

# Quincy Family Medicine Resident Handbook

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## Mission Statement

1. To train excellent family physicians, eligible for board certification
2. To provide excellent medical care to the people of Quincy and surrounding areas.

### **Vision**

In harmony with the Missions of the SIU School of Medicine and the SIU School of Medicine Department of Family and Community Medicine, Quincy Family Medicine Residency Program will provide quality healthcare to the people of Quincy and surrounding areas and will enhance public health through education, service, and scholarship. Our vision is to:

- Educate resident physicians in the principles and practice of Family Medicine
- Train residents to provide comprehensive, high-quality medical care for at least 90% of acute and chronic medical problems to patients of all ages, races, and socioeconomic status
- Provide compassionate and continuous patient-centered care at all levels---outpatient, inpatient, extended care, and care in the home.
- Recognize the impact of the environment, cultural background, the community and family upon the health and well-being of individual patients.
- Develop the knowledge and skills necessary for our graduates to establish practices that meet the criteria for a patient-centered medical home
- Provide educational opportunities for healthcare professionals other than resident physicians including medical students, pre-medical students, nurse practitioners, physician assistants, and others.
- Provide medical leadership in the community and mechanisms to enhance public health.
- Promote scholarly activity and academic inquiry into primary care medicine for the advancement of the discipline of family medicine.
- Enhance the healthcare delivery to medically vulnerable and rural populations.

### **Guiding Principles of the Vision**

- The Program will maintain a curriculum in accordance with the recommendations of the Residency Review Committee, assuring that the resident's training will be complete and that each resident will be eligible for board certification.
- The curriculum promotes the skills and competencies essential to the development of a family physician.
- All rotations will emphasize the development of clinical decision-making skills and residents will be deemed competent in these skills when the resident can perform a thorough history and comprehensive physical examination, employ appropriate diagnostic services, formulate an appropriate differential diagnosis, and take an appropriate action. This skill is not achieved unless proper communication is maintained with the patient and unless the resident is able to present this information correctly and concisely to other professionals.

- Both personal and professional growth of resident physicians is encouraged through non-clinical curricular elements that include self-assessment, cultural diversity, health literacy, community-oriented primary care, health systems management, and others.
- Preparing physicians to practice in rural and underserved areas requires the development of a “tempered independence” or a higher level of expertise in the areas of procedures, behavioral health, public health and obstetrics. The Program will provide opportunities for resident physicians to develop these higher level skills.
- The Program will train excellent family physicians who have a complete understanding of the philosophy of family medicine and who are capable of delivering comprehensive, continuous medical care to people and families in all walks of life.
- Research and scholarly activity will enhance the quality of patient care and advance the discipline of Family Medicine and will be encouraged among faculty and residents.
- The Program will actively collaborate with the community to improve health and access to healthcare.

## Vacation / Sickness / Bereavement Leave

All residents are allowed a total of **20 business days** (Monday thru Friday) that may be used for vacation, sickness, and/or bereavement leave each year. Vacation, sickness, or bereavement leave **CANNOT** be carried over to the following year. If a resident is absent from the residency for more time than available, additional time for residency completion will be required.

Vacation Request Guidelines:

- Vacation request must be submitted to the **chief residents** at least **3 months prior** to the time of vacation. Requests should be made on paper using the Absence Request Form (ask Mary Ann for these).
- In general, no more than 4 senior residents and 2 interns will be scheduled away from the program at any one time. This includes residents who may be on away rotations, scheduled sick time, educational leave, etc. Thus, if other people are off the day requested, it is possible to have your requested day denied.
- No vacation will be allowed while rotating on the Family Practice Service. *Special circumstances may be approved by a Chief Resident **and** the Program Director.*
- No vacation will be allowed during two week required rotations, the last week of June or first week of July. A maximum of 1 week may be scheduled off from required 4 week rotations (this includes education leave). If a resident is in need of extended time, this can be accomplished by using the last week of one block and first week of another or in other creative ways. Plan early and talk with us, we will try to help you. *Special circumstances may be submitted for approval to a Chief Resident **and** the Program Director.*
- Requests for vacation (not including the winter holiday schedule) will be honored according to the date of submission for approval, on a 1st come, 1st served basis.
- Any request for vacation without a 3 month notice will need to be approved by the Chief Resident and Program Director. The reason for late submission must be indicated on the Absence Request form.
- Exceptions to all of the above guidelines may be made only for significant extenuating circumstances. Such circumstances must be clearly communicated on the Absence Request Form.
- DO NOT make final plans or arrangements such as purchasing airlines tickets, paying for hotel rooms or rentals etc. until final approval is obtained.
- You need to find coverage and inform the person covering for you that you will be gone before you leave (PGY-1's cover each other, PGY 2-3 cover each other). Communication is key, including anticipated deliveries when you are gone.
- Remember, if more than 20 days of vacation are used, the contract obligations will be extended past graduation date which could cause problems for prospective employers and visas. Use your vacation days wisely! It is recommended you schedule your vacations carefully, so that if you do fall ill come April, May, or June, you will still have vacation/sick days available.

### **Education Leave**

All residents are allowed a total of 5 working days for educational leave per year, which can be split up in any way. Education leave CANNOT be carried over to the following year. The same restrictions with number of residents gone and 3 month time frame apply as in vacation section.

### **Maternity / Paternity Leave**

There is great flexibility in this program regarding parental leave. Up to (4) months of leave may be taken without prejudice and without compensation. Residents may use vacation / sick time as part of their paid leave. Contact the program director early to discuss scheduling when maternity/paternity leave is anticipated.

### **Academic Time**

Residents may use 1-2 days of their 5 education days as self-study in preparation for board exams. A clearly written study plan must be submitted to faculty for approval in advance.

### **Board Exams**

Vacation/education time will not be assessed for completion of boards and licensing exams. Travel to and from the closest available testing sites will not be assessed for vacation/education time as long as it is reasonable. Residents may elect to take their exam at a more distant location of their choice, but must use their vacation/education days to cover travel time.

### **Career Placement**

Successful career placement of the resident physician is the goal of this residency program. The SIU School of Medicine and affiliated hospitals foster, and allow for sufficient time in job search endeavors. The program director may grant up to **six calendar days** during the last two years of resident training for this purpose. Job search time requires written submission of the proposed interview agenda to the chief resident and program director for time off to be considered.

### **Sick / Bereavement Request Guidelines**

1. Call a Chief resident as soon as it is known that a leave is needed. (Are you on call? Are you scheduled for clinic? Expected return? Hospital duties?)
2. Notify Beth Koehler @ ext 5725 or via cortex. Make sure you speak to her or get a response from her Cortex. Never assume that she "received the message". Always get confirmation. If Beth is unavailable, ask to speak to Yvonne or MaryAnn.
3. Notify your attending physician (Who are you working with?).
4. Find someone to cover your pager. \*\*\*
5. Fill out Absence Request Form as soon as possible or when able to return back to work.
6. Of the 20 vacation/sick/bereavement days mentioned above, a maximum of 4, quarter day (2 hour), timeframes may be used for personal or family healthcare related appointments.

\*\*If you are physically / emotionally able, try to find another resident to cover your pager. \*\*

\*\*If unable to do this, ask the chief resident for assistance\*\*

## Call

This section outlines the call schedule in effect now. There is a potential for call schedules to change at any time. The philosophy of the program regarding call is that on-call duties will maximize each of the following:

- Contact with patients with a variety of medical illnesses.
- Supervised progressive increases in patient responsibility and learning
- Increasing responsibility and care for patients with emergent and urgent needs
- Time to read and study.
- Personal and family time.

Call Team and hours:

\*\*\*Call team consists of On-call intern and On-call Senior\*\*\*

- ED intern:
  - Is “On-call” intern every **Friday**, 5:30 p.m. – 10:00 p.m.
- On-call intern:
  - 5:30 p.m. – 10:00 p.m. weekdays, 6:00 a.m. – 10:00 p.m. weekends and designated holidays (days the clinic is closed).
  - Sign out patients and pager to On-Call senior from 10:00 p.m. - 6:00 a.m.
  - Exception: FPS interns sign out to FPS Senior on that day (not senior on call)—  
**\*\*This can be confusing! Make sure the “senior on call” has put his/her name on the patients that were admitted so the nurse knows who to call. Communication is key!\*\***
- On-call senior:
  - Answer Quincy, 4:30 p.m. - 9:00 a.m. weekdays, 6:00 a.m. - 6:00 a.m. weekends
  - Admissions: 5:30 p.m. to 6:00 a.m. weekdays, 6:00 a.m. – 6:00 a.m. weekends
- Must be **minimum** of 8 Pgy2 / Pgy3 and 4 Pgy1 residents available for call each block

### Responsibilities while on call:

**On Call Intern:**

- Dial “0” and ask for the SIU admission pager to be transferred to YOUR pager. It helps to know YOUR pager number in case they ask.
- For 5:30 pm call, touch base with the person that was on HITS for the FPS team to find out how many “No-docs” you have received for the day or any possible admissions.
- Immediately notify your senior resident when you have an admission.
- The resident on call for admissions does not physically have to be in the hospital, but can take call from home. However, the resident on call must be available within 20 minutes.
- Call senior on call for questions, or if you need help in any way. If you have multiple admits call senior for help with priority setting.
- Call family medicine service attending after senior resident discusses case with you.
- Call the patient's PCP if it is an SIU senior resident (PGY2 or PGY3). This allows them to be ready to round on them in the morning!

- Call attending at the time of admission, especially if the patient is in critical condition.
- Attend codes, rapid response, do procedures available.

**On-call senior:**

- Responsible for supervising or performing admissions from 5:30 p.m. - 6:00 a.m., and Answer Quincy.
- The senior resident is **required** to examine all potential admissions and to give advice to the first-year resident. Enter a brief note focusing on the physical exam, assessment, and plan. This examination should be done **PRIOR** to sign out to the attending physician.
- Must be at 6:00 a.m. sign-off to FPS team at end of call shift.
- If ED physician needs assistance, on-call senior must return to the ED after ED intern has completed shift.
- You will NOT have clinics scheduled the day after a call
- Senior resident must go to their scheduled rotation in the morning and attend noon conference. If able and not excessively fatigued, the resident is encouraged to attend educational activities in the afternoon.
  - If needed, you can request to be released from your rotation beginning after conference (or at 1:30 on days a conference is not offered) for post-call rest. It is your responsibility to communicate with your attending physician.
  - Once you are post-call, sign out your pager to the senior on call that day and provide them sign out of any patients you have in the hospital or OBs that are close to delivery.

**OB call/rotation:**

- 24/7 home call, except off weekends
- In house hours during the week: 7 a.m. – 5 p.m.
- In house hours during the weekend: 7 a.m. rounds on postpartum, may take call from home for the remainder of the day if no one is in active labor
- SENIORS: If your personal OB patient goes into active labor or is admitted from L&D, intern will contact you to take over

**Weekends, holidays, and other:**

Holidays (July 4th, Christmas, etc. -- when the clinic is not open) duties are the same as weekends. This means, seniors do not admit their own patients --treat as a weekend!

## INPATIENT PEDIATRICS AND SICK NEWBORNS

### DUTIES

- Round on ALL inpatient pediatric patients (QMG/BPS/FPS) **before** the attendings arrive. (Be aware that some attending physicians will round on the patients as early as 6:15 AM.)
- You will write progress notes on each of the patients seen each day. (sometimes twice!)
- You will write H&Ps on each new patient unless told otherwise. Be sure to touch base with the admitting attending (via Voalte/text, page, office phone).
- It is expected for you to round again in the early afternoon (or after clinic) and call the attending with update if needed. If there is a change in plan or patient status, document accordingly with a progress note.

The nurses and/or attending physicians will notify you if there's a **high-risk delivery**. You must attend these deliveries whenever possible. Ask if they want you to put in orders/do newborn admission template. Don't forget to note these deliveries in New Innovations.

*\*\*\*To help ensure that you are notified, please provide the **NURSERY** and **OB** unit secretaries with your name, pager number, and inform them to please notify you of high risk deliveries\*\*\**

- Other procedures to keep track of include any circumcisions, lines, LP's, suprapubic bladder aspirations you participated in or performed. Most physicians will perform circumcisions between 8 and 9 AM.

### HOURS

- **Resident takes admissions from 6 AM to 8 PM. This is a firm timeframe.**
- You're not expected to take admissions overnight, but you will be expected to perform the admission H&P the following morning.

### CONTACTING THE ATTENDING

- All the attendings' contact information including pager numbers, office, and cell numbers can be found by clicking the "telephone icon" in BAR. Some of the physicians are using Voalte. Alternatively the unit secretary is a wonderful resource for contact information.
- You should contact the attending physician any time you are unsure or uncomfortable with the patient's situation.
- Contact them with critical labs, or if a patient is "crashing", or any dramatic change in status.

### LEVEL 2 NURSERY

- Please provide the nursery a card/piece of paper with your name, pager number and request that they call you with any level II nursery baby admissions. (It helps to call/ report to nursery daily and inquire about any new admissions overnight!)
- There is a white dry-erase board in Labor and Delivery that you can put your name and pager number on and a brief note asking nurses to page you for any high-risk pediatric/level II nursery babies.
- You also are expected to round on, and write daily progress notes on the newborns in the sick nursery (level II). You are not expected to round or write progress notes on regular



newborns. You should follow the level II babies until they are discharged from hospital (even if they are released from level II status)

#### TIME OFF

- Days off should be communicated with the nursing staff, secretary (a written note works best), and attending physicians.
- Level II nursery babies should still be rounded on if inpatient peds/sick nursery resident is on vacation. This will be covered by the service team. Please communicate with the service team so that they are aware and can round on all level II nursery babies.

#### RESOURCES

- Harriet Lane book, located at the nursing station on the sixth floor
- STABLE book, located by the bookshelf by the wash station in the nursery
- NRP book, located on the postpartum unit and in level II nursery.

## FAMILY PRACTICE SERVICE (FPS)

### DUTIES

- FPS admits all patients from the ER and direct admits from clinic whose PCP is documented as an attending, sports medicine fellow, or a 3rd year resident (non-traditional tract) in AllScripts. (We also admit BPS Fam practice Peds, East Adams Clinic and area nursing home patients, as well as all EMTALA pediatric patients)
- Admit maximum of 3 “no doc (EMTALA)” patients in a 24 hour period unless instructed otherwise by FPS attending. Transfers from outside facilities will NOT be deferred because of the previous number of “no doc/EMTALA” patients admitted that day.
- Pre-round on all assigned patients before rounds, attempt to complete progress notes before rounds
- You are required to attend noon conferences while you are on service. Faculty has been advised to release you from rounds early enough to allow you to finish notes/discharges and present to noon conference on time – this should be 11:30am most days. Notify Chief Residents if this is not consistently happening.
- Progress notes should be completed by noon daily
- H&Ps need to be completed within 24 hours of admission and discharge summaries within 24 hours of discharge!!!! This should occur without fail.
- Discharge paperwork needs to be completed by noon daily. If controlled substance scripts are required at discharge, they should be printed out for the attending to sign during rounds
- If PCP of the patient is a PGY 2 or 3 (traditional tract) in Allscripts; and they are informed before 5pm they will admit and manage his/her own patients. If after 5pm then the on call team admits, until the senior can resume care the following morning at 6AM. Remember to update BAR accordingly. If direct admit is seen by a resident in clinic, that resident will do the H&P and admission orders until the care can be transitioned to the senior or service team. If direct admit is sent over by attending/PA/NP/fellow -- the resident on HITS for that day performs the H&P (or the on-call resident if they arrive or are notified after 5:30pm)
- Education topics are to be discussed daily. Assignments/plans will be made by the seniors on service.
- Seniors on service are responsible for oversight of the care provided by the interns. It is recommended that prior to Attending rounds the senior and interns meet to discuss patients. *Remember, the seniors should prepare the interns to look like ROCKSTARS to the attending physicians!*

Any time you see a patient, but especially, if you are called by a nurse or other member of the health care team to assess a patient, you must enter a note. This can be abbreviated and only address the request at hand. Be familiar with the times that you must contact an attending.

### HOURS

- Service am sign out: 6am
- The “Senior On” is **REQUIRED** to physically be in the hospital for signout in the morning.
- If you are on HITS (admissions), call the operator (0) at 6am and ask for the SIU admission pager (5701) to be transferred to you on days you are on call. They will ask for an “end

time". Usually, HITS will end at 5:30 pm, unless you are on-call intern, then HITS will end at 10pm.

- Resident on weekday call (hits): 6am until \*5:30pm, all admission calls received after 5:30pm will go to the intern on call. (FPS "senior on" will supervise intern until 5:30 pm, after which time the overnight senior will supervise)
- Intern on call weekend call/holiday: 6am until 10pm (home call) after rounds
- Interns on service, but not on call 6am until rounds can then go home, keeping pager on until signing out pager to senior on at 8pm.

#### PAGER:

- Respond to all pages promptly, even if you think it was an error. You cannot turn your pager off unless you are on vacation or education leave.
- As an intern on service, you may transfer your pager any day of the week to your senior only after 8pm **and** only after you have signed out to them. Communication is key. If you choose to keep your pager, please call/page your senior with any questions and if you have to come in to the hospital during the night for a patient, the senior resident **must** be notified—*wake them up!*
- Inform the senior right away as soon as you have an admission.

#### CONTACTING THE ATTENDING, see separate policy

- Anytime you have a concern after you have spoken to the senior about the patient.
- To sign out a patient after you have reviewed the admission with your senior
- Any significant change in status (transfer from ODU to IMC, transfer to ICU, death....). Be familiar with the document that outlines these specifics.

#### Osteopathic Recognition Residents

- Please see the Goals and Objectives for Osteopathic Recognition Residents as they apply to this rotation ( included in this Handbook and also available on Trello )
- Please note that an additional evaluation will be completed on you during this rotation when you are working with an Osteopathic Attending

## OBSTETRICS AND GYNECOLOGY

### DUTIES

- If acceptable with attending/patient, manage all patients on the labor and delivery unit from BPS and QMG.
- If there are no patients on labor and delivery contact the BPS OB/GYN on call. If that doctor has clinic attend that doctor's clinic.
- Triage all SIU family medicine obstetric patients and discuss directly with SIU attending on call for OB (you do not have a senior here, but, can use on call or FPS senior if questions)
- If SIU patient will be staying for delivery then inform the delivering provider. If it is an OB patient of a resident, they will assume care and do the H&P. If it is a SIU attending patient admitted for delivery, you will complete the H&P and manage the delivery. Do your own note/documentation as appropriate for the clinical circumstance.
- Do H&P and/or progress, postpartum and/or procedure notes of the BPS or QMG obstetricians if they ask you to (always offer). When you are present for the delivery, follow that patient post partum.
- Notify BPS OB-back up call when admitting any SIU family medicine patients for labor.
- Attend didactics with SIU OB attending (usually Tuesday afternoons) and noon conferences (unless delivering). If noon conference is to be missed due to a delivery/procedure, email Dr. Holcomb and Deb Cramsey to request an excused absence.
- Log all procedures, deliveries, complications, and OB continuities in New Innovations!

### HOURS:

- You are required to be physically present on the labor and delivery floor from 7am until 5pm on days you are working. You are on call 24/7 (from home when not at hospital) unless you are on vacation or sign that responsibility out to another resident. Please indicate to the unit secretary on L&D and postpartum your name and pager number so they get to recognize you and know who you are!

### PRESENTING AN OB TRIAGE:

This is a \_\_ year old \_\_\_\_\_ (ethnicity) G\_P\_PT\_A\_L\_ (P=term deliveries, PT=preterm, A=abortion or miscarriages and L=living children) at \_\_ weeks \_\_ days Gestational Age by \_\_\_\_\_ (U/S, LMP, reliable date of conception etc) dating with a pregnancy that is complicated by \_\_\_\_\_ . Patient of Dr \_\_\_\_\_ .

The patient is presenting to L&D today for \_\_\_\_\_ .

(Vaginal Bleeding/Discharge, RUQ pain, changes in vision, other complaints  
+/- Fetal movement, +/- Fetal heart tones)

What does the Rhythm strip look like? Are contractions present?

Fetal heart tones: variability, baseline, accelerations, decelerations

Category I strip

Category II strip

Category III strip

Sterile speculum exam: pooling of fluid, bleeding, os opened or closed

Sterile vaginal exam: dilation, effacement, station

Remainder of pertinent physical exam

Your Assessment and plan:

1. "Iv fluids and rest, if contractions cease, we will then discharge home"
2. "Admit for active labor"

## END OF YEAR POLICIES

- Residents stop seeing their hospital patients 5 business days before end of residency training.
  - Patients admitted to a current third year, will go to the FPS or their newly assigned PCP.
  - Patients admitted to the FPS, who are reassigned to a current 2<sup>nd</sup> year will have care taken over by that resident.
  - Patients admitted to the FPS, who are reassigned to a current 1<sup>st</sup> year will continue to be managed by the FPS until July 1.
- Current first years will start to see their own newly admitted patients 5 business days before July 1. (Excludes patients already being cared for by FPS—see above)
  - If patient is admitted prior to 5 business days before July 1<sup>st</sup>, FPS will continue with patient until July 1<sup>st</sup>.
  - If assigned to ED intern, the patient is seen by FPS until July 1<sup>st</sup>.
  - If current third year resident is scheduled to leave early for fellowship. They will stop seeing their hospital patients 5 business days prior to their scheduled final day of residency).
- Residents beginning their third year of training will be allowed to gear their training more closely to what they plan to be doing upon graduation. There will be 2 tracts that third year residents can choose between. The first will be a “traditional tract”, where third year residents will continue to admit and follow their own continuity patients in the hospital (the same as a second year resident). The second tract will be a “non-traditional tract”, where third year residents will no longer admit and follow their own patients in the hospital (excluding Ob patients and when the resident is on the FPS). For residents who choose to follow the non-traditional tract, they will need to meet with their advisor to discuss and develop a plan that will focus on the resident’s specific area of interest to prepare him/her for their future career as a physician after graduation. Here is a non-inclusive list of ideas for the project for third years on the non-traditional tract. The projects are longitudinal.

The resident and his/her advisor selects one of the ideas or comes up with an equivalent idea. They will work together until project completion. For example: if a resident picks a community talk: 1) the resident would come up with a topic and a place to present 2) resident would discuss a timeline with his/her advisor and work with the advisor as needed on the presentation (the advisor at minimum reviews a rough and final draft with resident before presentation). 3) Advisor would present an update to clinical competency committee at milestone meeting.

Examples of interest area and type of project
- Ambulatory medicine:
  - Develop Poster presentation, Develop EHR templates, Develop community outreach project, Present several extra talks on TV/Radio, Help implement group visits/meetings,

Perform a QI/patient safety project, Develop process flow for clinic, Attend a series of clinical operation meetings/staff/head of dept. meetings

- Sports medicine:  
Attend a series of Football games or other sporting events, Help coordinate or organize a mass sporting event, Develop a poster presentation, Do a community talk on this area
- Urgent care/Emergent Care:  
Organize a community talk, or Present additional conferences in this area, Complete an ATLS or ACLS or BLS instructor course and obtain certification in ATLS, Develop a poster/presentation in this area of emphasis
- Research:  
Develop a QI project/poster presentation, Write a paper, case presentation
- OB:  
Develop a Poster or case presentation in this area
- Osteopathic medicine:  
Develop a Patient information poster for the waiting area, Develop templates for hospital OMM, Perform a community outreach project such as a presentation on this topic to community group, Develop a case based poster in this area
- Informatics:  
Develop Templates EHR, Attend a series of committee meetings in this area, Develop a process improvement on EMR
  - Second and third year residents will work as a team and cover each other's patients on the weekends. However, each resident (excluding the residents on the FPS) will be limited to covering a maximum of 2 other residents in addition to their own patients on the weekend. Senior Residents will help with weekend and holiday inpatient coverage regardless of "track" and will be assigned responsibilities accordingly.

## CLINIC EXPECTATIONS

- Two half days per week as PGY-1
- Three half days per week as PGY-2
- Four half days per week as PGY-3

### NOTES

- Complete all notes within 72 hours

### TASKS/BOXES/CORTEXT

- Need to be checked at least once daily regardless of rotation or “post-call” state (including for individuals you are covering).
- Touch base with one of your team nurses at least once a day.
- Answer all messages promptly, as there is a good reason your team member sent them to you. It is a strong sign of professionalism!

### SIU E-MAIL Account

- Needs to be checked at least once daily

### Computer based learning (CBL) modules

- Need to be completed at least once every three months- don't let them build up, you will regret it.
- Failure to complete these will affect the “Professionalism” part of your evaluations in a negative fashion and may result in the resident being asked to discuss with the Program Director which Saturday they wish to spend at the clinic catching these up.

### **Osteopathic Recognition Residents**

- Please see the Goals and Objectives for Osteopathic Recognition Residents as they apply to this rotation ( included in this Handbook and also available on Trello )
- Please note that an additional evaluation will be completed on you during this rotation when you are working with an Osteopathic Attending



## NEW INNOVATIONS

Institution Login: SIU-QFPC

Login username:

Login password:

### 1. Procedure logging

Step 1: Select tab called Logger

Step 2: From drop down, select tab called Procedures

Step 3: Enter patient MRN, Gender, DOB, and all fields marked with \*

Step 4: Use + Add Procedure link at bottom if necessary

Step 5: Select Save & Retain

Step 6: To view your list of procedures select tab called View. You may use the Filters tab in this section to count the specific procedures in each category

**Note:** There are tons of things you could log under "Other". An unlogged procedure will only be missed if you have not listed it. It's better to get it counted than lost!

### 2. Evaluations

#### a. Evaluation Completion

Step 1: Select tab called Evaluations

Step 2: From drop down, select tab called Complete an Evaluation. Each Block should have one to complete about duty hours and rotation evaluation. THIS IS MANDATORY TO COMPLETE at the end of your block.

#### b. Completed Evaluations

Step 1: Select tab called Evaluations

Step 2: From drop down, select tab called Completed Evaluations. Check mark ones you want to see and click on View selected evaluations

## EMERGENCY MEDICINE

1. ED rotation 2 blocks during intern year with option for electives in the senior years
2. ED intern is on from 12:30pm to 12:30am. 12:30pm to come to conference, meet residency candidates if we have them, address task list and eat lunch.
3. Must be in the ER by 1:30pm Monday, and Friday; 5:30pm on Wednesday and Thursdays after didactics/clinic; and 3pm on Saturday and Sunday
4. Tuesdays are the normal Off Day for this rotation, although this can be adjusted by the program if necessary for other training.
5. ED intern is on call for admissions to the Family Medicine service on Fridays evenings. (see section titled "CALL")
6. Work with various ED attendings-try to learn from all.
7. Attend all trauma's, codes, and procedures possible.
8. Log all procedures in New Innovations!

# OSTEOPATHIC RECOGNITION PROGRAM REQUIREMENTS

## 2019-2020 UPDATED August 2019

### Curriculum

- Attend all OMM workshops conducted by faculty unless specifically excused (i.e. vacation, night float, business leave, etc.)
  - In the third year of training, residents are expected to assist as table trainers for junior residents and/or medical students.
- Participate in Osteopathic Focused Journal Club on a rotational basis.
- Attend regularly scheduled OPP webinars or educational sessions quarterly (unless otherwise excused.)

### Evaluations

- Complete biannual milestones self-assessment in years 1 and 2. During year 3 complete one mid-year milestone self-evaluation
- Complete annual osteopathic specific program evaluation
- Complete annual osteopathic faculty evaluation
- Complete annual ACGME Osteopathic Recognition Survey
- Meet semi-annually with Director of Osteopathic Education to review competencies and milestones

### Procedures

- Maintain logs of OMT procedures (expectation of 40 patient encounters over the course of 3 years)
- Document osteopathic structural exam in the hospital setting – 8 in the first year, 4 in the second year, and 4 in the third year of training. – Copy of each structural exam to be stored in a secure location in the program.

### Examinations

- Take the yearly ACOFP Plus (or Program-designated equivalent) osteopathic in-training exam
- Take either AOBFP (recommended) or ABFM boards.

### Scholarly Activities

- One scholarly project with osteopathic focus in the 3 years of training, which includes the submission of a poster presentation abstract to a regional or national conference.
- Residents will present a case presentation at a local interdisciplinary educational conference incorporating OPP/OMM (This can be used to meet the current program case presentation/grand rounds requirements with abstract submission.)

### Additional Osteopathic Learning Enhancement

- Attend one regional or national osteopathic conference in 3 years (to be approved by Director of Osteopathic Education).

## Goals and Objectives for Osteopathic Curriculum

### Goals

To maintain and further develop osteopathic skills so that, upon graduation from residency, the physician will confidently continue these skills in the everyday practice of medicine.

To gain deeper understanding of the osteopathic principles and promote and utilize these principles throughout their medical career.

### Objectives

#### Junior Residents

1. Be able to perform complete and focused osteopathic structural exams. (MK, PC, ICS, P)  
*Assessment tools: Direct Observation*
2. Applies the physician resident's osteopathic diagnostic skills to create accurate assessment and treatment plans. (MK, PC)  
*Assessment tools: Direct Observation, Chart Review, In-training Exam*
3. Identify and describe the indications and contraindications to the various methods of osteopathic manipulative treatment. (MK)  
*Assessment tools: Direct Observation*

#### Senior Residents

In addition to the Objectives set for the Junior Residents, the following objectives are to be met for the Senior Residents:

1. Applies appropriate documentation skills of an osteopathic structural exam in the inpatient and outpatient setting. (MK)  
*Assessment tools: Direct Observation, Chart Review*
2. Demonstrates the appropriate use of osteopathic manipulative techniques in all clinical settings. (MK, PC)

*Assessment tools: Direct Observation, Chart Review, Procedure Logger*

3. Performs appropriate osteopathic coding and billing. (SBP)

*Assessment tools: Direct Observation, Chart Review*

4. Recognizes the types of somatic dysfunctions that occur with certain disease states (MK, PC)

*Assessment tools: Direct Observation, Chart Review, In-training Exam*

5. Defines and integrates the osteopathic philosophy: that impairment of the body involves multiple systems including skeletal, arthroidal, myofascial, vascular, lymphatic and neural. (MK, PC)

*Assessment tools: Direct Observation, In-training Exam*

6. Defines and integrates the osteopathic principles, including treating the whole patient rather than the symptoms, in all aspects of patient care to provide complete comprehensive care. (MK, PC, ICS, P)

*Assessment tools: Direct Observation*

Updated September 2019

## ENCOUNTER NUMBERS FOR GRADUATION (Minimum)

### Inpatient over 3 years

Adults: 750

Children (1 week to 18 years old) 250

75 must be ED visits

75 must be inpatient visits

Remaining 100 can be either inpatient or ED

Newborn 40

To get an encounter counted towards your numbers, you must complete a History and Physical or a progress note in BAR. Discharge summaries completed on the day of discharge count toward your overall encounters. For ED encounters to be counted, you must do an "ED assessment." ED assessment note type is found under the documents tab and type that you saw/evaluated/treated the patient and the ED doctor involved. This is most important for your ED pediatric visits. During your NICU rotation, you will be required to keep a log of the newborns seen during your rotation and submit it upon your return. You should also keep track of those NICU babies you treated that were more than 7 days old. Bring those numbers back from your NICU rotation

*\*\*I recommend saving your daily census sheet and keeping these for your records. It makes tracking these numbers quick and easy\*\**

### Outpatient over 3 years

Total 1650

165 must be 0-10 years old

165 must be >60 years old

### Obstetrics (min numbers, get way more if this area interests you)

40 total deliveries

30 vaginal deliveries

3 must be continuity patients (your personal OB patients)

For more information on OB, see the OB section

It is often asked, "What happens if I don't reach these numbers?" The safe answer is, "Who in the heck wants to find out?" In reality, there is no reason why you should not meet any number requirement. You will have to be proactive and work hard, but it is definitely possible!

## IMPORTANT CODES

- Employee number BH:
- ED locker room:
- Resident lounge:
- Labor and Delivery:
- Postpartum and nursery: swipe badge
- NPI number:
- AAFP username/password:
- New Innovations username/password:
- ABFM username/password:
- Pager number:
- ABOFP (DO residents) username/password:

## USING THE PHONE

- Page: 75 - <pager #> - extension OR 9-2\*\*-\*\*\*\* (if pager # not a 4 digit code)
- Call attending: cell or page (ask for preferences)
- Call senior: cell or page (ask for preferences)
- Call operator: Press 0 (or 1200 from clinic)
- Dial out: 9-2\*\*-\*\*\*\* (if area code 217); 9-1-\*\*\*-\*\*\*-\*\*\*\* (if different area code)

## CONFERENCE REQUIREMENTS

- PGY-1: 1 case conference + 1 OB conference (while you are on OB)
- PGY-2: 1 case conference + 1 gyne conference (after some gyne completed)
- PGY-3: 1 case conference + 1 experiential conference (any away rotation)
- Residents following the “Osteopathic-Focused Program Requirements” may/will have additional requirements.
- Must have 80% non-Wednesday block conference attendance. It is expected that Wednesday afternoon block conference attendance be near 100%. Failure to maintain these standards will invite further discussion with the Faculty and Program Director and could affect your ability to graduate the program without significant remediation.
- Residents will not be excused for the routine coverage/admissions of inpatients. Unstable patients are of course an exception. On days with a “block” responsibility (1/2 day lectures, team building retreats, etc.), there should not be one resident expected to take care of all admissions for the Family Medicine Service for that afternoon. Rather, the inpatient service team should collectively address these as a team after the “block” activity is complete.
- Post-call senior residents are EXPECTED to be at the Wednesday 1/2 day didactic lectures which occur twice an academic block. These blocks are heavily structured around ABFM and

ABOFP Board Certification exam preparations. IF the Senior Resident feels like they are too fatigued to attend, or are in danger of violating AGCME Duty Hour restrictions, they must discuss this prior to the conference with Dr. Holcomb or her designee. The Senior Resident should be prepared with details such as the number of phone calls they received, the number of admissions and time of night they occurred, and/or a breakdown of their weekly work hours that have put them in peril of violating ACGME restrictions. Because the Block Didactic afternoons have tremendous advantages for board preparation, and because no direct patient care responsibilities should occur after conference starts, failure to contact and receive permission from Dr. Holcomb or her designee prior to the conference may result in those conference hours being an “unexcused” absence. Chief Residents will be asked to keep track of how often Senior Residents are “post-call” on a Wednesday didactic period and should distribute these as equitably as possible. This should average about twice an academic year.

## DICTATION CODES

- 6630 - <pager #> - dictation type – patient MRN number  
Dictation types
  - 01 - Discharge summary
  - 02 - History and Physical
  - 03 – Operative note/Procedure note
  - 04 - Consultation
  - 07 – Progress Note
  - 22 – Hospitalist Discharge Summary (For discharge summaries dictated the same day as discharge *only*; it is transcribed and sent more quickly to the PCP).

You can press <9> at any time to mark a dictation STAT. This will put it in the front of the transcription queue. Only do this when a dictation is **truly needed STAT**.



## HISTORY AND PHYSICAL

- Chief complaint
- HPI: Patient's age, gender, race, primary doctor, symptoms, timing, duration, quality, modifying factors, associated symptoms
- Review of systems: "A \_\_ (number 8, 12, 14, etc.) point review of systems was elicited from the patient with pertinent positives and negatives as noted above"
- Past Medical History: Add Birth/developmental history, immunizations and diet exposures for pediatric patients. Add prenatal history/obstetric and gynecology history for OB patients.
- Past Surgical History
- Family History
- Social History
- Allergies: List medication and symptoms; Do not say "See BAR" or "reviewed"
- Medications: List brief; Do not say "See BAR" or "reviewed"
- Physical Exam (at least 10 items with at least 2 assessments per each)
  - Vitals
  - General appearance
  - HEENT
  - Neck
  - Cardio
  - Respiratory: identify if on oxygen and what method of delivery
  - Abdomen: Identify all lines in and out of the body
  - Skin: Don't forget to look at the sacrum
  - Musculoskeletal: Identify ambulation
  - Neuro
  - Psych
- Laboratory
- Imaging: Including recent cath or echo results or other recent pertinent info
- Assessment/Plan: (number format with plan under each assessment)
- VTE prophylaxis: if inpatient
- GI prophylaxis: If needed
- Code status
- Disposition: Inpatient or observation (one midnight or more)
- Plan of care discussed with the patient and their family members at bedside. All questions and concerns are addressed extensively.

## PROCEDURE NOTE

- Attending
- Resident
- Pre-op diagnosis
- Post-op diagnosis
- Procedure name
- Anesthesia
- Procedure description (great templates online, just search your procedure)
- Complications
- Labs
- Disposition

## DISCHARGE SUMMARY/END-OF-LIFE NOTE

Transition of care from the inpatient to another setting is key to making sure that the care we provide for our patients is safe and quality-oriented. Good transition of care provides enough information to the provider who will take over care. This involves open and frequent communication between the inpatient provider and outpatient provider. One aspect of this is the Discharge Summary. We will provide guidelines for the discharge summary.

### Sample Report 1

PRIMARY CARE PHYSICIAN: Dr. Primary Care

ATTENDING PHYSICIAN: Dr. Hospital Care

RESIDENT PHYSICIAN: Dr. Resident

#### ADMITTING DIAGNOSES:

1. Vasovagal syncope, status post fall.
2. Traumatic arthritis, right knee.
3. Hypertension.
4. History of recurrent urinary tract infection. (Note elements from the PMH are good to know about but probably do not need to be mentioned in a d/c summary)
5. History of renal carcinoma, stable.
6. History of chronic obstructive pulmonary disease.

#### DISCHARGE DIAGNOSES:

1. Vasovagal syncope, status post fall.
2. Traumatic arthritis, right knee.
3. Hypertension.

4. History of recurrent urinary tract infection.
5. History of renal carcinoma, stable.
6. History of chronic obstructive pulmonary disease.

CONSULTANTS: None. Or list each physician and their specialty

PROCEDURES: None. Or list procedures

DISCHARGE DISPOSITION: Discharged to skilled nursing facility/home/etc.

DISCHARGE PHYSICAL EXAM: [Very Important!]

ACTIVITY: Per physical therapy and rehabilitation. (optional)

DIET: General cardiac. (optional)

MEDICATIONS: (Extremely important)

The new medications added from this admission are:

- Darvocet-N 100 one tablet p.o. q.4-6 h. p.r.n.
- Colace 100 mg p.o. b.i.d.

The medications discontinued from this admissions are: (indicate why any medicine was stopped)

- Zestril 40 mg p.o. daily
- Norvasc 5 mg p.o. daily

The medications changed from this admission are:

- Potassium chloride 20 mEq p.o. daily (from 40 mEq p.o. daily)
- Clonidine 0.2 mg p.o. bid (increased from 0.1 mg p.o. b.i.d.)

The medications at home to be resumed are:

- Plavix 75 mg p.o. daily
- hydrochlorothiazide 50 mg p.o. daily
- Atrovent inhaler 2 puffs q.i.d.
- albuterol inhaler 2 puffs q.4-6 h. p.r.n.
- Cardura 2 mg p.o. daily
- Macrobid for prophylaxis, 100 mg p.o. daily

FOLLOWUP (this will include all the labs, consults and family doc appointments):

1. Follow up per skilled nursing facility until discharged to regular residence.
2. Follow up with primary provider within 2-3 weeks on arriving to home.
3. BMP & CBC with differential at the primary care doctor's facility before the follow-up visit

DIAGNOSTIC STUDIES: All x-rays including left foot, right knee, left shoulder and cervical spine showed no acute fractures. The left shoulder did show old healed left humeral head and neck fracture with baseline anterior dislocation. CT of the brain showed no acute changes, left periorbital soft tissue swelling. CT of the maxillofacial area showed no facial bone fracture.

Echocardiogram showed normal left ventricular function, ejection fraction estimated greater than 65%.

**HOSPITAL COURSE:**

The patient is an (XX)-year-old female with history of previous stroke; hypertension; COPD, stable; renal carcinoma; presenting after a fall and possible syncope. While walking, she accidentally fell to her knees and did hit her head on the ground, near her left eye. Her fall was not observed, but the patient does not profess any loss of consciousness, recalling the entire event. The patient does have a history of previous falls, one of which resulted in a hip fracture. She has had physical therapy and recovered completely from that. Initial examination showed bruising around the left eye, normal lung examination, normal heart examination, normal neurologic function with a baseline decreased mobility of her left arm. The patient was admitted for evaluation of her fall and to rule out syncope and possible stroke with her positive histories.

1. Fall: The patient was admitted and ruled out for syncopal episode. Echocardiogram was normal, and when the patient was able, her orthostatic blood pressures were within normal limits. Any serious conditions were quickly ruled out.
2. Status post fall with trauma: The patient was unable to walk normally secondary to traumatic injury of her knee, causing significant pain and swelling. Although a scan showed no acute fractures, the patient's frail status and previous use of cane prevented her regular abilities. She was set up with a skilled nursing facility, which took several days to arrange, where she was to be given daily physical therapy and rehabilitation until appropriate for her previous residence.

<CC: Please send a copy of this dictation to patients PCP>

## RESIDENT BENEFITS/EDUCATION FUND

Residents receive an educational allowance for educational expenses. Approved educational expenses include attendance fees, travel and meals to, from and during an educational conference, medically related computer hardware and/or software, text books, medical equipment and other medically related educational expenses. (NOTE: Required training such as PALS, ALSO, ALS, BCLS, does not count towards educational leave, but the cost does come out of your educational fund automatically).

**\*\*Important to note:** You are responsible for keeping receipts and turning them in to MaryAnn if you desire repayment. If you have questions about certain items/courses being covered by your educational fund, confirm with MaryAnn PRIOR to purchasing such items.\*\*

## DRESS CODE

Be professional. If you would not wear it to church or to visit your grandmother, do not wear it work. Scrubs are not allowed in clinic unless you have procedure day, have an active patient in labor, or soil your clothes. Closed toe shoes only.

## ICU ROTATION

- The beginning months of PGY2 are reserved for pairs of PGY2s to work together in the ICU with the several intensivists we have at Blessing hospital.
- The two residents working together are to divide the days of the month and work together to form a HITs schedule and provide a copy to the ICU unit secretary.
- Morning rounds in the ICU are attending specific. Each Monday, a new intensivist begins his week-long shift. Touch base with them prior to that Monday so you can be ready for rounds at the desired time. Some attendings are liberal with the amount of freedom they give you, others like frequent updates and plan changes. Always update attendings if patient experiences sudden change in status or if you have any questions.
- We try to put residents that are on ICU on fewer calls that month, but there is no hard and fast rule.
- There are sleeping rooms available and posted in the lounge .The ICU usually has an open bed to catch a few hours of rest if you are on a busy service.
- The ICU is a great location to rack up procedures and gain experience. Be sure to log all procedures in new innovations.

Revised June 27, 2018

