General Internal Medicine Primary Care Resident Clinic Experience at the Adult Medicine Clinic: "The CC Block"

Revised June 2023

Your continuity clinic (CC) block is a vastly different experience than your rotations in the hospital. During this important part of your Internal Medicine training, you will be the primary care provider for a panel of patients who you will follow throughout your entire residency. You will learn the basics of ambulatory medicine including how to manage acute illness and chronic disease in an outpatient setting. Being a primary care provider is a huge responsibility that requires hard work, compassion, and thought, but the care you give to patients and the relationships you form with them can be extremely rewarding.

All residents have their continuity clinic in the Adult Medicine Clinic located in the Upstate Health Care Center (UHCC) which will be moving to the Nappi Wellness Institute this July. The CC block occurs every four weeks during your residency and will be divided into two experiences: a recurring continuity clinic experience (with 3-5 half-day sessions during the week) and various specialty-based clinics (with 3-5 half day sessions during the same week). Didactic sessions during your CC weeks include noon conference (lunch is provided for all clinic residents) and a dedicated intern curriculum. During your CC block time, you will also participate in simulation training that includes procedural training and simulation cases, a quality improvement curriculum, Learning To TALK (Treat All Like Kin), as well as Education Through Theater Arts (ETTA).

Given the expanding role of a primary care physician and the complexity of patients that we see, the Adult Medicine Clinic is composed of a multidisciplinary group of professionals that are here to help the patient and you in your role as primary care doctor. This includes but is not limited to advanced practitioners (nurse practitioner or physician assistant), pharmacists, care managers, social workers, nutritionists, RNs, LPNs, and a large administrative staff.

Educational Purpose and Structure:

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

staff, recognizing psychosocial problems and utilizing psychosocial providers.

CC Rotation Description

Internal medicine residents will be assigned a primary care experience one week out of each four week block. This experience includes:

1. Primary Care Panels: Each resident will be assigned a primary care panel of approximately equal size for three years. There will be some adjustments due to new patients, deaths, discharges, transfers but in general this should be a stable panel for the duration of the residency which should facilitate long term relationships. The panels are diversified by age, gender and heritage; we have many patients who require a translator (mostly refugees) and these account for up to approximately 15-20% of the resident panel.
2. Types of visits scheduled within the continuity clinic:
    - Follow-Ups/Physicals: regularly scheduled visits for evaluation and management of multiple chronic medical problems not managed by specialists. Patients co-managedwith our anticoagulation clinic and diabetes pharmacists will receive on-going assessments by the residents. Treatment is guided by evidence-based standards of care. Physicals ideally should focus on health maintenance (preventive medicine and screening measures).
    - Urgents: for urgent medical problems, usually scheduled within the same day.
    - Transition of Care: Extremely important and for ED and hospital discharge follow-ups. Hospital course including all consults, laboratory/imaging work-up, and medication reconciliation should be done in detail. Appropriate follow-up testing should be ordered, medications should be titrated/addressed for efficacy/tolerability, and incidental findings should be addressed. Note that a complete chart review with outside records (if necessary) should be done prior to these visits to ensure the best continuity of care. Actual review of the entire visit/hospitalization should be done (ie: do not rely on discharge summaries alone as important information can be left out of these).
    - New Patients: As expected, this visit will be the patient's first visit to the adult medicine clinic. A thorough history and physical should be completed.
    - Admin Jeopardy: Dedicated time to chart review your patient panel. Further details on this are included later in this document.
3. In basket maintenance: including prompt (within 48 hours or sooner if clinically indicated) follow-up of patient results, nursing/staff telephone encounters, and medication refills. Residents are responsible for signing out their inbox to their mentor prior to any significant leave of absence or vacation to ensure continuity of patient care.
4. Supervision: an attending of the Department of Medicine will supervise up to 4 residents at a time during a session.

Specialty outpatient rotations:

Half day rotations include but are not limited to cardiology, dermatology, endocrinology, hematology/oncology, infectious disease, geriatrics/palliative care, rheumatology, nephrology, neurology, gastroenterology, pulmonology, urgent care, women's health, and wound care.

Teaching methods

1. At the time of the patient visit, a preceptor will review the resident's formulation of the visit diagnosis list as the first step in ensuring an appropriate plan of care. Health maintenance tasks (vaccines, screenings, proxy) are reviewed on non-acute visits. Each case should provide at least one teaching point. Until January 1 of the R1 year the preceptor will always see the patient. After that, it will be at the discretion of the preceptor depending on the complexity of the patient and the reliability of the resident. The preceptor will review and sign the visit documentation promptly and give additional feedback as needed.
2. Clinic educational programs include but are not limited to daily noon conferences that include system-themed interactive didactics, quality curriculum, and journal clubs; the electronic physician education and assessment center (PEAC) module curriculum; simulation lab experiences; pharmacy team didactic sessions, and the point of care ultrasound (POCUS) curriculum.
3. Completion of an electronic curriculum in ambulatory care (PEAC) is required. These modules are spaced out through the R1-2 years and are assigned (and expected to be completed) monthly.
4. R1s attend a high intensity orientation or "boot camp" which introduces them to the principles and methods of primary care during their first block (July).
5. In the early months of the intern year, R2 and R3 residents are assigned as "junior mentors" to assist in the orientation of the interns in terms of data collection and clinic workflows.
6. The role of a "teaching resident" will be assigned to various R3s throughout the year where they will directly supervise R1 clinical encounters and provide constructive feedback.

Evaluation of residents:

Every 6 months, each resident is evaluated by the mentor using the ACGME criteria and forms on Medhub (electronic access and registration) as well as in-person meetings. Patient care including prompt in basket follow-up and general clinically knowledge base as well as academic curriculum participation are all reviewed in these clinic evaluations. Residents are also asked to a self-reflect on their strengths and weaknesses during these in-person meetings. Furthermore, residents are further asked how the residency can best assist in developing their skills and knowledge for their future careers.

Rotation specific competency objectives:

I. Medical Knowledge – The residents will apply knowledge of basic and clinical sciences in the diagnosis and management of common medical problems. They will demonstrate the ability to critically evaluate medical information and scientific evidence, and be expected to apply that in a progressively mature fashion through the three years of training. In addition to the provided didactics on the ambulatory medical knowledge, residents are strongly encouraged to read on a regular basis, especially about diseases that they see in their ambulatory patient care practice.

II. Patient Care – The residents will be evaluated on their ability to manage common acute and chronic ambulatory medical problems and to perform health maintenance counseling and screening. High quality and efficient patient care in the outpatient setting requires the development of good physical exam skills and an ability to logically and concisely create a diagnostic formulation and plan of action. The residents must demonstrate a commitment to compassion and appropriate care for each individual patient, whether it is for the promotion of health, prevention of illness, the treatment of disease, or at-the-end-of-life care.

III. Interpersonal and Communication Skills – The residents will learn interviewing skills and improve their ability to communicate with a broad cross-section of the population with differing socioeconomic backgrounds, cultural or religious backgrounds, and different ethnicities. The residents are expected to effectively communicate with patients and families, to communicate effectively and promptly with a variety of other health care professionals (especially their supervising attending) and be able to articulate the important issues and the management plans to the supervising attending of record. Unlike the inpatient rotations where interactions with patients are often for a brief time, the Adult Medicine Clinic offers residents the opportunity to get to know their patients on a more personal level and this is often one of the most rewarding parts of a resident's training.

IV. Professionalism –will be modeled by teachers and monitored in all. Professionalism is directed to our patients, their families and caretakers, and other health care workers. It includes honesty, respect, and compassion; intellectual curiosity, a demonstrated commitment to study and evaluation; prompt follow-up on inbox tasks; self-care; respect for differences in gender, age, culture, religious beliefs, sexual preference, socioeconomic status, abilities; confidentiality, informed consent and refusal. In addition: hand washing, appropriate attire, appropriate boundaries during patient interviews, the application of appropriate standards for modesty during physical exam.

V. Practice Based Learning and Improvement – The residents are expected to organize data and create logical precise formulations and care plans based on best evidence or expert opinion whenever possible. All residents will participate in quality assessment and improvement projects while at UHCC. The residents should be willing to learn from advice and mistakes and to use these in the improvement of future practices.

VI. Systems Based Practice – A multi-disciplinary standing committee chaired by the Medical Director will solicit and formulate measures to improve communications, efficient EMR documentation, ordering, data review and prescriptions. There is a standing written protocol for problematic orders in the EMR that is updated regularly. The residents are expected to gain an ability to work with the care delivery team, including social workers, case managers, nurse practitioners, office nurses, pharmacists, and clerical staff.

INTERNAL MEDICINE RESIDENT RESPONSIBILITIES & EXPECTATIONS FOR THE ADULT MEDICINE CLINIC

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

PROFESSIONALISM: is expected during your CC block at all times. This includes but is not limited to:

- Being on-time for ALL scheduled activities, ready to work and/or learn. This includes continuity clinic, subspecialty clinic, didactics, and administrative sessions.
    - Unexcused absences are unprofessional and forfeiture of CC weekend time-off; repeated unexcused absences will result in Academic Probation which may lead to termination or non-renewal.
- Professional attire – sweatshirts, jeans, and sneakers are not allowed.
- Being respectful of everyone, including your colleagues, clinic staff, and patients – this includes no phone use during conferences or in patient care areas unless it is directly related to patient care.
- Taking ownership of your patients and your clinical responsibilities – including completing ALL clinical tasks in a timely manner!
- Taking ownership of your own education – complete any reading or other assignments on time and active participation in conferences.
    - You are expected to attend ALL noon conferences and to contact the Ambulatory Chief Resident if unable to join any of the noon conferences.

TOOLS: stethoscope, monofilament (provided on request), reflex hammer, whitecoat.

ACCESS REQUIREMENTS: EPIC, Hopkins/PEAC modules, RHIO, Synapse, Remote Access, and Doximity video chat, Haiku. Access to these programs will be set up before or during your CC block orientation. If trouble with access to any of these programs, contact Susan DeAngelo.

IN-BASKET AND MAILBOX REVIEW: Perform daily and at 5PM when on clinic block with appropriate documentation of assessment and plan. When on other rotations, check your in-basket at least every 48 hours and address all results, telephone encounters, and medication refills. When on vacations or away due to other absences, sign out your in basket to your mentor. See Epic in basket review below for further details.

PANEL REVIEW: Appropriate use of Admin Jeopardy sessions (chart/panel reviews).

COMPLETE AND ACCURATE PROBLEM LISTS including all significant details, delineation of managing specialty, and health maintenance tracking. All conditions that are managed by Adult Medicine should be addressed at the time of the general follow up visit for multiple medical problems (not an urgent visit) or assigned as a return visit task.

MEDICATION REVIEW: All medications we prescribe should be accurate and have a rationale that is documented in the medical record. Renewals for medications we are prescribing should be completed at

the time of the follow up visit (non-urgent visit) if needed to ensure that there will be enough refills to last until the time of the next Adult Medicine visit or 6 months, whichever comes first. Medications not controlled or titrated by the Adult Medicine clinic should NOT be prescribed by our providers.

Note: review of controlled substances or other "high risk" *medications that Adult Medicine prescribes (as determined by the Medical Director, also antipsychotics, anticoagulants) should be reviewed on a regular basis including strict chart documentation requirements justifying rationale and addressing safety, every 6 months. Controlled substance agreements should be signed at the initiation of the controlled substance and scanned to file.*

PROGRESS NOTES:

Each billed visit diagnosis should have an HPI and an A/P (except health maintenance tasks which are handled separately). Visit/billing diagnoses should not include diagnoses handled completely by specialists unless those diagnoses are those that 1) you are co-managing with specialists or 2) directly impact your management of conditions directly under your purview.

- It is the resident's responsibility to complete the medication reconciliation during each visit. This includes reconciling Outside Medications (the orange banner in EPIC) and formally discontinuing medications as appropriate.
- Every visit should include an appropriate return visit plan and tasks.
- Notes must be **completed within 24 hours of the visit** unless it is discussed and approved by the supervising attending.

DATA REVIEW, CARE PLANNING, COMMUNICATIONS:

The resident is responsible for:
Prompt review of test results or consultations performed on your patient.

- Communicating **ALL** results to patient within **<u>24-48 hours</u>** (if unable to communicate with patient within this timeframe, it is essential that your reach out to your **preceptor**) and documenting this appropriately within Epic.
    - Significantly abnormal results should be relayed to the patient via phone or during a face-to-face encounter. A letter/My Chart message may also be sent but ONLY to request a callback for important results and NOT to convey any significantly abnormal results. Incomplete communications regarding significantly abnormal results must be communicated to your supervising attending.
    - Communicating normal results can be performed by the resident via phone, letter, or My Chart (if patient has previously agreed).
- Creating a subsequent plan of care, if needed, in coordination with the appropriate attending or pharmacist. The plan of care is documented and communicated to the patient and appropriate parties (which may include the PCP and mentor).
- Documenting any communication with the patient including the review of results and treatment plans. **Remember, if it isn't in writing, then you didn't do it…period.**
- Handoffs: The resident and/or preceptor seeing a patient on behalf of a PCP/mentor are responsible for addressing the new concern or data, setting up a plan to address it and communicating with the patient. For significant problems, a close follow-up with the PCP should be scheduled to follow-up on any pending results and/or issues. Any pending results and/or issues should be handed-off formally in writing (e.g. a result, document or telephone note, routed to the PCP and mentor) to the PCP and mentor to carry on responsibility going forward.
- **Faculty and/or Staff requests for action** (e. g. clinical care, patient contact, testing, documentation, editing, orders, clarifications) must be addressed at the time of review. These

requests may be in telephone encounters, staff messages, progress note addenda, or other in-basket messages and it is the responsibility of the resident to review these carefully and thoroughly.

EPIC IN-BASKET RESPONSIBILITIES:

When on your CC block, you are responsible for reviewing your in-basket daily, including at the end of the day before you leave for home, and ensuring that all notifications have been appropriately addressed with the necessary documentation. **When not on CC Block, you are still required to check your in-basket at least three times per week (Monday, Wednesday, and Friday) and complete any patient or clinical responsibilities in a timely manner. When off-site (i.e. vacation, interviews, conference attendance, etc.), you are responsible alerting your mentor to help with your in-basket.** Proper in-basket management is integral to good patient care as well as the CC block experience. Failure to routinely manage these responsibilities will result in disciplinary action.

ADMIN JEOPARDY:

As part of the Practice-Based Learning competency, you will have time to review your panel via "Admin Jeopardy sessions" during your CC block. Please note that these "AJ" sessions are not guaranteed every block and may be cancelled depending on clinic and patient needs. Let the Ambulatory Chief Resident know if you are not going to be ready to work during one of these sessions, otherwise it will be considered an absence. There may be assigned readings and various tasks during these sessions throughout the year, and you will receive more direction on your CC block:

- **20/20** - Interns during the first half of the year are expected to review **at least FIVE patient charts** per 20/20 session. You will receive more instruction on this when rotating on the CC Block. While the following should be done during any visit with a patient, part of these chart reviews will also include:
    - **Ensuring an Updated and Accurate Problem List:** as detailed above.
    - **Medication Review:** as detailed above.
    - At least one 20/20 per session will be reviewed with interns by the Teaching Resident, Ambulatory Chief Resident, or an attending.

- **Quality/Population Health** – We will be reviewing diabetes and cancer screening quality data throughout the year, on a clinic-wide level and of your own individual patient panel. The main purpose of these reviews is not to "evaluate" you on your screening rates, but rather for you to focus on developing a plan on how to improve the care that we provide our patients. Population Health requires a team-based approach; therefore, you will be working in a multidisciplinary team with other clinic team members including pharmacy, nursing, and social work to help improve your quality metrics and dashboard.

- **Outpatient Guideline/Literature Review -** This session will focus on the topic of the block, discussing relevant guidelines/literature to appropriate outpatient workup, management & follow-up. This may include being assigned to update a preexisting section of the Intern Survival Guide, creating a new section for the Intern Survival Guide, or creating other resources for clinic.

- **Modules** – For residents that have been assigned more than AJ session and have completed all the assigned work for that block will have the opportunity to complete required modules that have been assigned by the program (IHI, PEAC…) or can do QBank questions from True Learn.

TELE-TRIAGE:

A R2 is assigned to teletriage each clinic block. Pages from the call center needed to be responded to immediately. The resident should document non-urgent phone calls promptly and alert the attending via routing in Epic upon completion of the encounter. With any questions and/or with concerning symptoms, the resident should be contacting the attending on call via page/telephone. Documentation should be prompt (within an hour) and be routed to the appropriate providers (ie: PCP and mentor and if an appointment needs to be made, the nursing pool).

EVALUATION:

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

MEDICAL STUDENTS AND OTHER LEARNERS IN CLINIC:

Third year medical students are typically in clinic Monday, Wednesdays, and Fridays. Occasionally a fourth-year medical student as an "acting intern" will rotate through for 2-4 weeks at a time. These learners are generally paired R3s. Additionally, there will now be first year medical students in clinic as part of medical school's new longitudinal care model. These students will be paired with R1s. Residents who work with a learner are expected to complete a brief evaluation after the clinic session (paper evaluations available in the workspace) and returned to Susan DeAngelo.

ABSENCES FROM UHCC AND COVERAGE: <u>Time Off Requests and Wellness Sessions</u>

Time off: All time off requests during clinic week need to be directed to the Ambulatory Chief Resident (or Core Chiefs if Ambulatory Chief is not available). Any approved time off will be relayed to the appropriate clinic staff (continuity clinic or specialty clinic) by the Chief via email. Clinic staff and specialty clinics are **NOT** able to excuse house staff from clinical duties or change clinic schedules.

Wellness Sessions: The purpose of a wellness session is for you to perform activities that would otherwise be difficult to do as a busy resident. It can be difficult to define what a wellness session would entail, but please utilize this time to catch up on life (ie: schedule a dentist/physician appointment, renew your ID, etc.) Completing program requirements (such as ACLS) will NOT require you to use a wellness session **<u>unless</u>** you had the opportunity to complete the requirement during a non-required rotation but chose not to.

Wellness sessions can now be taken during specialty clinics **except for women's health services, wound care, and dermatology**. Wellness sessions CANNOT be taken during **continuity clinic, admin jeopardy, teaching resident, didactics, or bootcamp**. Each resident is allowed up to 3 wellness sessions per academic year, but residents are unable to take **more than 1** wellness session per clinic week. A wellness session can only be requested for one **HALF DAY** per clinic week during a subspecialty rotation (not during continuity clinic). Wellness session requests must be sent to the ambulatory chief at **least 2 weeks** in advance. If the Wellness session is approved, you are expected to communicate with the specialty clinic

program coordinator and faculty member via email to notify them of the day you will not be attending. Unused wellness sessions **CANNOT** be carried over to the following year.

OUTPATIENT JEOPARDY SYSTEM: To help ensure resident wellness and excellent patient care, all whilst working to be fair to all as it relates to leaves of absence from work, a clinic jeopardy system has been developed to assign back-up coverage for continuity clinic and subspecialty clinics where wellness sessions cannot be taken and after the first two pulls for subspecialty clinics.

The Ambulatory chief oversees clinic jeopardy assignments and will work with clinic leadership to ensure adequate on-site coverage for required clinic services. If on admin jeopardy and you do not respond to the Ambulatory Chief resident's page/call within 20 minutes, you will automatically be assigned a future shift (to be determined by the Ambulatory Chief resident). Same will apply if you are unavailable but have not notified the Ambulatory Chief resident of your unavailability prior to being paged/called.

The following are the number of points allotted for each pull:
Continuity Clinic Shift: - 1 point
Subspecialties not compatible with wellness sessions: - 1 point
Wellness compatible subspecialties: - 0.5 points

GENERAL CLINIC VACATION RULES:

1. Residents are allotted 20 days total off each year combined from inpatient and outpatient time.
2. R2s and R3s are allowed to take a maximum of 2 weeks of clinic vacation (equivalent to 10 clinic days) however these 10 days can ONLY be taken over 3 clinic blocks. No two consecutive CC blocks can be taken off in a row.
3. R1s cannot take off in CC until after January 1st.
4. R3s cannot take vacation in Block 12 as they have been excused from block 13. R2s cannot take vacation in Block 13 given the lack of R3s.
5. Any vacation change must be requested 90 days in advance to the clinic director, entered in MedHub, and emailed to UHCC chief *and* core chiefs.
6. There will be a maximum of 6 residents allowed on vacation (any combination of R1/2/3) off at any given time during clinic weeks.