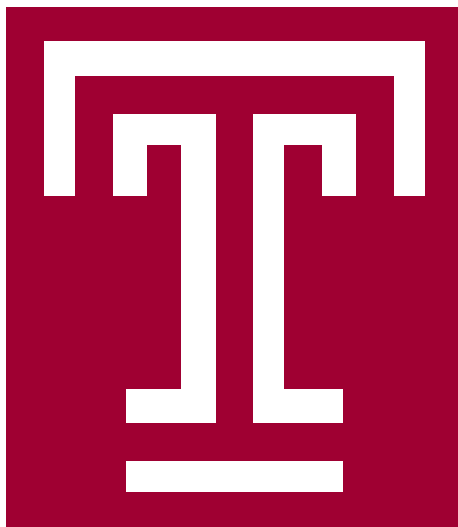


TEMPLE UNIVERSITY
MEDICINE GROUP PRACTICE
RESIDENT ORIENTATION HANDBOOK

June 19, 2009



Introduction

Welcome to the Temple University Medicine Group Practice!

During your residency, you will spend a significant amount of time in the continuity practice seeing your own panel of patients. Each of you will assume responsibility for a portion of the patient panel of an outgoing house officer. Over the next three years, you will see healthy, acutely ill and chronically ill patients in our practice. You will manage many patients with common outpatient conditions such as diabetes, hypertension, hypercholesterolemia, cardiac disease, depression, asthma, osteoarthritis, low back pain and thyroid disease. As primary care providers, you also will focus on disease prevention and health maintenance by counseling your patients concerning immunizations, cancer screening, diet, exercise and smoking cessation. In conjunction with specialists, you will also care for patients with collagen vascular disease, HIV, end stage renal disease and much more.

We believe it is a prime mission of both Temple University Hospital and Temple University Physicians to serve as a health care facility for the North Philadelphia population. Our practice serves as a major source of primary medical care for the residents of North Philadelphia and as a safety net healthcare provider for many of them. We see many patients that other physicians may not seek out to care for. The practice population is primarily African American and Hispanics of lower socio-economic status. Many have Medicaid insurance and often carry multiple medical diagnoses that have to each be followed and treated. This can make them challenging to care for, but rest assured, **if you learn how to care for this set of patients, you will feel quite confident managing any patient in the future that you see on an outpatient basis.**

The practice functions as a faculty-resident integrated medical practice. We work as a multidisciplinary team in conjunction with HIV specialists, a Registered Nurse, a dedicated practice social worker, 4 pharmacists, a Nutritionist and a Nurse Practitioner.

We hope that your experience over the next several years is educational and professionally rewarding. We very much look forward to collaborating with you to provide our patients with the utmost quality of care.

Medicine Group Practice Staff

PHYSICIAN PRECEPTORS

John Cacciamani, MD
Julie Collins, MD †
Tim Doberstein, MD †
Debra Feldman, MD *
Susan Gersh, MD
Sharon Herring, MD
Lawrence Kaplan, MD
Duane Kirksey, MD
Mary Kraemer, MD
Brett Laurence, MD †
Karen Lin, MD
Brian Meyer, MD,
Darilyn Moyer, MD
Anu Paranjape, MD
Alisa Peet, MD
Kyle Robinson, MD †
Gina Simoncini, MD †
Lawrence Ward, MD
Stephanie Ward, MD

* = part time volunteer
† = chief resident

CLINICAL STAFF

Medical Director:
Lawrence Ward, M.D.

Nurse Practitioner:
Anastasia Gray, CRNP

Registered Nurse
Ramona Christian, RN

Social Services:
Kenia Boone, MSW

Pharmacy/Coumadin Clinic:
Nima Patel, PharmD.
Deborah DeEugenio, PharmD.
Mirza Perez, PharmD.

Medical Assistants:
Maria Benjumia – Head MA
Maria Vicenty
Veronica Downing
Gloria Brown

ADMINISTRATIVE STAFF

Practice Manager:
Dorothy Newton

Practice Administrator:
Betsy Wolf

Administrative Specialist:
Iona Chisom

Registration:
Linda Ortiz
Linda Collins
Naomi Smalls
Joan Frazier

Medical records:
Angela Powell

Telephones:
Veronica Kegel-Coon

Medicine Group Practice Staff (continued)

Our practice staff shares an integral role providing comprehensive care to out patients. You will directly work with the following staff:

ADMINISTRATION

Medical Director: Lawrence Ward, MD
Practice Administrator: Betsy Wolf

Practice Manager: *Dorothy Newton*

Dorothy is in charge of running the day-to-day operations of the entire practice. She has the following specific responsibilities which pertain to the residents:

- coordination of all practice staff and clinical operations
- obtaining business cards and prescription pads
- troubleshooting and administrative issues that arise

Practice Coordinator/Administrative Specialist: *Iona Chisom*

Iona is in charge of running the day-to-day operations of the front desk of the practice. She has the following specific responsibilities which pertain to the residents:

- management of charts
- management of paper flow/paper filing/mailing
- management of mailboxes

Medical Assistants/LPNs: *Maria Benjumia (Head MA), Veronica Downing, Maria Vicenty, Gloria Brown*

The medical assistants have the following responsibilities:

- manage patient flow
- take patient vital signs (Ht, Wt, BP, P, T, Pox, and FSBG)
- perform fingerstick rapid PT/INR
- assist in PAP smears
- perform EKGs
- perform urinalysis and urine pregnancy results
- perform immunizations
- stock patient rooms
- call in prescription refills
- place and read PPD tests

They do not do BP checks separate from regular office visits!

Nurse Practitioner: *Anastasia Gray, CRNP*

- Anastasia does a significant portion of her clinical time in conjunction with the HIV practice. She often co-practices with residents on patients who are high-need and require more of a daily presence in the practice, which she can provide. The patients would be jointly seen by her with a resident with frequent communication from her on anything which occurs between resident office visits.

Registered Nurse: *Ramona Christian, RN*

- assist clinical staff with both clinical and nonclinical duties. She is the touchstone for the residents in the practice. If you need something done, ask her first!
- assist with facilitating patient care outside of the practice
- facilitating home health care
- triage of patients who walk-in or call the practice with clinical issues
- initial visits with patients to the HIV practice

Check-In/Check-out Registrar Staff: *Joan Frazier, Linda Ortiz, Linda Collins, Naomi Smalls.*

- Check-in and check-out patients
- make follow-up appointments
- make specialist appointments
- create insurance referrals
- schedule testing for patients

Medical records: *Angela Powell*

- organize the chart area
- pull charts for each practice session (and minimize lost charts)
- in charge of filing paperwork

Practice phones: *Veronica Kegel-Coon*

- answer all phone calls into the practice
- secondary (to the main call center) for making patient appointments

Pharmacy: *Nima Patel, Pharm.D., Deborah L. DeEugenio, PharmD, Mirza Perez, PharmD.,*

The pharmacists have 5 day/week coverage in the practice during the mornings. Dr. Perez also sees Spanish-speaking patients on Thursday afternoons. There are also pharmacy students who may see patients with you. The pharmacists may be consulted for some of the following reasons:

- Coumadin monitoring
- General education of patients regarding their medications
- Polypharmacy
- Smoking cessation
- Diabetes counseling
- Pain management consultation
- Asthma device education

Social Work: *Kenia Boone, MSW*

The social worker plays an invaluable role in helping to care for our patients. She is in the practice each afternoon and some mornings. When she is not on site, she can always be reached by pager in an emergency. She can help you with:

- placement issues (boarding home, nursing home, rehab, psychiatric, hospice, SNF)
- insurance problems
- prescription problems; pharmaceutical assistance programs
- transportation (Paratransit)
- mental health issues; coping/counseling
- community services (Meals on Wheels, HHA)
- abuse/neglect
- substance abuse
- PECO forms and payment plans

Resident Education and Supervision

Starting in June 2009, the Temple Medicine Group Practice will move to an innovative Micro-Firm Patient Care Model.

- Each resident is assigned to a regular clinic day with a single primary faculty preceptor. This preceptor heads up the micro-firm which is comprised of 6-7 residents spanning all three years of training. (see chart at end)
 - The micro-firm is intended to operate as a team. Though patients will be assigned to each resident as their primary care doctor, and thus each resident will have their own cadre of regular patients, teamwork will be key to the practice operations. Continuity to a specific clinic day of the week will be increased from years past and a familiarity will develop among firm members. If a member is out of the office in a given week, other firm members should take care to empty the other person's mailbox, for instance. Likewise, if a member's patient requests an urgent visit, attempts will be made to arrange an appointment with someone of the same firm and communication between members of the firm will take place in order to smooth the patient care process.
 - Residents will work primarily with a single firm preceptor. This improves faculty ability evaluate residents and assists in them knowing residents patients as well. Residents should attempt to always be precepted by your Firm faculty preceptor. In Firm A it is self explanatory but when in Firm B/C, where there are 2 preceptors at all times, all reasonable efforts should be made to work with your primary preceptor.
 - You must present every patient to your preceptor. The preceptor may see any patients that they want to or that you request for them to see. Attendings are expected to see every new patient, complicated patients and all patients seen by interns for the first 6 months of the year.
 - Precepting time is an integral part of the educational process. These are the moments when you gain the most practical knowledge of ambulatory medicine. The goals of the preceptors are to 1) ensure that your plan makes sense and is medically sound, 2) Assist you in learning methods of outpatient medicine and 3) to generate enthusiasm for the practice of outpatient medicine. Your goal should be to try to **take away at least one piece of new medical knowledge from each patient encounter**. Utilize the preceptors to help you with this.
 - You should **never be afraid to ask a question** in cases where you are unsure or feel that you need help.
 - You should always feel comfortable calling or paging one of your preceptors for patient care issues that arise outside of practice time
- Pre-clinic conference
 - Preclinic conference will be convened for 20-30 minutes prior to each practice session. This is a valuable time to discuss and learn about various outpatient topics. Each week, the full case-based topic discussion will be e-mailed to your TUHS account. It is suggested that you review it prior to your clinic day. Then, on the day of your clinic session, the attending preceptor will present outpatient topics in a case-based format to cover basic outpatients principles including the care of hypertension, diabetes, obesity, COPD, asthma, depression and renal disease. Additional areas to be covered include the joint exam, disease screening, how to approach the difficult patients, substance abuse, the utilization of community resources, billing and an orientation on insurance coverages. Residents are encouraged to share clinical cases or dilemmas encountered during recent practice sessions.
 - Each morning session will begin at **8:00 in the Firm B/C conference room**, and each afternoon session will begin at **1:00 in the Firm A conference room** with preclinic conference. **There will be no preclinic conference on Wednesday mornings**. We understand that your inpatient responsibilities can often seem overwhelming and may seem to take precedent over your time at your continuity practice. However, like morning report, this too is an important part of your training and you are expected to leave ample time to get to the practice. The rare late arrival is excusable but if tardiness becomes routine, the reasons behind it will need to be discussed, and the Chief residents may be eventually contacted.
- Resident evaluations
 - Twice a year you will receive formal feedback and evaluation from your preceptor with input from the staff. These evaluations will be discussed with the resident face-to-face. Resident evaluation will be based upon the ACGME competencies. We also employ a global feedback method for

your mid-year session which encompasses information from surveys of the faculty preceptors, the office staff and your own patients.

- Additional informal feedback will occur throughout the year.
- Interns will complete 4 mini-CEX evaluations during the course of the year. It is your responsibility to obtain **at least 2 of these** from your preceptors. The attending performing the mini-CEX should discuss their findings with you at the conclusion and submit it online to the Medicine office to be included in your file.
- Residents have the ability to anonymously evaluate their faculty preceptors each spring.

- Clinical Quality Improvement

- In the spring, each resident will complete a chart audit of 15 patients (Interns will complete only 7) from within their patient panel. Their data will be collated and compared with that of their peers, as well as national standards.
- From these results, each resident will develop a personal data-based action plan for improving their care of patients with assistance from their firm preceptor. This plan will be evaluated throughout the year and the data re-sampled the following Spring.

- Educational Materials

- A library of ambulatory texts is located the 4th floor conference rooms.
- All computers have access to UptoDate (www.uptodate.com)
- Computer workstations are available throughout the office and in the resident conference room.
- Additional materials, including letter templates, suggested web sites will be available on the Chief Owl web site.

Practice Schedules

- You will see patients on average one session (1/2 day) each week except for when you are on the following rotations:
 - 1) Intern Night float
 - 2) Scheduled vacation
 - 3) Post-call days
 - 4) House Chief
 - 5) RICU and CCU
 - 6) Some on-call days (during the fall for residents, spring for interns)

- **IT IS YOUR RESPONSIBILITY TO REMEMBER WHEN YOU HAVE YOUR CONTINUITY PRACTICE!!! Please check AMION for the most current schedule. Whatever AMION says goes!**

There is no post-call clinic for anyone. Unlike in past years, these clinics will not flip to another day in the same week.

In order to make up for the lost days of clinic, residents will often be scheduled for a full day (AM and PM) clinic during elective months. Which day that is of the week will be assigned based upon preceptor and room availability but expectations are that it will remain constant with their usual clinic day so continuity will be maintained with both your afternoon micro-firm preceptor, as well as the set of preceptors in the morning session across the entire year.

At the start of the year, and at the start of each block, please review your schedule in AMION. **Please look it over carefully for errors.** It is your responsibility to make certain that all necessary clinics have been rescheduled as above and vacation time has been taken into account. You will be held responsible if Reserve has to be used if you make a scheduling mistake. You must also make sure that you have no more than a 4 week gap between clinic sessions (except for vacation).

- You may not cancel or change a clinic session without prior permission of Dr. Larry Ward or Dr. Gina Simoncini. **All clinic schedule change requests must be sent to each of them.**
 - You must e-mail any changes to your clinic schedule for approval.
 - You must provide at least **6 weeks notice** if you plan to cancel a patient session so patients can be notified and rescheduled. If you need to cancel a session with less than 6 weeks notice, you must contact Dr. Larry Ward, Dr. Moyer or Dr. Gina Simoncini in order to arrange coverage for that session.
 - All cancelled practice sessions must be made-up as close to the date of cancellation as possible so as to make rescheduling efforts easier.
 - The make-up session date will need to be discussed with Dr. Larry Ward. It is now mandated that all residents must see patients for a minimum of 130 sessions over their three years of training.
 - For those residents who anticipate significant schedule disruption due to fellowship or job interviews, extra clinics may be scheduled earlier in the year and certain clinics cancelled during the interview time in order to minimize disruption and assist residents in scheduling interviews.
- **Patient scheduling:** The Medicine Group Practice runs on an appointment system. There is no walk-in clinic. Patients are given specific appointment times. The duration of appointments has been increased from years past and now average 40-60 minutes for new visits and 30-40 minutes for full-up appointments. The duration of visits decrease and the number of patients scheduled in a given session increase as residents progress through their residency. We make every attempt to work as closely to this schedule as possible, and do not see patients on a first come, first served basis. Patients are asked to come 10 minutes before we expect the provider to see them, to allow for registration and triaging. All patients receive a computerized reminder phone call 48 hours in advance of their appointments.

A patient who sees a resident should have an assigned person as their Primary/Family MD in the IDX scheduling system. All attempts are made for that patient to develop a longitudinal relationship with that single physician. However, some patients may need to be seen for an acute reason. This will be noted by the scheduler in the comments section and the visit should be used to address that specific issue only and the management of chronic conditions and preventive strategies should be delayed until the next visit with the PCP.

There are Reassign slots (REA) on your schedule. These are patients who are not new to the practice but are new to you. These are not urgent visits and you have now been assigned as their PCP. These follow the rules listed above for new patients. They should be billed as a follow-up visit though.

There are Emergency slots (EMG) on your schedule. These slots do not open for appointments until 24 hours prior to the actual date. They are for acute appointments. All acute appointments must have a reason for the visit listed on the schedule. For these visits, focus on the patient's chief complaint – the reason for the urgent visit – only. You may defer health maintenance to their PCP. Theoretically, all the patients on your schedule who are not a new patient, you will have either seen previously or will have an urgent complaint listed.

Beginning in 2009, residents will participate in 'Focused practices' in the morning while on Ambulatory block. These will be special clinics on the 4th floor that fellow residents can refer patients to for detailed care on 1) Difficult to control Diabetes, 2) PAP smears, and 3) Smoking cessation.

Residents are expected to be present at the Practice at the time of their scheduled session and remain there until they have "signed out" with their attending. The staff WILL NOT page you when your first patient arrives.

Your preceptor may ask you to see emergency, urgent patients who do not appear on your schedule. Additionally, you may be asked to help out a colleague who is running behind. For this reason, you should not leave for the day without checking with your preceptor.

Patient Care

- All new or reassigned patients should have a complete history and physical in the record within the first three visits.
- **You are expected to maintain an up to date problem list, medication list, allergy list and health care maintenance form located at the front of the chart.**
- **You are expected to leave your beeper with your covering resident when you are at practice.** Interns are to leave their beepers with their residents while they are in the practice. Interns should not receive pages regarding floor patients when they are in session.
- **Dress code:** All interns and residents are expected to dress in attire appropriate to their professional role. **You are not permitted to wear scrubs in the office** except when you are post call. **No one may wear open-toed shoes in the office.**
- **Practice Flow:** Patients check in at the front desk and are sent to the firm in which their physician is working for the day. The MA will take vital signs and ask the patient to return to the waiting room until called. They will place the chart on your door. When ready, you may call the patient by their last name only.

When you have finished with the patient and been precepted, place all forms and prescriptions in the thin red folder and hand it to the firm registrar. They will ensure that all materials go to their proper place, all necessary orders are carried out and all appointments are made.

- **Late patients:** If a patient is more than 20 minutes late, they may be asked to reschedule. The office staff have been trained that they must ask an attending preceptor if the patient could possibly be seen that same session. This decision is made between you and your preceptor. In reality, most patients are seen but they are asked to wait until it is convenient for you to fit them in. You can only

see them briefly if necessary, and should see them only when it does not mean inconveniencing someone who has shown up on time.

- **Interim visits:** you may ask patients to return to see the diabetes educator (Carol Otte) or pharmacist for only a few reasons (see below). NOTE: **The nurse practitioner, pharmacists and RN do not routinely do BP checks.** Neither do the MAs.

The pharmacists may be consulted for the following, among others:

- Initiating and educating insulin
- Medication non-compliance
- Warfarin monitoring
- Polypharmacy
- Education on device use (ie MDIs for asthma)
- Pain management consultation
- Asthma device education
- Diabetes education

If a patient is receiving a PPD on the day they are seeing you and need to return in 48-72 hours to have it read, leave the chart and completed form with the MA placing the PPD. They will return the form to the patient when they return for the reading.

- **Ordering studies:** NOTE: all orders for studies must have a diagnosis written on them. They must also note the attending preceptor name. The following are necessary to order studies:
 - **All studies:** Require a signed Diagnostic imaging form. These include
 - **Radiology (x-rays, mammograms)**
 - **Ultrasounds**
 - **GI Radiology (non-nuclear)**
 - **Non-nuclear cardiology tests**
 - **Nuclear tests including nuclear cardiology:** May require a Radiology Prior Authorization form so the office staff can get insurance approval for the test. These are available on the back of the diagnostic imaging form. **Do not call yourself to get an appointment for the patient.** The office staff will do this once the test has received insurance company approval.
 - **CT scans and MRIs:** Likewise, may require a Radiology Prior Authorization form to be completed.
- **Specialist consultations:** In order to consult a specialist who is not located on the 4th floor itself, all you need do is fill out a Consultation form. These are available in the box in each exam room and each conference room. Place it in the thin red folder at the end of the visit and the registrar will arrange the appointment. **Please do not call or e-mail the access center yourself unless you make sure the registrar is aware of it and can generate an official insurance referral for the patient.**

To consult a pharmacist, nutrition or to refer to one of the focused Ambulatory clinics, a consultation form is not required. It may be noted on the billing sheet and an appoint will be made for the patient.

- **Patient Lab Results:** The RN at MGP will review all labs that arrive in the practice. Any abnormal labs are given to the Ambulatory resident (see below) to be managed. However, as the ordering provider, **you will be expected to check any labs your ordered, via Meditech of Quest, within 72 hours of your time in the practice. It is also your responsibility to inform your patients about their lab results in a timely fashion.** This will be more strictly enforced than in past years and residents are expected to come to clinic within 72 hours of their last practice session to review their mailboxes. Acute issues will continue to be managed by the Ambulatory residents. Contact with the patient can be done either by phoning and speaking with the patient (results can not be left on answering machines!) or by sending a letter to them. Letter templates are also available on the Chief Owl. Prescriptions can also be changed or started in this way, if necessary.
- **No Shows:** There is great variability in the no show rate in the practice. When a patient does not show, it is important to look through prior visits to determine how urgently they need to be

rescheduled. The appropriate form must be filled out at the end of that day's continuity session and given to the back registrar so s/he can contact the patient.

- **Special needs patients:** We often see patients residing in community living arrangements (CLAs). These people are discharged from state institutions for the mentally ill or retarded. We provide their annual physicals and interim care.
- **Multidisciplinary care rounds:** At the request of any member of the care team, a multidisciplinary meeting may be called to discuss the patient's case in detail. Ideally, this will involve the RN, Social worker, and the primary physician. A pharmacist, nurse practitioner and faculty preceptor may also be asked to contribute to the meeting. The meeting will be documented in the chart with a plan of action clearly stated. Often, these patients will be shared with the office NP if they need to be more closely monitored than is possible by a typical resident schedule, though the primary provider remains the resident themselves and regular visits with them will continue.
- **Firm Rounds:** Attempts at monthly micro-firm rounds will be trialed this year. This will involved the entire micro-firm coming together at a non-patient care time in order to discuss aspects of care, specific cases and quality improvement with their faculty preceptor as well as with other members of the multidisciplinary team and office staff who would be appropriate.
- **Patient Phone Calls During Office Hours:** During regular office hours, 8:00am-5:00pm, for any question or issue that arises on a patient of yours, you will be paged. Please recognize that any page with the number 707-3416 will likely be from this practice and it is your responsibility to return this call promptly. This remains true even during ICU, ED and service rotations (although calls during these times will be avoided as much as possible). **Unless you are post call or on your day off, it is necessary for you to return all calls promptly.**

We do not suggest you give your page number out to any patient.

- **Patient Phone Calls Made After Hours or on the Weekend**
 - Residents are not expected to provide phone coverage after hours.
 - Patients should call 215-707-3416 if they should need to speak to a physician after hours. An answering service answers all calls and pages one of our covering attending.
 - If you speak to a patient after hours or at a time when you are not in the office, make a note so that you will be able to document a telephone encounter in the medical record at a later date.
- **Patient confidentiality:** Patient confidentiality always needs to be considered. Please avoid discussing patient information at the front desk, in the waiting area, and in the hallways where other patients may overhear.
- **Work between practice sessions and Correspondence**
 - Acute Medical Issues**
 - Lab and radiology results as well as paperwork, medication refills and phone calls constantly come into the practice. The residents on Ambulatory block, as well as the RN and NP, manage those which are acute in nature. They may often contact you – no matter the rotation you are currently on - with questions if your last medical note due not answer for them how to deal with the issue.
 - Mailboxes**
 - Mailboxes are located behind the front desk. They are arranged alphabetically by residency year.
 - It is your responsibility to check your mailbox when you come to practice each week. In addition, residents are expected to come to the practice in between patients sessions, approximately 72 hours after your clinic session, to manage non-urgent issues and to call/write patients about lab and radiology results. If you do not have a session any week due to being post-call or on-call on your regular practice day, you are also expected to come to clinic when marked as 'Admin' in AMION
 - If you will not be in the practice due to an off-site rotation/Unit block/Nightfloat or vacation, you must inform other members of your firm so that they can arrange to

manage timely information that is placed in your box while you are away. Each firm will manage this differently but in some cases, one other member of the firm will be assigned to manage the mailboxes of those who are out of the office for the week.

- After you have read and “signed off” on correspondence, **initial and date it** at the top and place it in a filing basket or add it yourself to the patient’s medical record.

Letters

Letters may be typed out yourself or written out and given to a front office staff member to mail. To assist you, there are letter templates that have been loaded onto the Chief Owl web site.

- **Medical Records:**

The Medicine Group Practice patient records are maintained within the center. Our records include general medical and medical subspecialty clinic records. They do not include records from other outpatient consultant charts, nor do they include hospital records. Charts are available for review anytime a patient is admitted or seen in the Emergency Room. **Please do not pull charts yourself – let the staff do this for you.** They should be reviewed in the center and pertinent data extracted and photocopied. **Please do not remove charts from the center.**

If you need to review several records at once, you must give 48 hours notice to the staff so they can pull them for you.

All patients who have not been seen in the practice in the past two years will have their chart in archives. You can request an archived chart - it will generally take 1-2 days to be pulled.

- **Managed Care:** The majority of our patients have managed HMO type health care plans. The most common are Americhoice, Health Partners, Keystone Health Plan East, Medicare and Aetna. The Medicare managed care plans that we accept most commonly are Bravo and Keystone 65 Complete. We do not accept Keystone Mercy.

The name of one of the attendings is listed on the patients’ card as their primary care provider. However, you will be listed in IDX (our scheduling system) as the PCP from Temple’s point of view.

The patient cannot see any specialist, have any laboratory work or x-rays without a referral from the office. The front desk staff is responsible for all patient referrals. Patients are required by their managed care insurer to see their primary care provider at least annually.

- **Admitting a patient:** If a patient is to be admitted from clinic you may either 1) send them to the Emergency room or 2) directly admit them to the floor.
 - **If directly admitting a patient** you must call the transfer center. They will ask a series of questions to ascertain the need for the admission. They will then hang up and get insurance approval, as well as assign a hospital bed for the patient. You should receive a call back within an hour. Let the MA know of the transfer once a bed is secured so they can call for transportation to the Admissions office where their stay should be brief. Residents must write a good note and give a copy of it to the patient. Once a bed is secured, you should call the schnook to give report.
 - **If sending a patient to the ED** you must let the MA know of your plan so they can call for transport. A good note should be written, copied and given to the patient. Report should be called to at ED attending and a note made in the chart of who you spoke with.

- **Inpatient Care:** When patients from our practice get hospitalized, they may or may not be admitted to the GIM service. **If you are on service and admit a colleague’s patient, please contact that person ASAP to inform them of what happened.** Likewise, the attending should make every attempt to alert you when a patients of yours has been admitted. We encourage you to see your patient if they are hospitalized. If alerted, the practice social worker can also see the patients prior to discharge to streamline the transition back to the ambulatory environment. Our practice has set up a system with the Admissions office so that it is alerted if a MGP patient is admitted and our practice staff will then alert you of the admission. Residents should do their best to see any patient of theirs who has been admitted to the hospital.

- **Billing:**

In order to bill to the true level of work, you should document everything you cover with the patient. Each section of the encounter should be filled out (HPI, Physical Exam and Assessment/Plan). Billing codes are assigned at the end of a patient encounter. The billing level

should be approved by the attending, prior to the end of the visit. The levels for the billing of Medicare visits (and consequently all other visits) are noted on this form. They can be summarized as follows:

- L5: A comprehensive visit on a new patient including a complete history and physical examination, and a formulation of a plan of care requiring decision making of "high complexity." An experienced physician would be expected to spend one hour on such a visit. Residents should bill for L5 visits for all new patients with whom they spend an hour and do a comprehensive examination, and for all old patients (old to the practice, or old to the physician) on whom an annual comprehensive examination is done and multiple medical problems are addressed. Usually a therapeutic lab must be checked and 3 problems be addressed with detailed documentation of each.
 - L4: An L4 visit on a new or established patient is one in which several medical problems are addressed, all of which require medical decision making of moderate complexity. An experienced physician would be expected to spend 45 minutes on a new L4 visit and 25 minutes on a return L4 visit. Examples might include a patient with diabetes out of control, and hypertension out of control. The majority of your patient encounters in MGP will be billed at this level if the attending sees the patient with you.
 - L3: An L3 visit is essentially a visit requiring a detailed history and examination, but in which medical decision making is of low complexity. No labs are checked, no workup performed and no prescription medication are managed. An example might be a 50 year old person with low back pain. An experienced physician would be expected to spend 30 minutes on a new L3 visit, or 15 minutes with a known patient. If an attending does not see the patient with you, this is the maximum that can be billed under the Medicare Primary Care Exception.
 - L2: Except in the most simple of cases, you will not be billing this level.
 - L1: A brief visit. In our clinic, these usually consist of pharmacist visits supervised by the physician. Almost NO physician visits should be L1 visits. Please do not underestimate your worth!
- **Patients lacking health insurance:**
MGP does not discriminate based on the ability to pay. A patient may see a physician at MGP after paying cash but in general, for many reasons, we do not see patients without insurance. Understand that **labs and other studies can not be obtained for uninsured patients**, however. In addition, they should all be referred to our social worker prior to their next follow-up appointment in order to determine eligibility for medical assistance. Often it turns out that these patients are better served by going to a city district or community health center.

General Office Policies

- **Office hours and days of closure:**

- Regular office hours: 7:30am - 5:00pm Monday thru Friday
- Holidays:
 - Independence Day (Friday July 3, 2009): Closed
 - Labor Day (Monday September 7, 2009): Closed
 - Thanksgiving (Thursday November 26, 2009): Closed
 - Day after Thanksgiving (Friday November 27, 2009): Closed
 - Day before Christmas (Thursday December 24, 2009): Closed
 - Christmas (Friday December 25, 2009): Closed
 - New Years (Friday January 1, 2010): Closed
 - Memorial Day (Monday May 31, 2010): Closed

- **Snow Policy and Other Unanticipated Closures:** On days when it is snowing or other severe weather is occurring, the practice administrator will make a decision regarding whether or not to open the practice to see patients. The practice may either 1) Open as normal, 2) Open late, or 3) Close for the entire day. This decision will be made by 6:30am and all affected staff and residents will be contacted by 7:00am via pager, optimally. Please plan to come in for continuity clinic until contacted regarding the schedule for the day.

- **Schedule II drugs:**

- Residents must have an attending physician sign for any Schedule II drugs. These include all opiates and benzodiazepines. Even if you have a DEA number (ie that you use to moonlight), you may not use it for business associated with the practice.
- See the attached Pain Management Policy for full details on the new policy that went into effect April, 2008.

- **Patient Termination:** If it is decided by you and your preceptor that a patient should be terminated from the practice, you should discuss it with Dr. Larry Ward. A registered letter should be sent by him to that patient. In the letter it should be stated the reason for the termination, and that the termination is effective 30 days from their receipt of the letter. This gives them time to find a new primary care physician. A copy of the letter should also be sent to the patient's insurance company alerting them to the action.

- **Medication Refills:** Medication refills must be called in to the practice at least 48 hours in advance. If the request is received sooner than that, we can not guarantee that the request will be completed in time.

- **Medication Samples: Pharmaceutical representatives have for the most part been banned from clinical areas of the MGP.** As a result, our stock of sample medications has decreased markedly over the past year. There is a not-so-well (anymore) stocked closet of pharmaceutical samples available behind the front desk.

- These medications are to be used with some amount of care. Many of the practice's patients may not be able to afford certain medications once the samples have run out. Therefore, when choosing to dispense sample medications, be sure to consider the long-term options available and whether that particular patient is the best long-term choice.
- It is suggested that these medication be used for several indications: 1) Short term therapy that will end when the samples given run out or 2) To test how a patient will react to a certain medication is being prescribed regardless or 3) To give a several day head start for a certain medication is being prescribed regardless or 4) To help as a last resort in instances of medical need and financial inability to obtain medications only if the particular sample medication would have been prescribed regardless.
- For all samples given to patients, you must complete a patient label and complete **all** information on label. Place the samples in a brown bag and place label(s) on the bag. This provides patients with proper instructions for use. This serves as documentation and tracking of all meds dispensed. Note of the sample must also be made in detail in the chart progress note.

Tests/Procedures and Treatments Available

- The practice is equipped to perform the following tests:
 - fingerstick rapid PT/INR
 - urinalysis (dipstick and microscope)
 - stool for occult blood
 - electrocardiograms
 - blood glucose measurement
 - KOH preparations
 - urine pregnancy tests
 - All test results should be documented in your note.
 - You must interpret and co-sign all EKGs, that must then be countersigned by your attending, and then placed in the patient's medical record.

- The practice is equipped to perform the following procedures:
 - Joint aspiration
 - Joint injection
 - Ear irrigations
 - Incision and drainage
 - Suture removal
 - Wound care
 - Pap smear

- The practice is equipped to administer the following treatments:
 - IV/SQ insulin
 - Nebulizer treatments
 - IM pain medication

**ALL PROCEDURES MUST BE RECORDED ON BILLING SHEET
AND DOCUMENTED IN YOUR NOTE.
A PATIENT CONSENT FORM MUST ALSO BE COMPLETED**

Outpatient Topics

The topics below represent some of the important topics in outpatient internal medicine that we believe you should be comfortable with by the end of your training. We will cover many of these topics in pre-clinic conference through case based discussion. It is also important that you review this list every few months to identify areas for self-directed learning.

Cardiology

- Congestive Heart Failure
- Hyperlipidemia
- Hypertension
- MI prevention

Dermatology

- Acne
- Common dermatologic diseases
- Alopecia
- Hirsutism
- Zoster

Gastroenterology

- Dyspepsia
- Hepatitis C
- Irritable Bowel Syndrome

Gynecology/Reproductive Endocrinology

- Oral Contraceptive Management
- Hormone Replacement Therapy
- The perimenopausal patient
- Menopause
- Dysfunctional Uterine Bleeding
- Amenorrhea
- Breast mass/nipple discharge

Hematology

- Anemia
- Thrombocytopenia

Office Based Practice

- Evaluation and Management Coding
- Telephone Medicine
- The non-adherent patient
- The difficult patient

Orthopedics/rheumatology

- Knee pain
- Shoulder pain
- Hip pain
- Low back pain
- Elbow pain
- Foot and ankle pain
- Gout
- Fibromyalgia
- Osteoarthritis
- Leg cramps

Pre-operative Assessment

- Cardiac
- Pulmonary
- Endocrine
- Endocarditis prophylaxis

Renal

- Renal stones
- Hypertension
- Urinary Tract Infections

Screening and Prevention

- Breast cancer screening
- Colon cancer screening
- Prostate cancer screening
- Osteoporosis: screening and management
- Cervical Cancer Screening
- Immunizations
- Influenza chemoprevention and treatment
- Primary prevention with ASA

Endocrinology

- Obesity
- Diabetes
- Thyroid nodule
- Hyperthyroidism
- Hypothyroidism

Geriatrics

- Urinary Incontinence
- Fall prevention
- Memory loss/dementia
- Geriatric Functional Assessment
- Screening in the Elderly

Neurology

- Headache
- Neuropathies
- Primary and secondary stroke prevention

Ophthalmology

- The Red Eye
- Cataracts
- Glaucoma

Otorhinolaryngology

- Tinnitus
- Hoarseness
- Sinusitis
- Pharyngitis
- Allergic rhinitis

Psychiatric disease

- Insomnia
- Anxiety
- Depression
- Somatization disorder
- Eating disorders

Public Health

- Population-based medicine
- Community resource utilization
- Understanding payment methods
- Domestic Violence

Pulmonary Disease

- Asthma
- Smoking cessation
- Interpretation of pulmonary function tests
- Chronic cough
- Positive PPD

Systemic Problems

- Unintentional weight loss
- Chronic Fatigue
- Lymphadenopathy

Travel Medicine

- Traveler's diarrhea

Urology

- Erectile dysfunction
- Benign prostatic hypertrophy
- Prostatitis
- Hypogonadism
- Microscopic hematuria

Contact Information

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Temple University Continuity Practice Assignments 2009-10

		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM		MOYER KIRKSEY	KAPLAN KRAEMER L WARD	CACCIAMANI COMERCI	GERSH PARANJAPE	MEYER HERRING COMERCI
PM	A	A1 - GERSH Abraham Worster Grinblat Patel, N Wu AUSTIN CHEN	A2 - S. WARD Bohm Kane Cherian Krahnke Singh FEINSTEIN KOLB	A3 - PEET Civic Kim, Joseph Cavallaro Lewis Ugbajah HAYWARD WEINBERG	A4 - LIN Sim Lathari Asamoah-Odei Lim Freidl AHULWALIA REMAKUS	A5 - L. WARD Hanley Soltani Sharma Freeman Kim, Chan CHANG NGUYEN
	B C	B1 - MEYER Escarcega Lee, E Caricchio Malik BAMAN YOO C1 - BRADY Alkhoul Khan Parameswaran Bhurki Gonzalez LUIS MENDONCA	B2 - BRADY Boyle Li Chi Czys NAVEED RILEY C2 - DOBERSTEIN FELDMAN Breish Machado Gupta Verrengia AFARI-ARMAH PATEL, C	B3 - L. WARD Eldakar Pargola Kretchman Vijayvergia BARNES MACCIOCCA C3 - SIMONCINI Man Reddy Garrett Modi Samimi NIEVES	B4 - KIRKSEY Luizaga Rivera Memon Logan MATHUR ORTEGA C4 - SIMONCINI Jain Manek Khawaja Tarabolous ALASFAR PRICE	B5 - PARANJAPE Goel Jacob Khayyam Moulder Sterling DOLL SIDDIQUI C5 - LIN Jaffe Oruganti Sun Yu GUZIEL PHONGANKUEL