriously ill child requiring admission the ICU. (SBP, MK, PC, ICS, PF)
12. Recognize the signs and symptoms of shock in a pediatric patient. (MK, PC)
13. Differentiate between compensated, uncompensated and terminal shock. (MK, PC)
14. Perform resuscitation of seriously ill child, including resuscitation of hypovolemic and septic shock. (PC, MK, ICS, SBP, PBL, PF)
15. Recognize the child in respiratory distress. (PC, MK)
16. Learn the indications for endotracheal intubation, and perform endotracheal intubation in children. (PC, MK)
17. Perform arterial puncture for blood gas examination in children. (PC)
18. Recognize the child with inspiratory stridor, and learn the differential diagnosis of stridor. (PC, MK)
19. Compare and contrast the presentation, evaluation and treatment of patients with croup, epiglottitis, and upper airway foreign bodies. (PC, MK, PBL, ICS, SBP)
20. Learn indications for hospitalization of children with croup. (PC, MK, PBL, ICS, SBP)
21. Learn the differential diagnosis of wheezing in children. (PC, MK)
22. Learn the indications for hospitalization of children with wheezing. (PC, MK, PBL, ICS, SBP)
23. Manage patients with respiratory failure of various etiologies. (PC, MK, PBL, PF, SBP)
24. Select appropriate settings for mechanical ventilation in children. (PC, MK)
25. Compare and contrast clinical presentations and management of different types of congenital heart disease. (PC, MK, PBL, ICS, SBP)
26. Recognize the cyanotic child, and Learn causes of cyanosis in children. (PC, MK, PBL, ICS, PF, SBP)
27. Recognize the child in congestive heart failure. (PC, MK, PBL, ICS, PF, SBP)
28. Learn the clinical manifestations of bacteremia, sepsis, meningitis, and pneumonia in children. (PC, MK)
29. Select appropriate antibiotic therapy for sepsis, meningitis, and pneumonia in children of different ages. (PC, MK, SBP)
30. Learn the differential diagnosis and appropriate workup of petechiae in children. (PC, MK, PBL, ICS, PF, SBP)
31. Learn the differential diagnosis of altered mental status or altered consciousness in children, and select appropriate diagnostic tests. (PC, MK, PBL, ICS, PF, SBP)
32. Perform lumbar puncture in children. (PC, ICS, PF)
33. Recognize the signs and symptoms of increased intracranial pressure in children. (PC, MK, PBL, ICS, PF, SBP)
34. Learn the differential diagnosis of seizures in children, and select appropriate therapy for the acute management of the child with seizure. (PC, MK, PBL, ICS, PF, SBP)
35. Compare and contrast clinical presentations and management of traumatic injuries in adults and children. (PC, MK, PBL, ICS, PF, SBP)
36. Learn the indications for hospitalization of traumatized pediatric patients. (PC, MK, PBL, ICS, PF, SBP)
37. Perform venipuncture and intravenous access techniques on critically ill children. (PC, ICS, PF)
38. Manage fluid and electrolyte and acid-base disorders in children. (PC, MK, PBL, ICS, PF, SBP)
39. Select appropriate medications for analgesia and sedation for children with pain and anxiety. (PC, MK, PBL, ICS, PF, SBP)
40. Become expert in essential pediatric procedural skills. (PC, ICS, PF)
41. Understand and encourage the practice of continuity of care. (SBP)
42. Demonstrate sound charting practices and expertise in quality assurance methodology. (PF, SBP)
43. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS)
44. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
45. Maintain personal wellness and assist colleagues in time of crisis. (PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The resident rotates in 1 to 4 week blocks and functions as a primary caregiver in the Children's Hospital Colorado Emergency Department. Children's Hospital Colorado is a tertiary care pediatric hospital. The resident is responsible for the rapid evaluation, diagnosis, and treatment of a variety of pediatric patients with traumatic complaints as well as an acute exacerbation of chronic illnesses. Children's Hospital Colorado offers significant educational opportunities in academic pediatrics, tertiary pediatric care, pediatric trauma care, pediatric burn care, and pediatric emergency medicine. Resident work hours are based off of a templated work schedule in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities.
3. Continue to complete their scheduled assigned readings and Rosh Review tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year.
Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff with current American Board of Emergency Medicine or Pediatric Emergency Medicine Subspecialty Board certification or eligibility will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the **on-duty** attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the **on-duty** attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the **on-duty** attending staff as outlined in the above point (1).
5. It is acknowledged that physicians without current American Board of Emergency Medicine or Pediatric Emergency Medicine Subspecialty Board certification or eligibility may serve as attending staff within the department of emergency medicine.

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation

form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), CORD EM tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Medicine – UCH EM Intern**
Institution:	**University of Colorado Hospital**
Rotational Service Director:	**Barbara Blok, MD**
Year of Training:	**EM-1**
Length of Rotation:	**12 weeks**

Last Revised: **8/2018**

Goal:

The goal of this Academic Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients presenting to a academic emergency room. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Dermatology
    d. Emergency Medical Services
    e. Environmental Illness
    f. Ethics
    g. General Medicine
    h. General Surgery
    i. Geriatrics
    j. Neurology
    k. Neurosurgery
    l. Obstetrics/Gynecology
    m. Orthopedics
    n. Ophthalmology
    o. Otolaryngology
    p. Pediatrics
    q. Psychiatry
    r. Resuscitation
    s. Toxicology
    t. Trauma
    u. Ultrasound
    v. Urology
    w. Physician Wellness
    x. Wound Management
2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)
3. Evaluate and treat all medical and trauma patients presenting with a wide variety of complaints. (PC, MK, PBL, ICS, PF, SBP). Particularly:
    a. Patients presenting with cardiac symptomatology

b. Major and minor general adult and pediatric trauma patients
c. Major and minor orthopedic trauma patients
d. Major and minor neurosurgical trauma patients
e. Major and minor vascular trauma patients
f. Patients presenting with gynecologic complaints
g. Patients presenting with respiratory complaints
h. Patients with substance abuse and addictions related complaints
i. Victims of domestic violence and sexual assault
j. Issues and conditions unique to patients with a lack of domicile
k. Issues and conditions unique to patients of non-American ethnicity and culture
l. Issues and conditions unique to patients presenting to a large county

4. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions. (PC, MK, PBL, ICS, PF, SBP)
5. Become proficient at understanding and identifying the indications from admission, in-hospital observation, and ED observation. (PC, MK, PBL, SBP)
6. Gain exposure in the management of multiple patients. (PC, MK, ICS, PBL, SBP)
7. Gain exposure in essential procedural skills. (MK, PC)
8. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
9. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
10. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF)
11. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting. (PBL, IC, PF, SBP)
12. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine. (MK)
13. Practice emergency medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
14. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC Patient Care
MK Medical Knowledge
PBL Practice Based Learning and Improvement
ICS Interpersonal and Communication Skills
PF Professionalism
SBP Systems Based Practice

Description of the Clinical Experience:

The resident rotates for 1-4 week blocks and functions as a primary care giver in the University of Colorado (UCH) Emergency Department reporting directly to their supervising attending EM physician and UCH EM Senior Resident. UCH emergency department is an academic level II trauma center and has a 24-hour emergent cardiac cath lab, which sees a large medical, cardiac,

sickle cell, gynecological, transplant population. It is directed by the Department of Emergency Medicine at the University of Colorado Hospital. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents, providing the typical academic emergency medicine experience. Residents work 5-6 rotating 8-hour shifts per week that are in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities except those didactics that occur after an overnight shift.
3. Continue to complete their scheduled assigned readings, weekly quizzes and EM tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:

Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Emergency Medicine. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory Lines of Responsibility for the Care of Patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Evaluation Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty and residents will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies and EM Milestones. The completed evaluation will be forwarded to the resident for review. All interval evaluations will be reviewed each 6 months by the Intern Clinical Competence Committee consisting of nurses, EM faculty, the intern Associate Program Director and the Program Director with an eye towards establishing a level of competency and providing constructive feedback for clinical growth. A summary of the resident's clinical performance,

strengths and weaknesses is included in their 6-month evaluation letter and reviewed in person with the resident. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, ROSH review questions, end of shift competency evaluations and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director and DHREM Education Committee. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to oral and written feedback provided by supervising faculty and residents. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the Intern Associate Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Program Evaluation & Advisory) for further discussion. Completely anonymous feedback may be given Abraham Nussbaum, MD, Psychiatry, and Chief Education Officer at Denver Health or submitted electronically via a Confidential Survey link available to all residents.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.

2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Medicine – UCH EM Junior**
Institution:	**University of Colorado Hospital**
Rotational Service Director:	**W. Gannon Sungar, DO**
Year of Training:	**EM-2**
Length of Rotation:	**19 weeks**
Last Revised:	**8/2018**

Goal:

The goal of this academic Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients presenting to an academic emergency room. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Dermatology
    d. Emergency Medical Services
    e. Environmental Illness
    f. Ethics
    g. General Medicine
    h. General Surgery
    i. Geriatrics
    j. Neurology
    k. Neurosurgery
    l. Obstetrics/Gynecology
    m. Orthopedics
    n. Ophthalmology
    o. Otolaryngology
    p. Pediatrics
    q. Psychiatry
    r. Resuscitation
    s. Toxicology
    t. Trauma
    u. Ultrasound
    v. Urology
    w. Physician Wellness
    x. Wound Management
2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)
3. Evaluate and treat medical patients presenting with a wide variety of complaints. (PC, MK, PBL, ICS, PF, SBP)
4. Particularly:
    a. Patients presenting with cardiac symptomatology
    b. Patients presenting with gynecologic complaints
    c. Acutely burned patients

d. Sickle cell patients presenting with acute complaints
e. Organ transplant patients presenting with acute complaints
f. Issues and conditions unique to patients presenting to a large tertiary care academic hospital
g. Patients with substance abuse and addiction related complaints
h. Victims of domestic violence
i. Issues and conditions unique to homeless patients
j. Issues and conditions unique to patients of non-American ethnicity and culture

5. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions. (PC, MK, PBL, ICS, PF, SBP)
6. Establish the ability to prioritize the management of multiple patients. (PC, MK, ICS, PBL, SBP)
7. Provide rapid assessment and stabilization of critically ill medical and trauma patients. (PC, MK, ICS, PBL, SBP)
8. Become expert in essential procedural skills. (MK, PC)
9. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
10. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
11. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF)
12. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting. (PBL, IC, PF, SBP)
13. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine. (MK)
14. Practice emergency medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
15. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Description of the Clinical Experience:

The resident rotates for 1-4 week blocks and functions as a primary care giver in the University of Colorado (UCH) Emergency Department reporting directly to their supervising attending EM physician and UCH EM Senior Resident. UCH Emergency Department is an academic level II trauma center and has a 24-hour emergent cardiac cath lab, which sees a large medical, cardiac, sickle cell, gynecological, transplant population. It is directed by the Department of Emergency Medicine at the University of Colorado Health Science Center. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents, providing the typical academic emergency medicine experience. Residents work 5-6 rotating 8-hour shifts per week that are in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.

2. Attend and participate in the mandatory weekly EM residency program didactic activities except those didactics that occur after an overnight shift.
3. Continue to complete their scheduled assigned readings, weekly quizzes and EM tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities except those didactics that occur after an overnight shift.
3. Continue to complete their scheduled assigned readings, weekly quizzes and EM tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam..

Duty Hours:

Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Emergency Medicine. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory Lines of Responsibility for the Care of Patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Evaluation Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty and residents will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies and EM Milestones. The completed evaluation will be forwarded to the resident for review. All interval evaluations will be reviewed each 6 months by the Intern Clinical Competence Committee consisting of nurses, EM faculty, the intern Associate Program Director and the Program Director with an eye towards establishing a level of competency and providing

constructive feedback for clinical growth. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter and reviewed in person with the resident. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, ROSH review questions, end of shift competency evaluations and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director and DHREM Education Committee. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to oral and written feedback provided by supervising faculty and residents. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the Intern Associate Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Program Evaluation & Advisory) for further discussion. Completely anonymous feedback may be given Abraham Nussbaum, MD, Psychiatry, and Chief Education Officer at Denver Health or submitted electronically via a Confidential Survey link available to all residents.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Medicine – UCH EM Senior**
Institution:	**University of Colorado Hospital**
Rotational Service Director:	**Bonnie Kaplan, MD**
Year of Training:	**EM-3**
Length of Rotation:	**18 weeks**
Last Revised:	**8/2018**

Goal:
The goal of this academic Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients presenting to an academic emergency room. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:
1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)

a. Anesthesia
b. Cardiology
c. Dermatology
d. Emergency Medical Services
e. Environmental Illness
f. Ethics
g. General Medicine
h. General Surgery
i. Geriatrics
j. Neurology
k. Neurosurgery
l. Obstetrics/Gynecology
m. Orthopedics
n. Ophthalmology
o. Otolaryngology
p. Pediatrics
q. Psychiatry
r. Resuscitation
s. Toxicology
t. Trauma
u. Ultrasound
v. Urology
w. Physician Wellness
x. Wound Management

2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)

2. Evaluate and supervise the treatment of medical patients presenting with a wide variety of complaints. (PC, MK, PBL, ICS, PF, SBP). Particularly:

a. Patients presenting with cardiac symptomatology (PC, MK, PBL, SBP)
b. Patients presenting with gynecologic complaints (PC, MK, PBL, SBP)
c. Acutely burned patients (PC, MK, PBL, SBP)
d. Sickle cell patients presenting with acute complaints (PC, MK, PBL, SBP)
e. Organ transplant patients presenting with acute complaints (PC, MK, PBL, SBP)
f. Issues and conditions unique to patients presenting to a large tertiary care academic hospital (PC, MK, PBL, SBP)
g. Patients with substance abuse and addiction related complaints (PC, MK, PBL, SBP)
h. Victims of domestic violence (PC, MK, PBL, SBP)
i. Issues and conditions unique to homeless patients (PC, MK, PBL, SBP)
j. Issues and conditions unique to patients of non-American ethnicity and culture (PC, MK, PBL, SBP)

3. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions. (PC, MK, PBL, ICS, PF, SBP)

4. Establish the ability to prioritize the management of multiple patients. (PC, MK, PBL, ICS, PF, SBP)

5. Provide rapid assessment and stabilization of critically ill medical and trauma patients. (PC, MK, PBL, ICS, PF, SBP)

6. Become expert in essential procedural skills. (PC, MK)

7. Establish the ability to direct patient flow through supervision of housestaff, interaction with consultants, and communication to the entire emergency department team. (PC, MK, PBL, ICS, PF, SBP)

8. Direct a medical arrest resuscitation. (PC, MK, PBL, ICS, PF, SBP)

9. Demonstrated the ability to supervise medical students, interns, and junior EMS residents. (PC, MK, PBL, ICS, PF, SBP)
10. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
11. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
12. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF)
13. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting. (PBL, ICS, PF, SBP)
14. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine. (MK)
15. Practice emergency medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
16. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The resident rotates in 1-4 week blocks and functions primarily as the supervising resident for the University of Colorado (UCH) EM junior resident, the UCH EM intern, any off-service rotating interns, and any rotating medical students. Additionally, on occasion the resident will provide primary care to assist with patient flow. In the University of Colorado Emergency Department, the UCH Senior resident reports directly to their supervising attending EM physician. The UCH emergency department is an academic level II trauma center and has a 24-hour emergent cardiac cath lab, which sees a large medical, cardiac, sickle cell, gynecological, transplant population. It is directed by the Department of Emergency Medicine at UCH. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents, providing the typical academic emergency medicine experience. Residents work 5-6 rotating 8-hour shifts per week that are in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities.
3. Continue to complete their scheduled assigned readings and Rosh Review tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), CORD EM tests, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to the written assessment provided by the supervising faculty. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via the anonymous comment box on the DHREM website.. In addition, an ombudsman is available to mediate issues in a confidential format.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Pre-Hospital Care / Emergency Medical Services**
Institution:	**Denver Health Medical Center**
Rotational Service Director:	**Whitney Barrett, MD**
Year of Training:	**EM-3 and EM-4**
Length of Rotation:	**4 weeks**
Last Revised:	**8/2018**

Goal:

The goal of the *Pre-Hospital Care / Emergency Medical Services* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients in the pre-hospital setting. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages. Additionally, residents will gain the knowledge of administration and function of a pre-hospital system.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Emergency Medical Services
    b. Administrative (as applicable)
    c. Anesthesia (as applicable)

d. Cardiology (as applicable)
e. Environmental (as applicable)
f. Geriatrics (as applicable)
g. Pediatrics (as applicable)
h. Psychiatry (as applicable)
i. Resuscitation (as applicable)
j. Toxicology (as applicable)
k. Trauma (as applicable)

2. Perform an age and complaint appropriate history and physical examination. (PC, MK, SBP)
3. Evaluate and treat patients in the pre-hospital arena presenting with a variety of medical and traumatic complaints. (PC, MK, SBP)
4. Direct medical and trauma resuscitations in the pre-hospital environment. (PC, MK, PBL, ICS, PF, SBP)
5. Become familiar with the difficulties encountered in performing procedures in the field environment. (PC, MK, PBL, SBP)
6. Participate as a team member in a ground EMS system. (PBL, ICS, PF, SBP)
7. Understand medicolegal liability relating to EMS systems. (PBL, PF, SBP)
8. Become familiar with medical care provided at mass gatherings and special events. (PC, MK, PBL, SBP)
9. Become familiar with on site medical care provided by paramedics at Denver International Airport. (PC, MK, PBL, SBP)
10. Gain independent knowledge of pre-hospital EMT protocols. (PC, MK, PBL, SBP)
11. Understand and encourage the practice of continuity of care. (PBL, PF, SBP)
12. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
13. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF, SBP)
14. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
15. Maintain personal wellness and assist colleagues in time of crisis. (ICS, PF, SBP)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:

This is a concentrated emergency medical services rotation in which the resident functions as a street paramedic with the Denver Paramedic Division. The resident may be responsible for the initial evaluation and triage of field patients; he/she functions under the paramedic protocols and is required to initiate base station contact as required by the pre-hospital protocols. The resident also participates in various administrative aspects of pre-hospital care and provides continuing EMS education at the Paramedic Academy (Presenting BLS and Paramedic Lectures). Residents, along with senior paramedics, participate in quality improvement in the format of a pre-hospital case conference. The resident also gains exposure to the function of medical teams in both helicopters and fixed-wing flights.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Attend and participate in the mandatory weekly EM residency program didactic activities.
2. Continue to complete their scheduled assigned readings and Rosh Review tests.
4. Supplemental readings:

Pre-hospital Emergency Care Secrets by Pons and Markovchick
Denver Metro Pre-hospital Protocols

5. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:

Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly assignments, patient simulation, oral examinations, 360 evaluations, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given online (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Ultrasound**
Institution:	**Denver Health**
Rotational Service Director:	**Molly Thiessen, MD**
Year of Training:	**EM-1**
Length of Rotation:	**2 weeks**
Last Revised:	**8/2018**

Goal:

The goal of the *Emergency Ultrasound* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the performance of Emergency Ultrasound. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages. Additionally, residents will gain the knowledge of administration and quality assurance of Emergency Ultrasound.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Ultrasound
2. Acquire the knowledge, skills, and attitudes necessary utilize Emergency Ultrasound to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Administrative (as applicable)
    b. Cardiology (as applicable)
    c. General Medicine (as applicable)
    d. General Surgery(as applicable)
    e. Obstetrics/Gynecology (as applicable)
    f. Resuscitation (as applicable)

g. Trauma (as applicable)
h. Urology

3. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
4. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF, SBP)
5. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
6. Maintain personal wellness and assist colleagues in time of crisis. (ICS, PF, SBP)

A. Physics and Instrumentation Objectives

1. Discuss the similarities and differences of ultrasound compared to ordinary sound in regard to characteristics such as frequency, amplitude and speed.
2. Discuss the principle of attenuation and the relationship between ultrasound frequency and depth of penetration.
3. Describe the tissue interactions such as reflection, echoes, transmission and scatter.
4. Discuss the relationship between echogenicity and the depiction of ultrasound images as white, gray and black.
5. Discuss the biologic effects and safety considerations related to ultrasonography.
6. Discuss the piezoelectric effect and the differences between mechanical sector scanners and linear electronic transducers in regard to their composition and ability to adjust focal length and direction of an ultrasound beam.
7. Demonstrate the conventional positioning of the marker on the transducer when scanning in the cross-sectional plane and describe the orientation of the resultant image on the display.
8. Describe the effect of transducer frequency, pulse duration, pulse dampening, and proximity of objects on axial resolution. Describe the effect of beam width on lateral resolution.
9. Discuss the use of receiver controls affecting gain and compensation (TGC).
10. Discuss the characteristics of A mode, B mode, M mode and B scan (2-D).
11. Discuss the causes and solution for the common ultrasound artifacts: pseudo-sludge (beam-width artifact), side lobe artifact, reverberation artifact (ring down artifact), mirror effect and gain artifact.

B. Cardiovascular Exam Objectives

1. Demonstrate the ability to identify the cardiac chambers, myocardium, pericardium and grossly evaluate cardiac chamber size.
2. Discuss the rationale for and demonstrate the use of ultrasound to diagnose electromechanical dissociation.
3. Discuss the difference between the ultrasound appearance of a simple pericardial effusion and that of organized pericardial hematoma; discuss the sensitivity of ultrasound for diagnosing pericardial fluid and the possible confusion with pleural effusion or hyperechoic pericardial fat.
4. Demonstrate the ability to recognize the key features of pericardial tamponade and to distinguish these findings from other causes of hypotension: cardiogenic shock, hypovolemia, and pulmonary embolism.
5. Demonstrate the ability to utilize ultrasound in penetrating cardiac trauma and describe the typical ultrasound appearance of fluid in the pericardial sac.
6. Demonstrate the ability to use 2-D echo in patients with suspected ischemic heart disease to assess qualitatively global wall motion function, and to rule out hemopericardium in thrombolytic candidates.
7. Discuss the role of transesophageal 2-D echocardiography (TEE) in the diagnosis of suspected aortic dissection. Describe the findings seen on the standard left parasternal 2-D cardiac echo that suggest aortic dissection.

C. Abdominal Exam Objectives

1. Demonstrate the ability to identify the gallbladder, liver, spleen, diaphragm, kidneys, aorta and its major branches, bowel (peristalsis) and bladder.
2. Discuss the benefit of rapid bedside sonography for the diagnosis of abdominal aneurysms. State the size of the aorta's external diameter at the level of the diaphragm and at the level of the renal bifurcation.
3. State the specific sonographic findings that lead to the diagnosis of abdominal aortic aneurysm and that enable us to distinguish between stable versus unstable aneurysms. Demonstrate the ability to diagnose AAA using ultrasound and state the diagnostic accuracy of this modality.
4. State the common errors encountered in scanning for AAA.

5. Discuss the role of ultrasound for detecting hemoperitoneum in blunt abdominal trauma, specifically comparing it to DPL for sensitivity, ease and time required for performing the procedure.
6. Describe the sonographic appearance of fresh blood in the abdomen and define the regions that are routinely examined. Demonstrate the technique for examining the hepatorenal recess (Morison's pouch), splenorenal recess, cul-de-sac (pouch of Douglas), and subdiaphragmatic abdomen as well as the pleural space.
7. Discuss the threshold for reliably diagnosing hemoperitoneum and state the qualitative fluid characteristics of blood over time. Discuss the significance of absent liver mirror image artifact above the diaphragm.
8. State common errors in scanning for hemoperitoneum including artifacts.
9. Discuss the indications for U/S in evaluating RUQ abdominal pain. Discuss the clinical scenarios in which it can optimize patient care in the ED setting.
10. State the various sonographic characteristics of the gallbladder that make it favorable for evaluation by ultrasound.
11. Discuss the significance of sonographic Murphy's sign, sludge, acoustic shadows, and gallbladder size and wall thickness in evaluating a patient for gallbladder disease.
12. Demonstrate the ability to diagnose cholelithiasis and cholecystitis.
13. State common errors in gallbladder scanning.
14. State the conditions in which ultrasound may be preferable to intravenous pyelography in evaluation of renal colic; state the specific focus of the ultrasound exam for renal colic.
15. Demonstrate the ability to distinguish between the renal cortex, medulla and pelvis; demonstrate ability to diagnose renal calculi.
16. State the various anatomic considerations that make visualization of the right kidney easier than the left; demonstrate the technique that helps circumvent problems with visualizing the left kidney.
17. Demonstrate the ability to diagnose hydronephrosis and hydroureter on ultrasound exam of kidneys; demonstrate the ability to distinguish between chronic and acute hydronephrosis.
18. Discuss common errors in scanning the kidney.

D. Pelvic Exam Objectives

1. Discuss the reliability of the physical exam and the advantages of immediately available emergency department ultrasound in the evaluation of pelvic pain in reproductive age women.
2. Demonstrate ability to identify: cervix and uterus, ovaries, cul-de-sac, bladder, iliac vessels.
3. Discuss the relative merits of transabdominal versus transvaginal U/S in evaluating the pregnant uterus and demonstrate the technique for each exam.
4. Demonstrate the ability to identify gestational sac, yolk sac, fetal pole/embryo, cardiac activity, and corpus luteum cyst.
5. Define the term "discriminatory zone," and discuss the expected sonographic findings transabdominal and transvaginal) of normal intrauterine pregnancy and HCG values at five, six and seven weeks since the start of the last normal menses.
6. Demonstrate the ability to identify the sonographic appearance of the following:
    - Definitive intrauterine pregnancy (IUP)
    - Probable abnormal IUP
    - Definitive ectopic pregnancy
    - No definitive IUP (Possible occult unruptured ectopic pregnancy)
    - Fetal demise
    - Cul-de-sac fluid, abnormal adnexal mass
7. State the common errors made in emergency pelvic sonography.

Corresponding ACGME core competencies identified in ( ):

PC Patient Care
MK Medical Knowledge

PBL Practice Based Learning and Improvement
ICS Interpersonal and Communication Skills
PF Professionalism
SBP Systems Based Practice

Description of the Clinical Experience:
This is a concentrated emergency ultrasound rotation in which the resident works closely with the ultrasound directors of Denver Health to achieve the above stated goals. This will be accomplished through one-on-one didactics, scanning shifts in the emergency department or radiology department, and individual meetings with the rotational director or their designee. The resident is responsible for making all meetings and scanning obligations assigned by the rotational director.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Attend and participate in the mandatory weekly EM residency program didactic activities.
2. Continue to complete their scheduled assigned readings and Rosh Review tests.
3. Complete any assigned readings by the rotational director
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year.

Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Supplemental readings/resources:
Kendall's Ultrasound in Emergency Medicine and Trauma CD-ROM, Discs 1-2, 1st Edition

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), CORD EM tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Ultrasound**
Institution:	**University of Colorado Hospital**
Rotational Service Director:	**Juliana Wilson, MD**
Year of Training:	**EM-3**
Length of Rotation:	**1 week**
Last Revised:	**8/2018**

Goal:

The goal of the *Emergency Ultrasound* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the performance of Emergency Ultrasound. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages. Additionally, residents will gain the knowledge of administration and quality assurance of Emergency Ultrasound.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Ultrasound
2. Acquire the knowledge, skills, and attitudes necessary utilize Emergency Ultrasound to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Administrative (as applicable)
    b. Cardiology (as applicable)
    c. General Medicine (as applicable)
    d. General Surgery(as applicable)
    e. Obstetrics/Gynecology (as applicable)
    f. Resuscitation (as applicable)
    g. Trauma (as applicable)
    h. Urology
3. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
4. Foster the incorporation of point-of-care ultrasound into appropriate clinical scenarios. (MK,PBL)
5. Learn advanced point-of-care techniques and participate in the quality assessment of ultrasound examinations. (MK, PBL, SBP)

6. Insure competency assessments for the core skills. (MK)
7. Fill in gaps of knowledge and technical expertise e.g. Transvaginal pelvic, DVT, cardiac and nerve blocks. (MK)
8. Foster teaching skills by having senior residents teach junior residents while on a scanning shift. (PBL, ICS)
9. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF, SBP)
10. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
11. Maintain personal wellness and assist colleagues in time of crisis. (ICS, PF, SBP)

A. Physics and Instrumentation Objectives

1. Discuss the similarities and differences of ultrasound compared to ordinary sound in regard to characteristics such as frequency, amplitude and speed.
2. Discuss the principle of attenuation and the relationship between ultrasound frequency and depth of penetration.
3. Describe the tissue interactions such as reflection, echoes, transmission and scatter.
4. Discuss the relationship between echogenicity and the depiction of ultrasound images as white, gray and black.
5. Discuss the biologic effects and safety considerations related to ultrasonography.
6. Discuss the piezoelectric effect and the differences between mechanical sector scanners and linear electronic transducers in regard to their composition and ability to adjust focal length and direction of an ultrasound beam.
7. Demonstrate the conventional positioning of the marker on the transducer when scanning in the cross-sectional plane and describe the orientation of the resultant image on the display.
8. Describe the effect of transducer frequency, pulse duration, pulse dampening, and proximity of objects on axial resolution. Describe the effect of beam width on lateral resolution.
9. Discuss the use of receiver controls affecting gain and compensation (TGC).
10. Discuss the characteristics of A mode, B mode, M mode and B scan (2-D).
11. Discuss the causes and solution for the common ultrasound artifacts: pseudo-sludge (beam-width artifact), side lobe artifact, reverberation artifact (ring down artifact), mirror effect and gain artifact.

B. Cardiovascular Exam Objectives

1. Demonstrate the ability to identify the cardiac chambers, myocardium, pericardium and grossly evaluate cardiac chamber size.
2. Discuss the rationale for and demonstrate the use of ultrasound to diagnose electromechanical dissociation.
3. Discuss the difference between the ultrasound appearance of a simple pericardial effusion and that of organized pericardial hematoma; discuss the sensitivity of ultrasound for diagnosing pericardial fluid and the possible confusion with pleural effusion or hyperechoic pericardial fat.
4. Demonstrate the ability to recognize the key features of pericardial tamponade and to distinguish these findings from other causes of hypotension: cardiogenic shock, hypovolemia, and pulmonary embolism.
5. Demonstrate the ability to utilize ultrasound in penetrating cardiac trauma and describe the typical ultrasound appearance of fluid in the pericardial sac.
6. Demonstrate the ability to use 2-D echo in patients with suspected ischemic heart disease to assess qualitatively global wall motion function, and to rule out hemopericardium in thrombolytic candidates.
7. Discuss the role of transesophageal 2-D echocardiography (TEE) in the diagnosis of suspected aortic dissection. Describe the findings seen on the standard left parasternal 2-D cardiac echo that suggest aortic dissection.

C. Abdominal Exam Objectives

1. Demonstrate the ability to identify the gallbladder, liver, spleen, diaphragm, kidneys, aorta and its major branches, bowel (peristalsis) and bladder.
2. Discuss the benefit of rapid bedside sonography for the diagnosis of abdominal aneurysms. State the size of the aorta's external diameter at the level of the diaphragm and at the level of the renal bifurcation.
3. State the specific sonographic findings that lead to the diagnosis of abdominal aortic aneurysm and that enable us to distinguish between stable versus unstable aneurysms. Demonstrate the ability to diagnose AAA using ultrasound and state the diagnostic accuracy of this modality.

4. State the common errors encountered in scanning for AAA.
5. Discuss the role of ultrasound for detecting hemoperitoneum in blunt abdominal trauma, specifically comparing it to DPL for sensitivity, ease and time required for performing the procedure.
6. Describe the sonographic appearance of fresh blood in the abdomen and define the regions that are routinely examined. Demonstrate the technique for examining the hepatorenal recess (Morison's pouch), splenorenal recess, cul-de-sac (pouch of Douglas), and subdiaphragmatic abdomen as well as the pleural space.
7. Discuss the threshold for reliably diagnosing hemoperitoneum and state the qualitative fluid characteristics of blood over time. Discuss the significance of absent liver mirror image artifact above the diaphragm.
8. State common errors in scanning for hemoperitoneum including artifacts.
9. Discuss the indications for U/S in evaluating RUQ abdominal pain. Discuss the clinical scenarios in which it can optimize patient care in the ED setting.
10. State the various sonographic characteristics of the gallbladder that make it favorable for evaluation by ultrasound.
11. Discuss the significance of sonographic Murphy's sign, sludge, acoustic shadows, and gallbladder size and wall thickness in evaluating a patient for gallbladder disease.
12. Demonstrate the ability to diagnose cholelithiasis and cholecystitis.
13. State common errors in gallbladder scanning.
14. State the conditions in which ultrasound may be preferable to intravenous pyelography in evaluation of renal colic; state the specific focus of the ultrasound exam for renal colic.
15. Demonstrate the ability to distinguish between the renal cortex, medulla and pelvis; demonstrate ability to diagnose renal calculi.
16. State the various anatomic considerations that make visualization of the right kidney easier than the left; demonstrate the technique that helps circumvent problems with visualizing the left kidney.
17. Demonstrate the ability to diagnose hydronephrosis and hydroureter on ultrasound exam of kidneys; demonstrate the ability to distinguish between chronic and acute hydronephrosis.
18. Discuss common errors in scanning the kidney.

D. Pelvic Exam Objectives

1. Discuss the reliability of the physical exam and the advantages of immediately available emergency department ultrasound in the evaluation of pelvic pain in reproductive age women.
2. Demonstrate ability to identify: cervix and uterus, ovaries, cul-de-sac, bladder, iliac vessels.
3. Discuss the relative merits of transabdominal versus transvaginal U/S in evaluating the pregnant uterus and demonstrate the technique for each exam.
4. Demonstrate the ability to identify gestational sac, yolk sac, fetal pole/embryo, cardiac activity, and corpus luteum cyst.
5. Define the term "discriminatory zone," and discuss the expected sonographic findings transabdominal and transvaginal) of normal intrauterine pregnancy and HCG values at five, six and seven weeks since the start of the last normal menses.
6. Demonstrate the ability to identify the sonographic appearance of the following:
    - Definitive intrauterine pregnancy (IUP)
    - Probable abnormal IUP
    - Definitive ectopic pregnancy
    - No definitive IUP (Possible occult unruptured ectopic pregnancy)
    - Fetal demise
    - Cul-de-sac fluid, abnormal adnexal mass
7. State the common errors made in emergency pelvic sonography.

Corresponding ACGME core competencies identified in ( ):

PC Patient Care

MK Medical Knowledge
PBL Practice Based Learning and Improvement
ICS Interpersonal and Communication Skills
PF Professionalism
SBP Systems Based Practice

Description of the Clinical Experience:
This is a concentrated emergency ultrasound rotation in which the resident works closely with the ultrasound faculty at University Hospital to achieve the above stated goals. This will be accomplished through one-on-one didactics, scanning shifts in the emergency department or radiology department, and individual meetings with the rotational director or their designee. The resident is responsible for making all meetings and scanning obligations assigned by the rotational director.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Attend and participate in the mandatory weekly EM residency program didactic activities.
2. Continue to complete their scheduled assigned readings and Rosh Review tests.
3. Complete any assigned readings by the rotational director
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year.

Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Supplemental readings/resources:
Kendall's Ultrasound in Emergency Medicine and Trauma CD-ROM, Discs 1-2, 1st Edition

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), CORD EM tests, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via anonymous comment box on the DHREM website). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Document Type: **Clinical Rotation Summary**

Rotation: **General Internal Medicine**

Institution: **University of Colorado Hospital**

Rotational Service Director: **Geoffrey Connors, MD**

Year of Training: **EM-1**

Length of Rotation: **3 weeks**

Last Revised: **8/2018**

Goal:

The goal of the *General Internal Medicine* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the primary venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the urgent stabilization, admission triage, admission transfer of care, and effective and compassionate treatment of *general internal medicine patients*. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC,MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Environmental Illness
    d. General Medicine
    e. Geriatrics
    f. Neurology
    g. Resuscitation
    h. Toxicology (as applicable)
    i. Urology (as applicable)
2. Gain knowledge regarding common general medical conditions.(PC, MK)
3. Understand and encourage the practice of continuity of care. (PC, SBP)
4. Develop an understanding of the differences between observation and inpatient status. (PC, MK, PBL, SBP)
5. Gain knowledge regarding the prioritization of diagnostic testing and which tests can be safely deferred to the outpatient setting. (MK, SBP)
6. Demonstrate sound charting practices and expertise in quality assurance methodology. (PF, SBP)
7. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS)
8. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
9. Maintain personal wellness and assist colleagues in time of crisis. (PF)
10. Gain exposure to a spectrum of bedside medical procedures. (MK, PC)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The EM resident rotates for a one month block and functions as a primary care giver on the ward medicine services at either the Denver Health Medical Center or the University of Colorado Hospital. The resident is responsible for the initial evaluation with complete history and physicals, continued in-patient diagnostic work-ups, treatment, and disposition of the patients admitted with medical conditions or complaints. Residents are also expected to significantly participate in daily rounds both from a patient care standpoint and an educational standpoint. Resident work hours are based off of a rotating work schedule in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM including morning report and noon conferences.
2. Attend and participate in the mandatory weekly EM residency program didactics least twice monthly.
3. Continue to complete their scheduled assigned readings, quizzes, and tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Medicine. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory Lines of Responsibility for the Care of Patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies and the EM Milestones. The completed evaluation will be forwarded to the resident for review. All interval evaluations will be reviewed

each 6 months by the Intern Clinical Competence Committee consisting of nurses, EM faculty, the intern Associate Program Director and the Program Director. A summary of the resident's clinical performance, strengths and weaknesses will be included in their 6-month evaluation letter and reviewed in person with the resident.
Other means of resident evaluation include Rosh tests, patient simulation, oral examinations, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director and the DHREM Education Committee. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the intern Associate Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Program Evaluation and Advisory) for further discussion. Completely anonymous feedback may be given Abraham Nussbaum, MD, Psychiatry, and Chief Education Officer at Denver Health.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**General Surgery**
Institution:	**Denver Health Medical Center**

Rotational Service Director: **Kshama Jaiswal, MD**

Year of Training: **EM-1**

Length of Rotation: **3 weeks**

Last Revised: **8/2018**

Goal:
The goal of the *General Surgery* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, urgent stabilization, and effective and compassionate treatment of *general surgical patients*. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages.

Specific Educational Rotation Objectives:
1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia (as applicable)
    b. Cardiology (as applicable)
    c. Environmental Illness (as applicable)
    d. General Surgery (as applicable)
    e. Geriatrics (as applicable)
    f. Neurosurgery (as applicable)
    g. Orthopedics (as applicable)
    h. Resuscitation (as applicable)
    i. Trauma (as applicable)
    j. Ultrasound (as applicable)
    k. Urology (as applicable)
    l. Wound Care (as applicable)
2. Understand and encourage the practice of continuity of care. (SBP)
2. Demonstrate sound charting practices and expertise in quality assurance methodology. (PF, SBP)
3. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS)
4. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
5. Maintain personal wellness and assist colleagues in time of crisis. (PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
The resident rotates for a 3-week block and functions as a primary caregiver on the ward surgical services at Denver Health Medical Center. The EM resident is responsible for the **initial evaluation** with complete history and physicals, continued in-patient diagnostic work-ups, treatment, and disposition of the patients admitted with surgical

conditions or complaints. Residents are also expected to significantly participate in daily rounds both from a patient care standpoint and an educational standpoint. Resident work hours are based off of a rotating work schedule in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities, as allowed by clinical duties.
3. Continue to complete their scheduled assigned readings and Rosh Review tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), CORD EM tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Medical Intensive Care Unit**
Institution:	**Denver Health Medical Center**
Rotational Service Director:	**Mark Kearns, MD**
Year of Training:	**EM-1**
Length of Rotation:	**4 weeks**

Last Revised: **8/2018**

Goal:
The goal of the *Medical Intensive Care Unit* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to learn to rapidly assess, stabilize, diagnose and treat critically ill medical patients. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages.

Specific Educational Rotation Objectives:
1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Cardiology
    b. Environmental Illness
    c. General Medicine
    d. Geriatrics
    e. Neurology
    f. Resuscitation
    g. Toxicology
    h. Urology
2. Provide ongoing management of patients admitted to an intensive care unit. (PC, MK, PBL, ICS, PF, SBP)
3. Become expert in essential procedural skills, especially resuscitation related procedures. (PC, MK)
4. Direct a cardiac arrest resuscitation. (PC, MK, PBL, ICS, PF, SBP)
5. Understand and encourage the practice of continuity of care. (SBP)
6. Demonstrate sound charting practices and expertise in quality assurance methodology. (PF, SBP)
7. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS)
8. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
9. Maintain personal wellness and assist colleagues in time of crisis. (PF)

Corresponding ACGME core competencies identified in ( ):
- PC Patient Care
- MK Medical Knowledge
- PBL Practice Based Learning and Improvement
- ICS Interpersonal and Communication Skills
- PF Professionalism
- SBP Systems Based Practice

Description of the Clinical Experience:
The residents rotate for a 4 week block and function as a primary care giver in the Medical Intensive Care Unit at Denver Health Medical Center. The EM resident is responsible for the initial evaluation with complete history and physicals, continued in-patient diagnostic work-ups, treatment, and disposition of the patients admitted with medical conditions or complaints to the MICU. Residents are also expected to significantly participate in daily rounds both from a patient care standpoint and an educational standpoint. Resident work hours are based off of a rotating work schedule in compliance with the ACGME duty hours.

Description of the Didactic Experience:
During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities, as allowed by clinical duties.
3. Continue to complete their scheduled assigned readings and Rosh Review tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), CORD EM tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-

annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Medical Intensive Care Unit**
Institution:	**University of Colorado Hospital**
Rotational Service Director:	**Geoff Connors, MD**
Year of Training:	**EM-1**
Length of Rotation:	**4 weeks**
Last Revised:	**8/2018**

Goal:

The goal of the *Medical Intensive Care Unit* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to learn to rapidly assess, stabilize, diagnose and treat critically ill medical patients. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Cardiology
    b. Environmental Illness
    c. General Medicine
    d. Geriatrics
    e. Neurology
    f. Resuscitation
    g. Toxicology
    h. Urology
2. Provide ongoing management of patients admitted to an intensive care unit. (PC, MK, PBL, ICS, PF, SBP)
3. Become expert in essential procedural skills, especially resuscitation related procedures. (PC, MK)
4. Direct a cardiac arrest resuscitation. (PC, MK, PBL, ICS, PF, SBP)
5. Understand and encourage the practice of continuity of care. (SBP)
6. Demonstrate sound charting practices and expertise in quality assurance methodology. (PF, SBP)
7. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS)
8. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
9. Maintain personal wellness and assist colleagues in time of crisis. (PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:

The residents rotate for a 4 week block and function as a primary care giver in the Medical Intensive Care Unit at University of Colorado Hospital. The EM resident is responsible for the initial evaluation with complete history and physicals, continued in-patient diagnostic work-ups, treatment, and disposition of the patients admitted with medical conditions or complaints to the MICU. Residents are also expected to significantly participate in daily rounds both from a patient care standpoint and an educational standpoint. Resident work hours are based off of a rotating work schedule in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities, as allowed by clinical duties.
3. Continue to complete their scheduled assigned readings and Rosh Review tests.

4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis

during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**General Internal Medicine**
Institution:	**University of Colorado Hospital**
Rotational Service Director:	**Geoffrey Connors, MD**
Year of Training:	**EM-1**
Length of Rotation:	**3 weeks**
Last Revised:	**8/2018**

Goal:

The goal of the *General Internal Medicine* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the primary venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the urgent stabilization, admission triage, admission transfer of care, and effective and compassionate

treatment of *general internal medicine patients*. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC,MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Environmental Illness
    d. General Medicine
    e. Geriatrics
    f. Neurology
    g. Resuscitation
    h. Toxicology (as applicable)
    i. Urology (as applicable)
2. Gain knowledge regarding common general medical conditions. (PC, MK)
3. Understand and encourage the practice of continuity of care. (PC, SBP)
4. Develop an understanding of the differences between observation and inpatient status. (PC, MK, PBL, SBP)
5. Gain knowledge regarding the prioritization of diagnostic testing and which tests can be safely deferred to the outpatient setting. (MK, SBP)
6. Demonstrate sound charting practices and expertise in quality assurance methodology. (PF, SBP)
7. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS)
8. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
9. Maintain personal wellness and assist colleagues in time of crisis. (PF)
10. Gain exposure to a spectrum of bedside medical procedures. (MK, PC)

Corresponding ACGME core competencies identified in ( ):

PC Patient Care
MK Medical Knowledge
PBL Practice Based Learning and Improvement
ICS Interpersonal and Communication Skills
PF Professionalism
SBP Systems Based Practice

Description of the Clinical Experience:

The EM resident rotates for a one month block and functions as a primary caregiver on the ward medicine services at either the Denver Health Medical Center or the University of Colorado Hospital. The resident is responsible for the initial evaluation with complete history and

physicals, continued in-patient diagnostic work-ups, treatment, and disposition of the patients admitted with medical conditions or complaints. Residents are also expected to significantly participate in daily rounds both from a patient care standpoint and an educational standpoint. Resident work hours are based off of a rotating work schedule in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM including morning report and noon conferences.
2. Attend and participate in the mandatory weekly EM residency program didactics least twice monthly.
3. Continue to complete their scheduled assigned readings, quizzes, and tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:

Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Medicine. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory Lines of Responsibility for the Care of Patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies and the EM Milestones. The completed evaluation will be forwarded to the resident for review. All interval evaluations will be reviewed each 6 months by the Intern Clinical Competence Committee consisting of nurses, EM faculty, the intern Associate Program Director and the Program Director. A summary of the resident's clinical performance, strengths and weaknesses will be included in their 6-month evaluation letter and reviewed in person with the resident.

Other means of resident evaluation include Rosh tests, patient simulation, oral examinations, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director and the DHREM Education Committee. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the intern Associate Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Program Evaluation and Advisory) for further discussion. Completely anonymous feedback may be given Abraham Nussbaum, MD, Psychiatry, and Chief Education Officer at Denver Health or submitted electronically via a Confidential Survey link available to all residents.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
Denver Health Residency in Emergency Medicine, Academic Probation Policy

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Medical Toxicology**
Institution:	**Rocky Mountain Poison Center**
Rotational Service Director:	**Christopher Hoyte, MD**
Year of Training:	**EM-3 and EM-4**
Length of Rotation:	**4 weeks**
Last Revised:	**8/2018**

Goal:

The goal of the Toxicology (Tox) rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients with toxicologic pathology, and environmental illnesses. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum (1) for: (PC, MK, PBL, ICS, PF, SBP)
    a. Environmental Illness.
    b. Toxicology.

2. Obtain a pertinent history and physical exam on patients with an acute poisoning. (PC, MK, PBL, ICS, PF, SBP)
3. Evaluate and manage patients with an acute poisoning. (PC, MK, PBL, ICS, PF, SBP)
4. Understand the role of a regional drug and poison center in providing urgent consultation to medical providers. (PBL, SBP)
5. Understand the principles of decontamination and enhanced elimination of toxins. (PC, MK, PBL)
6. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
7. Learn to recognize and manage common ingestions and poisonings that present to the emergency department. (PC, MK, PBL, ICS, PF, SBP)
8. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
9. Develop and maintain interpersonal skills essential to interactions with patients and staff. (PC, ICS, PF)
10. Practice medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
11. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
Residents will complete a 2 week rotation in the EM-3 year and a 2 week rotation in the EM-4 year at the Rocky Mountain Poison and Drug Center (RMPDC) in Denver, CO. Residents are responsible for actively participating in daily rounds of all toxicology consults and any other daily clinical activities as assigned by the toxicology attending. Residents perform these duties on weekdays during their rotation. Additionally, residents have the responsibility of giving one short didactic lecture on a toxicology related topic at the end of their rotational time. Time will also be spent observing in the call center and attending RMPDC research lectures, if scheduled.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Attend and participate in the mandatory weekly EM residency program didactic activities.
2. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
3. Continue to complete their scheduled Reading Modules and Rosh Review tests.
4. Complete supplemental procedural readings in the most recent edition of Clinical Procedures in Emergency Medicine, editors Roberts and Hedges.
5. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff and will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include, patient simulation, oral examinations, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.
The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given online in (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.

2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Neurosurgery**
Institution:	**Denver Health**
Rotational Service Director:	**Kathryn Beauchamp, MD**
Year of Training:	**EM-1**
Length of Rotation:	**3 weeks**
Last Revised:	**8/2018**

Goal:

The goal of the *Neurosurgery* rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, urgent stabilization, and effective and compassionate treatment of *neurosurgical patients*. Such competencies must extend across the range of patients presenting with urgent and lower acuity disease or injury, as they apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia (as applicable)
    b. General Surgery (as applicable)
    c. Geriatrics (as applicable)

d. Neurosurgery (as applicable)
e. Pediatrics
f. Resuscitation (as applicable)
g. Trauma (as applicable)

2. Acquire the skills to perform an efficient, comprehensive neurosurgical examination. (PC MC)
3. Evaluate and treat patients with acute intracranial pathology, including traumatic and atraumatic injuries. (PC, MK, PBL, ICS, PF, SBP)
4. Acquire skills in reading brain imaging studies. (PC, MK)
5. Evaluate and treat patients with acute spine pathology, including traumatic and atraumatic injuries. (PC, MK, PBL, ICS, PF, SBP)
6. Acquire skills in reading spine imaging studies. ((PC, MK)
7. Exposure to neurosurgical procedures required to stabilize critically ill patients. (PC, MK, SBP)
8. Demonstrate sound charting practices and expertise in quality assurance methodology. (PC, SBP)
9. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF)
10. Understand and encourage the practice of continuity of care. (SBP)
11. Practice medicine in a fashion that displays competence, consideration and integrity. (PBL, ICS, PF, SBP)
12. Maintain personal wellness and assist colleagues in time of crisis. (PF)

Description of the Clinical Experience:

The EM resident rotates for a three week block and functions as a primary care giver on the Neurosurgical service at Denver Health Medical Center. The resident is responsible for the initial evaluation with complete history and physicals, continued in-patient diagnostic work-ups, treatment, and disposition of the patients admitted with a Neurosurgical condition or complaint. Resident will review neurosurgical imaging with the supervising neurosurgery resident or attending. Residents are also expected to significantly participate in daily rounds both from a patient care standpoint and an educational standpoint. Resident work hours are based off of a rotating work schedule in compliance with the ACGME duty hours.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM including morning report and noon conferences.
2. Attend and participate in the mandatory weekly EM residency program didactics, excluding those that occur after an overnight duty period.
3. Continue to complete their scheduled assigned readings, quizzes, and tests.

4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:

Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Surgery. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory Lines of Responsibility for the Care of Patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies and the EM Milestones. The completed evaluation will be forwarded to the resident for review. All interval evaluations will be reviewed each 6 months by the Intern Clinical Competence Committee consisting of nurses, EM faculty, the intern Associate Program Director and the Program Director. A summary of the resident's clinical performance, strengths and weaknesses will be included in their 6-month evaluation letter and reviewed in person with the resident.

Other means of resident evaluation include Rosh tests, patient simulation, oral examinations, end of shift competency-based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director and the DHREM Education Committee. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six-month evaluations.

Feedback Mechanisms:

The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the intern Associate Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Directors as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Program Evaluation and Advisory) for further discussion. Completely anonymous feedback may be given Abraham Nussbaum, MD, Psychiatry, and Chief Education Officer at Denver Health or submitted electronically via a Confidential Survey link available to all residents.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Obstetrics and Gynecology**
Institution:	**Denver Health**
Rotational Service Director:	**Nicki Nguyen, MD**
Year of Training:	**EM-4**
Length of Rotation:	**2 weeks**
Last Revised:	**8/2018**

Goal:
The goal of the *Obstetrics and Gynecology (OB-GYN)* rotation of the Denver Health Residency in Emergency Medicine (DHREM) (REM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of *obstetrical and gynecological patients*. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:
1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum (1) for: (PC, MK, PBL, ICS, PF, SBP)
    a. Obstetrics/Gynecology
2. Perform primary assessments and appropriate emergent stabilization and treatment of *obstetrical and gynecological patients*. (PC, MK, PBL, SBP)
3. Perform focused histories and physical examinations of *obstetrical and gynecological patients* with particular attention to communicating effectively in order to interpret and evaluate the patient's symptoms and history; identifying pertinent risk factors in the patient's history; appropriately interpreting patient appearance, vital signs and condition; recognizing pertinent physical findings and performing proper maneuvers and techniques necessary for conducting the exam. (PC, MK, PBL, SBP)
4. Develop a differential diagnosis for *obstetrical and gynecological patients* and the establishment of the most likely diagnosis in light of the history, physical, interventions, and test results. (PC, MK, PBL, SBP)

5. Recognize age, gender, ethnicity, and barriers to communication, socioeconomic status, underlying disease, and other factors that may affect the management of *obstetrical and gynecological patients.* (PC, PBL, ICS, PF)
6. Provide ongoing management of *obstetrical and gynecological patients* admitted to the hospital. (PC, MK, PBL, SBP)
7. Become an expert in essential procedural skills, especially resuscitation related procedures. (PC, MK)
8. Select, perform, and interpret diagnostic studies most appropriate to evaluating and treating *obstetrical and gynecological patients.* (PC, MK)
9. Understand and apply the principles of professionalism, ethics, and legal concepts pertinent to the management of *obstetrical and gynecological patients.* (PBL, ICS, PF, SBP)
10. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
11. Select appropriate pharmacotherapy for *obstetrical and gynecological patients*, recognizing the pharmacokinetic properties, and anticipating any drug interactions or adverse effects. (PC, MK)
12. Evaluate and reassess the effectiveness of treatment for *obstetrical and gynecological patients*, including addressing complications and potential errors, as well as monitoring, managing, and maintaining the stability of one or more surgical patients who are at different stages of their clinical course. (PC, MK, PBL, SBP)
13. Collaborate with physicians and other professionals to evaluate and treat *obstetrical and gynecological patients*, arrange appropriate patient placement and follow-up, and communicate effectively regarding treatment plans with patients, family, and involved health care members. (PBL, ICS, PF, SBP)
14. Demonstrate and apply medical knowledge and epidemiology information to identify patients at risk for *obstetrical and gynecological complications*, educating patients regarding their condition, and selecting appropriate disease and injury prevention techniques. (PC, MK)
15. Document patient care for *obstetrical and gynecological patients* in a concise manner that facilitates quality care and coding. (PBL, PF, SBP)
16. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
17. Develop and maintain interpersonal skills essential to interactions with patients and staff. (PC, ICS, PF)
18. Practice medicine in a fashion that displays competence, consideration, and integrity. (PC, ICS, PF)
19. Maintain personal wellness and assist colleagues in time of crisis. (ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
Residents will complete a 2-week rotation during which he/she will take primary responsibility for providing patient care for *obstetrical and gynecological patients* at Denver Health Medical Center. Practice settings include the OB screening and the Labor Deck. Residents will perform the same duties as an intern in *Obstetrics and Gynecology.* These responsibilities include procedural, medical, resuscitative interventions, and any additional responsibilities typically performed by an intern on service. The resident is responsible for all facets of the patient's clinical management. Residents are assigned to daily clinical duties by the supervising attending faculty. Residents typically take two 24-hour weekend calls while on the rotation. During the rotation, residents will also have the opportunity to spend time in prenatal ultrasound.

Description of the Didactic Experience:
During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities, as allowed by clinical duties.
3. Continue to complete their scheduled weekly assigned readings and Rosh Review tests.
4. Complete supplemental procedural readings in the most recent edition of Clinical Procedures in Emergency Medicine, editors Roberts and Hedges.
5. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:

The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Orthopedic Consult Service**
Institution:	**Denver Health Medical Center**
Rotational Service Director:	**Kyros Ipaktchi, MD**
Year of Training:	**EM-1**
Length of Rotation:	**3 weeks**
Last Revised:	**8/2018**

Goal:

The goal of the orthopedic rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of acute *traumatic musculoskeletal disorders.* Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages. There should be a specific emphasis and exposure to *fracture/dislocation reduction procedures* which are critical to the community practice of emergency medicine.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum (1) for: (PC, MK, PBL, ICS, PF, SBP)
    a. Orthopedics (as applicable)
    b. Resuscitation (as applicable)
    c. Trauma (as applicable)
2. Perform primary assessments and appropriate emergent stabilization and treatment of patients with musculoskeletal disease or injury. (PC, MK, PBL, SBP)
3. Perform focused histories and physical examinations of patients with musculoskeletal complaints with particular attention to communicating effectively to interpret and evaluate the patient's symptoms and history; identifying pertinent risk factors in the patient's history; appropriately interpreting patient appearance, vital signs and condition; recognizing pertinent physical findings and performing proper maneuvers and techniques necessary for conducting the exam. (PC, MK, PBL, SBP)
4. Recognize age, gender, ethnicity, barriers to communication, socioeconomic status, underlying disease, and other factors that may affect the management of musculoskeletal injuries or disease. (PC, PBL, ICS, PF)

5. Understand and apply the principles of professionalism, ethics, and legal concepts pertinent to the management of patients with musculoskeletal injuries or disease. (PBL, ICS, PF, SBP)
6. Select, perform, and interpret diagnostic studies most appropriate to the presenting musculoskeletal injury or disease. (PC, MK, PBL)
7. Develop a differential diagnosis for patients presenting with musculoskeletal complaints and the establishment of the most likely diagnosis in light of the history, physical, interventions, and test results. (PC, MK, PBL)
8. Perform procedures pertinent to musculoskeletal injury and disease that include but are not limited to pain management (local anesthesia, regional nerve block, and sedation/pharmacologic analgesia), fracture/dislocation immobilization techniques, fracture/dislocation reduction techniques (**minimum of 10 fracture/dislocation reductions** during rotation), spine immobilization techniques, and tendon laceration repair. (PC, MK)
9. Evaluate and treat acute hand injuries (PC, MK)
10. Select appropriate pharmacotherapy for specific musculoskeletal injuries or diseases and any pain resulting thereof, recognize pharmacokinetic properties, and anticipate drug interactions and adverse effects. (PC, MK)
11. Evaluate and reassess the effectiveness of treatment for musculoskeletal injury or disease, including addressing complications and potential errors, as well as monitoring, managing, and maintaining the stability of one or more orthopedic patients who are at different stages of their work-ups. (PC, MK, PF, SBP)
12. Function as an orthopedic consultant to the emergency department and the urgent care clinics. (PC, MK, PBL, ICS, PF, SBP)
13. Collaborate with physicians and other professionals to evaluate and treat patients with musculoskeletal disease or injury, arrange appropriate patient placement and follow-up, and communicate effectively regarding treatment plans with patients, family, and involved health care members. (PBL, ICS, PF, SBP)
14. Demonstrate and apply medical knowledge and epidemiology information to identify patients at risk for musculoskeletal disease or injury, educating patients regarding their condition, and selecting appropriate disease and injury prevention techniques. (PC, MK, PBL, SBP)
15. Document patient care for musculoskeletal disease or injury in a concise manner that facilitates quality care and coding. (PBL, PF, SBP)
16. Multitask effectively through the prioritization of multiple patients with musculoskeletal injury or disease in order to provide optimal patient care while maintaining effective interaction, coordination, education, and supervision of all members of the patient management team. (PC, MK, PBL, ICS, PF, SBP)

Corresponding ACGME core competencies identified in ( ):

PC Patient Care
MK Medical Knowledge
PBL Practice Based Learning and Improvement
ICS Interpersonal and Communication Skills
PF Professionalism
SBP Systems Based Practice

Description of the Clinical Experience:

The EM-1 resident will complete a 3 week rotation during which he/she will take primary responsibility for providing orthopedic consultations for patients presenting with musculoskeletal injury or disease to the Denver Health Emergency Department, the Denver Health Adult Urgent Care Center, the Denver Health Pediatric Emergency Department, or, on occasion, as inpatients on other services for whom orthopedic consultation has been requested.

The EM-1 resident will not provide assistance in the operating room and will not be responsible for the ongoing inpatient care of patients with orthopedic concerns. Rather, the EM-1 resident will serve as the nighttime consultative orthopedic resident, working overnight shifts 5-6 days/week.

Description of the Didactic Experience:
During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities, as allowed by clinical duties.
3. Continue to complete their scheduled reading assignments and EM tests.
4. Complete supplemental procedural readings in the most recent edition of Clinical Procedures in Emergency Medicine, editors Roberts and Hedges.
5. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff and will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given to Abraham Nussbaum, MD, Psychiatry, and Chief Education Officer at Denver Health.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type: **Clinical Rotation Summary**

Rotation: **Surgical Intensive Care Unit**

Institution: **Denver Health Medical Center**

Rotational Service Director: **Clay Cothren-Burlew, MD**

Year of Training: **EM-2**

Length of Rotation: **4 weeks**

Last Revised: **8/2018**

Goal:

The goal of the surgical intensive care unit (SICU) rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of critically ill trauma and surgical patients. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum (1) for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia (as applicable)
    b. Cardiology (as applicable)
    c. Environmental Illness (as applicable)
    d. General Surgery (as applicable)
    e. Geriatrics (as applicable)
    f. Neurosurgery (as applicable)
    g. Orthopedics (as applicable)
    h. Otolaryngology (as applicable)
    i. Resuscitation (as applicable)
    j. Trauma (as applicable)
    k. Ultrasound (as applicable)
    l. Urology (as applicable)
    m. Wound Care (as applicable)
2. Perform primary assessments and appropriate emergent stabilization and treatment of critically ill trauma and surgery patients. (PC, MK, PBL, SBP)
3. Perform focused histories and physical examinations of critically ill trauma and surgery patients with particular attention to communicating effectively to interpret and evaluate the patient's symptoms and history; identifying pertinent risk factors in the patient's history; appropriately interpreting patient appearance, vital signs and condition; recognizing pertinent physical findings and performing proper maneuvers and techniques necessary for conducting the exam. (PC, MK, PBL, SBP)
4. Learn the principles of ventilator management. PC, MK)
5. Learn the principles of fluid and electrolyte management in the critically ill patient.
6. Develop a differential diagnosis for critically ill trauma and surgery patients and the establishment of the most likely diagnosis in light of the history, physical, interventions, and test results. (PC, MK, PBL, SBP)
7. Recognize age, gender, ethnicity, barriers to communication, socioeconomic status, underlying disease, and other factors that may affect the management of critically ill trauma and surgery patients. (PC, PBL, ICS, PF)
8. Provide ongoing management of critically ill trauma and surgery patients admitted to a SICU. (PC, MK, PBL, SBP)

9. Become an expert in essential procedural skills, especially resuscitation related procedures. (PC, MK)
10. Select, perform, and interpret diagnostic studies most appropriate to critically ill trauma and surgery patients. (PC, MK)
11. Understand and apply the principles of professionalism, ethics, and legal concepts pertinent to the management of critically ill trauma and surgery patients. (PBL, ICS, PF, SBP)
12. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
13. Select appropriate pharmacotherapy for critically ill trauma and surgery patients, recognizing the pharmacokinetic properties, and anticipating any drug interactions or adverse effects. (PC, MK)
14. Evaluate and reassess the effectiveness of treatment for critically ill trauma and surgery patients, including addressing complications and potential errors, as well as monitoring, managing, and maintaining the stability of one or more surgical patients who are at different stages of their clinical course. (PC, MK, PBL, SBP)
15. Collaborate with physicians and other professionals to evaluate and treat critically ill trauma and surgery patients, arrange appropriate patient placement and follow-up, and communicate effectively regarding treatment plans with patients, family, and involved health care members. (PBL, ICS, PF, SBP)
16. Demonstrate and apply medical knowledge and epidemiology information to identify patients at risk for acute trauma or surgical disease, educating patients regarding their condition, and selecting appropriate disease and injury prevention techniques. (PC, MK)
17. Document patient care for critically ill trauma and surgery patients in a concise manner that facilitates quality care and coding. (PBL, PF, SBP)
18. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
19. Develop and maintain interpersonal skills essential to interactions with patients and staff. (PC, ICS, PF)
20. Practice medicine in a fashion that displays competence, consideration, and integrity. (PC, ICS, PF)
21. Maintain personal wellness and assist colleagues in time of crisis. (ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
Residents will complete a 4-week rotation during which he/she will take primary responsibility for providing primary intensive care for patients admitted to the Denver Health Medical Center SICU with critical trauma or surgical conditions. These responsibilities are to include procedural, medical and resuscitative intervention. Residents are assigned to a Trauma Team composed of an attending, chief surgical resident, and consult surgical resident in addition to himself or herself. There are no consultative or Operating Room responsibilities. There are no ward cross-coverage duties. The resident is responsible for all facets of the patient's clinical management. Residents typically take call every third or fourth night, the same as the surgical residents.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities, as allowed by clinical duties.
3. Continue to complete their scheduled reading assignments and Rosh Review tests.

4. Complete supplemental procedural readings in the most recent edition of Clinical Procedures in Emergency Medicine, editors Roberts and Hedges.
5. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.
The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via drop boxes in the ED clinical areas (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Pediatric Intensive Care Unit**
Institution:	**Children's Hospital Colorado**
Rotational Service Director:	**Leslie Ridall, MD**

Year of Training: **EM-3**

Length of Rotation: **3 weeks**

Last Revised: **8/2018**

Goal:

The goal of the Pediatric Intensive Care Unit (SICU) rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of critically ill pediatric patients. .

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum (1) for: (PC, MK, PBL, ICS, PF, SBP)
    a. Pediatrics
    b. Cardiology (as applicable)
    c. Environmental Illness (as applicable)
    d. General Surgery (as applicable)
    e. Neurosurgery (as applicable)
    f. Orthopedics (as applicable)
    g. Otolaryngology (as applicable)
    h. Resuscitation (as applicable)
    i. Trauma (as applicable)
    j. Ultrasound (as applicable)
    k. Urology (as applicable)
    l. Wound Care (as applicable)
2. Perform primary assessments and appropriate emergent stabilization and treatment of critically ill pediatric patients. (PC, MK, PBL, SBP)
3. Perform focused histories and physical examinations of critically ill pediatric patients with particular attention to communicating effectively to interpret and evaluate the patient's symptoms and history; identifying pertinent risk factors in the patient's history; appropriately interpreting patient appearance, vital signs and condition; recognizing pertinent physical findings and performing proper maneuvers and techniques necessary for conducting the exam. (PC, MK, PBL, SBP)
4. Learn the principles of ventilator management. PC, MK)
5. Learn the principles of fluid and electrolyte management in the critically ill pediatric patient.
6. Develop a differential diagnosis for critically ill pediatric patients and the establishment of the most likely diagnosis in light of the history, physical, interventions, and test results. (PC, MK, PBL, SBP)
7. Recognize age, gender, ethnicity, barriers to communication, socioeconomic status, underlying disease, and other factors that may affect the management of critically ill pediatric patients. (PC, PBL, ICS, PF)
8. Provide ongoing management of critically ill pediatric patients admitted to a PICU. (PC, MK, PBL, SBP)
9. Become an expert in essential procedural skills, especially resuscitation related procedures. (PC, MK)
10. Select, perform, and interpret diagnostic studies most appropriate to critically ill pediatric patients. (PC, MK)
11. Understand and apply the principles of professionalism, ethics, and legal concepts pertinent to the management of critically ill pediatric patients. (PBL, ICS, PF, SBP)

12. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
13. Select appropriate pharmacotherapy for critically ill pediatric patients, recognizing the pharmacokinetic properties, and anticipating any drug interactions or adverse effects. (PC, MK)
14. Evaluate and reassess the effectiveness of treatment for critically ill pediatric patients, including addressing complications and potential errors, as well as monitoring, managing, and maintaining the stability of one or more pediatric patients who are at different stages of their clinical course. (PC, MK, PBL, SBP)
15. Collaborate with physicians and other professionals to evaluate and treat critically ill pediatric patients, arrange appropriate patient placement and follow-up, and communicate effectively regarding treatment plans with patients, family, and involved health care members. (PBL, ICS, PF, SBP)
16. Demonstrate and apply medical knowledge and epidemiology information to identify patients at risk for acute injury, educating patients regarding their condition, and selecting appropriate disease and injury prevention techniques. (PC, MK)
17. Document patient care for critically ill pediatric patients in a concise manner that facilitates quality care and coding. (PBL, PF, SBP)
18. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
19. Develop and maintain interpersonal skills essential to interactions with patients and staff. (PC, ICS, PF)
20. Practice medicine in a fashion that displays competence, consideration, and integrity. (PC, ICS, PF)
21. Maintain personal wellness and assist colleagues in time of crisis. (ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:
Residents will complete a 3-week rotation during which he/she will take primary responsibility for providing primary intensive care for patients admitted to the Pediatric Intensive Care Unit (PICU). These responsibilities are to include procedural, medical and resuscitative intervention. Residents are assigned to a Team composed of an ICU Attending, Fellows and NP/PAs. There are no ward cross-coverage duties. The resident is responsible for all facets of the patient's clinical management. Residents typically take call every third or fourth night. The Emergency Medicine Residents will also play a role on the Rapid Response Team for the hospital.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities, as allowed by clinical duties.
3. Continue to complete their scheduled reading assignments and Rosh Review tests.
4. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), Rosh Review tests, end of shift competency based evaluations, and annual ABEM in-training examinations.
The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via the anonymous feedback box on the DHREM website. In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:

Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:

1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Denver Health Residency in Emergency Medicine

Document Type:	**Clinical Rotation Summary**
Rotation:	**Emergency Medicine – UCH Instructional Senior**
Institution:	**University of Colorado Hospital**
Rotational Service Director:	**Bonnie Kaplan, MD**
Year of Training:	**EM-4**
Length of Rotation:	**1 weeks**

Last Revised: **8/2018**

Goal:

The goal of this academic Emergency Medicine rotation of the Denver Health Residency in Emergency Medicine (DHREM) is to serve as one of the venues by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of patients presenting to an academic emergency room. Such competencies must extend across the range of patients presenting with critical, emergent, and lower acuity disease or injury, and they must apply to patients of all ages.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives outlined in the Denver Health Residency in Emergency Medicine (DHREM) Curriculum Goals and Objectives for: (PC, MK, PBL, ICS, PF, SBP)
    a. Anesthesia
    b. Cardiology
    c. Dermatology
    d. Emergency Medical Services
    e. Environmental Illness
    f. Ethics
    g. General Medicine
    h. General Surgery
    i. Geriatrics
    j. Neurology
    k. Neurosurgery
    l. Obstetrics/Gynecology
    m. Orthopedics
    n. Ophthalmology
    o. Otolaryngology
    p. Pediatrics
    q. Psychiatry
    r. Resuscitation
    s. Toxicology
    t. Trauma
    u. Ultrasound
    v. Urology
    w. Physician Wellness
    x. Wound Management

2. Acquire the essential cognitive, attitudinal and psychomotor skills needed to care for all patients presenting to the emergency department. (PC, MK, PBL, ICS, PF, SBP)
3. Evaluate and treat medical patients presenting with a wide variety of complaints. (PC, MK, PBL, ICS, PF, SBP). Particularly:
    a. Patients presenting with cardiac symptomatology (PC, MK, PBL, SBP)
    b. Patients presenting with gynecologic complaints (PC, MK, PBL, SBP)
    c. Acutely burned patients (PC, MK, PBL, SBP)
    d. Sickle cell patients presenting with acute complaints (PC, MK, PBL, SBP)
    e. Organ transplant patients presenting with acute complaints (PC, MK, PBL, SBP)
    f. Issues and conditions unique to patients presenting to a large tertiary care academic hospital (PC, MK, PBL, SBP)

g. Patients with substance abuse and addiction related complaints (PC, MK, PBL, SBP)
h. Victims of domestic violence (PC, MK, PBL, SBP)
i. Issues and conditions unique to homeless patients (PC, MK, PBL, SBP)
j. Issues and conditions unique to patients of non-American ethnicity and culture (PC, MK, PBL, SBP)

4. Become proficient in the acquisition and use of a limited database to make rapid and effective bedside decisions. (PC, MK, PBL, ICS, PF, SBP)
5. Establish the ability to prioritize the management of multiple patients. (PC, MK, PBL, ICS, PF, SBP)
6. Provide rapid assessment and stabilization of critically ill medical and trauma patients. (PC, MK, PBL, ICS, PF, SBP)
7. Become expert in essential procedural skills. (PC, MK)
8. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
9. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
10. Develop and maintain interpersonal skills essential to interactions with patients and staff. (ICS, PF)
11. Understand the role of the emergency medicine specialist and how he or she relates to all other physicians caring for an individual patient, both inside and outside the hospital setting. (PBL, ICS, PF, SBP)
12. Acquire a sound knowledge base in emergency medicine and demonstrate this understanding in both the practice and board certification process of emergency medicine. (MK)
13. Practice emergency medicine in a fashion that displays competence, consideration and integrity. (PC, ICS, PF)
14. Maintain personal wellness and assist colleagues in time of crisis. (PBL, ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism
SBP	Systems Based Practice

Description of the Clinical Experience:

The resident rotates for a maximum of 1 week at the University of Colorado (UCH) Emergency Department and functions as a integral member in the department working with present attendings, 2-4 medical students and residents in each of the ED zones. Residents report directly to the supervising zone attending EM physician and supervise and teach medical students. This rotation will be the capstone to a longitudinal educational curriculum for our residents. The EM resident is responsible for the rapid evaluation, diagnosis, and treatment of any patient that presents, providing the typical academic emergency medicine experience. Resident will work closely with the other zones on procedures and education around procedures while maintaining the roles of the graduated responsibility of all residents. Residents work 4 rotating 7-hour shifts per week and are in compliance with the ACGME duty hours. The UCH emergency department is an academic level II trauma center and has a 24-hour emergent cardiac cath lab, which sees a large medical, cardiac, sickle cell, gynecological, transplant population. It is directed by the Department of Emergency Medicine at UCH.

Description of the Didactic Experience:

During the rotational time, EM residents will:

1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities.
3. Continue to complete their scheduled assigned readings.

4. This 4th year rotation is the capstone to a longitudinal education curriculum for our residents.
5. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Details of Rotation:

1. Senior residents will begin after first week of July, and be scheduled into 17 weeks during academic year.
2. Longitudinal teaching curriculum will include
    a. 4 real time didactic sessions with learners
    b. Bedside teaching
    c. Feedback on their teaching

Duty Hours:

Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:

1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:

Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director. Otherwise, supervising faculty will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.

Other means of resident evaluation include weekly quizzes, patient simulation, oral examinations, a unique patient care assessment tool called the D-DOT (Denver Direct Observation Tool), CORD EM tests, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.

The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.

The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the supervising faculty. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given via anonymous feedback comment box on the DHREM website. In addition, an ombudsman is available to mediate issues in a confidential format.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.

Document Type:	**Clinical Rotation Summary**
Rotation:	**Neonatal Care**
Institution:	**Denver Health**
Rotational Service Director:	**Patricia Hagan, MD**
Year of Training:	**EM-4**
Length of Rotation:	**1 weeks**
Last Revised:	**8/2018**

Goal:
The goal of the *Neonatal Care* rotation of the Denver Health Residency in Emergency Medicine (DHREM) (REM) is to serve as a primary venue by which residents will gain the broad competencies expected of board-certified emergency physicians in the recognition, emergent stabilization, and effective and compassionate treatment of

neonatal patients. Such competencies must extend across the range of patients presenting with critical, emergent, and stable deliveries.

Specific Educational Rotation Objectives:

1. Acquire the knowledge, skills, and attitudes necessary to achieve the educational objectives as outlined in the DHREM Curriculum (1) for: (PC, MK, PBL, ICS, PF, SBP)
    a. Neonatal Resuscitation
2. Perform primary assessments and appropriate emergent stabilization and treatment of *neonatal patients*. (PC, MK, PBL, SBP)
3. Perform focused histories and physical examinations of *neonatal patients* with particular attention to communicating effectively in order to interpret and evaluate the patient's symptoms and history; identifying pertinent risk factors in the patient's history; appropriately interpreting patient appearance, vital signs and condition; recognizing pertinent physical findings and performing proper techniques necessary for conducting the exam. (PC, MK, PBL, SBP)
4. Develop a differential diagnosis for *neonatal patients* and the establishment of the most likely diagnosis in light of the history, physical, interventions, and test results. (PC, MK, PBL, SBP)
5. Recognize age, gender, ethnicity, and barriers to communication, socioeconomic status, underlying disease, and other factors that may affect the management of *neonatal patients.* (PC, PBL, ICS, PF)
6. Provide ongoing management of *neonatal patients* admitted to the hospital. (PC, MK, PBL, SBP)
7. Become an expert in essential procedural skills, especially resuscitation related procedures. (PC, MK)
8. Select, perform, and interpret diagnostic studies most appropriate to evaluating and treating *neonatal patients.* (PC, MK)
9. Understand and apply the principles of professionalism, ethics, and legal concepts pertinent to the management of *neonatal patients.* (PBL, ICS, PF, SBP)
10. Understand and encourage the practice of continuity of care. (PC, PBL, ICS, SBP)
11. Select appropriate pharmacotherapy for *neonatal patients*, recognizing the pharmacokinetic properties, and anticipating any drug interactions or adverse effects. (PC, MK)
12. Evaluate and reassess the effectiveness of treatment for *neonatal patients*, including addressing complications and potential errors, as well as monitoring, managing, and maintaining the stability of one or more surgical patients who are at different stages of their clinical course. (PC, MK, PBL, SBP)
13. Collaborate with physicians and other professionals to evaluate and treat *neonatal patients*, arrange appropriate patient placement and follow-up, and communicate effectively regarding treatment plans with patients, family, and involved health care members. (PBL, ICS, PF, SBP)
14. Demonstrate and apply medical knowledge and epidemiology information to identify patients at risk for *neonatal complications*, educating patient's parents regarding their condition, and selecting appropriate disease and injury prevention techniques. (PC, MK)
15. Document patient care for *neonatal patients* in a concise manner that facilitates quality care and coding. (PBL, PF, SBP)
16. Demonstrate sound charting practices and expertise in quality assurance methodology. (PBL, PF, SBP)
17. Develop and maintain interpersonal skills essential to interactions with patients and staff. (PC, ICS, PF)
18. Practice medicine in a fashion that displays competence, consideration, and integrity. (PC, ICS, PF)
19. Maintain personal wellness and assist colleagues in time of crisis. (ICS, PF)

Corresponding ACGME core competencies identified in ( ):

PC	Patient Care
MK	Medical Knowledge
PBL	Practice Based Learning and Improvement
ICS	Interpersonal and Communication Skills
PF	Professionalism

SBP Systems Based Practice

Description of the Clinical Experience:
Residents will complete 1-week rotations during which he/she will take responsibility for providing patient care for *neonatal patients* at Denver Health Medical Center. Practice settings include the NICU, PICU and the Labor Deck. Residents will perform the same duties as a third year pediatric resident. These responsibilities include procedural, medical, resuscitative interventions, and any additional responsibilities typically performed by a third year pediatric resident on service. The resident is responsible for all facets of the patient's emergent clinical management. Residents are assigned to daily clinical duties by the supervising attending faculty.

Description of the Didactic Experience:
During the rotational time, EM residents will:
1. Participate fully in all didactic activities of the service that are not in conflict with the didactic activities of the DHREM.
2. Attend and participate in the mandatory weekly EM residency program didactic activities, as allowed by clinical duties.
3. Continue to complete their scheduled weekly assigned readings and Rosh Review tests.
4. Complete supplemental procedural readings in the most recent edition of Clinical Procedures in Emergency Medicine, editors Roberts and Hedges.
5. Take the ABEM In-Training Examination which occurs on the last Wednesday in February every year. Residents are excused from any clinical duty from 11pm the night before the exam until 1pm the day of the exam.

Duty Hours:
Residents will perform their clinical duties during pre-set duty hours that comply with mandates on residency duty hours set forth by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Anesthesia. Residents are responsible for bringing forth any duty hour violations to the residency leadership for investigation. Additionally, the Rotational Service Director is responsible for assuring duty hour regulations and assisting in any duty hour violation investigations.

Supervisory lines of responsibility for the care of patients:
1. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.
2. When applicable, Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
3. When applicable, Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).
4. When applicable, Senior Level Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on-duty attending staff as outlined in the above point (1).

Assessment Methods:
Any urgent concerns regarding resident performance and progress will be referred directly to the EM Program Director or Associate Program Director. Otherwise, the Rotational Service Director will complete a non-anonymous rotation specific evaluation form that assesses the ACGME's six core competencies. The completed evaluation will be forwarded to the resident for review. A summary of the resident's clinical performance, strengths and weaknesses is included in their 6-month evaluation letter. All evaluations will be periodically reviewed by either the Program Director or Associate Program Directors.
Other means of resident evaluation include pre/post test assessment, NRP completion prior to rotation, patient simulation, oral examinations, end of shift competency based evaluations, and annual ABEM in-training examinations.

The resident will complete anonymous evaluations of each rotation on an annual basis. These evaluations will be reviewed by the EM Program Director and Education Committee. Strengths and weaknesses of each clinical rotation will be addressed, with the aim to improve the educational experience.
The resident will also complete monthly anonymous evaluations of the supervising faculty. In order to preserve resident anonymity, these evaluations will be reviewed by the EM Program Director and the supervising faculty member on a quarterly basis.
The resident will maintain an individual procedure log specific to interventions performed during the rotation, which will be reviewed at the six month evaluations.

Feedback Mechanisms:
The resident will have timely access to the written assessment provided by the Rotational Service Director. Additionally, the resident will receive oral feedback regarding his/her progress and performance during the semi-annual meetings with the appointed faculty advisor and the EM Program Director/Associate Program Director. Any significant deficiencies will be addressed with either a written action plan or academic probation, if needed. (See Academic Probation Policy).

Residents are encouraged to discuss any perceived deficiencies with the EM Program Director as the situation requires. Oral feedback concerning the curriculum and clinical rotations is also sought on a semi-annual basis during the chief resident-run Resident Advisory Committee meetings. Urgent issues are brought directly to the Program Director with the remaining issues brought to residency leadership committees (Wellness, Education, Compliance, Program Advisory) for further discussion. Completely anonymous feedback may be given on-line (University and Denver Health). In addition, an ombudsman is available to mediate issues in a confidential format.

Both the EM Program Director and the Rotational Service Director will receive written feedback from each resident regarding this rotation.

Resources and Facilities Available:
Residents rotating on this service will have full availability of all needed clinical (patient care space, medical records, patient care resources, laboratory, and faculty consultation, faculty supervision) and academic (administrative offices, library, and faculty consultation) resources and facilities at the institution at which the rotation takes place.

References:
1. Denver Health Residency in Emergency Medicine, Curriculum Goals and Objectives Handbook.
2. Denver Health Residency in Emergency Medicine, Academic Probation Policy.