RESIDENT CONTINUITY CLINIC

2018
2019

Adult Medicine Center Resident Manual

Resident Continuity Clinic

Welcome to the Adult Medicine Physicians Group! We are excited to have you join us and we are committed to make your time with us as enjoyable and educational as possible. We believe we can provide you with a unique educational experience as you learn the practice of primary care in a group practice model. The basic skills you will acquire should provide you with a solid base as a physician, whether you continue a career in primary care or elect to subspecialize. This manual will guide you through some of the unique aspects of ambulatory medicine at the University of Illinois at Chicago/Advocate Christ Medical Center residency program. We look forward to working with you!

Armand Krikorian, MD, FACP, FACE
Program Director
Internal Medicine Residency

Jacqueline Ivey-Brown, MD, FACP
Associate Program Director
Internal Medicine

Sarah Hicks, MD
Attending Physician
Internal Medicine

Kevin Loughry, MD,
Attending Physician
Internal Medicine

Parimal Sura, MD
Attending Physician
Adult Medicine Center

Lee Tai, MD, FACP
Director,
Undergraduate Medical Education

Anupam Goel, MD
Attending Physician
Internal Medicine

Melanie Gordon, MD
Attending Physician
Internal Medicine

Sophia Majid, DO
Attending Physician
Internal Medicine

Joy Iskandar, DO
Ambulatory Chief Resident
Internal Medicine

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1. Practice Description

The Adult Medicine Physicians Group is a physician group practice specializing in Internal Medicine and Geriatrics. The group practice consists of faculty attending physicians and Internal m]Medicine residents. Our philosophy is one of providing quality, evidence-based, primary and comprehensive care to our patients.

Resident physicians function as primary care providers and work in a collaborative fashion with their supervising attending to attain a state of readiness for independent practice. The ongoing attending and resident interaction promotes continuous learning and facilitates state-of-the art patient care. Through their supervision and teaching, the faculty emphasize the importance of the patient-doctor relationship as well as caring for the patient as a whole.

Because the patient-doctor relationship is of prime importance in the therapeutic alliance, the education experience and for patient satisfaction, we emphasize continuity of care as much as possible. To this end, we try to ensure that patients identify you as their primary care provider and look to you for their medical needs. Patients should be scheduled to see the same provider for their visits. In the event that the resident is unavailable, a "buddy" system will ensure that the clinical relationship incurs minimal disruption.

Our group practice is organized to simulate a "real world" group practice experience as much as possible in order to give you a foundation for practice after you finish your training. To that end, residents will participate in an on-call schedule, provide internal coverage for their colleagues, and will be encouraged to "build" their practice.

The practice is located at 4220 West 95th Street, Unit 200, Oak Lawn, IL 60453. The Center provides access to adult primary care as well as Geriatric, Rheumatology, Endocrinology, Cardiology and Trauma Services.

2. Adult Medicine Continuity Clinic Curriculum

LEARNING OBJECTIVES

The goal of the Primary Care Curriculum is to produce physicians skillful in providing primary, comprehensive and longitudinal care to patients. This is achieved through the following learning objectives:

- Developing effective patient-doctor relationships
- Skillfully managing common outpatient medical problems
- Utilizing a comprehensive bio-psycho-social approach to patient care
- Acting as patient advocate, sensitive to ethical and moral issues
- Emphasizing disease prevention and health promotion

GENERAL COMPETENCIES

Competency/Goal	PGY 1	PGY 2	PGY 3
Patient Care			
Perform a history and physical examination of an ambulatory patient. Gather accurate, essential information from all sources, including medical interviews, physical examinations, medical records and diagnostic and therapeutic procedures.	√	√	√
Make informed recommendations about preventive, diagnostic and therapeutic options and interventions that are based on clinical judgment, scientific evidence, and patient preference.		√	√
Develop, negotiate and implement effective patient management plans and integration of patient care.		√	√
Know the indications for ordering, significance and limitations of laboratory tests and radiological studies used in the evaluation of general medical patients.	√	√	√
Know the indications, risks and limitations for procedures done in the management of general medical patients, namely, Pap smear and Endocervical culture.	√	√	√

Competency/Goal	PGY 1	PGY 2	PGY 3
Demonstrate skill in performing procedures used in the management of general medical patients, namely, Pap smear and Endocervical culture.		√	√
Synthesize results of laboratory data, radiology studies and electrocardiograms used in evaluating general medical patients.		√	√
Initiate the management, including evaluation and treatment of an ambulatory patient.	√	√	√
Evaluate general medical patients and present summary to attending.	√	√	√
Work with the consultants in ongoing patient care.	√	√	√
Medical Knowledge			
Know the etiology, pathogenesis, clinical presentation and natural history of commonly encountered medical problems in the outpatient setting.	√	√	√
Know the etiology, pathogenesis, clinical presentation and natural history of commonly and uncommonly encountered medical problems in the outpatient setting.		√	√
Recognize common symptoms and signs; formulate initial assessment and plan.	√	√	√
Identify common and uncommon symptoms and signs; formulate a comprehensive patient care plan. Understand and apply appropriate patient management guidelines.		√	√
Know the sensitivity and specificity of commonly used diagnostic tests; formulate initial diagnostic plan	√	√	√
Understand and apply the sensitivity and specificity of commonly and uncommonly used diagnostic tests; formulate a comprehensive diagnostic plan. Understand and apply appropriate patient guidelines.		√	√
Access and critically evaluate current medical information and scientific evidence in primary care medicine	√	√	√
Apply this knowledge to clinical problem-solving, clinical decision-making, and critical thinking with respect to primary care medicine.		√	√
Practice-Based Learning and Improvement			
Research and learn from patient care issues with respect to primary care medicine. Use information technology or other available methodologies to assess and manage information, support patient care decisions and enhance both patient and physician education.	√	√	√

Competency/Goal	PGY 1	PGY 2	PGY 3
Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes and processes of care.	√	√	√
Keep a log of unique cases in general internal medicine	√	√	√
Acquire appropriate evidence-based information with respect to primary care medicine and be facile in using this information during evaluation of patients.		√	√
Use information about self-errors to improve practice and change behavior; learn from previous experience to improve patient care.	√	√	√
Develop and maintain a willingness to learn from and use errors to improve the systems or processes of care.		√	√
Analyze and evaluate practice experiences and implement strategies to continually improve the quality of patient care.			√
Use consulting services effectively and efficiently to improve both patient care and self-knowledge.	√	√	√
Participate in the teaching of junior students or peers.	√	√	√
Recognize one's limitations and seek outside assistance when necessary.	√	√	√
Interpersonal and Communication Skills			
Use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families.	√	√	√
Communicate with and educate the patient and family when appropriate.	√	√	√
Sustain therapeutic and ethically sound professional relationships with patients, their families and colleagues.	√	√	√
Maintain comprehensive, timely and legible medical records.	√	√	√
Communicate with consultants in a professional, respectful and appropriate manner.	√	√	√
Communicate effective and in a timely manner with other members of the health care team.	√	√	√
Professionalism			
Understand and appreciate the role of the primary care physician.	√	√	√
Be available and responsive to patients, families and other members of the health care team.	√	√	√
Accept responsibility for patients willingly and enthusiastically.	√	√	√

Competency/Goal	PGY 1	PGY 2	PGY 3
Demonstrate respect, compassion, integrity and altruism in relationships with patients, families and colleagues.	√	√	√
Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disability.	√	√	√
Demonstrate responsibility, commitment, cooperation, and respectfulness to patients, families and other members of the health care team.	√	√	√
Exercise accountability to self and peers, responsibility to the profession, and contribution to the review of practice and standard setting.	√	√	√
Systems-Based Practice			
Understand, access and utilize the resources, providers and systems necessary to provide optimal care.	√	√	√
Apply evidence-based, cost-conscious strategies to prevention, diagnosis and disease management.		√	√
Collaborate with other members of the health care team to assist patients and to improve care.	√	√	√
Understand coordination of inpatient and outpatient care and provide appropriate follow-up.		√	√
Recognize and surmount obstacles to appropriate patient care.		√	√
Understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient.			√

EDUCATIONAL ENVIRONMENT

Residents are exposed to primary care throughout their entire training period through didactic and patient based conferences and caring for patients in a variety of clinical settings. The foundation of the learning experience will be in the Adult Medicine Center, which will provide a structured environment to teach the basics of primary care. After the initial year, residents gain additional experience in the community and in various non-internal medicine specialty clinics to complement their training.

I. CONFERENCES

Multiple didactic and patient-based conferences exist to provide an organized and expansive foundation for primary care. A description of each conference follows:

A. NOON CONFERENCE/CORE LECTURE SERIES

During each academic year, 15-20 lectures during the Noon Conference series

are devoted to topics in primary care. Over a two-year period, topics are covered on a rotating basis to ensure that housestaff are exposed to all areas during their training. Lectures are directed primarily at the level of the housestaff, focusing on pathophysiology, clinical presentation, interpretation and appropriate use of clinical studies and management. The latest relevant literature is also reviewed. Topics that are reviewed are within the specialties of:

- Adolescent Medicine
- Dermatology
- Psychiatry
- Orthopedics
- Gynecology
- Surgery
- Radiology

B. GRAND ROUNDS

Each year, the Department of Internal Medicine Grand Rounds series offers multiple topics devoted to general internal medicine. These conferences draw on the expertise and experience of outside speakers. The speakers review recent advances in medical research and clinical medicine, targeting audiences that include all levels, from medical students to attending physicians. Topics vary by year according to the surveyed needs of the attending physicians.

C. MORNING REPORT

Residents will also present at Morning Report during their Ambulatory rotation. Morning Report provides an opportunity for residents to discuss the diagnostic approach to clinical problems and to review management decisions as they occur in the outpatient setting.

D. JOURNAL CLUB

Through Journal Club, residents learn how to evaluate the medical literature and apply evidence-based medicine to realistic patient scenarios. Residents are given articles and asked to apply them to a case. In the process, they assess features of the studies such as study design, sample selection, statistical analyses, and conclusions.

II. PATIENT-BASED ACTIVITIES

A. ADULT MEDICINE CENTER

All categorical residents participate in the Adult Medicine Physicians Group, an

innovative group practice in which the residents and attending practice side-by-side in the same modern facility. In this setting, residents learn to deliver primary, comprehensive and longitudinal care to their patients. Residents participate in ambulatory clinic one half-day per week. Residents are introduced to their responsibilities as a member of the practice during an orientation session.

Residents are responsible for their own panel of patients, which includes patients from a wide variety of payor sources, including managed care. Residents see their own patients as much as possible, to foster a relationship with, and a sense of responsibility and ownership for care of the patient. Patients are to be given a card with their physician's name and scheduled to see the same resident on return visits. Phone calls from patients are directed to the patient's physician. When residents are on planned or unplanned absence, they need to ensure cross coverage with their "buddy" or other resident within their patient care team.

Residents are supervised by a faculty preceptor who stresses elements of primary, comprehensive and longitudinal care of patients. After evaluating the patient, the resident formulates an assessment and plan. The attending may confirm physical findings, suggest alternative treatment plans or highlight relevant teaching points. Preceptors may also observe the resident-patient encounter and/or procedures and demonstrate counseling or dealing with the difficult patient.

Residents review and sign-off on any laboratory or radiology studies with the attending. They notify patients of these results by letter or phone as indicated under the direction of the attending preceptor.

Residents are integral in coordinating care among specialists. Recommendations from consultants are sent back to the resident who, with supervision from the preceptor, interprets recommendations, interacts with the consultant, decides on treatment options, reviews these with the patient, and obtains informed consent.

Residents participate in the on-call schedule for the practice, learning how to triage phone calls and give telephone advice with indirect supervision of the attending physician on call.

Each patient chart has a health maintenance flow sheet with permanent problem list, preventive care practices flow sheet, immunization records, and medication list. It is the responsibility of the resident serving as the patient's primary care provider to make sure all of these elements are up to date.

B. AMBULATORY CARE ROTATION

This is a block rotation for resident physicians with an opportunity to be interacting with out-patient problems on a daily basis. Additional reading/study will be a part of this rotation along with a quality improvement case presentation at morning report.

C. PROCEDURES

Residents will receive instruction and feedback and will have opportunity to develop expertise in the following procedures:

- PAP smears and speculum examination of the vagina
- KOH and wet prep examination of vaginal discharge
- Incision and drainage
- Arthrocentesis of the knee
- Skin punch biopsy
- Cerumen removal

EVALUATION AND FEEDBACK

Residents are evaluated using information from multiple sources (Attendings, AMC clinical/support staff, patients). Residents are evaluated by their faculty preceptor who observes their performance in the ambulatory clinic. Attendings use the ABIM evaluation forms, which evaluate the residents in terms of clinical judgment, medical knowledge, clinical skills, humanistic qualities, professional attitudes and behavior, and medical care. This evaluation will be done at least bi-annually and will be entered into the resident's file.

Residents are also evaluated by faculty members using the mini-clinical evaluation exercise (mini-CEX) which focuses on the core skills that residents demonstrate in patient encounters. These skills include medical interviewing skills, physical examination skills, humanistic qualities/professionalism, clinical judgment, counseling skills, organization/efficiency and overall clinical competence.

In addition, other indicators of quality and patient satisfaction will be monitored, such as:

- Periodic chart review for quality indicators
- Number of patient return visits
- Results of patient satisfaction surveys

The results will be used to provide feedback as needed.

Policies and Procedures

GENERAL

SCHEDULED ABSENCES

Any changes in the monthly schedule **REQUIRE** prior approval by the Chief Resident and Dr. Ivey-Brown. Planned schedule change requests should be made at least 4 weeks in advance.

UNPLANNED ABSENCES

Any unscheduled absences require immediate notification to the Chief Resident who will complete the necessary documentation and communicate this information to the front desk.

VACATION COVERAGE (Role of the "Buddy")

The role of the clinic "buddy" system is to maintain continuity of the patient-doctor relationship while his/her partner is on vacation or unavailable. The duties of the clinic "buddy" are the following:

- Check task list **DAILY** and physical mailbox WEEKLY and follow up on lab results
- Answer phone calls from patients and handle medication refill requests (in coordination with the clinic preceptor)

As a courtesy, please notify your preceptor ahead of time when you will not be going to the office. The Chief Resident will also notify your preceptor.

FLOOR RESPONSIBILITIES

Every attempt will be made to avoid overlap of clinic schedules of the members of the GMF floor teams so that other members of your team will cover your inpatient responsibilities while you are in clinic. If additional coverage is necessary, the Chief Residents will ensure back is available during the clinic session.

PATIENT CARE ISSUES

CLINIC SESSIONS

Residents must be physically present during the entire scheduled session. In order to maintain patient confidentiality and professionalism, please use the conference rooms when discussing any patient issues as well as any other educational topic.

URGENT VISITS

If your patient is acutely ill and needs to be seen urgently in the Adult Medicine Center before your next scheduled clinic day, the front desk must be notified ***in advance*** so that the patient may be given an allotted time. Either the patient or the physician may call the front desk and obtain a designated appointment time. Please discourage patients from "walking-in", as it

disrupts patient flow for those who have scheduled appointments. It also follows from this policy that ***you may be assigned to see patients that usually see another physician.*** Please remember that we function as a group practice.

WALK-IN VISITS

Patients who do "walk in" without an appointment will be assigned to be seen by a physician already present in the clinic (if there is an appointment available). That physician should take care of the acute problem and refer the patient back to their primary physician.

LATE ARRIVALS

If a patient arrives late for their appointment, a determination will be made on the possibility to accommodate their visit based on the urgency of their needs and the impact on the rest of the scheduled patients.

PATIENT CALLS

It is very important that patients are encouraged to discuss their concerns with you and instructed on how to contact you. This is accomplished by giving your patient your business card which has the phone number of the Adult Medicine Center listed on it. You may also wish to give them the number of the hospital operator and your pager number. Please let your patients know that there is always a physician available to answer their concerns during business hours and after.

- Regular Business Hours
  If you anticipate that a patient may wish to speak to you about non-urgent issues during regular business hours, inform the patient of the day and time that you are in clinic, so the patient can call you during your session. If a patient calls the Adult Medicine Center on another day, the front desk staff will take a message and send it to your EMR task box. For this reason, it is essential that you ***check your task box/physical mailbox daily***. If you anticipate that you will be away from the hospital and unable to check your mailbox for more than 24 hours, please make arrangements with your buddy or a colleague to check your messages.
- After-Hours calls
  Patients should be directed to call the phone number of the Adult Medicine Center after hours. This will be referred to the hospital operator who will page the resident on call for the Adult Medicine Center. Residents participate in this telemedicine experience during their ambulatory rotation. If you are on call, an attending is always on call with you to help – don't hesitate to call him/her if you have any questions.

In general, when you receive a call, follow the following protocol:

1. **Determine the nature of the problem**
   Most often, calls are for refills, acute symptoms or illness or possibly requests for Emergency Room visits. Please refer to the section below on how to handle various common situations.

2. **Contact the attending on call and discuss the case**
   In general, while you do not need to discuss every call with the attending, if you are not sure about a situation, it is a good idea to contact the attending. The only exception to this is for patients that

need to go to the Emergency Room. To ensure appropriate ER utilization, follow up, and admissions, any and all patients that you wish to send to the Emergency Room must be discussed with the attending.

3. **Arrange appropriate care**
   This may involve arranging appropriate follow-up care, calling in prescriptions, giving medical advice, etc.

4. **Communicate with patient's physicians**
   Please be sure to inform the patient's physician(s) the following day if you received an urgent call from a patient so they are aware of and can follow up on the situation if necessary. If you are made aware of any admissions, please let the appropriate attending know.

5. **Documentation**
   Any calls that you receive must be documented in a timely manner in the EMR. The note should then be tasked to the patient's PCP for review.

The following are the most common scenarios you may encounter on call:

- **Patient or pharmacy calling for refills**
  Patients who call for refill requests should be given a minimal amount of medication and asked to call back during regular business hours. **NO NARCOTICS CAN BE REFILLED VIA PHONE.** Explain that this is a state policy and all controlled substance prescriptions should be picked up personally at the Adult Medicine Center.

- **Patient has an acute medical illness**
  Determine the nature of the problem. If the problem can wait until the next business day, provide the patient with appropriate interim instructions and ask them to call the Adult Medicine Center in the morning. In this situation, it is probably wise to contact the attending as well. The next day, contact the front desk and inform them that the patient will be calling for an appointment, and inform the patient's resident and/or attending.

  If you feel the patient needs to go to the Emergency Room, contact the attending on call and discuss the case with him/her. After instructing the patient to do so, call the Emergency Room and speak to the physician about the nature of the problem and ask the ER physician to call the attending on call to discuss the patient after the evaluation. Also, please document this telephone encounter in the EMR and the follow-up action.

AVAILABILITY

Physicians who receive calls from patients should return the call and address the patient's concerns in a timely manner. If the physician is not the primary physician for the patient (i.e. one who may have seen the patient on an urgent basis), the physician should still take responsibility for handling the call. This may involve communicating with the primary physician, obtaining lab results, etc. This will result in quality service and avoid lapses and errors in the care of the patient.

To ensure that patients are always able to reach a physician, residents should never have their pager signed out as "Unavailable". You have several options available during your off hours:

- Keep your pager signed on and answer your pages
- Sign out to the appropriate resident on call

AMC PATIENTS ADMITTED TO THE HOSPITAL
It is of great importance to maintain continuity of care by attending to your patients while they are in the hospital. All AMC patients should be admitted to the teaching GMF service.

Residents are encouraged to visit their patients daily during their hospitalization. While it is not necessary to write a progress note as this just duplicates the work of the floor team, be sure to communicate with the primary team and share any valuable input you may have regarding their condition.

CHART MAINTENANCE

LABORATORY/RADIOLOGY RESULTS

Attendings will review laboratory and radiology results daily. "Panic values" will be handled by the attending as he/she sees appropriate. Non-urgent results will be placed in the residents' electronic mailboxes. These should be reviewed by the resident and the "response" forwarded back to the attending's electronic mailbox for review and completion.

For non-urgent results, a form letter is available for use in the EMR. If you write a letter to your patient regarding his/her results, please use clear language and avoid the use of medical terminology. Your attending should review your letters with you prior to mailing. If you prefer to call your patient to discuss the results by phone, you need to document this in the electronic chart as well.

All results must be signed off by the attending and resident.

PROBLEM LIST/HEALTH MAINTENANCE RECORD/MEDICATION RECORD
Each medical record must have an up-to-date problem list and health maintenance record. This also is a quality assurance item. It is a very useful tool – please use it and keep it up to date. Also, verify and update the medication list on each visit.

PATIENT EDUCATION/DISCHARGE INSTRUCTIONS
All patients must have documentation of instructions at each visit. For "new" patients, physicians should orient them to the unit and explain any special instructions, i.e. laboratory testing, follow-up, etc. For "return" patients, physicians should ensure that the patient education, documentation of medication changes and follow-up appointments are given prior to leaving. All patient should have a printed clinical summary given to them at the end of their visit.

Building Your Practice

One of the markers of a successful practice is continued growth, i.e. recruitment and retention of new patients. We hope to give you the experience and opportunity to "build" your practice in the Adult Medicine Center. Following are some of the key components of effective practice building.

- **ESTABLISHED PATIENTS:** You will be assigned a panel of established patients that had been following up with a resident that has just graduated from our program. We have

informed those patients of this transition and they look forward to meeting and working with you.

- **ER REFERRALS**
  Patients who do not have a primary care physician and need follow up from the Emergency Room may be referred to the Adult Medicine Center. Although in many cases these patients require only a focused visit, residents should take this opportunity to begin discussion on the importance of health maintenance, i.e. disease prevention and health promotion, unless the situation dictates otherwise. Please ask those patients when their last physical was and offer a complete health screening, preferably during the initial visit. (If it is their first new contact with our group, they will need a new patient evaluation.)

- **ADVOCATE CHRIST HOSPITAL HEALTH PARTNERS**
  The attending in the Adult Medicine Center will be assigned new patients from the Physician Hospital Organization (PHO), some of whom will be directed to make appointments with the resident physicians.

- **HOSPITALIZED NON-AMC PATIENTS**
  Non-AMC patients cared for in the hospital by our resident teams will be given the opportunity of follow-up in our AMC medicine clinic if they do not have an established primary care physician.

- **REFERRALS FROM CURRENT PATIENTS**
  Hopefully, once the practice reaches a certain level, it will continue to grow from "word of mouth". One of the most effective ways to acquire and keep new patients is by providing such good service that your current patients refer all their friends, neighbors, and colleagues to you.

Patient Satisfaction

One cannot discuss patient satisfaction without stressing the importance of effective communication. Patient satisfaction correlates well with the communication skills of the physician. Good communication skills also lead to improved physician satisfaction, data gathering, enhanced patient compliance and lower malpractice claims

For physicians, communication is a "procedure" that will be performed thousands of times over our careers. Although some individuals may be inherently better communicators than others, communication is a skill that can be learned and improved with practice and experience.

Following are some "tips" during a patient encounter to help facilitate communication and patient satisfaction.

GENERAL

- Ensure that the patient be informed if there will be an unusual delay before being seen
- Apologize for the wait, even if short
- Maintain a professional, neat and clean appearance; recognize that physician attire influences initial patient response
- Maintain patient confidentiality; be certain you are out of hearing range when discussing any patient related issues.

GREETING THE PATIENT

- Greet the patient warmly, using the patient's name and introducing yourself.
- Use the patient's family name preceded by the appropriate title, i.e. Mr., Mrs.; avoid using first names unless the patient requests that you do so
- Maintain appropriate eye contact
- Avoid looking distracted, disinterested or impatient
- Body language and tone of voice communicate as much as the words you choose
- Arrange the seats so that you and the patient are at the same eye level without barriers between you.

HISTORY TAKING

- Use open-ended questions initially and allow the patient to respond without interrupting
- Ask about all problems the patient wants to discuss at the visit; prioritize issues with the patient if necessary
- When appropriate, use direct questions without leading the patient
- Be aware of and follow up on verbal cues that require exploration
- Be aware of non-verbal cues, or "body language"
- Convey a non-judgmental attitude at all times
- Take a moment to inquire about the patient's life situation

THE FLOW OF THE INTERVIEW

- When appropriate, elicit the patient's explanation of what is wrong
- Utilize transitional statements, especially when touching on sensitive topics, i.e. "Next, I'd like to just ask you some routine questions that I ask everyone during the initial visit . . . "
- Use language consistent with the patient's background; avoid medical jargon
- Summarize and check periodically
- Document elements of your note in a fashion that does not diminish rapport
- Have the patient sit next to you while you review the computer (your back should never be turned at the patient)

PHYSICAL EXAMINATION

- Communicate appropriately during the physical exam
- Explain what you are doing and why
- Explain your findings in a manner tailored to the patient's level of understanding
- Avoid transmitting important information during the exam

CLOSING

- Summarize the visit and assessment
- Tailor the treatment plan to the patient, taking steps to ensure comprehension and compliance (discussed below)
- Ask whether there are any further questions BEFORE leaving
- Give explicit instructions regarding follow up, whether it be a return visit, phone call or other communication regarding test results (Use the AMC Discharge Instructions sheet)
- Reemphasize your interest in the patient; provide your business card and encourage telephone contact as needed.

PATIENT EDUCATION

- Summarize using explicit categorization
- Provide written instructions and educational materials when appropriate
- Check for patient comprehension in a non-threatening manner
- Discuss noncompliance in a non-judgmental manner
- Prescribe medications with once-a-day dosing whenever possible
- Help keep the patient's pharmacy costs at a minimum by being knowledgeable about the patient's insurance and prescription plan (generic drugs cost less)

Principles Of Service Excellence

- We are in a service industry.
- We have to provide the best service.
- We need to strive to exceed the expectations of those we serve. Only then is it noticed.
- Service excellence is a skill. It can be taught, developed, and learned.
- Measurement of the service and feedback from the patient perspective should drive the process.
- Physicians must lead this effort.

Guidelines for a Patient Encounter

HISTORY

- Review the chart briefly to assess the reason for the visit and vital signs.
- Greet the patient, then take a moment to attend to patient's physical comfort, i.e., that the patient is seated in the chair, his/her coat is hanging on the hook, and that you and the patient will be at the same eye level.
- In taking the history, ask open-ended questions and attempt to elicit the patient's concerns.
- To conclude, summarize and ask if there is anything else before informing the patient you will do an examination.
- Hand the patient a gown, instructing the patient as to how much you would like him/her to undress and leave the room.

PHYSICAL EXAM

- While the patient is changing, this is an opportunity to begin documenting the history, look up things you may have forgotten or begin preliminary discussions with the attending.
- Return to the room. Perform the physical appropriate to the patient's visit and risk factors, (i.e. annual breast and pelvic exams for females, periodic foot exams for diabetics).
- Before leaving the room, summarize your preliminary impressions and inform the patient that you will be returning with the attending after you speak with him/her. Please ask the patient to remain gowned so that the attending may confirm any physical findings.

CONCLUSION

- Present your patient to the attending. The attending will return with you to greet the patient, confirm physical findings and finalize discharge plans.
- Allow the patient to dress and complete any prescriptions or paperwork. The attending will help you find patient education materials or forms if needed.
- Return with final discharge instructions and review these with the patient.
- After the patient leaves, complete your note, document your patient education including instructions for follow-up, fill out the encounter form and discharge instruction sheet.
- Give all the materials to the attending to review and complete.

Health Maintenance Guidelines

Please refer to:

1. USPSTF Recommendation on the Electronic Preventive Services Selector tool (ePSS) @ **http://www.epss.ahrq.gov** (for PDA or mobile phone) and on computers in conference rooms.

2. Recommended Adult Immunization Schedule – United States, 2018 **http://www.Immunize.org**

Medical App Resources

App	Cost	Description
Clinical Decision Support Apps		
ARUP	Free	Has over 300 pathologies for you to review with clinical decision algorithms.
Heart Failure Trials	$2.99	Summarizes key points of landmark trials in patients with CHF
Medical Calculator by QxMD	Free	Over 150 formulas organized by organ system
AHQR ePSS (Electronic Preventive Services Selector)	Free	Based on USPSTF recommendations. Download on apple, android, blackberry or windows devices
STAT Asthma NHLBI guidelines	Free	Table showing stepwise approach to asthma care
Snellen	Free	Snellen chart for mobile device
Visual Diagnosis App	$49.99/yr	Encyclopedia of 18,000+ dermatologic pictures for 900+ various disease pathologies. Special resident pricing.
MedCalc	$2.99	Multiple formulas including opiod conversion, dermatomal map, STOP BANG screening for OSA
ACP Immunization Advisor	Free	All vaccine schedules listed with tools to determine indications
ACP Clinical Guidelines	Free	Provides guidelines for common outpatient medical conditions
Coding Apps		
ICD-9 on the go Lite		Provides ICD-9 codes for diagnoses
STAT E&M Coder	$39.99	Built-in calculator to help you determine level of service for patient encounter
Study Apps		
ACP Doctor's Dilemma	Free	MKSAP-like questions to review
NEJM "This Week" App	Free	Provides audio summaries of articles for the week, videos, and images
Heart Murmur Lite	Free	Goes over basic murmurs, and you can quiz yourself. For $2.99 upgrade to full package with more murmurs to review, and more questions
JAMA Podcasts	Free	Can be found in itunes
ReachMD	Free	Audio podcasts regarding various topics that provide .25-1 AMA CME Credit

Frequently Asked Questions

Many residents feel very comfortable on the floors but experience slight adjustment difficulties when seeing patients in the ambulatory setting. This section will hopefully help with the transition and prevent some common mistakes that would have otherwise been discovered by trial and error.

What are the major differences between inpatient and ambulatory medicine?

- ***Continuous vs. Episodic Care***
  This is probably the most apparent difference. The patients you acquire in the clinic will stay with you for the duration of your training. As opposed to inpatient medicine, you have an opportunity to develop a relationship with your patients over time – one of the most gratifying aspects of medicine. Also, you will get to follow up on any diagnostic workup that you perform on your patient.

- ***Proactive vs. Reactive Care***
  Ambulatory medicine requires a slightly different mindset. Instead of responding to abnormal symptoms, signs and lab values, one has to think "proactively" about how to keep your patient healthy. This includes activities related to health maintenance, i.e. counseling on healthy behaviors and screening for diseases.

- ***Biopsychosocial vs. Traditional Medical Model***
  Often psychosocial issues have a great influence on the patient's behavior and illness. While these are just as important in the inpatient setting, one is often able to address these better in the outpatient setting because you have an ongoing longitudinal relationship with your patient.

- ***Uncertainty vs. Certainty***
  One has to become comfortable with a little bit of uncertainty in the outpatient setting. Often, decisions have to be made regarding a patient's care without the luxury of having laboratory or radiological study results immediately available.

My patient seems to have a lot of complaints. How do I handle this?

- ***Prioritize Problems***
  One may feel pressed for time, especially if the patient has a lot of issues to be addressed. In these instances, remember that it is not necessary to have everything done in one visit. Address the most pressing problems and inform the patient that you will address the other problems at another visit. The exact number that you address is not as important as being sure that the patient leaves feeling satisfied.

- ***Address Psychosocial Issues***
  If a patient has a lot of issues that do not make sense in the traditional medical model, or seem out of proportion to patient's general health status, this may be an indication that there are psychosocial issues that need to be addressed.

- ***Schedule Frequent Visits***
  In any case, it is probably a good idea to schedule the patient to come back as frequently as needed to address the issues and to assure the patient that you are taking his/her problems seriously.

What should be done in the initial visit?

- ***Inpatient vs. Outpatient H&P***
  Most of the time, the initial History and Physical will be similar to the one you do in the inpatient setting. There may be exceptions to this, however. If the patient is acutely ill or uncomfortable, one should simply address the acute problem and schedule the patient to return for a general health evaluation.

- ***Health Maintenance***
  During the initial visit, one should address health maintenance activities appropriate to the patient's age and sex. Perform the patient's health maintenance activities according to their previous schedule.

What should be done in the follow-up visit? How much should I have the patient undress?

Of course, this will be variable according to the patient's problems. Often an exam may require the patient to put on a gown. Some patients may not feel that they have been thoroughly evaluated unless they have changed into a gown and had a general exam which included having their heart and lungs examined. (Remember, blood pressures should not be measured through clothes or with a tight constricting sleeve on the arm!)

How much time should I be spending for each visit?

Again, this will be variable, depending on the patient's needs and your schedule. If you are pressed for time, you may explicitly tell the patient that you will save some problems for a later visit. However, be sure that you are not ending the visit prematurely from the patient's point of view and that the patient leaves satisfied.

How soon should I have the patient come back?

There are no hard and fast rules for this. The return date will depend on the number and acuity of the patient's problems, and whether you made any interventions or ordered tests that need timely follow-up. In general, the following guidelines may be helpful, but are not absolute rules.

See your patient:

- Within a week or two if something needs to be followed up (e.g. blood pressure control)
- In 3-4 months if patient has multiple problems that are stable
- In 6-12 months if patient is generally healthy

Also, be cognizant of your patient's anxiety level and schedule the patient to return soon enough so that the patient feels that you are taking his/her problems seriously. Finally, remember to document explicitly what you told the patient about when to return.

How often should I get labs? What labs should I get

Residents often feel uncomfortable if they do not have any laboratory data on their patient. Remember that not every patient needs a basic metabolic profile. Instead, the decision to

order laboratory data should be made depending on the patient's medical problems and health maintenance guidelines. For example, patients with diabetes should have labs at least every 3-6 months, and stable patients with hypertension may have labs every 6-12 months.

How do I keep track of all the patient's problems?
It is sometimes hard to keep track of all your patient's problems, especially if there are many. One helpful tool is the problem list located in the EMR. By keeping this up to date, one can simply glance at the list during the visit to remind yourself of all the problems.

How do I remember to address health maintenance?

- ***Health Maintenance***
  Utilize the EMR system to help you track patient's health maintenance. It is an excellent resource for you to use. It is a very useful tool and will save you time reviewing the whole chart.

How do I find out how much the patient has to pay for medication?
The simplest method would be to ask the patient how they pay for their medications. However, be careful whenever speaking to a patient about their insurance as this can be a sensitive area. Patients may wrongly assume that you are making judgments about them or that the quality of their medical care will be affected by their ability to pay. Instead of asking "What type of insurance do you have?" A better alternative might be "How do you pay for your medications? Is it covered by your insurance?

A little knowledge about different types of insurance and what they cover is also helpful (see also "A Basic Insurance Primer", which follows later):

- Patients with Medicare pay the price determined by their plan.
- Patients with Medicaid do not pay for most medications according to a limited formulary.
- Patients who belong to an HMO may pay a small amount for their medications as long as it is in the HMO formulary (generics are less costly).

In general, you can avoid difficulty by prescribing the least expensive medication. In most cases, prescribe a generic brand if available.

My patient needs narcotics. How should I handle this?
Some patients have a legitimate need for narcotics. Be sure to document this carefully in the chart. Prescriptions for narcotics require a DEA (Drug Enforcement Agency) number. Residents have a number assigned through the hospital for use. Because narcotics have a high abuse potential, be sure to protect this number and prescriptions so that others do not get inappropriate access to them.
For patients that need a regular supply of narcotics or other medications with abuse potential, be sure to document the reason for continuing need in the chart. Give the patient a limited supply and document the amount given at each visit. Ask the patient to use only one pharmacy and one physician. Patients on chronic pain medication (i.e. require the medication > 2weeks) will need to sign a "Pain Contract" and return regularly for refills (usually monthly). Your preceptor should be aware of all narcotics that you are prescribing and should co-sign all of these prescriptions with you. Utilize the Illinois Prescription Monitoring Site (www.ilpmp.org) to review a patient's narcotic use before giving a prescription. Patient's activity on the IL prescription monitoring site must be reviewed by state law prior to a new prescription being issued.

What do I do with the medical student?
Most of the time there will be 1-2 medical students in the Adult Medicine Center. Students can sometimes be helpful, especially if you have patients waiting to be seen. As a courtesy, let the patient know that you are seeing another patient and ask the patient if he/she would mind if the student sees him/her first.

In order to make the ambulatory experience a good one for the medical student, it is important to allow the student to take some initiative, develop problem solving skills and have a feeling of responsibility. Some general guidelines that have been found to be appreciated by medical students are:

- Reviewing the patient's medical background beforehand
- Telling the student what complaint to focus on
- Giving the student guidelines for the physical exam
- Allowing the student to see the patient independently for a portion of the exam time (dependent on scheduling)
- Allowing the student to formulate an assessment and plan
- Allowing the student to present to the attending and document the visit
  (*Note: Residents must still document their complete exam, assessment and plan for billing purposes – the student should not fill out the progress note.)*

A Basic Insurance Primer

What is Medicare?
Medicare is a health insurance program administered by the Federal government for individuals who are:

- 65 years or older
- Disabled
- On dialysis or have had a kidney transplant

Medicare has three parts: Part A (hospital insurance), Part B (medical insurance) and Part D (prescription insurance).

What does Medicare cover?
As hospital insurance, Medicare Part A covers the traditional things one associates with hospitalization, such as care in hospitals, skilled nursing facilities, hospice and some home health services. Most people do not have to pay for Part A because they or their spouse paid Medicare taxes while they were working.

Medicare Part B was designed as medical insurance to help pay for doctor services that are medically necessary. Medicare Part B covers doctors, outpatient hospital care and some other services not covered by Part A such as physical and occupational therapy. Part B also covers some health services, medical equipment and supplies. Most people pay a monthly payment or "premium" for Part B.

Medicare was designed to cover only services that are medically necessary. Thus, Medicare does not cover routine physical exams, eye glasses, custodial care, dental care, dentures, routine foot care, hearing aids, orthopedic shoes, cosmetic surgery. Recently however, Medicare expanded its coverage to include mammograms at specified intervals and other health maintenance items.

Medicare Part D is a prescription drug plan that covers prescription drugs at participating pharmacies. Medications should be on the Medicare formulary.

How do I know if my patient has Medicare?
If your patient is over 65, disabled or on dialysis, it is very likely the patient has Medicare. Also, patients on Medicare will have a "red, white and blue card".

What is Medicaid?
Medicaid is a jointly funded Federal and State health insurance program for certain low-income and needy people. Each state determines the rules for and administers its own program within guidelines established by the Federal Government.

States are mandated to provide insurance to certain groups which include, but are not limited to:

- Low income families with children
- The aged, blind and disabled
- Certain institutionalized individuals

Medicaid does not provide medical assistance for all poor persons, even the very poor, unless

they are in one of the designated groups.

What does Medicaid cover?
States must offer certain basic services under the Medicaid program. These include, but are not limited to, inpatient and outpatient hospital services, physician services, medical and surgical dental services, nursing facility services, home health care, family planning, laboratory and x-ray services, eyeglasses and hearing aids.

Medicaid also covers most, but not all, prescription drugs. Certain medications which are not covered may be paid for after requesting special approval from the agency in Springfield, Illinois.

How do know if my patient is on Medicaid?
A patient with Medicaid may say that he is on the "medical card". This card is issued monthly as verification of coverage. Medicaid is also sometimes referred to as "Public Aid".

HMO PPO PHO POS ACHHP – What do all these abbreviations mean?

HMO
HMO stands for Health Maintenance Organization. It is a "managed care" concept where patients have coordinated care with the goal to provide quality care while controlling costs. Most HMO plans also emphasize prevention. Integral to the coordination of care is the Primary Care Physician (PCP) who serves as a "gatekeeper".

A patient who belongs to an HMO must first choose a primary care provider from a list of doctors who belong to the plan. This physician is responsible for coordinating all aspects of the medical care for that patient. If the patient requires a visit for specialty care or the emergency room, he/she must obtain a referral from his/her primary physician. Some types of specialty care or diagnostic studies may also require "Pre-authorization" from the HMO. If the patient requires laboratory or radiology studies, he/she must use the laboratory or radiology facilities that are contracted with the HMO. Medications prescribed should be in the HMO formulary or the patient will have higher out-of-pocket costs. Formularies are distributed to the primary physicians' offices.

Of all the insurance options available, HMO's are generally the least expensive. Plans generally cover the costs of all care after a copayment. There are no deductible amounts to pay or claim forms to file for the patient.

PPO
PPO stands for Preferred Provider Organization. This can be thought of as the other end of the spectrum of managed care. Patients who belong to a PPO have more choice in their providers and do not have to pick a primary physician. Patients are free to go to a specialist without obtaining a referral.

The PPO maintains a list of "preferred providers", hence the name, Preferred Provider Organization. If the patient sees a participating provider, the plan will cover a higher portion of charges than if the patient saw a non-participating provider. The patient is free to see any physician he/she chooses, however.

PPO's are generally more expensive than HMO's. Patients pay more for greater freedom of

choice. There are usually deductibles and copays for the patients.

POS
POS stands for Point of Service. This can be considered a "hybrid" of an HMO and a PPO. The patient still has to select a primary care physician from the network who coordinates the patient's care. However, the patient can choose to see a physician outside the network. If the patient chooses to do so, the plan will still provide coverage for the care, but at a reduced level.

PHO
PHO stands for Physician Hospital Organization. PHO's serve as contracting agents between managed care companies and physician providers. This can be beneficial for physicians in several ways. Instead of maintaining individual contracts with many different managed care organizations, a physician can become a provider in a PHO and have access to all patients that belong to the PHO through their insurance plans. In addition, the physician and his office staff do not have to learn the rules and forms for each managed organization separately. Belonging to only one organization simplifies the paperwork and referral process.

What is indemnity insurance?
This is the traditional type of insurance that one usually thinks of in any discussion of insurance. There is generally little restriction on choice of physician, and the plan will cover a certain portion of the charges. This is sometimes referred to as "fee-for-service". Formerly one of the most prevalent types of insurance, this type of insurance is becoming less common. This is partially due to the fact that most individuals obtain their insurance as a benefit through their employer, and fewer companies offer this type of insurance.

What is Access to Care?
Access to Care is a primary health care program specifically targeting low-income, uninsured individuals who reside in suburban Cook County. The program covers the "working poor", those who earn too much money to qualify for Medicaid but do not have any health insurance through their employer and cannot afford private insurance. Often these individuals have part-time jobs that do not provide benefits or are students who cannot afford insurance. The Access to Care program coordinates a network of care among providers, pharmacies, laboratory, and radiology facilities. The physicians in the Adult Medicine Center are participating providers in the Access to Care program.

When prescriptions need to be written for Access to Care patients, an attending must sign the Access to Care prescription in order for a participating pharmacy to fill it. Services provided are considerably more limited than those patients covered by "Public Aid".

Coding and Documentation

The American Medical Association and the Health Care Financing Administration (HCFA), which administers the Medicare program, have developed documentation guidelines. These guidelines describe documentation needed to support codes to request reimbursement by Medicare for evaluation and management (E/M) services.

Many find it difficult to master the documentation guidelines, as they are somewhat detailed and complex, and not organized in the same manner in which physicians have been trained to think about patient care. The guidelines are revised periodically, adding to the difficulty. However, it is important to become familiar with them to ensure that your services are appropriately billed.

When reviewing documentation guidelines, it is helpful to keep in mind the following:

- The level of service for most visits is determined by the documentation for three key components:
    - History
    - Examination
    - Medical decision-making

- Each key component is further divided into four types, depending on complexity.

- The level of service is then selected depending on the type and location of visit and the three key components according to established guidelines.

- The time spent during the visit is not considered a contributing factor except in visits which consist predominantly of counseling or coordination of care.

- The component of medical decision-making should “drive” the code. Medical decision-making reflects the level of uncertainty, the volume of data to be reviewed, and the risk to the patient. Ideally, the documentation for the other components should be consistent with the level of medical decision-making.

- Document completely your differential diagnosis and treatment plan, including any instructions or education you may have given the patient. This will help support your level of service.

- Be sure to document when the patient is to return to see you, even if the return visit is to be prn. Many insurance companies now require this documentation.

- Many physicians have a tendency to “undercode”, thus denying themselves what they are entitled to. By knowing these guidelines, one can be assured of claiming what is rightfully owed.