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OVERVIEW OF EXPERIENCES, RESPONSIBILITIES AND CURRICULUM
Temple University Hospital Internal Medicine Residency
Ambulatory Block 2009-2010

Rotation Director: Shiva Chandrasekaran

Medicine Group Practice (4th Floor Clinic) Director: Larry Ward

Teaching Faculty: Tom Comerci, Karen Lin, Alisa Peet, Stephanie Ward

Chief Residents: Tim Doberstein, Gina Simoncini

Welcome to the ambulatory block rotation. The educational goals of this rotation are 1) to gain clinical skills and knowledge related to outpatient primary care and 2) to gain an understanding of practice based learning and systems based practice improvement through participation in specific projects. In addition, ambulatory residents evaluate and manage clinical information for patients of the medicine group practice and coordinate care with the patients' primary resident physicians.

The following summarizes the requirements components of the ambulatory block rotation:

Medicine Group Practice

1. Provide outpatient primary and emergency care for patients of the 4th Floor Medicine Group Practice (1 weekly continuity clinic and possible additional continuity practice sessions)
2. Review abnormal lab data/critical values, study results, mail, fax reports and other clinical information for your and your colleagues' patients; formulate *and document* plan of action (ideally with input from the patient's primary physician), and discuss with patient.

MGP Special Sessions

These are focused practice sessions in the Medicine Group Practice designed to provide residents an experience with common issues in outpatient practice. You will see patient scheduled for the specific session and routine EMG and FUP patients. They (may) include:

1. GYN Session (Preceptors: Gina Simoncini and Anastasia Gray. Each intern will have at least one session focused on women's health and prevention including cervical cancer screening (PAP tests), family planning, and STD counseling/prevention.
2. Hypertension
3. Motivational interviewing (smoking, alcohol or substance use)

Subspecialty Sessions

1. Attend assigned subspecialty clinical experiences (2-3 sessions per week)

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2. Review curriculum for each subspecialty assignment in ambulatory block folder

Projects and Presentations

1. R1 Screening Topic Review/R3 Health Maintenance Journal Club Presentations
2. R3 Primary Care Morning Report Presentation
3. Systems Based Practice Group (Quality Improvement) Project

Administrative Time

1. Administrative time without direct patient care responsibilities in which you are expected to 1) review colleagues' patient care related needs as above and 2) work on assigned projects and presentations (2-3 sessions per week)
2. Independent Study – You are expected to use this month as a time to focus on improving knowledge of common outpatient complaints and conditions. An extensive reading list of review articles, guidelines, and primary literature is available for your review in the **INT MED Residency Documents** Ambulatory Block folder (labeled “Reading List Ambulatory Medicine”). Please contact the chief residents if you do not see the **INT MED Residency Documents** icon on your desktop when you log into the TUHS network.

Please contact one of the faculty members below if you have any questions or concerns related to any aspect of the rotation.

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This document along with schedules, reading list, past resident presentations and other information is available in the INT MED Residency Documents folder (Ambulatory Block Folder).

Please see the following pages for detailed descriptions of the components of the rotation.

MEDICINE GROUP PRACTICE RESPONSIBILITIES
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Dr. Larry Ward is the Director of the 4th Floor Medicine Group Practice. Please speak with him if you have any questions or problems should arise during the course of your Ambulatory block. On the other hand, if he is not available or it is more convenient to discuss the matter with another attending, please feel free to do so.

PRIMARY CARE

1. You will have your typically weekly continuity clinic along with additional clinic sessions (depending on your PGY level). You will have both regular follow up and emergent care appointments during these sessions.
2. Your schedules while on ambulatory block will include same day “EMG” appointments for patients who need urgent care or are unable to make appointments with their PCP for various reasons. When providing urgent care or care for a patient who is not your patient, it is essential that you identify who the primary physician is (or assume care for the patient if you cannot) and ensure appropriate follow up. The care undertaken for emergency patients should be aimed at that complaint only and health maintenance left to the PCP.
3. For individuals who receive monthly prescriptions of opiates, NO OPIATE MEDICATIONS can be prescribed at a same day emergent care visit. They must make a regular appointment with their primary provider (or another provider in their firm if appointment not available). This is an overall practice policy and it is essential for the ambulatory residents to reinforce it. If you have any questions or have difficulties, discuss with the attending physician preceptor.

FIRM MAILBOXES

All ambulatory residents (AR) must work together to review the firm mailboxes daily. Within the group, plans must be made to take care of the charts that are put in the Ambulatory boxes by the end of the day. If your clinical responsibilities are finished for the day, arrangements must be made for someone to be available until at least 4:30 in the practice to manage last minute emergencies that may arise.

1. All radiology results, as well as all abnormal laboratory results (after review by the Nurse Practitioners), will be given to the AR to be reviewed.
 - a. If the result is abnormal and complex decisions are required, please contact (and document contact) the primary provider and consult with them about the appropriate plan of action.
 - b. If important communication with the patient needs to take place (i.e. breaking bad news) the primary MD should be the one to do it. Otherwise, the AR may contact patient and make appropriate clinical plans. Please make a reasonable effort to ensure primary physician is aware of and has input into plan (page if high priority, email, ensuring he/she will be in practice soon by checking IDX scheduling

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system, making appointment if none in system, etc.) and that this is documented either on the result form or in the chart.

- c. Once a result has been managed, please do not file the result back in the chart. All results should be placed in the PCP's mailbox.
 - d. If it is decided that a patient should be seen, all efforts should be made for that patient to see their PCP. If this is not possible, please arrange an acute appointment through one of the Nurse Practitioners, not through the front office secretarial staff. The NPs handle all appointments for patients who can not wait to see their PCP. An appointment with you would be the next best option to one with their PCP.
2. Faxes (home care, etc.) should be reviewed for accuracy and then signed off on and faxed. Home health care orders and all others that require a UPIN number or ask specifically for an attending's signature, may be placed in Dr. Larry Ward's mailbox.
 3. Phone messages should be addressed in a timely manner (ideally same day). Medication refills, however, may if necessary be returned within 48-72 hours en masse if necessary.

DOCUMENTATION AND COMMUNICATION:

Complete and legible documentation is essential. This is a major barrier to effective care in our practice. Telephone conversations, test ordering, referrals, etc. that you have with patients are important and essential for the primary provider or future urgent care providers to have access to when reviewing the chart. You may also use pre-prepared letters that can be used to inform them of lab results or can be used for brief instruction. If you are unable to reach a patient and you have tried multiple times or the old phone number is disconnected, you can send a certified letter/ or a telegram depending on the urgency of the message. Copies of correspondence that you mail out should be copied and placed in the chart progress note section. Please discuss any concerns or questions you have with attending physician preceptors. Please initial, date and note what action has been taken with paper work (indicate the date that you faxed a form, mailed a letter to come discuss results, or when you made appointments)

COMPUTER ACCESS

Temple has many different computer platforms with different login/passwords necessary to retrieve clinical information. It is absolutely essential that you have access to all clinical information systems in order to provide patient care. Please specifically make sure to have access to the IDX system (*scheduling- different from IDX radiology*) which allows you to view patient and provider outpatient schedules. **If you do not have access to this system or have lost access (due to not using for over 120 days), please contact Robin Alston at 2-4082 or email.** Please ask any faculty if you do not know how to use the system to retrieve scheduling information.

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SUBSPECIALTY EXPERIENCES
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Ambulatory block residents will be assigned to 1-3 weekly medicine/non-internal medicine subspecialty sessions. In most cases, you will be assigned to the same physician weekly for four weeks (this is not always possible). The goal is to gain experience, knowledge, and procedure skills that are relevant to outpatient medicine practice. Attendance at the sessions is required to meet the requirements of the rotation.

Please review the review articles and clinical practice guidelines for common outpatient problems related to each assigned subspecialty. These documents are stored in a subfolder titled "Subspecialty Curriculum" in the ambulatory block folder of the shared **INT MED Residency Documents** folder (found on your desktop when you login to the TUHS system at the hospital or remotely). Residents are expected to engage with the preceptor regarding these materials.

Please note that assigned subspecialty sessions take precedence over any other residency educational conferences including morning report. Residents are expected to be present at the session from the first scheduled patient (typically 8AM or 1PM) to the end of the session.

If there is an emergency and you are unable to attend a subspecialty session for any reason, please inform Dr. Chandrasekaran and the subspecialty preceptor as soon as possible and at least 48 hours prior to the scheduled session. Missing assigned subspecialty sessions without giving notice may result in you not receiving credit for the ambulatory block rotation.

Attendance at morning report on Mondays and Wednesdays is incorporated into the ambulatory block schedule for all residents.

At the end of the block, there will be scheduled time to give feedback about your experiences

Please contact Dr. Chandrasekaran if you have any questions, concerns, or problems with your subspecialty experiences.

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**SCREENING TOPIC PRESENTATION (R1) AND HEALTH MAINTENANCE
JOURNAL CLUB (R3) PRESENTATION
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All residents on ambulatory block are expected to review up to date health maintenance guidelines, evidence, and update the health maintenance information in their individual patient charts. Links to relevant information are available in the “links” section on the Blackboard site.

PLEASE REVIEW THE DIDACTIC CALENDAR SCHEDULE FOR YOUR ASSIGNED DATES FOR A HEALTH MAINTENANCE PRESENTATION.

Health Maintenance Topic Presentation (Interns): Chose a common screening related clinical issue in adult medicine practice. Briefly review the topic including screening recommendations including , data that supports screening, controversies that may exist, and any other issues that you would like to highlight. Use the USPTF web site www.ahrq.gov/clinic/uspstfix.htm as a guide if you are having trouble picking a topic. At the end of your presentation, focus on systems related issues for that topic including rate of screening at the local, state and national level and ideas to improve rates of screening in the Medicine Group Practice. Use the following sites as a start to find such data: <http://www.cdc.gov/node.do/id/0900f3ec8000ec28>
<http://www.dsf.health.state.pa.us/health/site/default.asp>

Health Maintenance Journal Club (Upper year residents): Choose a health maintenance issue with some controversy regarding clinical practice (for example, an issue for which different groups have conflicting guidelines). Identify one or two studies in the medical literature that directly bear on this issue. Review the study(ies) for the group. Focus more on the translation of the results to clinical practice rather than details about statistical analysis or study quality. The goal is to help your colleagues and patients make informed decisions about the issue.

Examples of controversies that would be appropriate to discuss and review evidence:

Should mammography screening begin at age 40 or 50?

Should all healthy patients over age 20 (NCEP) or only men over 35 women over 45 (USPTF, ACP) without other risk factors start lipid screening?

How should physicians present PSA screening to patients to allow for patient centered decision making?

What is the data supporting routine colonoscopy as opposed to flexible sigmoidoscopy/fecal occult blood testing for colon cancer screening?

Who should have cervical or breast or colon cancer screening be discontinued?

Should chemoprevention for breast cancer be offered to high risk patients?

What behaviors and/or medications should be recommended to patient at high risk for developing type 2 diabetes?

Please contact faculty *early in the block* if you are having trouble identifying a topic or relevant study.

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R3 PRIMARY CARE MORNING REPORT
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PLEASE REVIEW THE DIDACTIC CALENDAR SCHEDULE FOR YOUR ASSIGNED DATES.

Review previous resident presentations in the Ambulatory Block folder, (INT MED Res Documents) to get ideas for format and presentation.

Each R3 on ambulatory block will present a patient oriented clinical question and then use primary literature to answer the question. This will be a formal “Primary Care Morning Report Part A” presentation given to all residents. The clinical question should be based on a *real patient* seen by the resident in outpatient practice. The scenario should involve a specific diagnostic or management dilemma without an obvious “right” answer. The presentation should begin with a description of the patient and the clinical question. We encourage you not to choose a topic based on a recent “interesting article” and then ask a question based on the study.

Format: 20-25 minute presentation that begins with a description of the patient and the clinical question. One to three *relevant* articles from the primary literature should be reviewed. The talk should not focus on a detailed review of the literature – rather it should focus on how the findings in the literature relate to the specific patient and question. Do not present slides with large amounts of data or text – focus on the big picture. Include consideration of patient’s personal values. The presentation should end with a return to the specific patient that prompted the question along with a *clear commitment to a course of action for the specific patient based on a summary of the available evidence*. A major goal of this exercise is for the resident to formally describe the clinical decision making process in the absence of “perfect” evidence. Limit presentations to ~ 20 slides or so to ensure it is completed in 25 minutes.

Examples of previous Clinical Questions:

Should a 55 year-old woman with gastritis but no ulcer on EGD with H. pylori positive biopsies be treated with triple therapy antibiotics and PPI?

Should a 36-year old woman with first idiopathic DVT be anti-coagulated for 6 months then monitored for recurrence or indefinitely? At what target INR?

Should a 62-year old male with a history of elevated PSA and negative prostate biopsy be followed with repeat PSA testing? If so, at what threshold is a repeat biopsy indicated?

Should a 54-year old woman with type 2 diabetes and Hgb A1C of 8.4 on maximal doses of two oral medications be started on insulin glargine or insulin NPH or an insulin NPH mix formulation?

Should a 72-year old male with history of stroke and carotid stenosis who is not a surgical candidate and has never been observed to have atrial fibrillation be treated warfarin rather than anti-platelet therapy?

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Should a 74-year old woman with early dementia be treated with donezepil or memantadine or neither?

Should a 68-year old woman with osteoporosis by bone mineral density screening started on bisphosphanate have repeat bone density scanning? If so when and how often?

Should a 58-year old male with coronary disease who develops myalgias on statin therapy safely be switched to another statin? If so which statin(s) are preferred?

Should patients with atrial fibrillation with indications for anticoagulation based on CHAD score and known stable vascular disease (history of MI, angina, history of ischemic stroke, claudication) be on warfarin or warfarin + aspirin. Does the benefit of adding aspirin outweigh the additional bleeding risk?

Are there adverse consequences to long term PPI use in the elderly for mild dyspepsia/heartburn?

What are the indications for coronary stenting in patients with stable coronary disease and single or mild two-vessel disease who do not have angina or LV dysfunction?

In type 2 diabetes patients on metformin whose A1C is above goal, is going straight to insulin more efficacious and better for long term glycemic control than using second line oral agents (e.g. sulfonylureas)?

In patients with dyspepsia and suspected peptic ulcer disease but no melena or anemia is a "test and treat" (H pylori antibody) strategy safe and more cost effective than referral for endoscopy?

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SYSTEMS BASED PRACTICE (GROUP PRACTICE IMPROVEMENT) PROJECT
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This is a longitudinal group project designed to expose residents to the concepts of systems based practice and quality improvement including problem identification, systems walk, analysis of possible root causes, and development of detailed implementation plan for change. A secondary goal is to study and focus on real issues affecting the care of patients in the medicine group practice and create sustainable changes that can improve care.

Ambulatory block faculty select an issue affecting care in the practice and present to each group engaged in the project. This initial presentation includes faculty concerns about patient care and long term goals for improvement. The first group is given specific goals of problem definition, systems walk (listing all processes that occur in the current system related to the issue being studied) and an initial evaluation of the scope of the problem (typically involving an audit of charts or events). The initial group then presents their data at the end of the rotation and guides the following group to study possible root causes that should be addressed.

The next 2-3 groups are instructed engage in further refining of the problem and systems walk and detailed root cause analysis with guidance from previous groups and ambulatory block faculty. Identifying the root cause involves both *qualitative* (interviews, personal experience, anecdotes) and more importantly *quantitative* study. Techniques might include chart audits, patient care observations and audits, surveys of physicians/staff/patients, etc. Residents are also tasked with detailed literature review related to the issue to identify published material that might be relevant to the Medicine Group Practice. Residents are also directed to identify Temple University, Philadelphia, state, and national resources available to improve care related to the problem.

As the groups identify root causes, appropriate literature/tools that could be incorporated into practice, and resources available to help improve care, faculty guide the final group(s) towards designing a multifaceted solution proposal. Residents are expected to consider data from previous groups, colleagues, attending physicians, patients, staff and practice plan/health system employees as they design this detailed plan that is feasible and sustainable. They are also expected to specify specific measurable goals in a specific time frame including a mechanism for assessment.

Ambulatory block faculty refine the solution proposal with the goal of real implementation – ideally in the same or the following academic year. Faculty and residents active in the project present findings from the project to the entire residency as implementation nears – through email, the morbidity and mortality conference, ambulatory conference, etc. Residents involved in the project see the fruits of their labor with real implementation and are asked to actively monitor success of the initiative. Ideally, the project becomes more than an academic endeavor – one that improves patient care and resident ownership of their practice

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ADMINISTRATIVE TIME
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- 1) Work on assigned individual or group projects/presentations
- 2) Reviewing labs, studies, and correspondence from Firm mailboxes as needed
- 3) Use this time to improve the quality of care you provide to your patients:

These sessions should also be used to accomplish the following goals:

- 1) Complete your flow sheets by making sure your diagnoses, medication lists and health maintenance are up to date. (**MAKE A NEW ONE if the old one is old and confusing for you**)
- 2) Note down for yourself issues that need to be addressed at the next visit
- 3) Obtain hard copies of mammograms/ PAP/ colonoscopy, etc. reports/ consultations that you need
- 4) **DUPLICATE** reports should be removed
- 5) Review chronic diagnoses to be sure of accuracy.
- 6) Reorganize charts correctly so that you can save time and be accurate when you care for patients in future

INDEPENDENT STUDY/CURRICULUM

All materials for the ambulatory block rotation are stored in the **INT MED Residency Documents** Ambulatory Block folder.” This should automatically be on your desktop when using your network login to the TUHS Windows system directly or through access.templehealth.org (go to “Desktop Shortcuts” after logging in). If you do not see the folder, please contact the chief residents. Materials include schedules, goals and objectives, detailed descriptions guidelines for presentations along with past presentations, and an extensive reading list on core topics in outpatient medicine.

Residents are expected to independently review these materials during the rotation to improve your fund of knowledge and clinical reasoning skills related to common issues faced in outpatient practice.

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**EVALUATION FORM (FACULTY OF RESIDENT)
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Scale:

(1) Unsatisfactory, (2) Deficient, (3) Marginal, (4) Approaching Expected,
(5) Expected, (6) Above Expected, (7) Very Good, (8) Excellent, (9) Exceptional

PATIENT CARE

Medicine Group Practice Responsibilities

1-3

Minimal motivation and cooperation with other members of team to triage phone messages and other clinical information appropriately; at times provided poor clinical care; often was not present in practice to assist colleagues during administrative time.

4-6

Satisfactorily worked with other ambulatory block residents to review and act upon patient phone messages, lab results, study results and other clinical information in a timely manner.

7-9

Exceptionally thorough in evaluating and acting upon incoming phone messages, lab reports and study reports; efficiently utilized all available resources to coordinate and communicate care with primary care physician.

N/A

PRACTICE BASED LEARNING AND IMPROVEMENT

R3 Primary Care Morning Report

1-3

Chose topic that was extremely narrow or broad; summarized single source of information without review of primary literature; gave poorly organized presentation with inaccuracies and/or irrelevant information; did not focus on practical clinical decision making.

4-6

Performed thorough literature review for a primary care topic/clinical question; gave presentation that was accurate, clinically relevant, and focused on practical clinical decision making.

7-9

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Presented exceptionally organized presentation including succinct background information based on thorough review of primary literature; initiated thoughtful discussion of implications for clinical practice.

N/A

Health Maintenance Topic Review (R1)/Journal Club (R3) Presentation

1-3

Gave superficial presentation of health maintenance topic without discussion of practical clinical material or controversies; did not discuss ideas to improve practice

4-6

Gave thorough and practical presentation of selected health maintenance topic, discussed basic ideas to improve practice, accurate review of relevant studies.

7-9

Gave presentation based on thorough review of guidelines and primary literature; discussed well-reasoned systems change proposal to improve practice, sophisticated discussion of relevant research and implications for clinical care.

N/A

SYSTEMS BASED PRACTICE

Systems Based Practice (Quality Improvement) Project

1-3

Showed no interest in learning systems based practice concepts; minimal participation with other residents on project; presented superficial root cause analysis and vague proposal for systems change.

4-6

Participated with other members of ambulatory block to effectively review assigned problem; designed and implemented thoughtful root cause analysis; conceived of feasible, multifaceted solution to improve practice.

7-9

Expressed sophisticated understanding systems based practice concepts; enthusiastically participated with and/or led group in analyzing root causes; sought out practice administrators, staff, preceptors and colleagues to gain better understanding of issues; presented comprehensive plan to improve practice along with mechanism to assess success.

N/A

Overall Performance (1-9)