

General Internal Medicine Primary Care Resident Clinic Experience at the Adult Medicine Clinic, Upstate Health Care Center

Educational Purpose and Structure:

1. The residents are to become the primary care physician of their patients, supported by the advice of attending physicians (from the Department of Medicine) who precept them. Each resident is assigned to one attending physician (the “mentor”) who has special duties concerning resident evaluations and the ongoing care of that resident’s patients (e.g. administrative forms and controlled substance prescription). The residents have primary responsibility for carrying out timely and appropriate assessment, communication and follow-up of their patients.
2. Residents are trained to identify standards of care and adhere to standards of documentation.
3. Internal medicine residents in the primary care clinic should become proficient in
 - a. Data acquisition including chart review, patient and family history, physical exam, obtaining additional or missing data,
 - b. Interpreting data especially data patterns
 - c. Naming diagnoses or hypotheses at the highest level of specificity
 - d. Planning: education, observation, further testing, consultation, treatments, release of information.
 - e. Health maintenance guidance including vaccines, cancer and other screenings, and advanced directives.
 - f. Professionalism, interpersonal and communication skills, an understanding of the logic and complexity of primary care, working with a team of nurses, pharmacists and administrative staff, recognizing psychosocial problems and utilizing psychosocial providers

Rotation Description

Internal medicine residents will be assigned a primary care experience one week out of every 4 week block. During that week they will spend half the day in a continuity clinic and half a day in specialty outpatient rotations.

Continuity clinic:

1. Primary Care Panels: Each resident will be assigned a primary care panel of approximately equal size for 3 years. There will be some adjustments due to new patients, deaths, discharges, transfers but in general this should be a stable panel for the duration of the residency which should facilitate long term relationships. The panels are diversified by age, gender and heritage; we have many patients who require a translator (mostly refugees) and these account for up to 20% of the resident panel as of 11/1/15.
2. Types of work scheduled:
 - a. Chronic medical problems: regularly scheduled visits for evaluation and management of multiple chronic medical problems not managed by specialists. Patients co-managed with

- our anticoagulation clinic and diabetes pharmacologists will receive on-going assessments by the residents. Treatment is guided by evidence-based standards of care.
- b. Health Maintenance (preventive medicine, Wellness exams): depending on age, gender, medical conditions according to evidence-based standards of care
 - c. Acute Care: for urgent medical problems and urgent follow-up of ER or hospital admissions.
 - d. "20/20": one of the five sessions is devoted to chart review, preparation and re-organization, communications and prescription management
3. Supervision: an attending of the Department of Medicine will supervise up to 4 residents.

Specialty outpatient rotations:

1. R1s: dermatology, chronic disease management, diabetes management, Occupational health; study time in an electronic curriculum in ambulatory care (PEAC)
2. R2-3s: Quality Assurance (new 2015), HemOnc, Endo, ID, Geri, GI, Rheum, Neph, Neuro, Pulm, Research/Standards of Care (new 2015), VA mix

Teaching methods (in redesign as of 11/10/15):

1. Huddles are encouraged before each clinic session to announce changes in medical advisories, emphasize core presentation skills and clarify preceptor priorities. At the time of the patient visit, a preceptor will review the resident's formulation of the visit diagnosis list as the first step in ensuring an appropriate plan of care. Health maintenance tasks (vaccines, screenings, proxy) are reviewed on non-acute visits. Each case should provide at least one teaching point. Until January 1 of the R1 year the preceptor will always see the patient. After that, it will be at the discretion of the preceptor depending on the complexity of the patient and the reliability of the resident. The preceptor will review and sign the visit documentation promptly and give additional feedback as needed.
2. Daily educational programs include A) Mondays: administrative procedures and chart analysis, B) Tuesday: template development and physical exam drills, C) Wednesday: ambulatory pharmacology, D) Wednesday: our own noon conference (13 major topics per year, one for each block), E) Friday: targeted case conferences (led by a resident) and testing (13 additional major topics per year, one for each block). The Wednesday and Friday major topics will be repeated in a 2-year cycle (totaling approximately 52 major topics in the 3 year residency)
3. Readings in standard primary care tests (e.g. Goroll's Primary Care Medicine; the "In the Clinic" section of the Annals of Internal Medicine) are assigned each 4-week block for specific major primary care subjects (e.g. COPD evaluation and treatment) and tested prior to a resident-led conference on the same subject on Fridays (see above).
4. Completion of an electronic curriculum in ambulatory care (PEAC) is required.
5. The Hundred Lights Campaign: As a daily teaching moment, a minor primary care topic will be reviewed in a self-study format. For each topic, 2-3 residents will be assigned to review a reading in a standardized review text or journal article (beyond Up to Date), formulate a brief

summary of the teaching points (<125 words), and compose one multiple choice. These 2-3 documents will be melded into a single one page document and published electronically each day for residents assigned to the clinic in a 3-year cycle (totaling approximately 190 minor topics in the 3 year residency.)

6. Each week a resident is assigned to a “Research, Standards of Care and Teaching” outpatient “specialty” rotation (20 hours) in which a standard of care for a common outpatient condition is formulated (simple, brief, practical, measurable) and posted for review and comment.
7. Every resident is assigned a session each week of their outpatient experience to complete standardized chart reviews, to formulate a complete and accurate problem list, medication list and health maintenance task list for those patients who have upcoming appointments.
8. Interns attend a 20-hour high intensity orientation to the principles and methods of primary care in their first block (July).
9. In the early months of the intern year, R2 and R3 residents are assigned as “junior mentors” to assist in the orientation of the interns in data collection and work-flows.

Evaluation of residents:

1. Every 6 months, each resident is evaluated by the mentor using the ACGME criteria and forms on Medhub (electronic access and registration). In addition each mentor is encouraged to design, implement and file their own evaluation tool with the residency and Medical Director.
2. Results of formal cumulative testing (as of 11/15/15 still in a trial mode) may supplement the above evaluations:
 - a. Medical knowledge: multiple choice questions on the weekly reading (electronic access and registration)
 - b. Physical exam drills (timed and scored for completeness)
 - c. Documentation submissions (e.g. templated progress notes for pre-op, hospital follow up, controlled substances prescription)
 - d. Evaluation of Wednesday noon and Friday case conference performance.
 - e. Completion of assigned exercises including the Hundred Lights Campaign
3. Every 6 months residents are asked to complete a self evaluation including strengths and weaknesses. They are asked how the residency can best assist in developing their skills and knowledge.
4. R2 and R3 residents complete a Quality Assessment self study program once each year which scores system compliance in cancer screening, vaccinations and other health maintenance tasks, as well as high risk medications (controlled substances, antipsychotics, anti-coagulants.)

Rotation specific competency objectives:

- A. Medical Knowledge – The residents will apply knowledge of basic and clinical sciences in the diagnosis and management of common medical problems. They will demonstrate the ability to critically evaluate medical information and scientific evidence, and be expected to apply

- that in a progressively mature fashion through the three years of training. In addition to the provided didactics on the ambulatory medical knowledge, residents are strongly encouraged to read on a regular basis, especially about diseases that they see in their ambulatory patient care practice.
- B. Patient Care – The residents will be evaluated on their ability to manage common acute and chronic ambulatory medical problems and to perform health maintenance counseling and screening. High quality and efficient patient care in the outpatient setting requires the development of good physical exam skills and an ability to logically and concisely create a diagnostic formulation and plan of action. The residents must demonstrate a commitment to compassion and appropriate care for each individual patient, whether it is for the promotion of health, prevention of illness, the treatment of disease, or at-the-end-of-life care. House calls are encouraged when appropriate.
 - C. Interpersonal and Communication Skills – The residents will learn interviewing skills and improve their ability to communicate with a broad cross-section of the population with differing socioeconomic backgrounds, cultural or religious backgrounds, and different ethnicities. The residents are expected to effectively communicate with patients and families, to communicate effectively and promptly with a variety of other health care professionals (especially their supervising attending), and be able to articulate the important issues and the management plans to the supervising attending of record. Unlike the inpatient rotations where interactions with patients are often for a brief time, the Adult Medicine Clinic offers residents the opportunity to get to know their patients on a more personal level and this is often one of the most rewarding parts of a resident’s training.
 - D. Professionalism –will be modeled by teachers and monitored in all. Professionalism is directed to our patients, their families and caretakers, and other health care workers. It includes honesty, respect, and compassion; intellectual curiosity, a demonstrated commitment to study and evaluation, self-care; respect for differences in gender, age, culture, religious beliefs, sexual preference, socioeconomic status, abilities; confidentiality, informed consent and refusal. In addition: hand washing, appropriate attire, appropriate boundaries during patient interviews , the application of appropriate standards for modesty during physical exam.
 - E. Practice Based Learning and Improvement – The residents are expected to perceive data , organize data and create logical precise formulations and care plans based on best evidence or expert opinion whenever possible. All residents will participate in quality assessment and improvement projects while at UHCC. The residents should be willing to learn from advice and mistakes and to use these in the improvement of future practices.
 - F. Systems Based Practice – A multi-disciplinary standing committee including residents and chaired by the Medical Director will solicit and formulate measures to improve communications, efficient EMR documentation, ordering, data review and prescriptions. There is a standing written protocol for problematic orders in the EMR that is updated regularly. Standards of care will be developed by the residents for the top 25 diagnoses of concern. The residents are expected to gain an ability to work with the care delivery team, including social workers, case managers, nurse practitioners, office nurses, pharmacists and clerical staff.

?????”Resident suggestions for improvement are encouraged ad hoc or through the Clinic Resident Liaison Committee that meets biannually. DOES this still exist??”

INTERNAL MEDICINE RESIDENT RESPONSIBILITIES & EXPECTATIONS FOR ADULT MEDICINE CLINIC, UHCC: JUNE 2016

PURPOSE: The residents are to become the primary care physician of their patients, supported by the advice and guidance of attending physicians.

PROFESSIONALISM*: On site, ready to work at time of every conference, other teaching session and patient care sessions. For teaching sessions, come prepared having completed any assigned readings or study. Willingness to learn and to adopt new work-flows; participation in workflow development.

TOOLS: stethoscope, monofilament (provided on request), reflex hammer. Access: Chartmaxx, H drive, Hopkins, Rhio, Synapse, remote access.

IN-BASKET AND MAILBOX REVIEW*: Perform daily and at 5PM when on clinic block with appropriate documentation of assessment and plan. When on other rotations, check your in-basket every Monday, Wednesday and Friday. When on vacations or away due to other absences, sign out your In-Basket to a mutually agreed co-resident.

PANEL REVIEW: H drive tracking of concerns and 20/20 completion dates; 20/20 (3-6 per session) chart review.

Complete and accurate problem list including, in the Overview sections, all significant details, delineation of managing specialty, and Health Maintenance tracking. All conditions that are managed by Adult Medicine should be addressed at the time of the general follow up visit for multiple medical problems (not an urgent visit) or assigned as a return visit task.

MEDICATION REVIEW: All medications we prescribe should be accurate, have a rationale and documented in the medical record. Renewals for medications we are prescribing should be completed at the time of the follow up visit (non urgent visit) if needed to ensure that there will be enough refills to last until the time of the next Adult Medicine visit or 6 months, whichever comes first.

Note: review of controlled substances or other “high risk” medications that Adult Medicine prescribes (as determined by the Medical Director, as of 1/1/16 also antipsychotics, anticoagulants) on a regular basis including strict chart documentation requirements justifying rationale and addressing safety, every 6 months.

PROGRESS NOTES:

- Each billed visit diagnosis should have an HPI and an AP (except health maintenance tasks which are handled separately). Visit/billing diagnoses should not include diagnoses handled completely by specialists.
- It is the resident’s responsibility to review the nurse’s medication reconciliation (“Rooming” Home Meds) critically and formally discontinue meds or dosing in EPIC which the patient is no longer taking (this may require a call to the pharmacy).

* First occasion of concern will be a warning, second will be a consequence (call on clinic weekend) and third will be academic probation (the duration of academic probation will be determined by members of the Clinical Competency Committee). Exceptions for emergencies at the discretion of the chiefs.

- Every visit should include an appropriate return visit plan and tasks, including wellness visits.
- Note Completion: On the day of service requested but always within 24 hours.*

DATA REVIEW, CARE PLANNING, COMMUNICATIONS:

Data review: The resident is responsible for

- Prompt review of test results or consultations ordered by the resident (or by an attending on behalf of the resident).
- Communicating ALL significantly abnormal results to the patient via phone or during a face to face encounter. A letter may also be sent but ONLY to request a callback and NOT to convey any abnormal results. Communicating normal results can be performed by the resident, nursing staff (upon request) or via letter.
- Creating a subsequent plan of care if needed in coordination with the appropriate attending or pharmacist. The plan of care (if needed) is documented and communicated to the patient and appropriate parties (which may include the PCP and mentor).
- Documenting any communications, review of results and treatment plans.
- Handoffs:** The resident and/or preceptor seeing a patient on behalf of a PCP/mentor are responsible for addressing the new concern or data, setting up a plan to address it and communicating with the patient. For significant problems, after 1-2 weeks they should formally in writing (e.g. a result, document or telephone note, routed to the PCP and mentor) hand over the issue to the PCP and mentor to carry on responsibility going forward.

Faculty and/or Staff requests for action (e. g. clinical care, patient contact, testing, documentation, editing, orders, clarifications) must be addressed at the time of review. These requests may be in staff messages or progress note addenda and it is the responsibility of the resident to review these carefully.

Tele-triage: The resident should document non-urgent phone calls promptly and alert the attending via EPIC within 24 hrs. Urgent (e. g. significant symptoms, triage to ER, deaths, uncertainty) phone calls should be addressed immediately with the attending physician by phone. Documentation should be prompt (within hours) and include the time of the call.

EVALUATION: Twice yearly the mentor will provide formal face-to-face and written feedback.

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