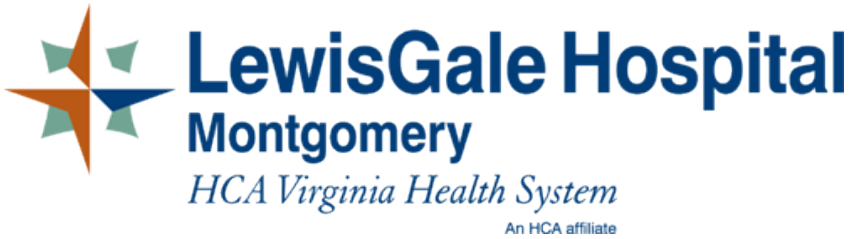
LEWISGALE HOSPITAL – MONTGOMERY




# Family Medicine Manual

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LGHM Family Medicine Residency Program at its option, may change, delete, suspend, or discontinue parts or the policy in its entirety, at any time without prior notice.

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# 1 Welcome

Welcome to LewisGale Hospital – Montgomery. We are thrilled to have you as a member of our family.

The mission of LewisGale Hospital – Montgomery is Above All Else, we are committed to the care and improvement of human life.

The vision of LewisGale Hospital – Montgomery is to be the first choice for healthcare in the New River Valley.

Equal employment opportunities are provided to all employees and applicants for employment without regard to race, color, religion, sex, national origin, age, disability, or status as a Vietnam – era or special disabled veteran in accordance with applicable federal laws. This policy applies to all terms and conditions of employment, including, but not limited to, hiring, placement, promotion, termination, layoff, transfer, leaves of absence, compensation, and training.

# 2 Introduction

This document has been developed by the Department of Graduate Medical Education (hereafter called "GME Department") and the Family Medicine Residency in order to provide Residents (hereafter called "Housestaff") with information about their residency.

The mission of the Family Medicine Residency Program is to provide residents with a comprehensive structured clinical and didactic education and procedural clinical education in both inpatient and outpatient settings that will enable them to become competent, proficient and professional osteopathic physicians.

The Program Director (PD) has the responsibility and authority at all times to assure the Housestaff's effectiveness in the programs.

This manual supersedes all previous residency manuals and memos.

While every effort is made to keep the contents of this document current, LGHM at its option, may modify, delete, suspend, or discontinue portions of this manual at any time without prior notice. It is the Housestaff's responsibility to obtain the most current version of this manual. A current copy of this manual is available in the GME Department. Any changes in this manual shall apply to existing as well as to future Housestaff.

## 2.1 History

LewisGale Hospital-Montgomery is the administrative section for all the components of the system that includes the hospital, outpatient surgery centers, the Pulaski Affiliate Hospital, Diagnostic Centers, and hospital sponsored practices. The Department of Medical Education is a hospital subdivision responsible for all medical education sponsored by this institution and for the appropriate training and experience of interns and residents who are assigned here through an affiliation agreement with another institution. The Director of Medical Education is a physician who is also appointed by the hospital and the sponsoring academic institution to be responsible for the education of medical interns, residents, and students from that College.

The GME programs are accredited by the American Osteopathic Association. Policies and procedures for GME are largely determined by the AOA and are applied to all intern and residency programs. As a member of the Intern and Resident Staff, you are enrolled in a Residency Training Program (RTP), according to the residency you have selected. The hierarchy in a RTP starts with the Chief Resident, the Attending Physician, the Program Director and the Director of Medical Education. Each Residency Program is also connected to the clinical department at a sponsoring medical college and the Osteopathic Post Graduate Training Institute.

Your participation in the governance of Academic Affairs is critical to our success. There are two routes of access to hospital and medical staff information for intern and resident physicians: (1) The Medical Staff Committees and (2) Regular meetings held by your Department and the DME. These are described in the next section.

## 2.2 Changes in Policies

This manual supersedes all previous family medicine residency manuals and memos.

While every effort is made to keep the contents of this document current, LewisGale Hospital-Montgomery reserves the right to modify, suspend, or terminate any of the policies, procedures, and/or benefits described in the manual with or without prior notice to employees.

## 2.3 Educational Purpose

The family medicine rotation is structured to provide residents with the fundamental knowledge and essential principles requisite to the practice of family medicine. The basic techniques of physical examination, the necessary skills for performing clinical procedures including primary care osteopathic manipulative treatment, and the capability to communicate clearly with patients, their families and other members of the health care team are stressed in this residency.

## 2.4 General Goals and Objectives

The specialty of family medicine consists of the prevention, diagnosis and treatment of diseases in the child, adolescent, and adult patient. The major goal of the osteopathic family medicine program is to achieve mastery of the following core competencies:

1. **Osteopathic Philosophy and Osteopathic Manipulative Medicine**
    a. Integrate osteopathic principles into the diagnosis and management of patients.
    b. Apply osteopathic manipulative therapy to patient treatment and management.

2. **Medical Knowledge**
    a. Demonstrate competency in the understanding and application of clinical medicine as it relates to patient care.
        i. Demonstrate a thorough knowledge of the complex differential diagnoses and treatment options of the family medicine patient.
        ii. Integrate the sciences applicable in family medicine to clinical practice.

    b. Understand and apply the foundations of behavioral medicine as it relates to family medicine.
        i. Demonstrate an ability to provide end-of-life care.
        ii. Identify and address the socioeconomic, ethnic, religious, and cultural aspects of illness and their impact on a patient's clinical presentation and subsequent management.

3. **Patient Care**
    a. Demonstrate an ability to rapidly evaluate, initiate and provide appropriate treatment for patients who are critically ill.
    b. Demonstrate an ability to thoroughly evaluate, initiate treatment and provide appropriate long-term therapeutic recommendations to patients with chronic medical problems in hospital, extended care and ambulatory settings.
    c. Demonstrate an ability to make appropriate recommendations to promote health maintenance and disease prevention.
    d. Demonstrate an ability to gather appropriate essential medical information from patient interviews, relevant medical records, examinations and testing.

4. **Interpersonal and Communication Skills**
    a. Exercise effective patient interview skills

b. Demonstrate appropriate verbal communication with clarity, sensitivity, and respect,
c. Create well organized, clear, succinct but thorough and legible medical records.
d. Demonstrate an ability to interact with support staff in the hospital and ambulatory settings in a constructive, positive and professional manner.
e. Identify methods to communicate with non-English speaking patients, and with those having sensory deficits (verbal, visual, and auditory).

5. **Professionalism**
    a. Identify the role of family medicine as it relates to other medical disciplines.
    b. Develop the principles of appropriate ethical conduct and integrity in dealing with patients and the medical community.
        i. Identify potential areas of conflict of interest inherent in medical practice.
        ii. Demonstrate appropriate, judicious and efficient utilization of medical therapies, procedures, and testing without consideration of personal gain.
        iii. Demonstrate understanding of the implicit position of trust and authority into which patients often place the physician; recognize the ethical requirement to avoid exploitation of this trust either intentionally or unintentionally.
    c. Complete training in personal health information protection policies, and recognize their application in daily medical practice.
    d. Recognize the elements of religion, race, ethnicity, or cultural background in individual patients, and address them properly.
    e. Recognize the need for continuous quality of care in all patient populations, and demonstrate lack of discrimination.
    f. Provide medical care to those seeking it regardless of age, race, physical handicap or religious affiliation.

6. **Practice-Based Learning and Improvement**
    a. Develop professional leadership and practice management skills.
    b. Evaluate the progress of the training of the resident by using continuous assessment tools.
        i. Utilize systematic evaluation to include self-study and assessment, individual trainee assessment, and outcomes analysis.
        ii. Participate in quality improvement programs and assessment activities in the hospital and ambulatory setting.
    c. Expose the resident to research methodology in family medicine.
    d. Identify information technology applicable to the practice of medicine and research. Demonstrate the ability to effectively utilize such technology.
    e. Develop teaching skills in the family medicine resident.

f. Promote the development of commitment to habits of lifelong learning and scholarly pursuit in family medicine.
g. Prepare the resident to meet the eligibility requirements of the AOA to take the certification examination administered by the American Osteopathic Board of Family Physicians (AOBFP).

7. **Systems-Based Practice**
   a. Develop in the resident the skills needed to practice within a system-based health care environment and to use the resources to deliver quality care.
   b. Understand the national and local health care delivery systems and how they impact on patient care and professional practice.
   c. Develop and promote advocacy for quality patient centered health care in complex systems.

## 2.5 Expected Outcome

1. To produce outstanding clinicians in the field of family medicine.
2. To produce clinicians who are grounded in evidence based medicine.
3. To produce clinicians who are compassionate and embody what it means to be an osteopathic family physician.
4. To view the patient in their entirety, including mind, body and spirit.
5. To produce clinicians who are proficient in all seven AOA Core Competencies.
6. To have a program that is compliant with all AOA program standards.
7. To create an environment that fosters research opportunities as well as other scholarly pursuits.
8. To train family medicine physicians and prepare individuals for career goals in office based medicine or fellowship training.

## 2.6 Appointment

Appointments to the family medicine residency program are made on the recommendation of the Medical Education Committee, the Program Director, and the Director of Medical Education.

LewisGale Hospital-Montgomery is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, national origin or handicapped persons who, with reasonable accommodation, can perform the essential functions of the job.

The residency application process at LewisGale Hospital-Montgomery is as follows:

1. Interested osteopathic medical school students must apply through the National Residency Training Match Program (NRMP) via ERAS;
2. Upon receipt of information requested on the NRMP and available on ERAS, (i.e. three letters of professional reference, letter from your medical school Dean stating you are a student in good standing, board scores, and transcripts, the Department

of Medical Education will contact applicants to arrange an appointment for an interview;
3. Resident applicants are interviewed by the Program Director, Director of Medical Education, and members of the Medical Education Committee;
4. LewisGale Hospital-Montgomery completes the National Intern Registration Match forms that are returned within the appropriate timeframe, usually in January;
5. Results of the Match are returned, usually in February. Resident contracts are mailed out within the time allotted by the AOA/NRMP Match regulations.

## 2.7 Advanced Placement

(See AOA Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment, 7/2011 – Appendix I)

The Family Medicine Residency Training Program follows the guidelines for residents requesting advanced placement of the AOA. A request for advanced placement must be received from both the resident and the program director at the advanced placement institution. In all instances, the request for advanced standing will be reviewed by the Program director, who shall forward requests to the ACOFP Committee on Evaluation and Education. The ACOFP Committee on Evaluation and Education shall report to the AOA PTRC all approvals for advanced placement. In no instance is the Program Director compelled to recommend advanced standing to the ACOFP Committee on Evaluation and Education:

Credit may be granted according to the following criteria:

1. Training taken in an osteopathic family practice residency will be compared and the quality of that training assessed according to the Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment and month for month or service for service credit may be recommended.
2. Training taken in any discipline other that osteopathic family practice be assessed by the Program Director to determine if it is applicable to osteopathic family practice and a maximum of six months of credit beyond completion of OGME-1 or its equivalent may be recommended for approval.

## 2.8 Promotion Criteria

**First Year Resident (Intern):**

**Osteopathic Manipulative Medicine**

1. Demonstrates competency in basic modalities of osteopathic diagnosis and treatment in the inpatient and primary care clinic settings, and proper documentation and billing

**Patient Care:**

1. Prioritizes a patient's problem
2. Prioritizes a day of work
3. Monitors and follows up patients appropriately
4. Demonstrates caring and respectful behaviors with patients and families
5. Gathers essential/accurate information via interviews and physical exams and reviews other data
6. Provides services aimed at preventing or maintaining health
7. Works with all health care professionals to provide patient-focused care
8. Knows indications, contraindications, and risks of some invasive procedures
9. Competently performs some invasive procedures

**Medical Knowledge:**

1. Uses written and electronic reference and literature sources to learn about patients' diseases
2. Demonstrates knowledge of basic and clinical sciences
3. Applies knowledge to therapy and treatment of the patient

**Practice-Based Learning Improvement:**

1. Understands his/her limitations of knowledge
2. Asks for help when needed
3. Is self-motivated to acquire knowledge
4. Uses PowerPoint, Word, Internet, and other computerized sources of results and information; such as "Up-to-Date" to enhance patient care
5. Accepts feedback and develops self-improvement plans

**Interpersonal and Communication Skills:**

1. Writes pertinent and organized notes
2. Has timely and legible medical records
3. Uses effective listening, narrative, and non-verbal skills to elicit and provide information
4. Works effectively as a member of the health care team

**Professionalism:**

1. Establishes trust with patients and staff
2. Does not refuse to treat patients on financial status, race, ethnicity or age
3. Is honest, reliable, cooperative and accepts responsibility
4. Shows regard for opinions and skills of colleagues
5. Is free from substance abuse or satisfactorily undergoing rehabilitation
6. Demonstrates respect, compassion and integrity for patients and staff
7. Is responsive to the needs of patients and society, which supersedes self-interest

**Systems-Based Practice:**

1. Is a patient advocate
2. Makes constructive comments

3. Advocates for high quality patient care and assists patients in dealing with system complexity

**Second Year Resident:**

**Osteopathic Manipulative Medicine**

1. Demonstrates competency in increasingly advanced techniques of osteopathic diagnosis and treatment including trigger point injection.
2. Demonstrates further integration of osteopathic manipulative medicine into longitudinal treatment of family medicine continuity patients for acute and chronic conditions.

**Patient Care:**

1. All criteria for First Year Resident above; and,
2. Understands and weights alternatives for diagnosis and treatment
3. Uses diagnostic procedures and therapies appropriately
4. Elicits subtle findings on physical examination
5. Obtains a precise, logical and efficient history
6. Interprets results of procedures properly
7. Is able to manage multiple problems at once
8. Makes informed decisions about diagnosis and therapy after analyzing clinical data
9. Develops and carries out management plans
10. Considers patient preferences when making medical decisions
11. Triages patients to appropriate location
12. Competently performs an increasing number of invasive procedures
13. Knows indications, contraindications and risks of an increasing number of invasive procedures

**Medical Knowledge:**

1. All criteria for First Year Resident above; and,
2. Is aware of indications, contraindications and risks of commonly used medications and procedures
3. Demonstrates knowledge of epidemiological and social-behavioral sciences
4. Demonstrates mastery of

**Practice-Based Learning Improvement:**

1. All criteria for First Year Resident above; and,
2. Undertakes self-evaluation with insight and initiative
3. Facilitates the learning of students and other health care professionals

**Interpersonal and Communication Skills:**

1. All criteria for First Year Resident above; and,

2. Creates and sustains therapeutic and ethically sound relationships with patients and families
3. Provides education and counseling to patients, families and colleagues
4. Is able to discuss end of life care with patient/families
5. Works effectively as a member or leader of the health care team

**Professionalism:**

1. All criteria for First Year Resident above; and,
2. Displays initiative and leadership
3. Is able to delegate responsibility to others
4. Demonstrates commitment to on-going professional development
5. Demonstrates commitment to ethical principles pertaining to the provision or withholding of care, patient confidentiality, informed consent and business practices
6. Demonstrates sensitivity to patient culture, gender, age, preferences and disabilities
7. Acknowledges errors and works to minimize them

**Systems-Based Practice:**

1. All criteria for First Year Resident above; and,
2. Applies knowledge of how to partner with health care providers to assess, coordinate, and improve patient care
3. Uses systematic approaches to reduce errors
4. Participates in developing ways to improve systems of practice and health management

**Third Year Resident:**

**Osteopathic Manipulative Medicine**

1. All criteria for Second Year Resident above; and,
2. Masters practice management skills necessary to integrate osteopathic manipulative treatment into a successful family medicine practice including scheduling, billing, and promotion

**Patient Care:**

1. All criteria for Second Year Resident above; and,
2. Competently performs AOBFP required invasive procedures
3. Knows indications, contraindications and risks of all AOBFP required invasive procedures
4. Spends time appropriate to the complexity of the problem

**Medical Knowledge:**

1. All criteria for Second Year Resident above; and,
2. Demonstrates an investigatory and analytic approach to clinical situations

**Practice-Based Learning Improvement:**

1. All criteria for Second Year Resident above; and,
2. Analyzes personal practice patterns systematically, and looks to improve
3. Compares personal practice patterns to larger populations
4. Locates, appraises and assimilates scientific literature appropriate to specialty
5. Applies knowledge of study design and statistics

**Interpersonal and Communication Skills:**

1. All criteria for Second Year Resident above; and,
2. Works effectively as a leader of the health care team

**Professionalism:**

1. All criteria for Second Year Resident above; and,
2. Is effective as a consultant

**Systems-Based Practice:**

1. All criteria for Second Year Resident above; and,
2. Demonstrates ability to adapt to change
3. Provides cost effective care
4. Understands how individual practices affect other health care professionals, organizations, and society
5. Demonstrates knowledge of types of medical practice and delivery systems
6. Practices effective allocation of health care resources that does not compromise the quality of care

## 2.9 Qualifications

All residents shall be graduates of an approved college of osteopathic medicine and shall make application on the forms provided by the NRMP for prospective candidates. Residents **must be members** of the American Osteopathic Association (AOA) and American College of Osteopathic Family Practice (ACOFP), **and maintain membership** throughout residency. ****It is highly suggested** that you become a member of the American Academy of Family Physician (AAFP).

The residency training program in family medicine is thirty-six (36) months in duration. The first twelve (12) months of which are in an AOA-approved specialty track internship in family medicine taken in an institution in which an AOA-approved family medicine residency exists and which meets the criteria for approval by the ACOFP and the AOA. Prior to starting residency, all residents must pass Comlex Step I, II and PE**. Residents must pass Comlex Step III, prior to the start of their post-graduate year three.**

## 2.10 Terms of Service

Family Medicine Residency training is thirty-six (36) months. The contract will be issued for a period of one year. Contracts for the next year of training will be issued in February of each year upon satisfactory performance during the current year. The Program Director, Director of Medical Education and the Graduate Medical Education Committee will determine if continuation in the training program will be granted.

Under qualifying circumstances, residencies may be extended through the FMLA. All leaves must be reported to the Program Director and the Director of Medical Education, the Graduate Medical Education Committee, Human Resources and the subcommittee on Residency Training of the American Osteopathic Association. All additional time taken off during residency must be made up at the end of the contract year and prior to the next level of training.

## 2.11 Status

You are an employee of the hospital. As a resident employee, you are responsible to the Board of Trustees through the Director of Medical Education. The hospital is liable for your acts. Remember – during your first year of training, you do not have a license to practice medicine outside of the institution unless on a rotation approved by the Program Director and the Department of Medical Education. You will not be covered by malpractice insurance unless you are on an approved rotation. Under no circumstances may the resident engage in moonlighting during their first year of residency, i.e. employment outside of the hospital. Moonlighting during the first year of residency is grounds for immediate termination. Moonlighting may be allowed in subsequent years with the expressed written permission of the Program Director. In general, moonlighting will not be allowed until the third year of residency and then only for residents (1) who are not on probation and (2) who have in-service training exam scores over the mean.

## 2.12 Time Away

Refer to the Paid time Off for Interns and Residents Policy.

**Above and beyond the policy, Please notify your Program Director and your Chief Residents *via email* AT LEAST 3 months ahead of time of anticipated vacation time or time away. This is absolutely necessary for continuity clinic scheduling reasons. Our goal is to have our continuity clinic schedule prepared 3 months in advance. If these requests are not had within 3 months, you may not be granted time away.**

## 2.13 Absences

The resident will not be permitted to leave the hospital premises during scheduled duty hours without the permission of the Program Director, Director or Administrative Director of Medical Education, or Clinic Medical Director.

If it becomes necessary for a resident to leave the premises during inpatient or scheduled continuity clinic duty hours, permission must be first obtained as stated above. If you are in continuity clinic, you MUST run this by your Program Director. NO CLINIC SWITCHES ARE TO BE MADE WITHOUT THE CONSENT OF YOUR PROGRAM DIRECTOR. The resident must arrange for another resident to cover the service or clinic, notify the switchboard and nursing station involved that you will be off the premises, and the name of the covering resident.

Upon returning to the hospital or clinic, the resident is to notify the switchboard, the Department of Medical Education and the nursing station, that you are back on duty.

## 2.14 Illness

If a resident is unable to report to duty due to illness, he/she is to notify the Program Director, Department of Medical Education, the attending physician that the resident is rotating with, the switchboard, and the Continuity Clinic Manager when applicable (scheduled from clinic that day). The resident may be required to go to their Primary Care Physician/Urgent Care or Emergency Room for an examination.

## 2.15 Unauthorized Absence

An unauthorized absence from duty will result in disciplinary action. Any unauthorized absence of three or more consecutive business days may constitute a voluntary resignation from the program.

## 2.16 Revocation of Off-Duty Hours

In the case of delinquent medical records, or other incomplete work, the resident may be assigned extra call and/or additional clinic hours by the Program Director, Associate Program Director, Director of Medical Education, or the Medical Education Committee Chairman, pending the completion of work.

## 2.17 Continuity Clinic Expectations

1) **Time in Continuity Clinic**: **Interns –** 1, ½ day/week on average. As you become more comfortable, if rotation allows

(elective rotation) &/or depending on your numbers, you may be placed up to 3, ½ days in continuity clinic. Interns are expected to have **150** continuity patient visits by the end of their intern year. **2nd Year Residents –** 3, ½ days/week on average. This may be more or less depending on rotation assignments &/or continuity clinic numbers. 2nd Year Residents are expected to have **650** continuity patient visits by the end of their 2nd Year. **3rd year Residents –** 4-5, ½ days/week on average. This may be more or less depending on rotation assignments &/or continuity clinic numbers. 3rd Year Residents are expected to have **1650** continuity patient visits by the time they graduate which leaves at least **850** patient visits during their 3rd year.

2) **Patient Visit Templates: Interns** may have one patient/hour for their first 6 months. For the last 6 months, they may have one patient every 30 minutes. **2nd years** may have one patient every 30 minutes for the first 6 months. For the last 6 months of the 2nd year, there will be a mix of 15 and 30 minute visits which will stay consistent during their **third year.** The goal is to train our family medicine residents to be efficient in the ambulatory setting upon graduating by working to see a patient load up to 12 patients/half day or 24 patients/day.

3) **Chart Completion**: Residents will have **24 hours** from the time their clinic session ends to complete & assign their charts to the precpetor for that day. If charts are not completed within 24 hours, the preceptor will notify the resident and the Program Director. The charts will be expected to be completed immediately after this initial notice. If the charts remain incomplete, the resident will meet with the Program Director for discussion and potential disciplinary action.

4) **Test Ordering during Clinic (Blood Work/In-House Testing):** Orders MUST be placed in the chart prior to the nurse completing the test ordered. Please place the order in the EMR and follow-up by discussing this with your assigned nurse for the day so they are aware of the order and things get done in a timely manner.

a. EKGs, Spirometry, etc MUST be reviewed with your attending during the patient visit.

5) **Immunizations:** NO IMMUNIZATIONS WILL BE GIVEN BY NURSING WITHOUT AN ORDER IN THE EMR FROM THE PHYSICIAN. This includes triage visits.

6) **Triage Visits:** If you are having your patient return to clinic for a triage visit (fasting blood work, immunizations, urinalysis, TB placement/read, etc.) they MUST make and appointment for this. They can stop or call the front desk to make a triage appointment for their needed tests which can be discussed with our front dest staff. Future orders MUST be placed for this triage visit. No testing/immunizations, etc. Will be given without a future order in the chart.

7) **Precepting**: **Interns**: **1st 6 months –** ALL patients must be seen by the preceptor. **2nd 6 months –** ALL Medicare/Medicaid patients must be seen by the preceptor regardless of level of service. **2nd/3rd Year Residents**: ALL Medicare/Medicaid patients must be seen by the preceptor regardless of level of service. **Level 4 Private Insurance DOES NOT have to be seen by the preceptor. ****Please note**, be sure to discuss with your precpetor for the day how they prefer you "precept" your patients. Each preceptor is different and some may prefer to hear about &/or see every patient prior to the patient leaving clinic!

8) **Documentation**: Please be sure you are abiding my our clinic policies regarding Patient Centered Medical Home/Meaningul Use when documenting. If you are unsure what these policies are, please ASK. Dr. Hilary Lois is our PCMH physician lead and can answer any questions you may have.

a. Telephone calls/Labs/Imaging/Other Testing: You will have **72 hours** to return patient phone calls/address labs that have been ordered (from the time they are ordered). **If you order something STAT, this must be resulted IMMEDIATELY upon being formally read/addressed by radiology. If you are on a rotation that does not permit you to check your EMR regularly, you MUST discuss this with the

preceptor on for the day the testing was ordered or a colleague who can help you cover your inbox.

b. If you cannot check you telephone calls regularly, this MUST be discussed with an attending or colleague who can help you manage your inbox.
c. IT IS UNACCEPTABLE AND WILL NOT BE TOLERATED FOR TELEPHONE CALLS/LABS/IMAGING/OTHER TESTING TO GO UNRESULTED FOR MORE THAN 72 HOURS AND WILL RESULT IN DISCIPLINARY ACTION. If you need help, please ASK.

9) **Vacation**: Once vacations have been approved, please be sure to assign your inbox to a colleague who can cover this while you are on leave. Also, please send an EMR message through the "M Jellybean" to the entire clinic notifying them you will be out on leave, the dates you will be out and who will be covering your inbox. Please also verbally discuss this with your assigned clinic nurse so she is aware and can help streamline requests while you are out.

10) **Huddles**: From 8-815 and 1-115 daily, you will be expected to huddle with your assigned nurse for the day to discuss your patient panel. This is extremely beneficial with patient flow and can help with visit efficiency. If you are late for your huddles &/or are repetedly missing your huddle session, this will be brought to your Program Director's attention and for repeated offenses, you will meet with the Program Director for further discussion and potential disciplinary action.

## 2.18 Evaluations

All interns must be evaluated by the Program Director each Quarter of the Academic Year. Documents required prior to the evaluation include: Admit H&P's, Discharge Summaries, Progress Notes, OMM Notes, and Continuity Clinic Notes.

All residents are evaluated by the Program Director Semi-Annually. Documents required prior to the evaluation include: Continuity Clinic Notes and OMM Notes.

Interns/Residents will place all documents in binders housed in GME.

# 3 DIDACTICS

## 3.1 Meeting and Lecture Requirements

Morning and noon lecture attendance is **required** for family medicine residents as follows:

**Interns July-December: Mandatory** Morning Report and Noon Lecture (when rotation allows). **January-June**, Morning report is **NOT Mandatory unless you are on rotation that requires.** It is **highly recommended** that you attend **Morning report** when time allows. **Noon Lecture is highly encouraged** as well when time allows. If you are not attending morning report/noon lecture during your intern year, you ARE EXPECTED to be at your Family Medicine Didactics every Thursday morning from 8A-1P in the APCA Classroom.

**2nd/3rd Year Residents**: **Mandatory** Thursday Morning (8AM-1PM) Family Medicine Didactics in the APCA Classroom. **Excused absences –** Block Nights, LGH-Montgomery Internal Medicine Wards, VA Wards, VA ICU and those discussed with Program Director on an individual basis. **Please try not to schedule ER shifts during this time.

****AOA standard**: The program must provide residents with regularly scheduled lectures, conferences, workshops or educational activities. Didactics shall be available for an average of **at least five hours per week**.

**If you are not attending your protected didactic time, it is **your responsibility** to attend at least 5 hours/week of scheduled lectures, conferences, workshops or other educational activities!

Example Schedule:

| **Interns—** July thru December | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| Morning Lecture 7-8 AM | IM Morning Report | IM Morning Report | IM Morning Report | IM Morning Report | IM Morning Report |
| Noon Lecture 12-1 PM | Derm, Practice Mgmt, OB/GYN | Systematic Peds Curriculum (Pediatrics Faculty) | Grand Rounds, OMM, Radiology | 8A-1P: Family Med Protected Didactic time (see above)<br><br>OR: Journal | Systematic Adult Medicine Curriculum (Medicine Faculty) |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Club, Board Review Questions (Chief Resident) - noon lecture | |

| **All Others, Including Interns Jan-June** | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| Morning Lecture 7-8 AM | IM Morning Report | Systematic Family Med Board Review (Family Faculty) | Systematic Family Med Board Review (Family Faculty) | IM Morning Report | Challenging Case Review (Family Faculty) § |
| Noon Lecture 12-1 PM | Derm, Practice Mgmt, OB/GYN | Systematic Peds Curriculum (Pediatrics Faculty) | Grand Rounds, OMM, Radiology | 8-1: Family Medicine Protected didactic time | Systematic Adult Medicine Curriculum |

§ Third Friday of every month: family medicine Chief Resident Meeting from 7 to 9 AM at APCA.

**Excused absences**: Each resident is responsible for promptly contacting the Institutional Educational Officer (ADME) by email to notify her of each excused absence other than pre-approved vacation. A certain number of absences are expected due to educational requirements during surgical, obstetric, and emergency medicine rotations, but notification by email is mandatory. **Family Medicine Residents MUST notify your chief residents and Program Director.**

**Unexcused absences**: Any resident with more than one unexcused absence during a block will be assigned an equal number of additional weekend family-medicine call days. A pattern of repeated absences may result in loss of vacation days at the discretion of the Program Director. A resident who is more than 10 minutes late will be considered absent for that session.

**Chief Resident Meeting (Mandatory)**: Please note that all family medicine residents are required to attend the Chief Resident Meeting on the third Friday of very month from 7 to 9 AM. This includes Internal Medicine, Salem VA, and surgical rotations. A special

exception will be made for residents on away rotations, but they are expected to contact the family medicine chief resident to review information missed.

You are also required to attend your assigned committee meetings such as Quality Assurance, Pharmacy and Therapeutics, etc. You will receive this assignment during orientation.

### 3.2 Attendance Rosters

Attendance rosters will be prepared for each meeting, conference, and lecture, etc., which the resident is required to attend. In order to document your training for the American Osteopathic Association, it is mandatory that these rosters be completed and personally signed by those residents who are in attendance.

### 3.3 Morbidity/Mortality

M&M conference will be faculty lead chart reviews from cases provided by the UM/QM committee and conducted under peer review protocols with Risk Management and Utilization/Quality Management staff also in attendance.

### 3.4 Morning Report/Case Presentations

Case Presentations

1. The presenting intern with the junior/senior resident should choose a topic at least fourteen (14) days prior to the scheduled presentation.
2. The topic should pertain to a recent case.
3. The topic should reflect that intern's clinical exposure.
4. The topic should be very narrow and precise.
5. Upon choosing a topic, prior to proceeding with preparation, it should be reviewed and accepted by the Director of Medical Education.
6. Each accepted topic will then be given to the Medical Education Office for announcement purposes at least five (5) days prior to the scheduled presentation.
7. The presenting intern/resident should have pertinent materials available on the day of the lecture (projectors, x-rays, scans, etc.).
8. A written bibliography is to be distributed at the lecture.
9. It is encouraged, but not required, to have hand-outs including graphs, outlines and diagrams.
10. Each prepared topic should have been reviewed in the recent literature as available from Up-To Date.

**Morning Report**

Interns during their first 6 months, as well as all family medicine residents rotating on an inpatient service, participate in inpatient morning report and are to assemble in the designated meeting room for morning report at 7:00 a.m. daily Monday through Friday. Residents are expected to be present. The intern coming off of night call will write the name of admissions (patient initials) on the dry erase board at the front of the classroom, and review pertinent symptoms with the interns coming on duty.

### 3.5 EKG Conference

The third Monday of the month (day subject to change), selected faculty will conduct a review of basic EKG reading skills with the house staff and medical students. Initial lectures will be basic EKG review and subsequent lectures will focus on arrhythmia recognition and treatment; Acute Coronary Syndromes, inclusive of myocardial infarction patterns, and treatment; bradycardia; tachycardia; interesting cases; ACLS review; and pacemaker/AICD guidelines and indications. Residents will additionally be quizzed during the presentations and audience participation is quite high. Formal testing and feedback on EKG reading will also occur as part of competency based training.

### 3.6 OMM Lecture

On a monthly basis, the Medical Education Department and Family Medicine Department will provide formal lecture and hands-on laboratory to review basic and advanced osteopathic techniques. **All family medicine residents are required to attend unless** excused by the Medical Education Department. Second and third-year residents may also serve as faculty for the purposes of review and technique review with their first year colleagues. Periodic evaluation of osteopathic skills by the Program Director may take place and will be announced ahead of time. l

## 4 COMPORTMENT

### 4.1 Continuity Clinic Responsibility – See 2.17 Above for SPECIFIC Details of your clinic

Residents are expected to arrive for scheduled continuity clinic on time and prepared to see patients. Clinic schedules are frequently updated with new schedules sent from the Continuity Clinic Manager to all clinic physicians, including residents, by email. Residents are responsible for checking email daily on business days to monitor for schedule changes.

Each resident has a mailbox in the continuity clinic area. First year residents are required to check their mailbox, complete any outstanding paperwork, and address any outstanding results A MINIMUM OF ONCE PER WEEK. Second and third year residents are required to check their mailbox A MINIMUM OF TWICE PER WEEK. This activity should be completed during business hours at which time clinic staff are

available to carry out consequent physician orders**. **If you are unable, please assign a colleague to help you with this task!**

Similarly, each resident will receive documentation electronically including test results, refill requests, nurse messages, and other staff/faculty messages. These electronic transmissions must be addressed: See section 2.17 Above. Please note: A resident who is only scheduled for one half-day of clinic in a week, such as an intern, IS STILL REQUIRED TO CHECK THE ELECTRONIC MEDICAL RECORD AT LEAST ONE OTHER TIME PER WEEK OR PER ABOVE POLICY AND ADDRESS ANY RECEIVED DOCUMENTATION OR MESSAGES.
****YOU WILL NEED TO HAVE REMOTE ACCESS!!!**

If a resident is away from the continuity clinic for more than 1 week, including vacation and approved away rotations (living out of town), they must do the following prior to leaving:

1. Complete all mailbox and electronic results/message activities as above.
2. Designate a fellow resident to check your mailbox and electronically received results and messages while you are away.
3. Check hospital and continuity clinic call schedule to verify call responsibilities while away.
4. Communicate the above to the Chief Resident, the resident's team nurse, the clinic head nurse, and the clinic manager (or medical director if not available).
5. Have a fellow resident or residents cover his slots in the continuity clinic while away and notify the clinic manager of the changes.

Medical student teaching is an integral part of the continuity clinic activities. All residents are expected to engage and support medical students rotating at the clinic site.

The continuity clinic maintains a zero-tolerance for any violence or sexual harassment in the work place. Any such behavior may be grounds for immediate termination. Proper attire in the continuity clinic is business casual. Neck ties are not required. Hospital scrubs are allowed for residents on inpatient medicine, but a white coat must be worn in this case.

See Section 4 below for additional information.

### 4.2 Continuity Clinic Call Responsibility

Second and third-year family medicine residents will be schedule by the Chief Resident and Clinic Medical Director for telephone call on a rotating basis. See Section 4.7 below for additional information.

The on-call resident may NOT physically see a patient in the clinic facility during closed hours unless (1) the supervising faculty person gives prior approval and (2) the

supervising faculty person is also physically present in clinic for the duration of the encounter.

### 4.3 Hospital Responsibilities

1. Residents on inpatient medicine are responsible for their respective service between 6 a.m. – 6 p.m. daily. Once per week, each family medicine intern will have an afternoon or evening continuity clinic during which coverage is to be provided by other residents/interns on service. Family medicine second and third year residents will have two (2) continuity clinics during which coverage is to be similarly provided.
2. Residents on an inpatient service are responsible for making sure orders are written and reviewed if written by an intern for patients admitted to their service during the day and while on call for all unit patients on inpatient services or co-managed by an inpatient physician.
3. History and physical forms are not the responsibility of the resident.
4. Residents are required to review the admit notes of all admissions to their service and discuss them with the interns and students. Residents will have a note written to supplement the admit note on all unit patients on an inpatient service or co-managed by an inpatient physician with a plan or recommendations when on call.
5. Residents are to round on their service patients daily, unless scheduled off and either review the note written by interns/students or write the daily progress note.
6. Residents when on an in-house rotation are to actively participate in morning report.
7. Residents are to attend all in-house lectures, unless a patient's well-being is at risk.
8. Residents are not to work more than 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and any allowed moonlighting. NO EXCEPTIONS TO THIS POLICY SHALL BE PERMITTED.
9. Duty hours:
    a. First year residents (interns) must not exceed a maximum duty period length of 16 hours; they must have eight hours free of duty between scheduled duty periods. Second year residents and above may not exceed 24 hours of continuous duty on service; they must have at least 12 hours free of duty after 20-24 hours of continuous in-house duty.
    b. Upon completing a duty period of at least 12 hours but less than 20 hours, a minimum period of 10 hours off must be provided.
    c. Trainees shall have 48-hour periods off on alternating weeks or at least one 24-hour period off each week. At-home call cannot be assigned during these free periods.
    d. In-house Night Float: Residents must not be scheduled for more than six consecutive nights of night float.
    e. Second year residents and above must be scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period.
10. When a resident is called to admit a patient, the attending must be called to go over the admission by that resident.

11. It is not the responsibility of the resident to review Emergency Room EKGs or lab work on patients not admitted.
12. Medicine residents are not responsible for pediatric patient care unless it is a "Code Blue."
13. It is not the resident's responsibility to obtain DNR's on patients unless they are admitting the patient or it is a new change of the family's thinking or the patient's wishes. The resident is not to discuss the DNR with families of patients that they are not acquainted with their progress. This is the responsibility of the attending physician.
14. Residents cannot take verbal orders from family physicians that have patients in the unit. They must discuss the case with the IM physician or subspecialist who is managing the patient in the unit.
15. The residents are to assume the role assigned by the attending physician when on service and to notify the attending or any acute change in the patient's condition.
16. Residents are to respond to all Codes within the hospital.

## 4.4 Hospital Call Responsibility

1. 1st, 2nd, and 3rd year residents on-call Sunday night through Friday morning will provide unit coverage from 6 p.m. – 8 a.m. daily. This includes IM admissions from 6 p.m. – 6 a.m. as well as complications that develop on the wards. From Friday night through Sunday evening, 1st year residents will work 12-hour shift (6 p.m. – 6 a.m., 6 a.m. – 6 p.m., 6 p.m. – 6 a.m., 6 a.m. – 6 p.m.). From Friday morning through Sunday morning, 2nd and 3rd year residents will work 24-hour shifts starting F (6 a.m. – 6 a.m., 6 a.m. – 6 a.m.). 1st year residents are not responsible for consults unless specified by the attending.
2. Residents must see and write an admit note on all admissions while they are on call.
3. On weekends the residents will evaluate all unit patients under IM service or with co-manage of IM and conduct daily care under the supervision and wishes of the respective attending.
4. If an internist has a patient in the unit who is critical, they may sign out to the evening resident if that particular internist does not have a resident or intern on their service. However, if a student/intern is on the service, they are also responsible to sign out to the evening resident.
5. It is the duty of the medical resident on call to evaluate all the patients in the unit who have an acute change, write a note, and notify the attending if warranted.
6. If an acute situation in the unit occurs and supervision or input is needed and the attending is unable to be reached, then either the Chairman of Medicine or the Director of the unit are to be called for that input or supervision until the attending has responded.
7. No patient is to be admitted to the unit unless verified or approved by the patient's respective attending (managing the patient in the unit).

8. Residents are not to be called to order routine lab work, x-rays, or EKGs on patients when on call.
9. If a patient is directly admitted to the unit, orders are to be written by the attending or the attending is to call the resident with a history and preliminary diagnosis and the resident will write the orders.

## 4.5 Procedures

Residents are provided the opportunity to perform procedures as they arise. Residents are expected to become proficient in the following procedures:

1. Sufficient experience and training to ensure proficiency in the following procedures, including indications, contraindications, complications, limitations and interpretation:

**Mandatory Procedures**

a) Incision and Drainage of abscess
b) Biopsy of skin
c) Excision of subcutaneous lesions
d) Cryosurgery of skin
e) Curretage of skin lesion
f) Laceration repair
g) Injection of shoulder
h) Injection/aspiration of knee joint
i) Injection of SI joint
j) Endometrial Biopsy
k) Colposcopy with biopsy
l) Office Microscopy
m) Casting
n) EKG interpretation
o) Office spirometry
p) Toenail removal
q) Defibrillation
r) Removal of cerumen from ear canal
s) Insertion of urethral catheter
t) Endotracheal intubation

**Optional Procedures**

a) Vasectomy
b) Central line placement
c) Vaginal delivery
d) Episiotomy repair
e) Flexible sigmoidoscopy
f) Colonoscopy
g) Lumbar puncture
h) IUD insertion

i) Breast cyst aspiration
j) Epistaxis management (nasal packing/anterior cautery)
k) Trigger point injections
l) Allergy testing
m) Neonatal circumcision

2. Sufficient experience and training to ensure proficiency in the interpretation of the following procedures:
    a. Arthrocentesis
    b. Paracentesis with ultra sound
    c. Thoracentesis with ultra sound
    d. Peripheral blood smears
    e. Exercise stress tests
    f. Holter monitors
    g. Sputum gram stain
    h. Urine microscopy
    i. Vaginal wet mounts
    j. Office microscopy
    k. CLIA waved testing in the continuity clinic

Formal lectures, hands-on labs, and videotape procedure demonstrations are used to introduce the procedure and review anatomy and indications/contraindications of the procedure. Residents are assigned or designated as the "procedure resident" on the internal medicine rotation. This arrangement rotates on a monthly basis and residents are directly supervised by attending staff until proficiency develops.

Residents will develop procedural skills on elective rotations; such as, cardiology, pulmonary, nephrology, gastroenterology, radiology and hematology under the direct tutelage of the attending physicians. Additional skills in intubation and central lines are obtained, if needed, with the assistance of the anesthesiology department, by assigning the resident to the department in the morning hours from 0700-1000 to perform intubations, central lines, and peripheral IV access.

Mastery of skills is demonstrated during the second residency year on intensive care unit and internal medicine service. Resident logs are reviewed and the resident is signed off as independent in the procedure and the medical staff office will be notified in writing.

The following rules apply:

1. All procedures are done under the supervision of an attending physician who is responsible for the care of that patient.
2. Do not start any non-emergency procedure until you obtain permission from the responsible attending physician.
3. Interns should have first opportunity to do procedures on patients assigned to their care.
4. Informed consent must be obtained before starting unless it is an emergency.

5. Procedure notes must be written immediately after the procedure.
6. Procedure logs must be completed by the resident in a timely manner and signed by the supervising resident/attending electronically in New Innovations as per Section 6 below.

Residents unable to master their skill level as indicated above will be assigned additional procedure assignments until such time that the level is mastered. Those residents in their PGY 3 level will not be eligible for graduation. Individual adjustments and accommodations are made on a case-by-case basis for those residents unable to master the skills as indicated above and additional training options are constantly evaluated.

## 4.6 Moonlighting

Family medicine interns are expected to devote themselves entirely to the family medicine training program. Under no circumstances may the first year resident engage in moonlighting, i.e. employment outside of the hospital. Moonlighting during the first year of residency is grounds for immediate termination.

Furthermore, interns operate under a restricted training license that allows their practice of medicine only within the approved Intern Training Program of LewisGale Hospital-Montgomery and affiliated institutions.

Moonlighting may be allowed in subsequent years with the expressed written permission of the Program Director. In general, moonlighting will not be allowed until the third year of residency and then only for residents (1) who are not on probation and (2) who have in-service training exam scores over the mean.

Residents who Moonlight must have obtained a full, unrestricted medical license and DEA number and must have the expressed, written consent of their Program Director. Such activities may not interfere with their training obligations. House Officers who moonlight are responsible for their own medical malpractice insurance coverage while engaged in moonlighting activities.

The resident shall not go over the hour's restriction as mandated by the duty hours and the moonlighting hours are added to this total for the week.

## 4.7 Chief Resident Job Description

The Chief Resident for the Family Medicine Residency Program will be nominated by the Program Director upon consultation and advice from the Graduate Medical Education Committee, Director of Medical Education, and the ADME. It contains both a leadership and administrative position meant to improve and facilitate the training programs for medical students, interns, and residents at LewisGale Hospital-Montgomery.

*Qualifications:*

1. Resident in good standing at LewisGale Hospital-Montgomery preferably in their senior year of training.
2. Demonstrates an interest and participation in the educational programs at LewisGale Hospital-Montgomery.
3. Demonstration of excellent rapport with peers.
4. Approval for acceptance of the position of Chief Resident by the applicant's Program Director.
5. Demonstrates and participates in scholarly activity, as well as possessing the work habits appropriate and consistent with the mentoring responsibilities of the position.
6. Willingness and ability to attend training and skill development courses or CME as suggested by the DME/ADME to prepare and guide the applicant in performing their duties as Chief Resident.
7. In good standing with continuity clinic Medical Director, Manager, and office staff.

*Responsibilities:* (Inclusive of but not limited to)

1. Assist in development of the Resident rotation schedule.
2. Assist in development of and supervision of the Resident on-call schedule.
3. Assist in the development of Resident continuity clinic schedules with Clinic Office Manager and assist in filling clinic openings.
4. Is responsible for scheduling topics for FM lectures, journal club and board review.
5. Introduce all Guest Lecturers/Presenters at Morning and Noon lectures.
6. Act as liaison between the Department of Medical Education and all House Staff Officers, Medical Students and Allied Health Students.
7. Act as liaison between House Staff Physicians and Nursing Staff.
8. Serve as member of Peer Review Committee, subcommittee of the GME Committee as needed.
9. Assist with development and procurement of resources to support Medical Education Activities at Lewis Gale Hospital-Montgomery.
10. Actively mentor the House Staff, Medical Students, and Allied Health Students in the areas of scholarly activity, professional/ethical behavior and work habits.
11. Attend all Graduate Medical Education Committee meetings (usually the 1st Thursday of the month).
12. Attend House Staff meetings monthly.
13. Must keep all logs and inpatient and outpatient charts current.
14. The Chief Resident(s) is/are directly responsible to the Director of Medical Education (DME). In the absence of the DME, the Chief resident is responsible to the Program Director, Administrative DME, the Chairperson of the Graduate Medical Education Committee, and the Vice President of Medical Affairs, in this order.

*Compensation:*

Chief Resident Annual Stipend: $6,000 (to be divided if more than one chief)

Terms of appointment: July 1, 20__ through June 30, 20__ (at the discretion of the program director)

## 4.8 Research Responsibility

Each resident is **required** to complete an original research project that is either accepted for publication by a peer review journal or accepted and presented at Local, Regional or National Convention (poster presentation).

In lieu of this requirement, a resident may complete by demonstration and documentation (via Portfolio) of any three of the following:

1. Participation in Journal Club, inclusive of obtaining, assigning and presenting articles with written critique of articles submitted for review by program director twice annually. Resident participation in Journal Club will be review and evaluated twice annually by the Program Director.
2. Participation in Review of Medical Literature Didactics, in conjunction with VCOM, offered twice annually
3. Participation in and submittal of written reports reviewing the medical literature for Peer Review Activities in compliance with policies and procedures of the QM/UR Committee, Critical Care Committee or Department of Internal Medicine
4. Participation in and submittal of written reports, inclusive of medical literature review, in conjunction with the Quality Improvement Initiatives of LewisGale Hospital-Montgomery.
5. Presentation of four (4) lectures cumulatively in the second and third year of residency inclusive of medical literature review and evaluation by member of FP Faculty of the presentation at either House Staff Formal Didactics, Local, Regional or National Conference, or Medical Staff/Departmental Meeting
6. Authoring a grant.

# 5 CONTINUITY CLINIC

Goals: To create a Family Medicine Clinic experience designed to prepare Family Medicine Residents for osteopathic family medicine continuity of care experience. The continuity clinic will facilitate the diagnostic and therapeutic skills of physicians in training utilizing patients encompassing the total health care of the individual and the family. This includes the physiological, emotional, cultural, economic, psychological and environmental factors as they relate to the disease process.

## 5.1 Overview

Family Practice Rotation Goals & Objective and Primary Care Continuum Longitudinal Care Experience

Longitudinal outpatient care will be provided by family medicine residents in the continuity clinic throughout the residency. The continuity clinic experience will begin by

focusing on the acquisition of a small panel of patients under the supervision of the family medicine attending physician. The attending physician will help the resident identify a panel of patients for whom the resident will assume greater and greater responsibility throughout the longitudinal care experience. This will facilitate continuity of care. A requirement of the longitudinal curriculum will be that the resident must acquire responsibility for patients at different stages of lifecycle. In addition, efforts will be made to insure that each resident's panel represents variance in patient characteristics such as gender, socioeconomic status, and ethnicity. Finally, residents will be notified of a patient's admission to the hospital and will follow their patient's admission throughout the course of the patient's stay.

The goals of this experience for the resident are:

1. Gain an appreciation for the primary care practitioner's role as the physician on first contact who delivers holistic, family-oriented, comprehensive and continuous medical care to those patients entering the health care system;
2. Develop greater confidence in providing quality medical care in ambulatory settings;
3. Understand family systems concepts, the impact that family functioning and psychosocial factors have on health and illness, and the importance of involving the family in the treatment of the patient in order to provide effective overall health care;
4. Appreciate the use of computers to access current medical literature to complete learning as well as information about community resources for utilization in case management, disease prevention, health maintenance, and patient education;
5. Enhance diagnostic, interpersonal communications, procedural, OMT, and practice management skills to improve patient care;
6. Increase knowledge about the etiology, appropriate intervention and treatment, and possible complications of diseases and conditions commonly presented by patients and their families in the primary care setting;
7. Gain better understanding of the moral, ethical, political, legal, economic, and minority health issues affecting the practice of family medicine; and,
8. Nurture a sense of responsibility for lifelong learning in medicine and the advancement of the Osteopathic profession through scholarly endeavours and community service.

Upon completion of the residency, the resident will be able to:

1. Complete a through osteopathic assessment of a patient, determine the need for manipulative medicine, and perform osteopathic manipulative techniques;
2. Demonstrate knowledge of the indications, contraindications, interactions, pharmacokinetic, side effects, and special instructions to patients for drugs commonly prescribed for patients seen in family practice;
3. Demonstrate the ability to perform common clinical procedures, tests and skills;
4. Construct a differential diagnosis and develop a treatment or management plan for diseases commonly presented by patients seen in a family practice;

5. Demonstrate knowledge of the prevention, diagnosis, treatment and management of conditions commonly presented by patients seen in family practice;
6. Evaluate problems commonly presented by patients seen in family practice;
7. Recognize and respond appropriately to patients presenting with issues/concerns commonly encountered in family practice;
8. Demonstrate knowledge of the ethical, moral, and social challenges that may confront the patient, family, or physician when dealing with health care issues;
9. Demonstrate knowledge of the role of family dynamics in the delivery of health care;
10. Assess a patient's living conditions (e.g., environment, family members, health related behavior, etc.) and their impact on treatment strategies and medical care for the patient;
11. Identify community support agencies and how they can be utilized by the physician in his/her preventive care/health promotion efforts with patients and their families;
12. Develop preventive medicine and health maintenance protocols for patients based on current information sources and utilize patient education skills and compliance monitoring skills in the process of implementing those protocols with patients;
13. Demonstrate interpersonal communication skills with patients and their families to build rapport and facilitate a positive physician-patient relationship;
14. Utilize computers as a tool to enhance learning in the clinical setting;
15. Identify and provide patient education information and preventive care strategies appropriate to the primary care setting, and;
16. Demonstrate an understanding of medical record documentation.
17. Understand the basic principles of practice management of a continuity care clinic.

Residents are required to maintain an electronic log of patient encounters and procedures. This log must contain the patient's medical record number, diagnosis and the activity and/or procedure performed on each visit. See Section 6 below for additional information on the proper use of New Innovations to log visits.

## 5.2 Patient Visit Requirements

Residents will see a number of patients per half day commensurate with their level training. Residents must complete a minimum of **150** patient visits during their **first year** of training (internship). **2nd years** must complete a **minimum of 650** patient visits. The three-year continuity of care experience must include a minimum of 1,650 patient visits.

Residents must see patients at the continuity of care site for a minimum of 40 weeks per year. (A maximum of 12 weeks per year of away rotations is allowed.)

Residents will maintain approximately fifty (50) continuity patients per year in their patient panel.

## 5.3 Teaching Objectives

Residents will learn skills required to:

1. Deliver osteopathic care to patients in an ambulatory setting;
2. Manage effectively a normal caseload during a scheduled day;
3. Develop medical practice management skills;
4. Increase his/her expertise in:
    a. methods of referring patients
    b. methods of counseling
    c. providing patient education
    d. delivery of osteopathic manipulative treatment
    e. diagnosis and treatment of patients in all age groups
    f. providing preventative measures for a varied patient population
    g. diagnosing and managing medical and surgical problems
5. Develop a thorough understanding of family oriented care;
6. Become familiar with the evaluation of industrial injury and criteria for returning to work;
7. Become familiar with the basic guidelines for reporting communicable diseases;
8. Become familiar with the use of community resources in total patient care;
9. Become familiar with malpractice coverage and different types,
10. Learn how to be a part of a health care team; and,
11. Demonstrate team leadership skills.

Throughout the course of their training, residents will be exposed to osteopathic concepts, behavioral and psycho-social aspects of medical care, medical ethics, medical-legal implications and practice management lectures and discussions.

## 5.4 Resident Clinic Schedules

Number of half days of continuity clinic will vary according to the training year and current rotation as follows:

- PGY 1 = 1 to 2 half day clinic per week
- PGY 2 = 2 to 4 half day clinic per week
- PGY 3 = 2 to 5 half day clinic per week

Residents are expected to progressively expand their patient base and clinical skills with advancing academic year. As such, their individual clinic schedules will vary by post graduate year beginning with 4 patients per half day in internship and culminating with 12 or more patients per half day at the conclusion of the third year. Time allotted for each visit will also progress as per the following table:

| Time Allotments | New Patient/Consult | Established Patient | Procedures |
|---|---|---|---|
| PG-1 | 60 Minutes | 30-60 Minutes | 60 Minutes |
| PG-2 | 30-60 Minutes | 30 Minutes | 30-60 Minutes |
| PG-3 | 30 Minutes | 15-30 Minutes | 15-30 Minutes |

## 5.5 Continuity Clinic Supervision and Evaluation

The residents will be supervised by a board-eligible or board-certified family physician. Cases will be discussed and all charts will be reviewed. The resident will be exposed to a broad spectrum of medical diagnoses and will be taught to apply the concepts of disease prevention and health maintenance.

Residents will be evaluated by the supervising physician on their ability to perform a comprehensive history and physical examination, including structural examination for somatic dysfunction, pelvic exam, rectal exam, breast exam, male genital exam. Mastery of AOA core competencies will be assessed longitudinally as detailed in Section 1.5 above.

A 360° evaluation compiles subjective information from several sources to obtain a 'well rounded' view of the resident. Residents will be evaluated on a semi-annual basis using the 360° evaluation process, which includes input from nursing staff, reception staff, faculty, fellow residents, and patients.

Residents will be evaluated formally with respect to participation in didactic sessions, quality of charting, overall progress in clinic, attitude, professionalism, interpersonal communication, and procedural skills. Progress towards meeting Promotion Criteria detailed in Section 1.9 will be assessed. This will occur as an integral part of the Program Director's semi-annual written review (quarterly for first-year residents). Family medicine faculty physicians, who serve as continuity clinic supervisors, will meet as a group with the Program Director to give their input to be included in formal reviews. Also, the resident will provide evaluations of preceptors and constructive feedback for the preceptors and staff at the time of this formal review.

## 5.6 Clinic Didactics

Teaching during clinic sessions occurs informally with discussion of various family medicine topics as they pertain to the diagnoses of the patients seen in the clinic. Resident notes are reviewed by the supervising clinic attending and teaching points are reviewed with the resident.

## 5.7 Charting

Charting will be in standard SOAP format using the clinic approved electronic medical record. Components of history, physical exam, medical decision making, and medical coding will be included as appropriate for the level of care provided.

Clinical trials/research will be conducted from the Family Medicine Clinic with additional documentation requirements being requested of the participating resident/preceptor.

Residents are also expected to complete documentation regarding clinic quality improvement initiatives including but not limited to Physician Quality Reporting Initiative, Patient-Centered Medical Home, and Meaningful Use.

All encounter notes by residents are reviewed and countersigned by the resident's teaching attending and should be completed during the assigned clinic half day. Encounter notes will be completed and forwarded to the teaching attending within 1 business day of patient encounter (24 hours). The only exceptions to this rule are (1) compliance would cause a duty-hour violation or (2) delays due to a computer system malfunction. If either of these exceptional situation occur, it is the resident's responsibility to personally notify the preceptor for the day immediately.

All charting must be completed prior to vacations or graduation, and certificates will not be given till completed.

Feedback regarding the resident's documentation will occur during the clinic session, immediately following the clinic session via secure email, and/or a compiled for inclusion in the resident's annual performance review will be made.

## 5.8 Clinic "After Hours"

Second and third-year family medicine residents will be schedule by the Chief Resident and Clinic Medical Director for telephone call on a rotating basis. When scheduled, the resident on-call will answer telephone calls from continuity patients during hours that the clinic is closed (scheduled and holidays). The resident must be available by phone during the scheduled on-call hours. A cellular phone is available from the continuity clinic for the resident's use as requested. The resident may not use any intoxicating substances during the on-call period. The resident may travel out of the local area as long as uninterrupted cellular phone coverage is available. If the residents switch or change a scheduled day, they must notify the Program Director, Clinic Manager, Chief Resident and covering on-call physician. If the residents know that they will be temporarily out of range for communication, the resident shall notify the on-call attending prior to the occurrence and possibly notify another resident for coverage if it will occur for an extended period.

A back-up faculty supervisor will be scheduled at all times during which a resident is on-call. The resident should document any phone calls in the Electronic Medical Record and submit the note to the supervising faculty physician for review. The supervising faculty physician is available at all times for questions or other assistance.

The on-call resident may NOT physically see a patient in the clinic facility during closed hours unless (1) the supervising faculty person gives prior approval and (2) the supervising faculty person is also physically present in clinic for the duration of the encounter.

### 5.9 Procedures

Residents will develop proficiency in various procedures. The preceptor will supervise all procedures performed in Family Medicine Clinic. The resident is responsible for staffing and performing the procedure under the direct supervision of the attending physician, notification of the attending 24 hours prior to the procedure and completion of procedure documentation. Informed consent must be obtained prior to all clinic procedures. Signed written consent is required for cervical high-velocity low-amplitude osteopathic manipulative treatment (OMT) and all other non-OMT procedures. Verbal consent is adequate for other Osteopathic Manipulative Treatment. All resident procedures must be documented in New Innovations in order to meet graduation requirements as per Section 6 below.

### 5.10 Vacation/Time Off from Continuity Clinic

Follow the Paid Time Off for Interns and Residents Policy.

## 6 Additional Inpatient Medicine Responsibilities

### 6.1 Response to Floor Calls

Residents on inpatient medicine shall respond as soon as possible during the day or night when called to see a patient.

Instructions for giving medications and treatments may be given over the phone to the nurses only when the resident cannot report in person. Subsequently, he/she must respond when able and write all orders on the chart and sign and date. In addition, the resident must write a progress note on all patients requiring orders and evaluation.

### 6.2 Rounds

The resident should make rounds on all assigned cases each morning and write his/her progress notes at that time. The house officer will make rounds with the attending staff and

specifically with the staff member to whom he/she is assigned, on a daily basis. He/she will receive instruction, information, advice, suggestions and assistance from the staff who thus contributes to his/her bedside teaching. Prior to rounds, the resident should report to the attending physician all patients who present any new or unusual symptoms, unforeseen developments, emergencies or any dissatisfaction expressed by patients in regard to treatment, food, nursing, surroundings, or annoyances. After each patient visit, the house officer must make appropriate notes in the patient's chart.

Assigned patients are to be visited as soon as possible after admission regardless of the hour. The attending physician should be called if there is any question or concern beyond the residents comfort or new diagnoses determined.

## 6.3 Admission

The admission process is presently set up to:

1. Provide the attending physician with name of the resident who is responsible for the admission at the time the admission is being called to the Hospital. The attending physician can then, prior to the patient getting to the hospital, notify the responsible resident with information that is essential to facilitate the evaluation of the patient; such as labs, X-rays already done, severity of patients condition, consults, or other physicians who need to be notified.
2. Provide a more service-oriented admission process.
3. Provide for residents performing admissions, not just H & P's.
4. Provide more intern and resident supervision of students.
5. Improve communication between the house staff and the attending physician.
6. Improved patient care and avoid untimely evaluation of severely ill patients.

In order for the Admitting Department to appropriately assign your patient to the correct house officer, they need to know:

1. The admitting physician's name.
2. The preliminary diagnosis and unit of admission.
3. Consulting physician(s) and levels of participation.

After seeing the patient, the house officer doing the admission is to notify the attending physician of his/her findings and go over the appropriate orders. Consultations should be made only with attending approval.

PLEASE NOTE: It is our desire to make sure the attending physician knows which resident is in charge of the admission at the time they call the admission in. This is to encourage the attending physician to notify the resident in charge of their admission of any information that may be helpful to him/her in facilitating the admission, i.e. needs to be seen right away, etc.

The Admitting Department needs only to notify the respective house officer that they are in charge of the admission, and that name should be on the face sheet.

## 6.4 Admission Orders

After writing orders, return the chart to the Unit secretary or nurse caring for the patient. If you have written any STAT or "now" orders, notify the unit secretary or appropriate nurse so that undue delays do not occur. Always date, time and sign your orders. Include your printed name and pager number to facilitate nursing follow up of orders.

The American Osteopathic Association allows the attending physician to request consultations for his/her patient. This order must be written as the following:

1. Consultation only which leaves management to the attending physician and prohibits consultants from writing orders on the chart.
2. Consultation and management of a specific entity or procedure in which the consultant may write orders to manage the special entity or procedure but overall responsibility remains with the attending physician.
3. Consultation and co-management which permits the attending physician and the named physician to write orders, however, overall chart responsibility remains with the attending physician.
4. Consultation and full management where the consultant assumes full responsibility for writing orders and management of the patient and prohibits the attending physician from writing orders.
5. Transfer of management to another named physician in which case the patient care responsibilities in the hospital are transferred to the named physician and the admitting physician may no longer write orders.

## 6.5 Medical Records

1. Always write with a black pen, as some other colored inks will not Xerox adequately for insurance and legal purposes. Write legibly!
2. Physical workups must be done and dictated within 24 hours of assignment or prior to surgery whichever comes first. Surgery workups should be written so that the medical information is readily available.
3. When a physical workup is done, always write a progress note. It is to be written immediately following the physical workup.
4. When responsible for an admitting progress note, it is to be dictated immediately following the physical workup.
5. When responsible for interval progress notes, they should be written every working day. If the condition of the patient changes during the day, extra progress notes are to be written.
6. Case summaries, when assigned, are to be done within 48 hours of discharge of the patient.
7. Everything you write on the chart must be signed.
    a. When you write an order always include the name of the attending physician first, (e.g., James Monroe, D.O./Peter Smith, D.O.)

b. If done by an extern, or by an intern, in communication with the attending physician, always include the method of communication, preceded by his name, (e.g., V.O. for "voice order" or "verbal order" and P.O. for "phone order.")

Remember – the admitting physician may not be the attending physician at the time.

8. Whenever writing orders, always explain the reason in a program note.
9. All orders and progress notes must be dated, timed and signed.
10. Medical records may be checked out of the Medical Record Department only for their use in educational sessions. They may NEVER be taken out of the hospital.
11. Physical workups may be delegated to an extern, if one is in training at the hospital. However, the intern on service will be directly responsible for the accuracy of such physical workup examinations and must countersign it.
12. All charts must be completed within fifteen (15) days after the patient is discharged. Therefore, after seven (7) days, you will be considered delinquent in charting unless you are waiting for dictation to be typed. Medical Records will make your incomplete charts available to you at any time.

CHARTING IS A HABIT – Good or bad, it is up to you. If you are delinquent repeatedly, disciplinary action will be taken. Remember – the service you are on is no excuse. Go to Medical Records at least twice a week and do all of your charts and you will never be delinquent.

## 6.6 Routine Progress Notes

1. Before writing progress notes, always identify your service. Conclude your note with your signature, printed name and pager number. Most of the services require daily progress notes, and the SOAP format is usually acceptable. However, an ICU progress note is almost as detailed as a new complete H & P.
2. Do not over-use abbreviations. When using abbreviations, follow the guidelines from the hospital manual.
3. On all admissions, please use the following guidelines:
    a. Progress notes, dated and timed, shall be written by all participating Physicians or members of the house staff on all phases of a patient's hospital stay. All progress notes should be in the SOAP format.
    b. The admitting note (admitting summary) shall briefly state the chief complaint, the symptoms, and the physical findings that led to the working diagnosis, the expected therapy, and the possible consultations.
    c. All significant physical changes, new signs and symptoms, complications, consultations, and treatment including manipulative therapy shall be recorded.
    d. Progress notes shall describe in proper continuity, the course, progress, treatment, and disposition of the case.

e. Every progress note shall be signed by the house officer writing that note. The attending physician shall countersign your note after appropriate CMS documentation or may write his or her own progress note.
f. The final progress note, *which includes the discharge summary*, shall be performed by the house staff officer and signed or counter-signed by the attending physician.

## 6.7 Admitting Note

This note must briefly state the chief complaint, the symptoms and physical finding that led to the working diagnosis, the expected diagnostic regimen, therapy and possible consultations; also, the prognosis as of that time. Admitting notes will be completed on all hospital admissions in the appropriately designated area of the chart. The admission note is a brief, concise synopsis of the patient's presentation, chief complaint and reason for admission with documentation of therapeutic interventions indicated for the patient.

## 6.8 Interval Notes

These must cover all significant physical changes, new signs and symptoms, complications, consultations, and treatment given. They shall describe in proper continuity the course, progress, treatment and disposition of the case. They shall include significant results of tests or x-rays that influence the working diagnosis or therapy. Progress notes are the one place on the chart where the physician's philosophy of management is displayed. Notes may have to be written several times a day, if the patient's changing condition warrants it, or once a day may suffice on assigned cases.

All progress notes shall be dated, timed and signed by the physician writing them. Record your OMT on the progress notes. Include the biomechanical diagnosis for which you are treating (e.g., "somatic dysfunction of _____ due to _____"). Date and time as you do for all progress notes. Record the result. If it is a series of treatments, record results after several treatments, but no less than every three days his note must briefly state the chief complaint, the symptoms and physical finding that led to the working diagnosis, the expected diagnostic regimen, therapy and possible consultations; also, the prognosis as of that time.

# 7 NEW INNOVATIONS REPORTING

Family medicine residents (including interns) must log the following into New Innovations: ALL continuity clinic patient encounters, ALL procedures, ALL inpatient admissions, duty hours, and rotation evaluations.

The following particular requirements apply:

1. ALL Continuity Clinic patient office visits must be logged in New Innovations under "Continuity Clinic."
2. ALL procedures must be logged in New Innovations under "Procedure Logger."
3. Duty hours must be logged under "Duty Hours." These must be updated on a weekly basis.
4. ALL inpatient admissions must be logged under "Patient Log" for Internal Medicine, ICU, Block Nights and Pediatrics (including Lewis Gale-Montgomery Hospital, Salem VA, and other away rotations such as pediatrics). These should be completed within one week of completion of rotation.
5. Rotation evaluations should be completed within one week after rotation completion.
6. All New Innovations logging must be kept up to date and should be current before any time away is taken (including vacation, conferences, and job interviews).

New Innovations is the sole approved method used to track and report the above information the purposes of (1) program accreditation and (2) resident documentation. A resident who does not comply with these New Innovations Reporting requirements will not be eligible for advancement and/or completion of residency training. An ongoing pattern of non-compliance will be cause for termination from the program.

## 8 ROTATION SCHEDULING

Rotations are schedules as a series of thirteen 4-week blocks each year.

Residents will submit Rotation Request Form to ADME on or before March 1 for the upcoming year. Preferences for rotation order are taken into account when completing schedules. However, all requests are subject to approval by the Program Director and ADME based on availability, training requirements, and other factors.

Incoming interns will have an opportunity to choose from a selection of standardized schedules and may request their elective block once their contracts have been finalized.

# 9 ACKNOWLEDGMENT

I acknowledge that I have received a copy of the LewisGale Hospital-Montgomery's Family Medicine Residency Manual, and I commit to read and follow these policies.

I am aware that if, at any time, I have questions regarding LewisGale Hospital-Montgomery's Family Medicine Residency policies I should direct them to my Program Director, the Institutional Educational Officer, or the Director of Medical Education.

I know that LewisGale Hospital-Montgomery's Family Medicine Residency policies and other related documents do not form a contract of employment and are not a guarantee by LewisGale Hospital-Montgomery of the conditions and benefits that are described within them. Nevertheless, the provisions of such LewisGale Hospital-Montgomery policies are incorporated into the acknowledgment, and I agree that I shall abide by its provisions.

I also am aware that LewisGale Hospital-Montgomery, at any time, may on reasonable notice, change, add to, or delete from the provisions of the company policies.

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|---|---|
| Resident Printed Name | OGY Level |
| Resident Signature | Date |