



FLORIDA HOSPITAL
EAST ORLANDO

**CURRICULUM
MANUAL**

Department of Medical Education
July 2010

TABLE OF CONTENTS

Program Description	8
<i>I. Continuity of Care</i>	<i>8</i>
<i>II. Family Medicine Residency Training Services</i>	<i>8</i>
A. Family Medicine Residency Services (FMRS).....	8
B. Pediatric clinics and inpatient service	8
C. OB/GYN Service.....	8
<i>III. Month Long Clinical Rotations.....</i>	<i>8</i>
<i>IV. Didactics</i>	<i>9</i>
<i>Residency Features</i>	<i>9</i>
General Information.....	10
<i>Clinical Conferences.....</i>	<i>10</i>
<i>Hospital Care.....</i>	<i>10</i>
<i>Core Curriculum.....</i>	<i>10</i>
1. Category 1 (OMGME - 3).....	10
2. Category II (OMGME - 2).....	10
3. Category III (OMGME - 1).....	10
<i>Evaluation</i>	<i>11</i>
<i>Ambulatory Care Training.....</i>	<i>11</i>
Core Curriculum	11
<i>Ambulatory Family Medicine (mandatory)</i>	<i>11</i>
I. Educational Objectives	11
II. Plan.....	12
<i>Longitudinal In-Hospital Service.....</i>	<i>12</i>
I. Educational Objectives	12
II. Plan.....	13
<i>Osteopathic Manipulative Concepts</i>	<i>13</i>
I. Educational Objectives	13
CATEGORY I	13
A. Concepts.....	13
B. Skills (mandatory)	13
CATEGORY II (recommended).....	13
A. Concepts.....	14
B. Skills.....	14
II. Plan.....	14
Article V – Program Requirements	14
A. <i>Synopsis</i>	14
B. <i>Principles of Osteopathic Family Medicine</i>	14
1. Continuity of Care.....	15
2. Osteopathic Comprehensive Health Care	15
C. <i>Component Sections of the Core Curriculum</i>	15
1. General Information.....	15
2. Continuity of Care Training Site.....	15
Synopsis	16
1. Facility	16
2. Patient Pool for Continuity of Care	16
3. Scheduling of Continuity of Care	16
B. Goals.....	17
C. Objectives.....	17
3. Hospital Care	19

A. Synopsis	19
B. Goal:	19
C. Objectives:.....	19
4. Osteopathic Principles and Practice.....	22
A. Synopsis	22
B. Goals:	22
C. Objectives:.....	22
5. Behavioral Science.....	23
A. Synopsis	23
B. Goals:	23
C. Objectives:.....	23
6. Health Care Systems	26
A. Synopsis	26
B. Goal	26
C. Objectives.....	26
Specifics of Resident Rotations.....	27
<i>Ambulatory Continuity Training – Family Health Center East (FHCE)</i>	27
I. Educational Objectives	27
II. Plan.....	28
General Information.....	28
Administrative Resident (AR) - FHCE.....	28
Dress Code Policy.....	29
Electronic Medical Records (EMR).....	29
Family Medicine Guidelines for using EPIC at Family Health Center East	29
Pediatrics Guidelines for using EPIC at Family Health Center East	30
Computers Down	30
Chiefing and Video-Monitoring	30
Patient Schedules/Resident Duties.....	30
Changes to Schedules and Templates	31
Late for Appointment Policy	31
New vs Established Patient Amendment	32
Dismissal Policy.....	32
No Show Policy	33
Call – Ambulatory Clinic After Hours (Weeknight and Weekend)	33
Telephone Call Responsibilities	33
The Compliance Program	34
Resident Responsibilities	34
Abnormal Tests (Labs/X-Rays/Reports).....	35
Unresulted Orders Follow Up.....	35
At Office Visits	35
Unresulted Orders Reports.....	35
Motor Vehicle Accidents (MVA) and Workman Compensation (WC) Policy	35
Attention Deficit Hyperactivity Disorders	36
911 Acute Referrals	37
Medical Group Billing for Diabetes Group	37
Pharmaceutical Samples Guideline.....	37
Medication Discount Cards.....	38
Chart Completion Policy.....	38
Policy for Treating Clinic Staff.....	39
<i>Family Medicine Residency Service (FMRS)</i>	39
Synopsis	39

Goal.....	39
Objectives	39
OGME-2 and OGME-3 FMRS Resident Duties	40
OGME-1 Resident Duties.....	40
Medical Extern Duties	41
Orders.....	41
FMRS Admissions	42
General.....	42
Emergency Department Admissions.....	42
Clinic Admissions.....	43
Community Physicians	43
Consultation Services provided by FMRS.....	44
Consultation Orders	44
Discharge from the FMRS Service.....	44
Adverse Drug Events	45
FHCE Patients:.....	45
Non FHCE Patients.....	45
Home Care	45
<i>Behavioral Medicine / Psychiatry</i>	49
Process	50
Objectives for the 2 rotations and the longitudinal clinic experience.....	51
Evaluation	51
Recommended Reading/References	51
<i>Cardiology/Critical Care</i>	55
Objectives	55
<i>Dermatology</i>	58
Objectives	58
<i>Elective I – V</i>	58
Synopsis	58
Goal.....	59
Objectives	59
OGME-1 Residents.....	59
OGME-2 Residents.....	59
OGME-3 Residents.....	59
OGME-4 Residents.....	60
<i>Elective Options</i>	60
Allergy and Immunology.....	60
Community Medicine	60
Goal.....	60
Objectives	60
Endocrinology.....	60
Hematology.....	61
Infectious Disease	61
Nephrology	61
Neurology	61
Oncology.....	64
Ophthalmology	64
Otolaryngology	64
Radiology.....	64
Goal.....	64
Objectives	65

Rheumatology	65
Sports Medicine	65
Synopsis	65
Goal.....	65
Objectives	65
<i>Emergency Medicine/Radiology I</i>	65
Synopsis	65
Goal.....	65
Objectives	66
<i>ENT</i>	70
<i>Geriatrics</i>	70
Synopsis	70
Goal.....	70
Objectives	70
<i>Gastroenterology</i>	75
Objectives	75
<i>Gynecology I and III</i>	78
Synopsis	78
Goal.....	78
Objectives	79
Gynecology I.....	79
Gynecology III.....	79
<i>Gynecology/Oncology I and II</i>	79
<i>FM/NMM Residency (FM Requirements as per FM Manual) Neuromusculoskeletal Medicine</i> <i>(NMM) Requirements</i>	79
Resident Responsibilities	79
Resident Supervision	80
Inpatient Consultation OMM service.....	80
Documentation	80
NMM Continuity Clinic.....	80
Neuromusculoskeletal Medicine Requirements	81
Neuromusculoskeletal Medicine Schedule	81
OGME-2	81
<i>Administrative Resident</i>	81
OGME-3	81
<i>Administrative Resident</i>	81
OGME-4	82
<i>Elective</i>	82
Scientific Clinical Investigation.....	82
Logs.....	82
Didactic Sessions	82
Lectures & Presentations	83
<i>Nights/IM/FMRS/Pediatrics</i>	83
OGME-1 Residents.....	83
Residents.....	83
<i>Obstetrics/Gynecology</i>	83
Synopsis	83
Goal.....	84
Objectives	84
<i>OMM</i>	88
Synopsis	88

Goals	88
Objectives	88
<i>Orthopedics / Sports Medicine</i>	90
<i>Pediatrics</i>	93
Synopsis	93
Goal.....	93
Objectives	93
Hours.....	94
Hospital Rounds.....	94
Hospital Responsibilities	94
Clinic Responsibilities	95
Extern Responsibilities	95
Additional Responsibilities for Externs and Residents.....	95
Ambulatory Call – Residents	95
OGME-1 Residents.....	95
OGME-1 Resident Responsibilities.....	96
Residents.....	97
OGME-2 Resident Responsibilities.....	97
OGME-3 and OGME-4 Resident Responsibilities	97
<i>Pharmacotherapy</i>	101
Goals	102
Process	102
Objectives	102
Evaluation	103
Recommended Reading/References	103
<i>Practice Management/Radiology</i>	103
Process	103
Evaluation	104
Goal.....	104
Objectives	104
Core of Knowledge.....	104
Skills	106
Required Reading.....	106
Recommended Reading	106
<i>Pulmonology/Critical Care</i>	106
Objectives	107
<i>Surgery</i>	107
Synopsis	107
Goal.....	108
Objectives	108
<i>Surgery Elective</i>	112
<i>Urology</i>	113
Objectives	113
<i>Procedures</i>	113
Synopsis	113
Goal.....	113
Objectives	113
Research and Scholarly Activity Requirements.....	114
Related Nonclinical Areas.....	116
<i>Economics</i>	116
Educational Objective.....	116

<i>Epidemiology</i>	116
Educational Objectives	117
Category II and III	117
Concepts.....	117
<i>Sociological Concepts in Health</i>	117
I. Educational Objectives	117
<i>Computers in Medicine</i>	117
I. Educational Objectives	117
Category I, II, and III	118
A. Concepts.....	118
B. Skills.....	118
Protocol for Conferences and Papers	118

PROGRAM DESCRIPTION

Florida Hospital East Orlando's Family Medicine Residency Program emphasizes training Residents in clinical skills, medical knowledge and the Family Physician's thought processes. This training develops competence through hands-on experiences which stress ambulatory and preventative care. This education process is in preparation to maintain them through the Health Care evolution expected during their professional life.

The Family Medicine Residency program consists of four components:

I. Continuity of Care

The focus of the whole program is the longitudinal primary care experience obtained at the Family Medicine Resident Clinic, Family Health Center East. The clinic encourages the development of a patient panel for each trainee throughout their residency program. Residents apply the knowledge obtained from other program components to their own panel of patients. Initial visits for a Resident vary: walk-ins, established, old, young, acute, chronic, indigent, insured, Medicaid, Medicare, or managed care patients. Full-time and part-time board certified Family Physicians supervise the care. All patients' medical care is reviewed, discussed, and countersigned by the Attending faculty. Ambulatory training in procedures occurs at the clinic or through specialty supervised consultations. Discussions of clinical and management problems in ambulatory and managed care settings occur when indicated and appropriate. CMS guidelines as it pertains to the teaching program are adhered to closely.

II. Family Medicine Residency Training Services

Florida Hospital East Orlando's Family Medicine Residency Program operates three training services:

A. Family Medicine Residency Services (FMRS)

This service admits patients from the continuity of care clinic (FHCE), unassigned patients from the Emergency Department and referrals from specific Family Physicians. Two full-time Board Certified faculty Internists, and Family Physicians supervise the care which is provided by Family Medicine Residents. Patients are assigned to the Family Medicine Residents from admission to discharge to formulate and direct care. The majority of the patients are discharged into the Residents' panel of patients at the Family Health Center East. The Internists direct Morning Report two days a week with discussion of patients admitted to this service.

B. Pediatric clinics and inpatient service

This component provides clinical experience with both inpatient and ambulatory Pediatric patients. Our full time faculty Pediatricians supervise all inpatient and ambulatory patient care. The ambulatory Pediatric care is provided at FHCE. Family Medicine Residents care for the clinic's patients. Inpatient newborn and neonatal care experience is at Winter Park Memorial Hospital with inpatient pediatrics at FHEO.

C. OB/GYN Service

This component of the program provides clinical, hands-on experience in all aspects of prenatal care, postnatal care, and deliveries. The Loch Haven OB/GYN group is utilized for this service. The group is composed of seven, full-time faculty OB/GYN physicians. Deliveries are performed on the Labor and Delivery floor of Florida Hospital Orlando. Pathologic paps and other gynecological problem cases from the Family Health Center East will be referred there for medical care and training.

III. Month Long Clinical Rotations

Residents observe and assist Family Physicians and other specialists with the medical care of their patients. Rotations emphasize ambulatory treatment and involvement with inpatient admissions and care where appropriate. The ACOFM requirements in Internal Medicine and Surgery for the Family Medicine Residency may be met through training with General Internists, General Surgeons, or subspecialists in:

Cardiology
Dermatology

Infectious Diseases
Nephrology

Gastroenterology
Gynecology
Hematology
Plastic Surgery
Podiatry
Podiatry
Pulmonology

Neurology
Ophthalmology
Orthopedics
Otolaryngology
Rheumatology
Urology
Surgery

Orange County Public Health Department provides Community Medicine and STD training experiences. Emergency Medicine rotations in Florida Hospital East Orlando's Emergency Department exposes Residents to approximately 60,000 visits per year. The Emergency Department hires full-time physicians who supervise the care and training. The Emergency Department operation and standards are directed by Board Certified Emergency Physicians. OMM Rotations are required with physicians who practice exclusively OMM or those who extensively integrate it into patient care. At least one month of a Geriatric rotation is required. Other required rotations and electives are based on each Resident's weaknesses, interests, future practice plans, and program requirements. Elective rotations or moonlighting in potential future practice locations is encouraged. Moonlighting is permitted to stimulate confidence, challenge Residents and expand their knowledge, skills, and experiences; but must not interfere with Residency services and responsibilities.

IV. Didactics

A comprehensive didactic program is an essential component of the Family Medicine Residency Program. Educational sessions are held each Wednesday afternoon from 12:30 – 5:00 PM. The following core areas are covered: Internal Medicine, OMM, Pediatrics, Women's Health, Behavioral Medicine, Pharmacology, Ortho / Sports Med, Geriatrics, Surgery, Dermatology, Family Medicine, Procedural Workshops, Legal / Practice Management, EBM workshops. Full-time faculty or Family Medicine Residents lead case or topic discussions at any open sessions. A comprehensive morning report program is held once a week by our faculty Internist(s). Residents are required to attend 2/3 of the monthly Tumor Board presentations which are held at FHEO. Residents participate in Family Medicine department and Medical Staff meetings. Additional teaching through formal and informal discussions occurs on rotations and in the clinics. Assigned literature or reference reviews on current patients or topics are presented to the Attendings or at formal lecture sessions.

Residency Features

- Eight (8) Resident positions for each year (6 FM and 2 FM/NMM)
- Florida Hospital's 2200-plus bed resources, finances and stability
- Community hospital setting
- Full-time paid faculty in Family Medicine, Internal Medicine, Pediatrics, Pharmacy, Geriatrics, OMM and Behavioral Medicine
- Part-time paid faculty in Surgery
- Large volunteer faculty
- Residency clinic in Family Medicine, Pediatrics, Geriatrics, and OMM
- Continuity of care in Family Medicine Clinic
- Emphasis on training in ambulatory setting
- Family Medicine inpatient service for hands-on patient management
- OMM inpatient consultation service
- Procedural training at FHCE
- Annual Mission Trips
- A friendly flexible scheduling and a relaxed atmosphere
- Elective rotations available in many specialty or subspecialty areas
- *East Orlando Osteopathic Foundation* supporting extra financial needs of the program
- Moonlighting permitted
- An Osteopathic philosophy taught, modeled, and integrated

GENERAL INFORMATION

A portion of the training time is spent providing comprehensive primary care for patients in an ambulatory setting. The main emphasis of the program is training in the care of “ambulatory patients” as opposed to care of hospitalized patients. This is not to exclude totally the care of patients in the hospital as one of the basic capabilities of a family physician, but this is only a secondary purpose of the program. It is recognized that family physicians do their majority of patient care in an ambulatory setting and that it may be more advantageous for the “young” family physician to learn outpatient management in the ambulatory setting. The Residents are assisted in developing an understanding of the workings of a family medicine. The Residents are encouraged to participate in all aspects of originating and establishing a practice.

Clinical Conferences

Residents have the opportunity to attend postgraduate courses in areas of their choice, as well as those portions of the ongoing medical education of the hospital which are deemed to be of interest or need.

Hospital Care

The Residents have the opportunity to care for patients who have been hospitalized from their office practices. These patients are cared for by the Resident under the supervision of the certified specialists who are involved in the Program.

Core Curriculum

Realizing flexibility in curriculum is desirable and necessary, a basic core exists to provide a comparable educational experience for all graduates of the program. The expected goal of Family Medicine education is to train a physician who can handle 95% of the clinical problems presenting to his office and give him the knowledge and behavior skills to render continuing and designed as a general guide to concepts and skills that should be acquired while in a residency. It is also necessary for the Resident to learn personal limitations. The core curriculum concept can be divided into three categories and defined as follows:

1. Category 1 (OMGME - 3)

- A. Concept implies competency in evaluation and management in this particular area in 95% of the cases.
- B. Skills imply the ability to order, perform, and interpret procedures without consultation in 95% of the cases. A complete and adequate history and physical examination should be able to be performed in each of the specialty areas.

2. Category II (OMGME - 2)

- A. Concept implies that consultation may be required for some part of the management in this area.
- B. Skills imply that the physician recognizes the need for the procedure but may require consultation to perform or interpret the results.

3. Category III (OMGME - 1)

- A. Concept implies some knowledge, professional awareness of, but not a full understanding of the problem, and consultation would be required for diagnosis and management of specific problems in this area.
- B. Skills imply the professional awareness of the existence of the procedure; however, consultation is necessary for the performance of and/or interpretation of the procedure.

Evaluation

Residents prepare a summary of their experiences following completion of their outpatient experiences. Efforts are made to determine to what degree objectives have been met and suggestions offered for improvements or modification of the ambulatory care experiences.

Ambulatory Care Training

The Residents observe and work with generalists, as well as specialists, in an effort to improve and expand their knowledge of ambulatory care. One objective of this portion of the program is the development of guidelines to evaluate progress in the management of patients in an ambulatory setting. An added benefit is the communication created, allowing for improvement of referral methods and practices. The most common diagnoses in the ambulatory area are emphasized. The twenty most frequently seen reasons for seeking health care in the ambulatory setting are, in order: (*mandatory*)

1. Health Maintenance
2. Respiratory Infections
3. Pharyngitis
4. Hypertension
5. Otitis Media
6. Prenatal Care
7. Allergic Rhinitis and Asthma
8. Lacerations and Wound Management
9. Abdominal Pain
10. Diabetes Mellitus
11. Urinary Tract Infection
12. Sprain and Strains
13. Contusions and Abrasions
14. Obesity and Nutrition
15. Ischemic Heart Disease
16. Mental/Nervous Disorders and Substance Abuse
17. Back Pain
18. Dermatologic Disorders
19. Fractures
20. Arthritis and Joint-Related Disorder

Although an effort is made to provide a baseline of specialty training, the Residents are allowed great flexibility in selection of the areas where they wish to do elective training.

CORE CURRICULUM

Ambulatory Family Medicine (mandatory)

I. Educational Objectives

1. To learn the skills and art of providing ambulatory care and being able to care for 95% of the problems which are presented to him/her. These include but are not limited to:
 - Medical examination, no disease detected
 - Prophylactic immunization
 - Acute upper respiratory tract infection
 - Acute otitis media
 - Abdominal pain
 - Laceration, open wound
 - Hypertension, uncomplicated

- Low back pain without radiating symptoms
 - Hay fever
 - Bronchitis and bronchiolitis, acute
 - Cystitis and urinary tract infection
 - Contraception
 - Vaginitis
 - Prenatal care
 - Anxiety neuroses
 - Diagnosing pregnancy
 - Chronic and serious otitis media
 - Depressive neurosis
 - Boil and cellulitis
 - Advice and health maintenance instruction
 - Pain in joint
 - Bruise, contusion
 - Eczema and allergic dermatitis
 - Chest pain
 - Strep throat, scarlet fever, erysipelas
 - Influenza
 - Pain in limb
 - Rash and other nonspecific skin eruptions
 - Somatic dysfunction
2. Learn the necessity of time budgeting and how to effectively handle a normal case load during the day
 3. Develop management skills and a working knowledge of business and personnel management
 4. Increase the expertise of the Resident in:
 - Methods of referring patients
 - Methods of counseling
 - Providing patient education
 - Delivery of osteopathic manipulative therapy
 - Diagnosis and treatment of all age group patients
 - Providing preventative measures for a varied patient population
 5. Develop a thorough understanding of a family oriented master problem list type of medical chart
 6. Become familiar with the evaluation for industrial injury and appropriateness of return to work
 7. Become familiar with the basic guidelines for reporting communicable diseases
 8. Incorporate Patient Safety initiatives

II. Plan

The Resident starts training with a patient base of families and is responsible for their care throughout the training. In addition to the base of patients, each Resident acquires new patients as they present to the Family Medicine Center. As the skill and proficiency of the Resident improves, there is an increasing patient load so that by the end of the training the Resident can manage 20 patients per day. This equips the Resident to be successful in private practice.

Longitudinal In-Hospital Service

I. Educational Objectives

1. To appropriately seek consultation and follow the patient with the specialist
2. To gain a clear understanding of continuity and the importance of maintaining this during the transition from hospital to home or other ambulatory facility
3. Sharpen skills learned in previous hospital rotations and to document management experiences for credentials for future hospital privileges

II. Plan

All patients from the ambulatory family medicine setting described previously will be managed by the Resident who is the physician of record for that family unit. He/she is supervised by the ambulatory faculty.

Osteopathic Manipulative Concepts

I. Educational Objectives

Osteopathic education must play a key role in the curriculum of the family medicine residency program. Training should be provided in both the inpatient and ambulatory care settings. In developing a format to teach these principles, it will be stressed that osteopathic care does not imply specific manipulative techniques for specific problems. Rather, this format should enable the Resident to integrate the osteopathic philosophy into daily patient care. The philosophy is centered around the concept of body unity, the interrelationship of structure and function and the body's inherent neuropsychological healing capacity. The concept of holistic medicine is one that will be emphasized throughout this residency program.

CATEGORY I

A. Concepts

1. The role of the musculoskeletal system in disease
 - Somatovisceral reflex
 - Viscerosomatic reflex
 - Somatosomatic reflex
 - Viscerosomatovisceral reflex
 - Regional involvement
 - Alterations in body framework
 - Trauma
2. Philosophy of Osteopathic Manipulative Treatment (OMT)
3. Contraindications to OMT
 - Absolute
 - Relative

B. Skills (mandatory)

1. Differential diagnosis of findings
2. Methods of treatment
 - High-velocity low-amplitude (HVLA)
 - Muscle energy (Controlled Isometric Contraction)
 - Strain/Counterstrain (Spontaneous release by positioning)
 - Soft tissue
 - Physical therapy modalities
3. Utilization of x-ray and lab studies
4. Planning treatment regimens
5. Rehabilitation

CATEGORY II (recommended)

A. Concepts

1. The role of the Musculoskeletal System in disease
2. Philosophy of OMT
3. Contraindications to OMT

B. Skills

1. Care of the hospitalized patient
2. Treatment of children
3. Specialized techniques
 - Myofascial Release
 - Craniosacral
 - Indirect Techniques

II. Plan

1. Perform examination and treatment under supervision
2. One-on-one tutorial instruction in manipulative techniques
3. Attend lectures and utilize audiovisual presentations

ARTICLE V – PROGRAM REQUIREMENTS

A. Synopsis

1. All educational experiences shall be developed by the osteopathic family medicine faculty, with the assistance of other specialties as needed.
2. All required resident rotations must be educational in nature and properly supervised. Residents shall not be removed from rotations to perform unrelated institutional services.
3. Each individual program must have the required core curriculum as contained in this document. Specific curricular components may vary to allow each program to utilize local strengths. Weekly educational conferences must be a part of all core curriculum.
4. Any major change to an osteopathic family medicine residency program must be approved in writing by the Committee on Evaluation and Education of the A.C.O.F.P. prior to implementation. Requests for changes must include the educational impact of any request and documentation that the educational process will not be compromised by said change. Changes must be approved in advance. Major changes are defined as: a new Program Director or changes not consistent with these basic standards.
5. There shall exist in every osteopathic family medicine residency training program a required and structured curriculum. This shall incorporate the educational objectives listed in these basic standards. Each phase of the curriculum shall be properly allocated as to time, either longitudinally or as an intensive experience of shorter duration.
6. The following "core" curriculum is required. In addition to this portion of the training, each program is to define those areas of instruction that are unique to that specific program.
7. Specific methods of teaching and evaluation with written objectives and goals for each portion of the curriculum shall exist.
8. The residency training shall be three (3) years or thirty-six months in duration and shall meet all of the minimum basic requirements. During the residency training program, emphasis should be placed on ambulatory and longitudinal comprehensive patient care, with a strong didactic component as an integral part of the program. The program should encourage flexibility in meeting the needs of each resident.
9. Pilot or experimental programs and/or projects will be considered. Proposals must demonstrate equivalent training to the basic program as outlined in this document. All such proposals must be approved in advance by the Committee on Evaluation and Education of A.C.O.F.P.

B. Principles of Osteopathic Family Medicine

Family-oriented comprehensive care with demonstrated emphasis on continuity shall be an integral part of each curricular component. Residents must be taught to demonstrate and articulate osteopathic family medicine concepts to patients and colleagues.

1. Continuity of Care

Each program shall instruct residents of the importance of the interrelationship among the physician, the patient, the patient's family, the community, and the health care system.

Learning continuity of care is not limited to the continuity of care site and the hospital. For those patients unable to visit the continuity of care site, appropriate assignment to resident panels will be made in order to provide the resident with experience in home care and care in long-term care facilities.

Each resident is expected to maintain continuity of responsibility for his/her patients when such patients require hospitalization or consultation with other health care providers. The resident must maintain active participation in the decisions involving the health of the patient.

2. Osteopathic Comprehensive Health Care

Recognizing the validity of the principles of osteopathic medicine, especially that of treating the whole person, each program will provide the opportunity for the resident to gain a thorough understanding of the role social, cultural, behavioral, spiritual, and biologic dimensions play in the health of the individual.

Structure and function are integrally related. With this relationship intact, the body has the capacity to maintain health. The resident shall be provided the opportunity to achieve competence in health maintenance and disease prevention, utilizing the principles promoted in the osteopathic philosophy.

Health promotion and disease prevention is a major responsibility of the family physician. Teaching this to residents is an essential part of each component of the curriculum. This shall be done through stressing health assessment, health education, preventive care, behavioral counseling, genetic counseling, the role of the family in the care of the patient (especially end of life care), aging, nutrition, and epidemiology of illness, as well as acute and chronic disease management.

Methods of record keeping that facilitate longitudinal, comprehensive, preventive care shall be utilized. The resident will be taught the importance of this as it relates to health promotion and quality of care assessment.

C. Component Sections of the Core Curriculum

1. General Information

Recognizing that family physicians do the majority of their patient care in an ambulatory setting, the major portion of the training time must be spent providing comprehensive primary care for patients in that setting.

Flexibility in curriculum is desirable and necessary. A basic core exists to provide a comparable educational experience for all graduates of the program. The expected goal of osteopathic family medicine education is to train a physician to manage the majority of the patients presenting to his/her office and to provide the opportunity to acquire the knowledge and behavioral skills to render continuing and comprehensive health care to those patients. This curriculum is designed as a general guide to concepts and skills that should be acquired while in a residency. The curriculum assumes a three year integrated program, inclusive of an A.O.A. approved internship or its equivalent. Other sequences of educational experiences may result in deficiencies that would have to be corrected in order to attain the level of experience listed. Each of the topics listed on the following pages must be included in every residency program.

For each component section of the curriculum, a set of basic competencies has been identified. These should set the standard for the performance skills of all residents. These competencies can be found in the Competency Based Evaluation (CBE) document.

2. Continuity of Care Training Site

Synopsis

The "core" of the osteopathic family medicine curriculum is its longitudinal or continuity of care component. The continuity of care training is separate and distinct from any other ambulatory training in the osteopathic family medicine residency program. The continuity of care training requirement cannot be fulfilled by any discipline other than osteopathic family medicine. The test of continuity of care is whether or not the same resident has seen the same patient each time the patient presents to the continuity of care site. This should occur a majority of the time, except in emergencies. Schedules should be adjusted to accommodate this phase of the residency. It is the continuity of care training that has a defined time element.

The osteopathic family medicine training site shall be the central focus for the osteopathic family medicine resident's continuity of care experience. Osteopathic Family Medicine is a comprehensive specialty that encompasses the total health care of the individual and the family. Physiological, emotional, cultural, economic, psychological and environmental factors as they relate to the disease process are considered.

1. Facility

- a. For a given resident the continuity of care experience may be at no more than two sites. If the residency program elects to use two sites, the resident may be assigned to both sites simultaneously, or each site for twelve consecutive months during OGME-2 and OGME-3. During OGME-1, the continuity experience must be at the same continuity site. Each site must meet all the requirements for the continuity of care experience as outlined in these basic standards. Each site must be self-contained as to the required elements of patient care and education. With multiple sites, the sponsoring institution must have in place mechanisms to insure the required educational experiences at each site. Assignment of a resident to a single continuity of care site for the entire residency is the preferred method.
- b. Osteopathic manipulative treatment will be integrated into the continuity of care experience and documented on the charts.
- c. Supervision of the continuity of care experience will be provided by a family physician certified by the American Osteopathic Board of Family Physicians. A ratio of 1 FTE faculty for every 6 osteopathic residents in the program shall be maintained.

2. Patient Pool for Continuity of Care

- a. The patient population of the continuity of care facility should mirror that of the community as far as age, gender, ethnicity, and payer mix.
- b. Each resident will be assigned a panel of designated patients. This panel will consist of a sufficient number of patients to assure adequate training. Each resident panel should reflect the age, gender, ethnicity and payer mix of the community. The residents should be clearly identified as the health care provider for the panel. The resident will be responsible, under supervision, for the health care needs of their assigned panel of patients. A designated patient may be assigned to only one resident at a time. Patients assigned as part of a designated patient panel must have documented multiple visits to the facility. Each panel must reflect a variety of diagnosis compatible with the educational objectives of the residency. This should consist of at least seventy-five percent of all problems and diagnosis seen at the continuity of care site and should include somatic dysfunction. Throughout the training, the resident is responsible, under supervision, for the care of his/her patient panel. In addition to the base of patients, each resident will acquire new patients as these patients present to the osteopathic family medicine center. As the skill and proficiency of the resident improves, an increasing daily patient load is expected. By the end of the training, the resident should be able to manage an adequate number of patients to be successful in practice. It is anticipated that the patient volume will average 6 patients per half day at the beginning of the residency and at least 10 patients per half day at the completion of the residency. This is of course variable depending on the complexity of the patients' problems. Patients will be assigned exclusively to faculty only after the needs of the residents are met.

3. Scheduling of Continuity of Care

- a. The continuity of care assignment is the most important single feature of the residency. No rotation or discipline or other duties are to interfere with the intent or implementation of the continuity of care experience portion of the residency.

- b. The first year resident will spend one-half day per week for the entire year in the continuity of care training site. The patients seen during this longitudinal experience will be the nucleus of the resident's panel of patients that he/she will follow during the remaining months of the residency. This experience should be scheduled on the same day, Monday through Friday, throughout the year. In programs that have more than one continuity of care training site, each resident must complete this experience in the same facility so as to assure continuity of care training with the same patient population.
- c. During years two and three the resident shall spend an average of three half days per week at the osteopathic family medicine training site. There must be documented a minimum of three hundred twelve (312) half days in the continuity of care experience during the final twenty-four months of the residency. This continuity of care experience is separate from other ambulatory care experiences.
- d. Fifty-one (51) percent or one hundred fifty-nine (159) half days of the continuity of care experience should be completed at the institution granting the residency certificate.
- e. The sequence of the required three hundred twelve (312) half days may be adjusted to accommodate the need to utilize outside rotations. However, in no instance will the duration of the continuity of care experience be less than eighteen (18) months or seventy-two (72) weeks.

B. Goals

1. To provide didactic and clinical learning experiences in an ambulatory setting to assure competence in treating patients in this aspect of osteopathic family medicine.
2. To provide the opportunity for progressive responsibility in longitudinal patient care.
3. To provide instruction in outpatient procedures and ambulatory care practice.

C. Objectives

The resident will demonstrate competence in his/her ability to:

- Deliver osteopathic care to patients in an ambulatory setting.
- Manage effectively a normal caseload during a scheduled day.
- Develop medical practice management skills.
- Increase his/her expertise in:
 - Methods of referring patients
 - Methods of counseling
 - Providing patient education
 - Delivery of Osteopathic Manipulative Treatment
 - Diagnosis and treatment of patients in all age groups
 - Providing preventative measures for a varied patient population
 - Diagnosing and managing medical and surgical problems
- Develop a thorough understanding of family oriented care.
- Become familiar with the evaluation of industrial injury and criteria for returning to work.
- Become familiar with the basic guidelines for reporting communicable diseases.
- Become familiar with the use of community resources in total patient care.
- Learn how to be a part of a health care team.
- Demonstrate team leadership skills.

Competency-Based Continuity Clinic Curriculum

Competency	Curriculum	Teaching Methods	Evaluation Methods
Patient Care	<ul style="list-style-type: none"> • Proficiency in obtaining OB/GYN history • Perform GYN exam on non-pregnant and prenatal exam on pregnant patient • Develop differential diagnoses and evaluation and management plans for common presenting GYN symptoms • 	<ul style="list-style-type: none"> • Patient interaction • Conferences • Faculty modeling • Workshops • Procedural models 	<ul style="list-style-type: none"> • Record review • OSCE • Videomonitoring • Procedure / case logs • 360 degree evaluation
Medical Knowledge	<ul style="list-style-type: none"> • Preventative medicine • Chronic disease management • EBM knowledge base / guidelines for common outpatient conditions 	<ul style="list-style-type: none"> • Conferences • Access to virtual library and texts • Reading list 	<ul style="list-style-type: none"> • Written exam • Preceptor evaluation
Practice-Based Learning and Improvement	<ul style="list-style-type: none"> • Analyze and improve own practice • Use information technology for patient care and learning 	<ul style="list-style-type: none"> • QI projects / peer review • Access to virtual library and texts 	<ul style="list-style-type: none"> • Record review • Videomonitoring • Portfolio
Interpersonal and Communication Skills	<ul style="list-style-type: none"> • Value continuity of care • Manage patient expectations • Ancillary staff interaction • Documentation skills • Cultural competence • Coordinate and monitor care with other services and providers 	<ul style="list-style-type: none"> • Faculty modeling • Diversity training • Clinic orientation for interns and ancillary staff 	<ul style="list-style-type: none"> • Record review • Patient survey • Videomonitoring • OSCE • Preceptor evaluation
Professionalism	<ul style="list-style-type: none"> • Ownership of patients • Punctuality • Respect for patient and team • Appropriate attire • Prompt response to pages and emails • Lecture attendance 	<ul style="list-style-type: none"> • Faculty modeling • Conferences 	<ul style="list-style-type: none"> • Patient survey • Preceptor evaluation • 360 degree evaluation • OSCE
Systems-Based Practice	<ul style="list-style-type: none"> • Understand interaction between local and larger health care system • Practice cost-effective medicine • Identify resources for patients • Identify barriers to health for patients • Know how to work with other health care providers 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Identify available community resources 	<ul style="list-style-type: none"> • Patient Survey • 360 degree evaluation • Videomonitoring
Osteopathic Philosophy and OMM	<ul style="list-style-type: none"> • Integrates Osteopathic P&P into medical care • Treats the patient rather than symptoms • Effectively and efficiently utilizes OMT 	<ul style="list-style-type: none"> • Conferences • OMT credentialing • Faculty modeling 	<ul style="list-style-type: none"> • Record review • Preceptor evaluation • Videomonitoring • OSCE

3. Hospital Care

A. Synopsis

In-patient osteopathic family medicine must be incorporated into the residency program. Residents are expected to participate in the in-patient care of their patients from the osteopathic family medicine continuity of care training site. In the case where a defined in-patient osteopathic family medicine unit exists, this can be utilized for part of this requirement. The residents should care for hospitalized patients from their panel. All patients from the continuity of care osteopathic family medicine training site will be managed by the osteopathic family medicine residents, who will be supervised by the osteopathic family medicine faculty.

B. Goal:

To provide didactic and clinical learning experiences in a hospital setting to assure competence in this aspect of osteopathic family medicine.

C. Objectives:

The resident will demonstrate competence in his/her ability to:

1. Manage hospitalized patients
2. Appropriately seek consultation and participate in patient care with the consultant.

Clinical Competencies Internal Medicine

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
<p>Medical Knowledge:</p> <p>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care</p>	<ul style="list-style-type: none"> • Apply pertinent basic science principles to patients with internal medicine problems • Analyze pathophysiological principles to understand why patients develop signs and symptoms from various diseases • Apply basic pharmacological principles to the treatment of common internal medicine diseases <p><i>See list of common problems in Internal Medicine</i></p>	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • EBM Guidelines and Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</p>	<ul style="list-style-type: none"> • Demonstrate proficiency in obtaining a history from an adult patient • Perform a general physical examination on an adult patient • Perform a problem focused physical examination on an adult patient • Formulate a differential diagnosis for common presenting symptoms of adult disease • Develop specific motor skills necessary to perform procedures on IM patients <ul style="list-style-type: none"> ○ Lumbar puncture ○ Thoracentesis ○ Central venous pressure line insertion ○ Venipuncture / ABG 	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • EBM Guidelines and Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation

	<ul style="list-style-type: none"> • Detect commonly potentially serious medical diseases <ul style="list-style-type: none"> ○ Breast cancer - Perform a breast exam ○ Cervical Cancer – Perform a Pap smear ○ Colon Cancer – Perform a stool guaiac ○ Prostate Cancer – Perform a DRE • Evaluate the pre-operative patient • Manage the medical condition of the post-operative patient 		
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Develop communication skills that facilitate the transfer of information to persons from a different cultural or socioeconomic background • Utilize communication skills necessary to care for dying patients and their families • Employ sensitivity when dealing with people who are vulnerable or scared • Assess the psychosocial and spiritual needs of the patient 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> • Identify and utilize resources for dissemination of new information regarding the practice of internal medicine • Identify and utilize evidence-based medicine guidelines in the field of internal medicine • Apply these principles to regular health maintenance 	<ul style="list-style-type: none"> • Use of “virtual library” • QA / PI data • Journal Club • EBM workshops • Use of EBM order sets 	<ul style="list-style-type: none"> • AOA CAP program • QA / PI reports • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> • Employ a team oriented approach to problem solving in internal medicine • Consult other physicians and health care providers in a manner that maximizes patient care and minimizes communication barriers • Question the increasing larger role that financial considerations play in medicine • Advocate for the needs of the patient, in light of society’s inability to provide unlimited resources to everyone 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Community service (Shepherd’s Hope) • Involvement in Discharge planning 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Professionalism:</p>	<ul style="list-style-type: none"> • Exemplify behaviors such as altruism, 	<ul style="list-style-type: none"> • End of Life Care 	<ul style="list-style-type: none"> • OSCE

<p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.</p>	<p>accountability, excellence, duty, honor, integrity, and respect for others</p> <ul style="list-style-type: none"> • Altruism: the best interest of the patient must come before the interests of the doctor • Accountability: accountability to patients, patients' families, peers, faculty and society • Excellence: an effort to exceed ordinary expectations • Duty: a commitment to service • Honor and integrity: a commitment to the highest standards of personal and professional behavior • Respect for others: respect for patients, their families, peers, nurses, faculty, and other medical personnel and ancillary staff 	<p>Training (EPEC)</p> <ul style="list-style-type: none"> • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities.</p>	<ul style="list-style-type: none"> • Apply osteopathic principles to the diagnosis and treatment of the internal medicine patient • Identify specific internal medicine conditions where osteopathic manipulative medicine is a component of the treatment plan. Examples: <ul style="list-style-type: none"> ○ Pneumonia ○ Ileus • Apply holistic approaches to the diagnosis and management of internal medicine conditions 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly Distance Learning • OMT Clinics 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • Inpatient Credentialing • OSCE • Monthly Service Evaluation

Common Problems in Internal Medicine

Cardiovascular disease

- Acute Coronary Syndromes
- Congestive Heart Failure
- Valvular Heart Disease
- Atrial Fibrillation and Anticoagulation
- Hypertension

Endocrinology

- Diabetes Mellitus
- Hypo- and Hyperthyroidism
- Osteoporosis and Disorders of Calcium Metabolism

Hematology

- Anemia
- Coagulopathies

Gastroenterology

- Hepatitis
- Peptic Ulcer Disease
- Gastroesophageal Reflux Disease
- Diarrhea and Constipation

Medical Oncology

- Hematological Malignancy
- General Care of the Cancer Patient

- Management of Pain

Nephrology

- Electrolyte Disturbances
- Acid-Base Disorders
- Acute and Chronic Renal Failure

Rheumatology

- Rheumatoid Arthritis
- Osteoarthritis
- Monoarthritides
- Polyarthritides

Pulmonary disease

- DVT and Pulmonary Embolism
- Chronic Bronchitis and Asthma
- Emphysema

Infectious disease

- Fever of Unknown Origin
- Acquired Immune Deficiency Syndrome
- Pneumonia
- Urinary Tract Infection
- Cellulitis
- Subacute Bacterial Endocarditis

Allergy/Immunology

- Urticaria

Neurology

- Cerebrovascular Disease
- Headache
- Dementia and Coma

Dermatology

- Dermatological Manifestations of Chronic Medical Disease

4. Osteopathic Principles and Practice

A. Synopsis

This component of the curriculum shall be taught in a longitudinal fashion in all patient care settings. This may be accomplished through didactic lectures, one-on-one tutorial instruction, direct application of osteopathic manipulative treatment or other appropriate formats.

The continuity of care training site is key to the development of good skills in osteopathic manipulative treatment. Appropriate supervision shall be provided so that the resident will integrate these skills into the daily care of his/her patients. This shall be documented in the medical record.

B. Goals:

1. To teach the resident, through didactic as well as clinical settings, the application of osteopathic principles and osteopathic manipulative treatment in all patient care settings.
2. To expose the resident to multiple treatment techniques so he/she may choose the most appropriate method of treating any patient.

C. Objectives:

The resident will demonstrate competence in his/her ability to:

1. Describe the philosophy behind osteopathic manipulative treatment.
2. Describe the role of the musculoskeletal system in disease, including somato/visceral reflexes, alterations in body framework, and trauma.
3. Describe contraindications to osteopathic manipulative treatment.
4. Utilize multiple methods of treatment including, but not limited to, high-velocity/low amplitude (HVLA), strain/counter strain, and muscle energy.
5. Demonstrate, as documented in the medical record, his/her use of osteopathic principles and osteopathic manipulative treatment in the continuity of care training site in an integrated fashion. It is understood that

integration implies the use of OMT in such conditions as, (but not limited to) respiratory, cardiac, and gastrointestinal disorders, as well as musculoskeletal disorders.

5. Behavioral Science

A. Synopsis

Knowledge and skills in this area is a critical element in osteopathic family medicine. These elements should be acquired through a program that integrates these concepts with all disciplines throughout the resident's total educational experience. The continuity of care training site should serve as the primary location for training in this area. Family physicians and psychologists, as well as others, may be involved in the teaching of this curricular component.

B. Goals:

1. To provide training so the resident will be able to diagnose and manage the psychological component of disease.
2. To provide training so the resident will understand the importance of his/her own well-being and the prevention of impairment.

C. Objectives:

The resident will demonstrate competency in his/her ability to:

1. Understand psychological growth and development.
2. Utilize appropriate interviewing skills.
3. Utilize appropriate counseling skills.
4. Diagnose and manage substance abuse.
5. Diagnose and manage eating disorders.
6. Diagnose and manage common psychiatric disorders.
7. Manage the emotional aspects of non-psychiatric disorders.
8. Recognize signs of family violence including abuse, and neglect.
9. Recognize the role of ethics in patient care.
10. Understand the importance of being sensitive to gender, age, race, and cultural differences within his/her patient population.
11. Demonstrate knowledge of psychopharmacology.
12. Demonstrate an understanding of situations that have the potential of leading to his/her impairment.
13. Provide Whole Person Care.

Clinical Competencies Psychiatry / Behavioral Medicine

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
<p>Medical Knowledge:</p> <p>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care</p>	<ul style="list-style-type: none"> • Apply basic relevant genetic, epidemiology, pathophysiology, anatomy and pharmacology to psychiatric cases • Differentiate normal from abnormal emotional and cognitive development • Describe the causes of mood disorders, anxiety disorders, psychotic disorders, personality disorders, substance abuse disorders, eating disorders, childhood disorders, and geriatric disorders • Apply DSM IV nomenclature to psychiatric disorders • Distinguish between medical illnesses that present with 	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation

	<p>psychiatric symptoms, and psychiatric disorders that present with medical signs and symptoms</p> <ul style="list-style-type: none"> • Identify 1st and 2nd line psychopharmacological treatment options for the major psychiatric diagnoses • Explain psycho-social treatment options and referral process for psychiatric disorders <p><i>See list of common problems in Psychiatry</i></p>		
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</p>	<ul style="list-style-type: none"> • Conduct and record a psychiatric history • Conduct and record a mental status examination • Formulate differential diagnoses • Use a bio-psycho-social-spiritual model to participate in the development of treatment plans • Adjust interventions that affect levels of acuity based on accommodating new information pertaining to given patients • Identify high risk patients who are dangerous to self and others • Make appropriate safety and legal decisions for patients determined to be high risk 	<ul style="list-style-type: none"> • Morning Report • Didactic Programs • Bedside teaching 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Record Review • Case Logs • Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Demonstrate effective listening and communication skills • Effectively appraise the psychiatric conditions of given patients regardless of age, sex, ethnicity, or race • Provide empathic responses to patient's social stigma pertaining to mental illness • Protect patients' right to confidentiality • Identify support networks and exchange appropriate information following prescribed procedures, with family members and professional associates • Emphasize the role of the patient on the treatment team 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation

<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> Identify the major sources of psychiatric information Identify and utilize resources related to evidence-based guidelines and routine psychiatric care Discern irregularities of psychiatric care in comparison to evidence-based guidelines 		
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> Utilize the expertise of psychiatrists, psychologists and social workers with respect to indications for referral and coordination of care with primary care physicians Explain the overall mental health delivery system in the community Explain how the mental health delivery system and the social service delivery system interface with psychiatric care Be cognizant of the health care financing issues affecting the delivery of mental health services 		
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> Combine scientific curiosity with respect for the patient regardless of age, sex, ethnicity or race Demonstrate an empathic relationship with patients while obtaining information needed to participate in the development and utilization of treatment plans Adhere to the AOA ethics and parameters of confidentiality 	<ul style="list-style-type: none"> End of Life Care Training (EPEC) Role Modeling Cultural Diversity Training 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Portfolios Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities</p>	<ul style="list-style-type: none"> Be cognizant of a holistic approach to mental health problems Assess for and administer adjuvant OMT to aid in the lessening of suffering caused by concomitant medical illnesses that may be impacting, or are impacted by, mental health issues 	<ul style="list-style-type: none"> Inpatient Credentialing Weekly Didactic Sessions Monthly Distance Learning OMT Clinics Computer Modules 	<ul style="list-style-type: none"> In-service Exams COMPLEX III Inpatient Credentialing OSCE Monthly Service Evaluation

Common Problems in Psychiatry/Behavioral Science

Mood Disorders

- Depression
- Anxiety Disorder
- Bipolar Disorder
- Obsessive-Compulsive Disorder
- Suicide and Para suicide

Childhood and Adolescent Psychiatry

- ADHD
- Eating Disorders

Geriatric Psychiatry

- Dementia
- Delirium

Psychoses

- Schizophrenia

Behavioral Medicine

- Alcohol, Illicit and Prescription Drug Addiction
- Tobacco Abuse
- Weight Loss Counseling
- Stress Management
- Dysfunctional Family Issues

Women's Psychiatry

- Postpartum Depression
- PMDD

Personality Disorders

Somatoform Disorders

6. Health Care Systems

A. Synopsis

Health care in our society is undergoing significant dynamic changes which will impact the resident on completion of his/her training. In order to adequately prepare the resident for entry into the health care environment, experiences shall be provided to assist him/her in assuming a productive role in this complex environment. Data from the resident's own continuity of care training site experience will be used to illustrate the basic economic principles of medical practice. This data will include gross charges, contractual adjustments, balance billing, and reimbursement data.

B. Goal

To provide the resident with didactic and practical experiences designed to prepare him/her for the economic aspect of medical practice.

C. Objectives

The resident will demonstrate competency in his/her ability to:

1. Enter into contractual arrangements with health care systems.
2. Demonstrate an understanding of the issues of bio-ethics and medical jurisprudence.
3. Demonstrate an understanding of community systems and agencies that enter into aspects of health care.
4. Demonstrate an understanding of risk management.
5. Demonstrate an understanding of office management, principles of reimbursement, and coding.

SPECIFICS OF RESIDENT ROTATIONS

Ambulatory Continuity Training – Family Health Center East (FHCE)

I. Educational Objectives

1. To learn the skills and art of providing ambulatory care and being able to care for 95% of the problems which are presented to him/her. These include but are not limited to: (mandatory)
 - Medical examination, no disease detected
 - Prophylactic immunization
 - Acute upper respiratory tract infection
 - Acute otitis media
 - Abdominal pain
 - Laceration, open wound
 - Hypertension, uncomplicated
 - Low back pain without radiating symptoms
 - Hay fever
 - Bronchitis and bronchiolitis, acute
 - Cystitis and urinary tract infection
 - Contraception
 - Vaginitis
 - Prenatal care
 - Anxiety neuroses
 - Diagnosing pregnancy
 - Chronic and serious otitis media
 - Depressive neurosis
 - Boil and cellulitis
 - Advice and health maintenance instruction
 - Pain in joint
 - Bruise, contusion
 - Eczema and allergic dermatitis
 - Chest pain
 - Strep throat, scarlet fever, erysipelas
 - Influenza
 - Pain in limb
 - Rash and other nonspecific skin eruptions
 - Somatic dysfunction
2. Learn the necessity of time budgeting and how to effectively handle a normal case load during the day (mandatory).
3. Develop management skills and a working knowledge of business and personnel management (mandatory).
4. Increase the expertise of the Resident in: (mandatory)
 - Methods of referring patients
 - Methods of counseling
 - Providing patient education
 - Delivery of osteopathic manipulative therapy
 - Diagnosis and treatment of all age group patients
 - Providing preventative measures for a varied patient population

5. Develop a thorough understanding of a family oriented master problem list type of medical chart (mandatory).
6. Become familiar with the evaluation for industrial injury and appropriateness of return to work (mandatory).
7. Become familiar with the basic guidelines for reporting communicable diseases (mandatory).

II. Plan

The Resident starts his training with a patient base of families and is responsible for their care throughout the training. In addition to the base of patients, each Resident acquires new patients as they present to the Family Medicine Center. As the skill and proficiency of the Resident improves, there is an increasing patient load so that by the end of the training the Resident can manage 20 patients per day. This equips the Resident to be successful in private practice.

General Information

This is a one-year rotation with assigned half days each week. It is supervised by board certified Family Physicians.

The clinic hours are 8:15 to 12:00 p.m. and 1:15 to 5:00 p.m. Residents are expected to be on time and present for those periods and longer if patient care and clinic responsibilities are not completed. Moonlighting schedules shall not interfere or shorten these responsibilities.

Clinic assignments take precedence over other rotations. Vacation and CME are not allowed during block clinic rotations. Time off around holidays shall be worked out by the residents and approved by the DME and Clinic Medical Director 45 days in advance. A majority of the residents scheduled for the clinic at these times shall be present.

Ambulatory call will be the responsibility of the call resident as assigned. Document all calls in Epic Web as “Physician Call (Web only)” encounter.

Administrative Resident (AR) - FHCE

No personal leave is allowed during this rotation.

This is a four (4) week rotation for the OGME-2 and OGME-3 residents with all half days assigned at FHCE. The “AR” reports to the Clinic Medical Director or assigned AR Proctor.

Learning Objectives and responsibilities include:

- to obtain professional management skills, attitude, and knowledge
- to assume the role of triage physician in a office who provides health care services to a wide variety of patients and managed care organizations
- to meet the required continuity care exposure and patient care numbers for completion of the Residency
- to team with the office staff to achieve the patient care goals and requirements set for the Residency by the hospital (required follow up from the Emergency Department and inpatient services), by the managed care organization contracts, by the Residency’s ambulatory requirements and the acute care needs of our patients
- to learn the principles of time management of patients with same day appointments

The Administrative Resident (AR) will be assigned to the clinic (FHCE) for five (5) days a week, for both morning and afternoon. The AR is responsible for checking the “AR Inbasket” and will spend the first half-hour of the morning, the first half-hour of the afternoon, and one-half hour late in the afternoon dealing with patient phone messages. There should be no more than a 24-hour turn around time for refills. The AR will deal with urgent refills and patient problems by either forwarding the message to the patient’s doctor or dealing with the issue themselves. This may entail calling the patient directly. All residents are responsible for checking their in-box on a regular basis to address refill or patient issues. The AR tracks the amount of time other residents take to respond to their message. Residents who do not respond to their in-basket in a timely manner may face disciplinary measures including, but not limited to, extra call duty.

The AR will be scheduled in fifteen (15) minute time sequences for patient care. The major concept of this role is learning the art of triage. The long term continuity of care will be continued by the patient's primary care resident, or in the case of a new patient, the continuing care may be assigned to another resident or the AR may add the patient to his/her panel. The patient care will follow the compliance plan and will be supervised by the attending faculty who are preceptors that day.

Critical to this role of AR is:

- an understanding of the difference between ongoing comprehensive, longitudinal continuity patient care and addressing acute illness or problem that must be schedule the same day
- the ability to work together with the office staff
- to comprehend the concepts of team building for common goals and objectives
- to be flexible, cooperative, and have a positive attitude
- to be capable of developing effective efficient professional patient care qualities along with time management of urgent patients
- demonstrate leadership by taking responsibility for "extra" clinical daily tasks
- working effectively with other residents, medical externs, nurses and ancillary staff with the goal of establishing a "healthy" working environment

The Clinic Medical Director may assign other duties.

Dress Code Policy

Professional dress will be adopted by all residents. Residents will appear neat and observe the Florida Hospital dress code at all times while on duty at the Family Health Center East. Faculty may send a resident home to correct dress code infractions.

A white lab jacket and badge are to be worn at all times while on duty at the Family Health Center East. Jewelry will be limited and discreet as defined by Florida Hospital standards.

Male residents are to wear a dress shirt and clean unwrinkled slacks that comply with a professional appearance. Hair should be cut above the neckline, off the ears and without long side burns. Ponytails on men are not accepted. Open-toed shoes, athletic footwear, or sandals are not allowed.

Female residents are to wear a dress or pants consistent with modesty and a professional appearance. Hosiery should be worn. Shoes and socks conducive to comfort and a professional appearance are to be worn. Hair should be neat and well groomed. T-shirts and jeans are not acceptable.

Scrubs are not to be worn in the clinic.

The DME and Florida Hospital's dress codes will determine what constitutes a professional appearance. It is the responsibility of Med Ed to enforce the Florida Hospital dress code. All faculty members will insist each resident and extern follow the regulations.

First Infraction: The resident or extern will be sent home to correct the problem. The attending may recommend extra call or the loss of vacation time. Attending will submit the appropriate form to Med Ed.

Additional Infractions: Extra call may be assigned or vacation time may be taken away at the discretion of the DME. In addition, moonlighting privileges may be suspended. The resident must gain the written re-approval of the DME to begin moonlighting again.

Electronic Medical Records (EMR)

Family Medicine Guidelines for using EPIC at Family Health Center East

1. Never give out your OP ID or Password.
2. Make sure no one is looking directly at your screen/keyboard when signing in as they may discover your Password or OP ID.
3. Enter your clinical decisions or thoughts in the "comment" section next to the diagnosis (in the diagnosis screen).

4. Use **.DIAG** and **.PLAN** smart phrases. The **.DIAG** is essentially the Assessment portion of the S.O.A.P. note.
5. Edit **.PLAN** to include your plan. **.PLAN** is useful as it automatically puts in the medical advice. It is written to be generic so you must modify it to fit your present patients' needs.
6. Use **.ADVISE** to document that the patient understood and agreed with the plan and will follow your recommendations.
7. Residents are encouraged to complete the majority of the charting in the patient room.
8. All Charts need to be completed within 48 hours.
9. All Medicare charts need to be reviewed by a full time attending and completed before leaving the office that day.
10. All level 4 and level 5 Medicare visits require that the patient be seen and examined by a full-time attending.
11. All OGME-1's visits in their first six (6) months of training require a full-time attending to see the patient during the visit.

Pediatrics Guidelines for using EPIC at Family Health Center East

1. Always put **.me** either above dotted line exam or at the end of your progress notes in charting.
2. Use smart text for Pediatrics in charting. When you press on **P**, it will give you a series of options to pick from, e.g. Ped acute East, Peds recheck East, Ped Well Exam, etc.
3. Use smart sets for ordering immunizations, labs and screening tests for Well Baby visits.
4. For Well Baby checks of Medicaid patients use **EPSDT (W9881)** code for level of service. You can find insurance information in **exam**.
5. Please close all charts after immunizations are given.
6. Review all visits with the attending before the patient leaves.

Computers Down

If the computers go down while the physician is seeing patients, the physician will document his/her findings on the preprinted "EPIC Down" form. The written findings, including a full S.O.A.P. note, medication and referral information must be inputted by the physician in the electronic record once the computers are back on-line.

Chiefing and Video-Monitoring

Each resident is assigned to a chief on the chiefing schedule and is expected to chief their patients with that faculty member. If the chief assigned is busy, it is not acceptable to utilize another chiefing faculty unless that faculty has less than four residents assigned to them during that half day.

All resident charts must be co-signed by faculty. When the residents attempt to close their charts in EPICare, a screen will pop up asking the resident to designate a co-signer. The co-signer will be the chief assigned to the resident for that day. A list of the faculty responsible for co-signature will be posted in the chiefing rooms on the respective sides. If there are any questions regarding who should co-sign your chart, please ask the nurse coordinator.

All residents will be video monitored at some point either by the clinical attending faculty or the behavioral medicine attending faculty. Most of the time the resident will be informed in advance of any monitoring, but the faculty maintains the right to monitor without notice.

Patient Schedules/Resident Duties

Residents' schedules are placed in the clinic computer as far in advance as possible. Patients are assigned to each resident using the established guidelines.

OGME-1 residents are assigned four (4) patients per clinic session in July. Beginning in August and through December, OGME-1 residents are assigned six (6) patients per clinic session. OGME-1 residents are then assigned seven (7) patients per clinic session from January through June. They are expected to present EVERY patient to their attending for the day. During the first 6 months of their residency, the attending must see every Medicare patient. After the first six months, the attending need only see the Medicare patients who will be charged a level 4 or 5. OGME-1 residents are encouraged to discuss billing and charting with the attending.

OGME-2 residents are assigned nine (9) patients per half-day session for the full second year. OGME-2 residents must chief all Medicare, Medicaid and Medipass patients with the attending, as well as any patients they have questions about. The attending needs to see any Medicare patient who will be charged a

level 4 or 5. OGME-2 residents are encouraged to take an active role in choice of billing code, and are expected to be competent with charting on our current EMR.

OGME-3 residents are assigned twelve (12) patients per half-day session for the full third year. OGME-3 residents must chief all Medicare, Medicaid and Medipass patients with the attending, as well as any patients they have questions about. The attending needs to see any Medicare patient who will be charged a level 4 or 5. OGME-3 residents are expected to be competent with charting on our current EMR as well as choice of billing code. OGME-3 residents are encouraged to practice as independently as possible, although immediate supervision is always available.

The Family Health Center East clinic's goal is to maintain patient continuity of care.

Many factors interfere with the patient/resident relationship. The most important positive factor is availability of the resident. The largest negative factor is changes in the schedule. Schedule changes arise from many sources but the most frequent one is failure to follow the Residency policies and procedures. To reduce the impact of schedule changes, residents are assigned to Practice Groups. Each Group has first, second, and third year residents at least, one of which should be assigned to FHCE each day.

Time away requests must be submitted to the Department of Medical Education forty-five (45) calendar days in advance. All change requests must be on a *TIME OFF/SCHEDULE CHANGE FORM* and be signed by the Director of Medical Education, Clinic Medical Director and the Practice Manager. Planning ahead is important to all concerned.

Changes after the schedule is posted stress the system and interfere with continuity of patient/resident relationship for the following reasons:

1. Patients are **VERY** difficult to reach, especially on short notice.
2. Patients get upset with changes in their schedule.
3. Up to two hours of work is required to cancel a full schedule.
4. Unnotified patients come in and get very upset.
5. The practice looks inefficient. It's poor business and it reflects poorly on Family Health Center East.
6. When a resident is absent from the Clinic all patients will be assigned to other residents. Patients will not be canceled without advance notice.

Changes to Schedules and Templates

Changes to schedules/templates should only occur if they are absolutely necessary. When changes are made, the following process should occur:

1. The Medical Director needs to be notified initially.
2. Medical Education needs to be notified of the change(s).
3. Medical Education, if it is appropriate, should revise pertinent schedules and forward them to all personnel including the Medical Director, the Practice Manager, the Staffing Coordinator, the Nursing Coordinator, and the Office Coordinator.
4. The Staffing Coordinator makes appropriate changes to the EPIC template based on what was received from Medical Education.
5. Patients that are affected by these changes are notified by telephone and rescheduled appropriately.

Late for Appointment Policy

Our goal is to provide quality Primary Medical Care to our patients in a timely manner. Our mission is to combine quality patient care with quality ambulatory training of Family Medicine. The two processes may be out of sync due to problems in any of the steps of the office patient flow. Examples of flow problems include:

1. The patient arrives late;
2. The patient does not sign in immediately;
3. The patient has problems with new insurance or verifying eligibility;
4. The resident is late for the clinic session;
5. The resident is running behind;
6. The resident does an unscheduled procedure;

7. A resident calls in sick and the patient chooses to be seen by another physician (we do not automatically reschedule all patients);
8. Walk-in patients request to be seen and have urgent problems;
9. A delay in obtaining medical records and/or test results.

Policy:

All patients are expected to arrive before their scheduled appointment time. At the time their appointment is made they are advised to arrive 15 minutes prior to their appointment for their scheduled check-in time to register and verify their insurance. We will allow for a 20-minute grace period past the scheduled appointment time, however this is an internal rule and is not to be published.

Since the arrived time in Epic is not an accurate reflection of the patient’s true arrival time, the front desk personnel under the direction of the Office Manager, will be the timekeepers. The patients will automatically be seen if they arrive any time within the 20 minute grace period. If the patient is more than 20 minutes late, the front desk will ask the patient to see the Appointment Scheduler by stating: “I’m sorry you have missed your appointment time. However, our appointment scheduler will be happy to see what she can do to help you. She is located ….”

The appointment scheduler will see if there is another appointment available within two hours. If there is not, and there seems to be extenuating circumstances such as transportation issues or illness, the scheduler will text page the team leader to see if the faculty physician would like the patient to wait to be seen or rescheduled to another day.

All patients are given a reminder call the day before their appointment and again instructed to register 15 minutes before their scheduled appointment time. The staff will do its best to keep the physicians informed as to the status of their schedule.

The main purpose of the late policy is to prevent inconvenience to the patients that are on time.

Attitudes that are supportive of the nurses, front desk, and appointment staff are required for FHCE to function properly and most efficiently. A Residency Practice is a complex, dynamic operation that requires teamwork. This is the concept a mature healthcare provider will need to be successful throughout their professional career.

New vs Established Patient Amendment

New Patient: A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past **three** years.

Established Patient: An established patient is one who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

At FHC Orlando and FHC East, Family Medicine physicians are considered to be in one group practice rather than two group practices. Pediatricians are considered part of this group as primary care physicians (PCP) and are not considered separate from the family medicine physicians.

Specialists within the Medical Education group include Loch Haven OB/GYN physicians, the Dermatologist, and the Podiatrists. Patients referred to the specialists will be considered new patients if the specialist has not seen the patient within the past three years.

Patients seen by one Family Health Center and then seen at the other center will be considered established.

Dismissal Policy

Potential reasons for patient dismissal include:

- Persistent and intentional non-compliance despite appropriate counseling and employing different strategies with the patient.
- Verbally or physically abusive patients.
- Prescription alteration.
- In appropriate behavior including sexual advances and misconduct.
- Non-compliance with opioid medications per the FHCE “Pain Management Contract.”
- See “No Show” addendum.

Procedure for Patient Dismissal:

1. One or more of the above criteria must be met.
2. The treating Resident must present the reason(s) for dismissal to the assigned Attending.
3. If in agreement, then the request is presented to the Medical Director for approval or disapproval.
4. Upon approval, appropriate documentation must be performed in the medical record and a standard “smart text” dismissal letter is created by the Medical Director and sent to the patient via certified mail.
5. The letter will convey to the patient that we will provide urgent/emergency care for **thirty days** following the receipt of the letter and will forward medical records at the patient’s request to the new treating physician.
6. If the certified letter is returned, it must remain unopened and placed in the patient’s file. A second certified letter is then sent to the patient and if it is again returned the dismissal process commences.

No Show Policy

1. After **two** unexplained “no shows”, the patient is to be contacted by the Resident either in person or on the telephone to determine the reason(s), in hopes of eliminating any barriers. Potential barriers include transportation issues, family emergencies and schedule conflicts.
2. After the **third** unexplained “no show,” a certified letter is sent notifying the patient that he or she will be discharged from FHCE if one more appointment is missed.
3. After the **fourth** and final unexplained “no show,” the patient is discharged from FHCE per the dismissal policy.

Call – Ambulatory Clinic After Hours (Weeknight and Weekend)

Clinic call starts at 5:00 p.m. and ends at 8:00 am - Monday through Thursday. Weekend call starts at 5 p.m. Friday until 8 a.m. Monday.

The resident covering is responsible for all emergent and urgent call for those patients seen in FHCE. This resident will also be on call for FMRS and Pediatrics. On Tuesday and Thursday nights the Pediatric resident covers Pediatric Call and the FMRS resident covers FMRS call and admits. **FMRS residents are required to be in-house for call.**

Included in the after hours attending call coverage may be physicians who contribute time to the Residency program.

The answering service will take the messages (per protocol) and contact the resident either by beeper or telephone.

Every after hour call received is documented on the *Telephone Message Form* by the resident and returned for review by the Family Medicine and Pediatric faculty of FHCE. After review, messages are to be entered in the patient’s electronic (EMR) medical record. The carbon copy will be kept in the telephone record book for future reference.

Calls taken for other community physicians covered by the resident call schedule will be faxed or mailed to the appropriate office after review by faculty. Calls requiring direct communication with a physician are the responsibility of the call resident and are also noted on the *Telephone Message Form and EMR*.

FMRS call attendings will back up the resident on call. Faculty and DME will provide additional back up call for consultation or to answer questions.

Telephone Call Responsibilities

Telephone calls from patients during/after hours are a vital part of this Residency program. In order to ensure a smooth transition and continuity of care, the following procedures should be followed:

Documentation of the off-hours calls is an important part of Family Medicine. Family Health Center East utilizes a standard *Telephone Message Form*. The form provides a copy of the off-hours patient problems for transfer to the EMR and gives the resident a copy for his/her record. The telephone messages must be entered into the EMR by 8:00 am the following morning. If the patient was directed to contact one of the offices, the call resident must notify that office, either by FAX or telephone. The Pediatric Faculty will review the pediatric off-hours call notes with each resident. The FHCE Medical Director or a designated faculty member reviews the FHCE off-hours calls. Calls for other services covered by the resident on call should be given to the Clinic office of medical records who will fax or mail them to the appropriate office. Calls that require direct communication with an attending physician

should be documented on the off-hours telephone message form. On Tuesday and Thursday nights, calls from another hospital requesting to transfer a patient to our service **must be referred to the Family Medicine Resident Service on call resident**, who will contact the service attending.

Each office included in our off-hours call schedule has an attending on call. If there are any questions pertaining to the problem(s) being presented, the FMRS or other attendings should be contacted. If for any reason the Attending is unavailable, the resident may call any one of the following:

Dr. Joseph Allgeier, Director of Medical Education FHEO
Dr. Lyn Johnson, Medical Director FHCE
Dr. Brian Browning
Dr. Thomas Crow
Dr. Margarita Delgado
Dr. Maria Gonzalez
Pediatric Faculty on Call for pediatric questions

Off-hours call coverage is a very important aspect of practice management. All calls, which cannot be managed by phone, do not have to be sent to an emergency room. Some may be seen in the clinic in the morning (Be sure to inform the clinic.). Some may be sent to Centra Care or other offices with extended hours. These calls have a high risk for malpractice claims. All the Managed Care Organizations (MCO) conduct patient satisfaction surveys. Off-hour availability and unnecessary referrals to the Emergency Room are major areas of concern for them. We expect the resident to be accessible and respond according to protocol.

The Compliance Program

The funding of Residency training is regulated by The Centers for Medicare and Medicaid Programs. They establish specific protocols for supervising Resident faculty. In order to meet these requirements the residents must do the following:

1. The Faculty will supervise all OGME-1 residents for every patient for the first year. New OGME-1 residents must see each patient with the proctor for the first six months, then as needed. All OGME-1 residents will verbally discuss each case with the attendings for the entire year. The faculty will review the notes, clarify any necessary history, and examine the patient. The faculty will also write a note relating to the visit and the review of the appropriate finding and treatment.
2. All Medicare, Medicaid, and/or Medicare/Medicaid HMO patients must be seen by the faculty supervising the residents. The faculty must write notes attesting to their direct involvement with the patient's care.
3. All invasive procedures for all patients must be observed, and a chart note completed by the faculty.
4. As residents become credentialed and more proficient with patient care normally carried out in Family Medicine, supervision can be indirect. Proctors will be present for the critical portions of all procedures. The problem will be presented, the notes and plan reviewed and the chart signed by the faculty. The exceptions are all the Medicaid, Medicare and their associated HMO's, which must be supervised as stated above.

Resident Responsibilities

The Family Health Center East (FHCE) has a goal of providing quality primary care while training residents in Family Medicine. The center is dedicated to providing friendly professional service to our patients. Residents will be evaluated on their professionalism and the medical care provided.

Responsibilities include:

- Appropriate evaluation and management (E&M) documentation.
- Document patient education.
- Complete and close all charting by the end of the day.
- Follow CPT code protocols and ensure they match the E&M level of service.
- Code every procedure, for example; urinalysis, wet mounts, etc.
- List the ICD-9 primary diagnosis appropriate for the patient's visit.
- Follow the patient checkout procedures, including the follow up appointment, patient education, and appropriate Rx's and refills.
- Maintain your appointment schedule by knowing your rotations, electives, vacation, etc. - ensuring continuity contact with your patients.

- Follow the compliance plan to ensure the Residency meets the letter of the law.
- Be flexible, respectful and supportive of the office staff as they provide service for “our patients.”
- Maintain a professional demeanor at all times.
- Maintain the electronic medical record as directed in the Residency documentation training.

Abnormal Tests (Labs/X-Rays/Reports)

Residents are directly responsible to notify their patient(s) of abnormal tests. The patient should be reached by telephone as soon as possible and shall be reached by telephone if it is an urgent abnormal test. A letter may be sent by the resident if s/he can not reach the patient by telephone and it is a non-urgent abnormal test. If the phone number is disconnected, wrong number, busy or no answer the resident may ask clinic nursing to assist in obtaining a valid method of contacting the patient. All efforts to contact patients shall be documented in the EMR.

Unresulted Orders Follow Up

At Office Visits

1. When rooming the patient check all orders from the last visit, if any are unresulted ask the patient if they had them done.
2. If they had the test(s) done find the results, give a copy to the doctor and place a copy in the scanning box or give to the person who will enter them into EPIC.
3. If they didn't have the test(s) done, ask them “Are you going to have the test(s) done?”
4. If they say **yes**, go to ‘enter/edit results’, select the test(s) in question and under narrative document ‘ent’ and your initials, and a brief description of what they said. Then, go to the bottom of the page and put the order in a ‘Preliminary Results’ status.
5. If they say **no**, and they are not going to have the test done go to ‘enter/edit results’ and select the test(s) that they have indicated they will not have done and cancel the test using either ‘Patient refused exam/test’, ‘Patient did not have test done’, or ‘Cost’.

Unresulted Orders Reports

1. Check EPIC to see if there is a duplicate order. If there is a duplicate order, write ‘DO’ at the end of the line. Check all canceled orders and if there is not an order with a result look for results for the order. Sometimes other departments cancel orders and if they aren't reordered correctly they don't come back across the interface into EPIC and the test may have actually been done.
2. If it is not a duplicate order and there is no result in EPIC, then check HOST/Sunport/Sunquest or any system that might have the result, or call for them if necessary. If you find results, print them and paper clip them to the sheets you are working on. Write ‘RF’ at the end of the line. If you do not find results write ‘RNF’ at the end of the line.
3. If there are not results in EPIC and you do not find results on HOST/Sunport review to see if the doctor has sent the patient a letter or called them to see if they had the test done. If you see that they have called or sent a letter write ‘PC’. If the order is in preliminary status because we asked the patient about it when they were in for a visit write “prelim”.
4. After you have researched all of the unresulted orders please give the results that you printed/found to the person you were instructed to give them to.
5. For all of the orders that you were unable to find results for, and there was no further documentation of follow-up work with the ordering physician to determine if they want to call the patient, send them a letter, or other means of follow up. Document as above any follow up on the report.

Motor Vehicle Accidents (MVA) and Workman Compensation (WC) Policy

Family Physicians are responsible for the initial and appropriate follow-up care of their patients with MVA and WC injuries if it is requested. In today's medical practice this includes patients seen in the practice and their immediate family. Also included are those patients on managed care panels assigned to a physician whether the physician has seen them or not. This may include evaluation of a patient who has been injured in a motor vehicle accident (MVA)

or while on the job and a potential workman compensation (WC) case. The patients may be seen for an initial evaluation, follow up to an ER visit, or in a chronic state.

Two aspects of these cases cause resistance to providing medical care. The first is the associated legal implications. If lawyers and insurance companies are involved, potentially there are more obligations for paperwork and time. Requests for information can initially be satisfied with copies of the visit documentation when a release from the patient is provided. If the documentation provides normal or minimal evidence of problems, lawyers will have little interest in the information. The time required for a deposition is usually compensated and arranged around the physician's schedule. The proctoring attending is to be involved and the physician of record for the case, they would be the individuals with these obligations.

Secondly, residents must be trained to be competent and confident in their ability to evaluate all patients. The normal history and physical skills are applied to patients who present to the physician with MVA or WC injuries. Diagnostic evaluations and required treatments are no different for these problems than for injuries from other sources. If the patient has been to an ER, it is best to obtain these records as part of the evaluation and review of the case before definitive recommendations are made. It is not appropriate to refer the patient to an ER from the office for the initial evaluation unless there is indication of truly emergent problems. Some patients with MVA or WC injuries may be past litigation or the statute of limitation and a family physician should provide appropriate care. A family physician can facilitate and expedite care and avoid a prolonged process and psychological dependency for the patient.

Once the initial evaluation is completed, the physician must decide whether the patient needs care and if so who should provide it. If there is evidence of minor or moderate injury, the physician may decide to care for the patient. Other patients may be referred to appropriate specialists.

The key to treating MVA and WC injuries is adequate evaluation and correct documentation. The data obtained through the evaluation should be the same for all patients. All positive findings need to be followed up and recorded accurately or referred to specialists for such data collection and documentation. If the injuries are minor or moderate, the interest in legal action should be minimal and usually could be managed by the family physician. More serious cases should at least have a specialist consultation.

Policy

1. All known MVA and WC injury cases will not be accepted at FHCE except those patients identified in #2.
2. FHCE established patients, their immediate family, and patients assigned to FHCE through Managed Care/third party payers will be evaluated initially if requested, source of injury is not known or relative information is provided in advance.
3. FHCE will not see patients who do not qualify under item 2.
4. The physician will instruct the patient to:
 - a. Identify and document whether the injury was at work or a motor vehicle accident and where.
 - b. Ask and document whether the patient has informed their employer about the accident.
 - c. Explain that by treating them, it may affect their WC coverage.
 - d. Explain that the patient should see a WC physician.
 - e. Explain that potentially chronic or serious MVA injuries will be sent to appropriate specialists for consultation and care.
5. All MVA and WC patients seen by a resident shall have an attending physician involved completely with the case including a note documenting their involvement.
6. An adequate history and physical examination to determine the preliminary diagnosis, work up and/or referrals must be completed and documented. Referrals may include: Orthopedics; Neurology; Neurosurgery; Physical Therapy; Rehabilitation; Cardiology; Surgery or others.
7. Appropriate work up, referral, treatment and follow-up must be planned, initiated and documented with an attending's approval.

Attention Deficit Hyperactivity Disorders

Protocol: Medication Refill Request

- 1) If we receive a request for a Rx, and the patient has been seen in the office within THREE (3) months and the medicine is not on the medication list, we will do the following:
 - a) If the patient has been out of the medication for weeks they should schedule an appointment with pediatrics.
 - b) If the patient is on medication and will be out shortly, refill the Rx, enter it on the chronic medication list and schedule an appointment. The pediatrician of record will cosign for the AR's prescription and sends it to the appropriate inbasket. Instruct the patient's mother/father that the patient must be seen to get the next Rx.
 - c) If the patient has been seen in the past ONE or TWO months, medication may be refilled and an appointment made for the third month visit. The parents will be instructed the medication will not be refilled unless they keep that appointment.
 - d) Patient not seen in the past three months or not an FHCE patient will be referred to set up an appointment.
- 2) When the patient follows up for the above appointment and is reevaluated for ADD, the Attending may refill the Rx and shall, at the same time, enter into the record the number of refills in the comment section of the chronic medication list. A variation on the above might be if the patient is seen in pediatrics for another reason and has ADD on the Dx list, a Rx may be ordered appropriately and entered into the chronic medication list with a comment for the number of refills to be given. Parents should be instructed on the need to keep the scheduled follow-up appointment for this condition. Medication will not be refilled beyond the scheduled time for follow up, unless written by the pediatricians and instructions placed in the record.
- 3) Refill requests to the Triage nurses will be checked for the necessary orders in the chart, and forward it to the AR. He/she will write the prescription in the name of an attending Pediatrician present in the clinic. The Pediatrician will be informed by her inbasket to cosign the AR's order and not and sign the Rx.
- 4) Everyone should place the medication in the Chronic Medication List if an Rx is written.

Ideally, there should be a continuity of patient and physician relationship to monitor care, medication and progress. Periodic reports should be secured from the patient's school.

911 Acute Referrals

In the event a patient needs a 911 referral, the resident and attending faculty must see the patient prior to the call being placed. The resident will remain with the patient and/or family member(s) until 911 personnel arrive. The attending will be with the patient when 911 personnel arrive and when they leave. Nursing will explain to other waiting patients of the resident they will be delayed due to an emergency and/or waiting patients will be seen by other residents in the Clinic or the TA as needed. The resident is responsible for notifying appropriate family members if the patient is transported on a 911 referral. All encounters must be documented in EPIC by the resident and attending.

Medical Group Billing for Diabetes Group

FHCE patients visits are considered individual visits. The patient's will be billed for an established office visit under a medical diagnosis such as diabetes, asthma, CHF, obesity, etc. The level of service will be 99213. A physician faculty member must be present.

Documentation required:

- A progress note reflecting the patient's past medical history, current medications, results of diagnostic tests ordered and treatment provided including patients' education provided during the group part of the visit is to be documented by the attending physician prior to the group session.
- Objective and subjective information such as blood pressure and vitals are to be added by the nurse prior to the group session.
- Co-signature by the faculty physician present during the group session is required. (Billing will not be made if this step is not completed.)

Pharmaceutical Samples Guideline

Medical Education maintains samples to allow for short-term trials of medications for evaluation of efficacy and tolerability and to provide medications for indigent patients. The quantity of samples dispensed is at the discretion of the physician, with appropriate faculty supervision in the case of residents.

Only faculty members, residents, and authorized administrative personnel will have access to the sample area. This is accomplished by the presence of a lock on the sample area door. Only authorized personnel will be given access, and will be instructed not to share access with any non-authorized personnel. Only physicians are allowed to dispense samples. Administrative personnel are given access for emergency purposes only.

When a physician desires to provide samples for a patient, he or she will access the sample area. It is the physician's responsibility to ensure that all necessary information is documented on the outgoing sample log, including quantity and dosage strength. The Outgoing Sample Log must be filled out completely. The samples may be placed in one of the bags provided. A check mark or the word "yes" must be entered under the "couns" heading to document that the patient was counseled regarding adverse effects and what to expect from the therapy. This is a critical aspect of dispensing which must be documented each time.

The physician will fill out a Sample Label and affix it to the samples. If the samples have been placed in a bag, the label may be affixed to the outside of the bag.

The order must be entered into the chart as a prescription normally would be to ensure that our medical records are accurate. If the therapy is to be continued beyond the time for which the samples will last, another prescription must be given to the patient to take to his or her pharmacy so that they can continue therapy without having to call the office for a refill.

When a pharmaceutical representative desires to leave samples at the office, he or she must seek out a physician for a signature. The physician will escort the representative to the sample area and ensure that all samples being left are logged in on the Incoming Sample Log.

All samples left for patient pickup need to remain in the sample area until the patient arrives.

Oversight of the sample room is the responsibility of the faculty pharmacist. The samples will be checked for outdates on a monthly basis.

Every 3 months the FMR faculty pharmacist will audit three sample products, by counting sample units and comparing this with the values recorded on both Incoming and Outgoing sample logs. If discrepancies are found appropriate action will be taken to facilitate adherence to the guideline.

Medication Discount Cards

Five different medication discount cards are available to patients who have Medicare and limited income. Pfizer, Glaxo, Novartis, Eli Lilly and Together Rx Card (includes many drug companies), provide 800 numbers for your patients to call. Promote these to your patients to save them money. The patient needs to complete the paperwork in advance. For refills every ninety (90) days additional paperwork is required. Patients need to give the residents completed paperwork forty-eight (48) days in advance of when they will run out of the medicine. Then residents will complete the physician requirements and submit over thirty (30) days in advance of when the prescription will run out. Shannon Miller, Pharm.D. can provide further information.

Chart Completion Policy

Timely chart completion and closure is essential for appropriate patient follow-up and for the delivery of high-quality medical care.

1. All Charts need to be completed/closed within **48 hours** of seeing the patient.
2. All Medicare Charts need to be reviewed by a full-time attending and completed/closed before leaving the office **that day**.
3. In-baskets will be reviewed on a regular, on-going basis by an assigned faculty member, who will give a report to the FHCE Medical Director.
4. Residents who are not compliant with the above policy will be assigned extra call, other responsibilities or adjustments in allowed time off at the discretion of the FHCE Medical Director and/or the DME.

Policy for Treating Clinic Staff

1. All clinic staff members require an appointment to be evaluated or treated for both acute and chronic medical problems.
2. Chronic medical problems require management and treatment by **one** primary physician within the Clinic.
3. All clinic staff visits and subsequent prescriptions must be approved by the FHCE Medical Director or his designee.
4. Time off from working in the clinic secondary to medical reasons, must be approved by the FHCE Medical Director and coordinated with the Practice Manager.
5. The clinic staff's help in assisting the Residents to abide by these policies is greatly appreciated.

Pregnant Patients and Children Under 3 Months of Age

All pregnant patients and children under the age of 3 months of age, must be precepted with a faculty member, regardless of PGY class.

Family Medicine Residency Service (FMRS)

No personal leave is allowed during this rotation.

Synopsis

The minimum duration of this portion of the curriculum shall be six (6) months with two (2) months completed during OGME-1. The two (2) months during OGME-1 shall consist of at least one (1) month of critical care medicine and one (1) month in general internal medicine. During OGME-2 and OGME-3, emphasis will be placed on the specific subspecialty areas listed below. Procedures appropriate to osteopathic family medicine shall be emphasized. A mix of hospital based and ambulatory experiences is required.

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, educational experiences that will expand his/her knowledge and skills in the management of adult, medical diseases.

Objectives

The resident will demonstrate competency in his/her ability to:

- Recognize those patients who should be managed in a hospital setting.
- Manage patients in the hospital setting.
- Manage hospitalized patients after discharge.
- Seek specialty consultation when appropriate, and maintain direct responsibility for the management of the patient.
- Perform specific medical procedures as outlined in the procedure section of these basic standards.
- Understand and utilize appropriate pharmacologic interventions.

The FMRS rotation is the hospital IM service supervised by the faculty.

Team Composition:

FMRS Attending Faculty plus 4 postgraduate trainees; usually:
4 residents and 1-2 medical externs

Night and Weekend Coverage:

An evenly divided rotation of all residents will be printed on the call schedule. Tuesday and Thursday night FMRS call is the responsibility of the assigned FMRS resident. Pediatrics call is the responsibility of the night resident. The FMRS resident on call will be required to be in-house for night and weekend coverage.

Call Schedule:

An evenly divided rotation of all residents will be printed on the call schedule.

OGME-2 and OGME-3 FMRS Resident Duties

1. Weekday duty hours for senior Residents are 7 a.m. - 5 p.m. daily. The senior residents are expected to be in the hospital during these hours. Residents are required to stay beyond 5 p.m. to complete patient follow-up or to admit new patients. Weekend and night duty hours follow the assigned call schedule.
2. Residents are responsible for admission and discharge of patients as outlined in the FMRS Admissions and Hospital Discharge sections of the manual. Each admission should be discussed with the responsible Attending as soon as possible.
3. Residents are responsible for the organization and timeliness of work and teaching rounds.
4. A senior resident will see all patients daily. The senior resident will write a brief note on all patients seen. The notes may be written after the completion of attending rounds. Completion of notes prior to Attending rounds is encouraged. Each senior resident is to have a thorough working knowledge of ALL patients on service. Any significant change in a patient's condition should be reported to the responsible Attending physician as soon as possible.
5. If a patient is being referred to FHCE for the first time from the FMRS and primarily a medical extern is following the patient, the patient should be assigned in FHCE to the FMRS resident who supervised the patient's care in the hospital. A patient referred to FHCE for the first time from FMRS service should be referred to the resident who provided the continuity care for the patient during the hospital stay.
6. FMRS on-call resident is required to be in house. For all others, during on-call times the resident **MUST** arrive at the hospital within thirty (30) minutes of notification of an admission or other emergency. Admissions must be completed in sixty (60) minutes (see below). The resident will remain in the hospital whenever there is a patient with an ongoing critical problem, i.e. DKA, evolving MI, hypotension/sepsis or other unstable medical condition.
7. FMRS residents are to attend all educational conferences. The on-call resident conducts morning report the morning following call.
8. OGME-2 and OGME-3 residents on FMRS will attend clinic at FHCE three (3) half days per week. The resident remains responsible for the care of all in-patients on his/her service on clinic days.
9. Residents on FMRS are to direct all case based learning, including assignments of reading and literature searches. The Residents are responsible for teaching basic concepts and skills to OGME-1 residents and externs. The Resident will be involved in the evaluation of OGME-1 residents and externs.
10. Continuity of care includes admission H&P (H&P form AND Osteopathic Structural form) or Admit Note, AOA structural form, follow-up evaluation and management as evidenced by daily notes and orders on most hospital days, and follow-up outpatient care for patients who are new to the FHCE.

OGME-1 Resident Duties

1. The weekday duty hours for OGME-1 residents are 7 am until 7 p.m. OGME-1 Residents are to be available for patient follow-up and new admissions during these hours. Weekend duty follows the on-call schedule. OGME-1 Residents may be on call until 11 p.m. on Tuesdays and Thursdays as assigned.
2. OGME-1 Residents, under the direction of the OGME-2 and OGME-3 Residents, are responsible for admission and discharge of patients as outlined in the FMRS Admissions and Hospital Discharge sections of the manual.
3. All patients are to be seen by, and have a primary note written by, an OGME-1 resident or medical extern. Whenever possible, there should be continuity in patient care. That is, a patient should have the H&P and

Osteopathic Structural Exam form done and be seen by the same OGME-1 resident/medical extern each day. Adequate time will be allotted for work rounds to allow each OGME-1 resident to comfortably evaluate and manage four (4) to six (6) patients per day. The notes may be written after the completion of Attending rounds. Completion of notes prior to Attending rounds is encouraged. Attending physicians are to sign off all OGME-1 resident notes and orders. Each OGME-1 is to have a working knowledge of ALL patients on service. Any significant change in a patient's condition should be reported to the on-call Resident and the responsible Attending physician.

Continuity of care includes admission H&P (H&P form AND Osteopathic Structural form) or admit note, AOA structural form, follow-up evaluation and management as evidenced by daily notes and orders on most hospital days, and follow-up outpatient care for patients who are new to the FHCE. A patient referred to FHCE for the first time from FMRS service should be referred to the OGME-1 resident who provided the continuity care for the patient during the hospital stay.

4. OGME-1 Residents on FMRS will attend clinic at FHCE one half day per week. On an OGME-1 resident's clinic day, the supervising resident may elect to do the primary management and noting on the clinic OGME-1 resident's patients.

The OGME-1 resident is expected to complete his/her duties prior to leaving the hospital for the day. The OGME-1 resident is responsible for in-patient care on clinic days and is to report back to the hospital upon completion of duties.

5. OGME-1 Residents on FMRS are to attend all educational conferences and will be assigned one case presentation for morning report per rotation.
6. OGME-1 Residents on FMRS are responsible for case based reading on all patients. They will share this reading with the team. The OGME-1 residents are also responsible for teaching basic concepts and skills to the externs on service.

Medical Extern Duties

1. The duty hours for medical externs on FMRS is 7 am - 7 p.m. The FMRS resident may NOT dismiss the extern(s) early. Only the Attending Physician may dismiss an extern. On admission day the extern is expected to stay until 7 p.m.
2. Weekend duties will be assigned in accordance with the Extern Manual. A night call and weekend call schedule will be published monthly.
3. Each extern on FMRS will be assigned primary patients. The externs' duties with the patients are outlined in the extern manual. In general each extern will follow two to four patients each day. Whenever possible, the externs will follow the patient throughout the patient's hospital stay. This includes completing admission H&P and Osteopathic Structural forms. Externs are NOT to dictate discharge summaries.
4. Externs on FMRS service are required to attend ALL educational conferences.
5. Externs on FMRS are responsible for case based reading on all patients. The extern will share this reading with the team.
6. Days off and partial days off for externs must be approved by the Medical Education Office IN ADVANCE. The extern MUST apply for Time-off (including Holidays) by completing an *Extern Time-Off Form* at least two (2) weeks prior to the requested day(s). Forms are available in the Medical Education office.
7. All extern absences for illness or emergency are to be reported to the Department of Medical Education by 8:00 am. Externs who are ill for more than two (2) days must present a return to work authorization from a licensed physician.
8. All orders written by externs must be signed by a resident or an attending before giving to the nursing staff.

Orders

Transfers to ICU or from ICU require new orders to be written and switched to/from the ICU service. New orders are to be written post operatively. ALL orders written by housestaff must be co-signed by an attending physician. Externs may not write orders and submit them to a nurse without an resident or attending's signature. The medical externs cannot independently write orders and must be accompanied by a member of the housestaff when orders are written. The senior Resident on each service is strongly encouraged to review and co-sign all orders however; hospital regulations require Attending signature on all housestaff orders. All orders are to be dated, timed, and signed in accordance with AOA and Florida Hospital regulations.

FMRS Admissions

General

ALL patients must have an admit note written and dictated by the resident who admits the patient. This note may be a brief outline of the salient points of the case if it accompanies an H&P and Osteopathic Structural Exam Form. The name of the Attending with whom the case was discussed must be included in the note along with management issues.

Patients will be admitted to FMRS/Lee. However, orders and notes should be signed and slashed with the name of the attending covering that day (e.g. *Resident Name/Clinton*). Orders should always be slashed with the name of the Attending physician with whom the orders were discussed.

The FMRS service will accept any unassigned ED admission from 7 a.m. Tuesday to 7 a.m. Wednesday and those referred by our regular referring physicians.

Jeffrey Downing, DO
Richard Dycus, DO
Charles Morgan, MD (if requested)
Robert Schamberger, DO
William Silverman, DO

Referrals from other sources, (e.g. Surgery, GYN, GI, or Pulmonary) **MUST** be approved by the FMRS Attending **PRIOR** to evaluation of the patient by the resident. If there is a question about such referral, the referring physician should be encouraged to discuss the case with the FMRS Attending.

Emergency Department Admissions

In order to participate in decision making concerning admissions of patients, the Family Medicine resident will be contacted by the Emergency Department physician whenever there is a patient to be admitted to the FMRS service. The resident will rapidly assess the patient and determine the need for admission and contact the appropriate FMRS attending to discuss the case.

Daytime admissions will be called by the ED physician to the on-call resident for that day. The on-call resident will review the case with the ED physician and make a determination of bed assignment (ICU, PCU, Tele etc.). If the on-call resident is unsure about bed assignment the resident next discusses the case with the FMRS attending on call.

The on-call resident and the night OGME-1 resident will do night and weekend admissions.

The process of admitting an FMRS patient, which is the time from the initial phone contact of the resident to the time preliminary orders for transfer to the floor, will take less than sixty (60) minutes. In order to facilitate this time constraint the following process is delineated.

1. Emergency Department physician will discuss each case directly with the FMRS resident on-call and review the salient points of the patient's work-up and the indication(s) for admission (Interqual criteria). The resident will immediately assess the patient. If further work-up is required the resident will recommend this work-up to the Emergency Department physician during the initial phone conversation.
2. If a bed is available, the resident will quickly evaluate the patient, contact the FMRS Attending, write a brief admit note, and write a preliminary set of orders to get the patient to the floor. The OGME-1 resident can evaluate the patient, complete and dictate the H&P, discuss the case with the resident and complete the admission orders. If the resident is not immediately available an OGME-1 resident will be assigned to

begin the initial evaluation, discuss the patient with the resident and initiate orders. The resident will examine the patient as soon as possible and work with the OGME-1 resident to complete the admission.

3. If a bed is not available, the resident may assign an OGME-1 resident to do the initial evaluation and work-up of the patient. The resident will examine the patient when the OGME-1 resident has completed his/her evaluation and work with the OGME-1 resident to complete the admission. The resident will directly observe each OGME-1 resident, once per FMRS rotation, perform a complete admission. This includes observing the OGME-1 resident complete a full H&P/Osteopathic structural exam, writing orders and discussing the important points of the case.
4. In the event of disagreement concerning need for admission, the admitting resident will discuss the admission criteria for the patient with the Emergency Department physician. If the disagreement is not resolved then the FMRS Attending will be contacted and s/he will discuss the case directly with the Emergency Department attending. If the ED Attending says to admit, the FMRS Attending must come in and evaluate the patient to override the admission and dismiss the patient.
5. The Surgical OGME-1 resident will perform admissions to the services of Drs. Baig, McDonald, and Bennett during the day and the On-call OGME-1 Resident at night. These physicians may elect to give preliminary orders to get the patient to the floor before the OGME-1 resident completes the admission.

Clinic Admissions

FHCE patients admitted from the clinic will be either admitted through the ED or as a "Direct Admit" at the discretion of the Attending physician in the clinic. Unstable patients from the clinic should be referred, via ambulance, to the ED. If a bed is not immediately available for a stable patient, the patient may be referred to the ED. An ED physician should be contacted by the referring resident anytime a patient is sent to the ED. The admission work-up for any patient evaluated by the ED will be completed by the FMRS admission team.

OGME-3 and OGME-4 residents have the option of admitting their own patients seen at FHCE to the service of one of the FHCE attendings. The resident is responsible for coordinating rounds with the attending and is responsible for all aspects of the admission, including weekend coverage.

Stable patients will be admitted directly to the floor, if a bed is available. The admission work-up including Admit Note, Attending Admit Note and admission orders should be completed at FHCE and accompany any directly admitted patient. The receiving team will review the admission work-up and write a brief acceptance note.

The FHCE resident must directly communicate with the receiving FMRS resident concerning all patients referred for admission. The FHCE attending is encouraged to communicate with the receiving FMRS Attending.

Daily care for the FHCE patient is provided by the FMRS service resident. The patient's FHCE resident will follow the patient daily and write notes in the in-patient record where appropriate. The patient's FHCE resident will not write orders on the patient unless the orders are first discussed with the FMRS team.

Community Physicians

Patients are referred to FMRS by community physicians (refer to current list). These patients will be managed by the FMRS Attendings.

If patients are admitted through the Emergency Department for a medical illness, the usual admission procedures should be followed. The admission orders should be discussed with the FMRS attending. Like FMRS admissions, a referred patient is not accepted until the FMRS Attending is consulted. For non-medical illnesses (e.g. acute abdomen, intrauterine pregnancy, etc.) the admission should be discussed with the FMRS attending prior to the resident working up the case.

For patients referred directly from a community physician's office the following apply:

Daytime referrals:

- The referring physician will contact the on-call resident via the hospital operator.
- The on-call resident will then contact the covering FMRS Attending, who will in turn contact the referring physician to determine the disposition of the patient.

Nighttime referrals:

- Patients should be directed to the emergency department for evaluation prior to admission.
- The referring physician may contact the on-call resident to provide background patient information and may request to speak to the covering FMRS Attending.
- When accepting a direct admission referred by a community physician, the resident must inquire about insurance information. The resident then discusses the case with the FMRS Attending. If the FMRS Attending approves the admission the resident calls for admissions for a bed and provides the insurance information. The resident then notifies the community physician of the out come of the bed search.

Consultation Services provided by FMRS

The FMRS service will perform consultations for medical problems on any patient, if requested, by the patient's Attending physician. Such consultations should be evaluated promptly by the on-call resident and discussed with the FMRS Attending. If the FMRS service is full and the patient is not an FHCE patient, faculty patient, or community referral (see above), the resident should immediately discuss the situation with the FMRS Attending with the consideration of contacting the referring physician and decline the consult. The resident may recommend the ED back-up physician as a substitute. Any conflicts should immediately be referred to the FMRS Attending. Medical consultations will be accepted at all times on FHCE, community referred, and faculty patients.

Consultation Orders

- **Consult** order means that you are requesting an opinion by another physician on your case. In general, the person you consult does not write orders nor is obliged to come back to check on the patient. **Co-management** means that another physician shares in the management of a part or all of the care for your patient.
- If you want a consultant to manage a part of the case, it is important to write a consult/co-management order. Specify which part(s) of the case you wish to be managed by each consultant.
- For billing purposes, it is important to be specific about whether the consult is strictly consultation, or consultation and co-management.
- *Write* what attending you wish to see the case, and the question you're going to ask (what is the consult for). This also applies to clinical studies such as, x-rays, pathology reports, etc. When writing for a study, the indication or a brief clinical synopsis should be included.
- Always write for the consultant that you wish to see the patient, not the name of the covering consultant. It may be harder to find the covering consultant for follow-up.
- Consultation orders are not to be canceled without the express permission of the FMRS Attending. Under certain circumstances it may be appropriate to "curbside" a consultant and then officially consult that person if a need is indicated.
- Do not consult another FMRS attending.
- When we refer a patient to a consultant for outpatient follow-up, that patient may be readmitted to the FMRS service upon the request of the consulting physician.

Discharge from the FMRS Service

When a patient is discharged from the FMRS service the following procedure will be followed:

1. A complete set of discharge orders will be written, including:
 - a. A complete list of discharge diagnoses
 - b. Follow-up instructions with physician phone numbers and appointment dates and times. This list will include the name of the resident who will be responsible for the patient at FHCE.
 - c. Any home care arrangements
 - d. A complete list of medications with dosages
 - e. A complete list of pending or ordered laboratory, cardiology, radiology, or other studies.
2. A clinical resume should be completed on each patient at the time of discharge. If it is not possible to complete the clinical resume at the time of discharge, the resume should be completed within twenty-four (24) hours following discharge. The clinical resume is required for two important reasons. First a completed clinical resume is required for the hospital to receive payment from many third party payers. Secondly, the clinical resume serves as a resource for continuity of care for all physicians who subsequently care for the patient.

Residents who have clinical resumes greater than 30 days past due may be subject to additional call duties at the discretion of the DME.

Hospital rules require a typewritten clinical resume on all patients admitted to the hospital for greater than forty-eight (48) hours. The program encourages the use of typewritten clinical resumes for all patients with complex medical problems, regardless of the length of the hospital stay. A copy of the clinical resume should be sent to the physician who is to follow the patient after discharge.

The clinical resume should be consistent with the format outlined in the *General Rules and Regulations of the Medical Staff*.

Adverse Drug Events

Adverse drug reactions need to be reported, as well as significant medication errors. There is a standard form that needs to be completed. Only write about adverse drug reactions in the SOAP note to the extent that the patient is affected. Be careful when you report on adverse reactions - do not imply that a medication was the culprit if it was not.

New definition of Adverse Drug Reaction, as defined by JCAHO standards:

Significant adverse drug reactions and significant medication errors:

Unintended, undesirable and unexpected effects of prescribed medications or medication errors that:

- a. requires discontinuing a medication or modifying the dose*
- b. requires initial or prolonged hospitalization*
- c. results in disability*
- d. requires treatment with prescription medication*
- e. results in cognitive deterioration or impairment*
- f. are life threatening, results in death or result in congenital anomalies*

The standards go on to state "intense analysis should also occur for those topics chosen by leaders as performance improvement priorities or when undesirable variation occurs that changes the priorities."

FHCE Patients:

1. The resident discharging the patient will call FHCE for a follow-up appointment and record this appointment date and time on the discharge orders. If the discharge occurs when FHCE is closed the patient and the patients' family are advised to call for an appointment during the next business day for FHCE. This should be written into the discharge orders. (See FMRS Duties section for selection of FHCE resident for discharged patients.)
2. Copies of the following are to be faxed to FHCE by the FMRS resident at the time of discharge:
 - The face sheet
 - The discharge orders
 - The two page discharge instruction sheet.
 - Additional information such as labs may also be faxed or may be carried to FHCE by the resident.

Non FHCE Patients

When patients are to be followed by another physician, the physician should be contacted and the follow-up plans should be discussed. This conversation should be documented in the progress notes. Copies of the above stated materials should be faxed as a courtesy to the physician who will follow the patient.

Home Care

When a patient is to receive Home Care Services, a licensed physician must approve these services. Home care law requires that a patient be seen within thirty (30) days of any home care order.

When a patient is discharged from the hospital with a home care need, a home care nurse will evaluate the patient. The home care nurse will then contact either the resident responsible for the patient's care at FHCE or the discharging FMRS attending to discuss and approve the plan of care. If the resident is contacted, the resident should discuss the plan of care with the discharging FMRS attending prior to approving the initial plan of care. The FMRS Attending discharging the patient will sign the initial Plan of Care. A copy of the Plan of Care will be included in the patient's FHCE record. **The FMRS attendings will not be involved in any subsequent decision regarding homecare.**

If home care is initiated following an FHCE visit, the initial plan of care will be signed by the supervising FHCE attending physician. The patient must be seen by an FHCE Attending prior to the institution of home care for patients referred to home care from the FHCE.

The home care provider may contact the resident concerning changes in the Plan of Care for the patient. If a resident is contacted by a home care provider to make a change in a patient's care plan the following applies:

If the change is minor and consistent with the existing care plan; such as, use of a different dressing in a wound care patient or modification of insulin dose in a patient sent home from the hospital with a plan of insulin dose titration or discharge from home care services after a planned length of care, then an order may be given by phone by a licensed resident with attending approval. The attending will then sign the new care plan. If the resident is not licensed, or an OGME-1 resident is caring for the patient, changes in care plan should be discussed with an FHCE Attending physician prior to giving any orders and the new care plan must be co-signed by the attending physician. Any change in the Plan of Care for a home care patient must be documented in the patient's FHCE chart.

If the change in the Plan of Care is significant, such as, a new wound infection or changing a patient from an oral agent to insulin or extending home care services beyond thirty (30) days or prescribing new durable medical equipment, then the patient MUST be seen by a licensed physician prior to change of the care plan. The home care provider will be advised to have the patient make an appointment at FHCE for evaluation. If the change in the patient's condition is serious and warrants immediate attention, the patient should be referred to the Emergency Department. Any discussion with the home care provider must be documented in the FHCE chart.

Clinical Competencies Internal Medicine (FMRS)

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
Medical Knowledge: Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care	<ul style="list-style-type: none"> Apply pertinent basic science principles to patients with internal medicine problems Analyze pathophysiological principles to understand why patients develop signs and symptoms from various diseases Apply basic pharmacological principles to the treatment of common internal medicine diseases <p><i>See list of common problems in Internal Medicine</i></p>	<ul style="list-style-type: none"> Morning Report Didactic Conferences Journal Club EBM Guidelines and Procedure Workshops Board Review 	<ul style="list-style-type: none"> In-service Exams COMLEX III OSCE Monthly Service Evaluation
Patient Care: Provide patient care that is compassionate, appropriate, and effective for the treatment of health	<ul style="list-style-type: none"> Demonstrate proficiency in obtaining a history from an adult patient Perform a general physical examination on an adult patient Perform a problem focused physical examination on an adult patient Formulate a differential diagnosis for 	<ul style="list-style-type: none"> Morning Report Didactic Conferences Journal Club EBM Guidelines and Procedure Workshops 	<ul style="list-style-type: none"> In-service Exams COMLEX III OSCE Monthly Service

<p>problems and the promotion of health</p>	<p>common presenting symptoms of adult disease</p> <ul style="list-style-type: none"> • Develop specific motor skills necessary to perform procedures on IM patients <ul style="list-style-type: none"> ○ Lumbar puncture ○ Thoracentesis ○ Central venous pressure line insertion ○ Venipuncture / ABG • Detect commonly potentially serious medical diseases <ul style="list-style-type: none"> ○ Breast cancer - Perform a breast exam ○ Cervical Cancer – Perform a Pap smear ○ Colon Cancer – Perform a stool guaiac ○ Prostate Cancer – Perform a DRE • Evaluate the pre-operative patient • Manage the medical condition of the post-operative patient 	<ul style="list-style-type: none"> • Board Review 	<p>Evaluation</p>
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Develop communication skills that facilitate the transfer of information to persons from a different cultural or socioeconomic background • Utilize communication skills necessary to care for dying patients and their families • Employ sensitivity when dealing with people who are vulnerable or scared • Assess the psychosocial and spiritual needs of the patient 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> • Identify and utilize resources for dissemination of new information regarding the practice of internal medicine • Identify and utilize evidence-based medicine guidelines in the field of internal medicine • Apply these principles to regular health maintenance 	<ul style="list-style-type: none"> • Use of “virtual library” • QA / PI data • Journal Club • EBM workshops • Use of EBM order sets 	<ul style="list-style-type: none"> • AOA CAP program • QA / PI reports • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the</p>	<ul style="list-style-type: none"> • Employ a team oriented approach to problem solving in internal medicine • Consult other physicians and health care providers in a manner that maximizes patient care and minimizes communication barriers 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Community service (Shepherd’s Hope) 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service

larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value	<ul style="list-style-type: none"> • Question the increasing larger role that financial considerations play in medicine • Advocate for the needs of the patient, in light of society's inability to provide unlimited resources to everyone 	<ul style="list-style-type: none"> • Involvement in Discharge planning 	Evaluation
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.</p>	<ul style="list-style-type: none"> • Exemplify behaviors such as altruism, accountability, excellence, duty, honor, integrity, and respect for others • Altruism: the best interest of the patient must come before the interests of the doctor • Accountability: accountability to patients, patients' families, peers, faculty and society • Excellence: an effort to exceed ordinary expectations • Duty: a commitment to service • Honor and integrity: a commitment to the highest standards of personal and professional behavior • Respect for others: respect for patients, their families, peers, nurses, faculty, and other medical personnel and ancillary staff 	<ul style="list-style-type: none"> • End of Life Care Training (EPEC) • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities.</p>	<ul style="list-style-type: none"> • Apply osteopathic principles to the diagnosis and treatment of the internal medicine patient • Identify specific internal medicine conditions where osteopathic manipulative medicine is a component of the treatment plan. Examples: <ul style="list-style-type: none"> ○ Pneumonia ○ Ileus • Apply holistic approaches to the diagnosis and management of internal medicine conditions 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly Distance Learning • OMT Clinics 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • Inpatient Credentialing • OSCE • Monthly Service Evaluation

Common Problems in Internal Medicine

Cardiovascular disease

- Acute Coronary Syndromes
- Congestive Heart Failure
- Valvular Heart Disease
- Atrial Fibrillation and Anticoagulation
- Hypertension

Endocrinology

- Diabetes Mellitus

- Hypo- and Hyperthyroidism
- Osteoporosis and Disorders of Calcium Metabolism

Hematology

- Anemia
- Coagulopathies

Gastroenterology

- Hepatitis
- Peptic Ulcer Disease
- Gastroesophageal Reflux Disease
- Diarrhea and Constipation

Medical Oncology

- Hematological Malignancy
- General Care of the Cancer Patient
- Management of Pain

Nephrology

- Electrolyte Disturbances
- Acid-Base Disorders
- Acute and Chronic Renal Failure

Rheumatology

- Rheumatoid Arthritis
- Osteoarthritis
- Monoarthritides
- Polyarthritides

Pulmonary disease

- DVT and Pulmonary Embolism
- Chronic Bronchitis and Asthma
- Emphysema

Infectious disease

- Fever of Unknown Origin
- Acquired Immune Deficiency Syndrome
- Pneumonia
- Urinary Tract Infection
- Cellulitis
- Subacute Bacterial Endocarditis

Allergy/Immunology

- Urticaria

Neurology

- Cerebrovascular Disease
- Headache
- Dementia and Coma

Dermatology

- Dermatological Manifestations of Chronic Medical Disease

Behavioral Medicine / Psychiatry

No vacation or CME time is allowed during this rotation.

This is a required two (2) week rotation for PGY-2 and PGY-3 residents at Family Health Center East. Goals established during the rotation will be monitored following its completion in the ambulatory clinic during the remainder of the year and certain skills will be required to be logged in New Innovations. The Attending Coordinator is Timothy Spruill, Ed.D.

Five principles addressed by curriculum:

1. A holistic model in which biological, psychological, social, and spiritual factors are integrated in the care of the patient.¹

¹ "We endeavor to deliver high-quality service, showing concern for patients' emotional and spiritual needs as well as their physical condition."
(FH mission statement)

2. Prevention through patient education and promotion of healthy lifestyles.²
3. Practicing medicine within the context of the family unit.³
4. Continuity of patient care fostered through a warm, trusting physician—patient relationship⁴.
5. Investment of time and energy in addressing the biological, psychological, social and spiritual needs of residents/interns.⁵

Process

Residents will maintain three scheduled clinic half-days during this rotation. No vacation or CME days may be taken during this rotation.

For PGY2 residents, 14 half-days are utilized as follows:

1. Residents will conduct evaluations and make a treatment recommendations for at least three suicidal patient in the ED. (approximately 5 half-days)
2. Review of Practice-based learning requirements. Completion of 1 Patient Orientated Evidence that Matters (POEMS) (1 half-day)
3. Physician self-care will be explored and assessed in order to move towards an optimal balance of personal and professional lives. Additional focus will be directed at managing stress and avoiding burnout or impairment. (1 half-day)
4. Individual strengths, beliefs and attitudes will be identified and related to their role in the practice of Family Medicine. Consists of structured self-reflection exercises designed to identify, assess and make explicit core physician beliefs/personal philosophy. Specific physician practices affected by these beliefs will be explored, including:
 - a) establishing a caring relationship with the patients that will foster continuity of care,
 - b) whether or not to address patient's psychological problems or refer. (2 half-days)
5. Knowledge level of behavioral medicine skills will be identified along with barriers to implementing behavioral medicine principles into their daily practice of medicine. Develop specific plans for overcoming these barriers. Residents will set individualized personal goals for integrating behavioral medicine principles and skills into their approach to patient care. They will also identify the means for monitoring and assessing the accomplishment of those goals. (1 half-day)
6. Clinical Application: Residents select 1-2 challenging patients with psychological co-morbidity or simply a strong negative "gut reaction" to seeing them. These patients' cases and charts will be reviewed and treatment and management plans will be devised. (1 half-days)
7. Clinical Application: Develop approaches to common situations such as: 1) Sharing "bad news" with patients, 2) Assessing patient readiness for change and motivating them to change unhealthy lifestyle behaviors, 3)

² "Doctors of osteopathic medicine help patients develop attitudes and lifestyles that don't just fight illness, but help prevent it, too." (Quotes from AOA homepage under description of osteopathic medicine)

³ "Family Practice is comprehensive medical care with particular emphasis on the family unit, in which the physician's continuing responsibility for health care is not limited by the patient's age or sex nor by a particular organ system of disease entity." (Excerpts from the official definition of "Family Practice" adopted by the American Academy of Family Physicians Congress Delegates from STFM newsletter, vol. 4, No. 6, Nov./Dec. 1984, p.3)

⁴ "Family practice is the medical specialty which provides continuing and comprehensive health care for each member of the family." (quote from AAFP homepage)

⁵ "We show concern for the whole person, respecting each worker's individuality and listening to each one's concerns and suggestions." (FH mission statement)

Developing an approach to counseling patients with common psychological problems such as depression and anxiety disorders, 4) Treating patients with panic disorder who depend on drugs. 5) Learning to recognize and treat patients with somatoform disorders. (2 half-days)

8. Introduce practical behavioral modification principles to be used for the treatment of pediatric disorders commonly encountered in Family Medicine. (1 half-day):

For PGY3 residents, 14 half-days are utilized as follows:

1. Participate in curriculum developed by Center for Drug Free Living to enhance knowledge and skills in treating patients with addictions. (6 half-days)
2. Review of Practice-based learning requirements. Completion of 1 Patient Orientated Evidence that Matters (POEMS) (1 half-day)

The Second week will consist of one of the three following “selectives”:

1. A second week at the Center for Drug Free Living (7 half-days)
2. Participate, under Dr. Allen’s supervision, in Center for Behavioral Health treatment activities. (7 half-days)
3. Work on completion of Research Project (7 half-days)

Objectives for the 2 rotations and the longitudinal clinic experience

The Resident shall demonstrate a working knowledge of the following behavioral medicine skills during the rotation and for the year following the rotation:

1. Identify and treat depression, anxiety and somatoform disorders.
2. Master basic counseling skills, including dealing with crisis situations such as suicidal patients.
3. Facilitate parental use of behavior modification techniques for treatment of common childhood disorders
4. Attempts to foster in patients a sense of responsibility for their health maintenance.
5. Prescribe and motivate health-promoting lifestyle changes.
6. Respect for the patient's experience of their illness in the context of their family, work and cultural setting.
7. Improved sensitivity to and skill in addressing “end-of-life” care.
8. Increased skill in treating addictions
9. Increased skill in the use of psychotropic medications
10. Address sources of personal stress/distress related to personal effectiveness as a physician.
11. Demonstrate good personal/social adjustment in their interactions with patients and other medical staff.

Evaluation

1. Written exercises designed to aid in self-reflection must be completed.
2. Standard rotation evaluation form
3. Skills associated with related credentialing criteria must be logged in New Innovations (and confirmed by Dr. Spruill) prior to residency completion including the following:
 - a. attendance at least (1) FH biomedical ethics committee meeting
 - b. completion of at least (2) Crisis Interventions (E.R. or ambulatory clinic)
 - c. completion of at least (5) Strategy sessions (3 jointly with Dr. Spruill & 2 conducted while video-monitored by Dr. Spruill)
 - d. completion of at least (2) Strategy sessions targeted at psychosocial treatment of chronic pain (1 conducted while video-monitored)
 - e. completion of at least (2) strategy sessions targeted at addressing alcohol/drug abuse/dependency (1 conducted while video-monitored)
 - f. completion of at least (2) strategy sessions targeted at motivating healthier lifestyle (diet/exercise) (1 conducted while video-monitored)
 - g. completion of at least (2) strategy sessions targeted at motivating healthier lifestyle (smoking cessation) (1 conducted while video-monitored)
 - h. completion of at least (2) sessions targeted at sharing bad news (1 conducted while video-monitored)
 - i. completion of at least (2) strategy sessions targeted at motivating non-compliant patients (1 conducted while video-monitored)

Recommended Reading/References

Novack, Dennis et al, Calibrating the Physician: Personal Awareness and Effective Patient Care, JAMA, August 13, 1997—Vol 278, No. 6, pages 502-509

Shank J., Zoppi, K, Behavioral Medicine in Family Practice: The well-trained resident in behavioral medicine, Clinics in Family Practice, March 2001—Volume 3, No. 1, pages 127-138.

Spruill, Timothy, Summary of Solution-focused Counseling. (Available from Dr. Spruill)

Spruill, Timothy, Assessment form for evaluating suicidal patients. (Available from Dr. Spruill)

Clinical Competencies Psychiatry / Behavioral Medicine

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
<p>Medical Knowledge:</p> <p>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care</p>	<ul style="list-style-type: none"> • Apply basic relevant genetic, epidemiology, pathophysiology, anatomy and pharmacology to psychiatric cases • Differentiate normal from abnormal emotional and cognitive development • Describe the causes of mood disorders, anxiety disorders, psychotic disorders, personality disorders, substance abuse disorders, eating disorders, childhood disorders, and geriatric disorders • Apply DSM IV nomenclature to psychiatric disorders • Distinguish between medical illnesses that present with psychiatric symptoms, and psychiatric disorders that present with medical signs and symptoms • Identify 1st and 2nd line psychopharmacological treatment options for the major psychiatric diagnoses • Explain psycho-social treatment options and referral process for psychiatric disorders <p><i>See list of common problems in Psychiatry</i></p>	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</p>	<ul style="list-style-type: none"> • Conduct and record a psychiatric history • Conduct and record a mental status examination • Formulate differential diagnoses • Use a bio-psycho-social-spiritual model to participate in the development of treatment 	<ul style="list-style-type: none"> • Morning Report • Didactic Programs • Bedside teaching 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Record Review • Case Logs • Monthly

	<p>plans</p> <ul style="list-style-type: none"> • Adjust interventions that affect levels of acuity based on accommodating new information pertaining to given patients • Identify high risk patients who are dangerous to self and others • Make appropriate safety and legal decisions for patients determined to be high risk 		<p>Service Evaluation</p>
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Demonstrate effective listening and communication skills • Effectively appraise the psychiatric conditions of given patients regardless of age, sex, ethnicity, or race • Provide empathic responses to patient’s social stigma pertaining to mental illness • Protect patients’ right to confidentiality • Identify support networks and exchange appropriate information following prescribed procedures, with family members and professional associates • Emphasize the role of the patient on the treatment team 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> • Identify the major sources of psychiatric information • Identify and utilize resources related to evidence-based guidelines and routine psychiatric care • Discern irregularities of psychiatric care in comparison to evidence-based guidelines 	<ul style="list-style-type: none"> • Use of “virtual library” • QA / PI data • Journal Club • EBM workshops • Use of EBM order sets 	<ul style="list-style-type: none"> • AOA CAP program • QA / PI reports • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> • Utilize the expertise of psychiatrists, psychologists and social workers with respect to indications for referral and coordination of care with primary care physicians • Explain the overall mental health delivery system in the community 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Community service (Shepherd’s Hope) • Involvement in Discharge planning 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation

	<ul style="list-style-type: none"> • Explain how the mental health delivery system and the social service delivery system interface with psychiatric care • Be cognizant of the health care financing issues affecting the delivery of mental health services 		
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> • Combine scientific curiosity with respect for the patient regardless of age, sex, ethnicity or race • Demonstrate an empathic relationship with patients while obtaining information needed to participate in the development and utilization of treatment plans • Adhere to the AOA ethics and parameters of confidentiality 	<ul style="list-style-type: none"> • End of Life Care Training (EPEC) • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities</p>	<ul style="list-style-type: none"> • Be cognizant of a holistic approach to mental health problems • Assess for and administer adjuvant OMT to aid in the lessening of suffering caused by concomitant medical illnesses that may be impacting, or are impacted by, mental health issues 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly Distance Learning • OMT Clinics • Computer Modules 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • Inpatient Credentialing • OSCE • Monthly Service Evaluation

Common Problems in Psychiatry/Behavioral Science

Mood Disorders

- Depression
- Anxiety Disorder
- Bipolar Disorder
- Obsessive-Compulsive Disorder
- Suicide and Para suicide

Childhood and Adolescent Psychiatry

- ADHD
- Eating Disorders

Geriatric Psychiatry

- Dementia
- Delirium

Psychoses

- Schizophrenia

Behavioral Medicine

- Alcohol, Illicit and Prescription Drug Addiction
- Tobacco Abuse
- Weight Loss Counseling
- Stress Management
- Dysfunctional Family Issues

Women's Psychiatry

- Postpartum Depression
 - PMDD
- Personality Disorders**
Somatoform Disorders

Cardiology/Critical Care

No more than one-week of personal leave can be taken during this rotation.

Objectives

The resident will demonstrate competency in his/her ability to:

- Understand the variety of management strategies for cardiac disease.
- Recognize symptoms of cardiac disease.
- Understand the cardiac effects of pulmonary disease.
- Understand cardiac manifestations of systemic diseases.
- Understand the indications for open-heart surgery.
- Understand the role of somatic dysfunction in cardiac disease.
- Integrate osteopathic manipulative treatment into the management of patients with cardiac disease.
- Perform a preoperative cardiac assessment

This is a four-week rotation for OGME-1 residents under the supervision of Drs. Brian Kelly, Glenn Harris, Alexander Alperovich and Chika Okereke. The OGME-1 resident will be responsible for:

- Following all cardiology and critical care patients under the supervision of the attendings
- Writing daily progress notes for all patients
- Assisting attending with all special procedures
- Examining and assessing consults under the direct supervision of the attendings
- Following the reading program
- Supervising externs on the service
- Providing a daily educational component for OGME-1 residents and externs
- May be assigned to diabetic group patient education

The OGME-1 resident will be scheduled for one (1) clinic sessions each week at FHCE during this rotation.

Clinical Competencies Critical Care

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
Medical Knowledge: Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care	<ul style="list-style-type: none"> • Expand clinically applicable knowledge base of the basic and clinical sciences underlying the care of patients with critical medical illness • Analyze pathophysiological principles to understand why patients develop signs and symptoms from various diseases • Understand the physiologic and pathophysiologic principles of invasive hemodynamic monitoring including indications <p><i>See list of common problems in Critical Care</i></p>	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • EBM Guidelines and Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation

<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</p>	<ul style="list-style-type: none"> • Effectively evaluate and manage patients with critical medical illness, including those on mechanical ventilation and vasopressors • Formulate a differential diagnosis for common presenting symptoms of the critically ill adult • Develop specific motor skills necessary to perform procedures on critically ill patients: <ul style="list-style-type: none"> ○ Lumbar puncture ○ Thoracentesis ○ Central venous pressure line insertion ○ Venipuncture / ABG • Manage the medical condition of the post-operative patient 	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • EBM Guidelines and Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Develop communication skills that facilitate the transfer of information to persons from a different cultural or socioeconomic background • Utilize communication skills necessary to care for dying patients and their families, including discussion of end-of-life issues and limits of care • Employ sensitivity when dealing with people who are vulnerable or scared • Assess the psychosocial and spiritual needs of the patient • Communicate effectively with colleagues when signing out patients or turning over care to another service 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> • Identify and utilize resources for dissemination of new information regarding the practice of critical care medicine • Identify and utilize evidence-based medicine guidelines in the field of critical care medicine • Apply these principles to regular health maintenance 	<ul style="list-style-type: none"> • Use of “virtual library” • QA / PI data • Journal Club • EBM workshops • Use of EBM order sets 	<ul style="list-style-type: none"> • AOA CAP program • QA / PI reports • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> • Employ a team oriented approach to problem solving in internal medicine • Consult other physicians and health care providers in a manner that maximizes patient care and minimizes communication barriers • Question the increasing larger role that financial considerations play in medicine • Advocate for the needs of the patient, in light of society’s inability to provide unlimited resources to everyone 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Community service (Shepherd’s Hope) • Involvement in Discharge planning 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation

<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.</p>	<ul style="list-style-type: none"> • Exemplify behaviors such as altruism, accountability, excellence, duty, honor, integrity, and respect for others • Altruism: the best interest of the patient must come before the interests of the doctor • Accountability: accountability to patients, patients' families, peers, faculty and society • Excellence: an effort to exceed ordinary expectations • Duty: a commitment to service • Honor and integrity: a commitment to the highest standards of personal and professional behavior • Respect for others: respect for patients, their families, peers, nurses, faculty, and other medical personnel and ancillary staff 	<ul style="list-style-type: none"> • End of Life Care Training (EPEC) • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities.</p>	<ul style="list-style-type: none"> • Apply osteopathic principles to the diagnosis and treatment of the critically ill patient • Identify specific conditions where osteopathic manipulative medicine is a component of the treatment plan. Examples: <ul style="list-style-type: none"> ○ Pneumonia ○ Ileus • Apply holistic approaches to the diagnosis and management of internal medicine conditions 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly Distance Learning • OMT Clinics 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • Inpatient Credentialing • OSCE • Monthly Service Evaluation

Common Problems in Critical Care Medicine

Cardiovascular disease

- Acute Coronary Syndromes
- Congestive Heart Failure
- Valvular Heart Disease
- Atrial Fibrillation and Anticoagulation
- Hypertension

Endocrinology

- Diabetes Mellitus
- Hypo- and Hyperthyroidism
- Disorders of Calcium Metabolism

Hematology

- Anemia
- Coagulopathies

Gastroenterology

- Hepatitis
- Peptic Ulcer Disease
- Gastroesophageal Reflux Disease
- Diarrhea and Constipation

Medical Oncology

- Hematological Malignancy
- Medical Emergencies of the Cancer Patient
- Management of Pain

Nephrology

- Electrolyte Disturbances
- Acid-Base Disorders
- Acute and Chronic Renal Failure

Rheumatology

- Rheumatoid Arthritis
- Osteoarthritis
- Monoarthritides
- Polyarthritides

Pulmonary disease

- DVT and Pulmonary Embolism
- Chronic Bronchitis and Asthma
- Emphysema

Infectious disease

- Fever of Unknown Origin
- Acquired Immune Deficiency Syndrome
- Pneumonia
- Urinary Tract Infection
- Cellulitis
- Subacute Bacterial Endocarditis

Allergy/Immunology

- Urticaria

Neurology

- Cerebrovascular Disease
- Headache
- Dementia and Coma

Dermatology

- Dermatological Manifestations of Chronic Medical Disease

Dermatology

Objectives

The resident will demonstrate competency in his/her ability to:

- Recognize and manage common dermatological conditions.
- Identify allergic etiologies of dermatologic lesions.
- Know the indications for dermal biopsy.
- Recognize dermatologic manifestations of systemic disease.

This is a four-week rotation under the supervision of Dr. Martin Yungmann. The resident will be responsible for:

- Attending clinic with the Attendings
- See consults with Attendings
- Follow assigned reading schedule
- Complete assigned clinical responsibilities
- Completing procedural logs and evaluations

The Resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation; usually Wednesday am and p.m. and Friday p.m.

Elective I – V

Synopsis

1. There shall be a minimum of five (5) months and a maximum of seven (7) months of supervised electives available to all residents during the course of the residency. At least one month must be completed during OGME-1, at least two months in OGME-2, and at least two months in OGME-3.
2. All electives must be approved by the Program Director in advance of the start of the rotation.

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with additional educational experiences that will enhance his/her training with experiences relevant to his/her plans for future practice.

Objectives

The resident will demonstrate competency in his/her ability to:

Complete elective rotations that will allow the resident to increase his/her competency in areas of special interest, which may include but not be limited to, administrative medicine, critical care, geriatrics, or sports medicine.

OGME-1 Residents

Each OGME-1 resident will have one two-week elective rotation. The resident will arrange the rotation. The *Elective Rotation Form* (available in the Department of Medical Education) must be completed and submitted to the ME department before the rotation is scheduled. All forms must be submitted at least thirty (30) days prior to the start of the rotation or the resident will be assigned an attending by the DME. All electives shall be within the FH system. Elective I is with any area of medicine the resident chooses. There must be a signed Off-Site Agreement form in the ME department with the elective attending.

Rotation sites must be approved by the DME prior to completion of the *Elective Rotation Form*. All rotation sites must be within the FH system.

The resident will be scheduled for one (1) clinic session each week at FHCE during this rotation.

OGME-2 Residents

Each OGME-2 resident will have one elective rotation. The resident will arrange the rotation. The *Elective Rotation Form* (available in the Department of Medical Education) must be completed and submitted to the ME department before the rotation is scheduled. All forms must be submitted at least thirty (30) days prior to the start of the rotation or the resident will be assigned an attending by the DME. All electives shall be within the FH system. Elective II is with any area of medicine the resident chooses. Elective II is for four (4) weeks. There must be a signed Off-Site Agreement form in the ME department with the elective attending.

Rotation sites must be approved by the DME prior to completion of the *Elective Rotation Form*. All rotation sites must be within the FH system.

The resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation.

OGME-3 Residents

Each OGME-3 resident will have two elective rotations. The resident will arrange the rotation. The *Elective Rotation Form* (available in the Department of Medical Education) must be completed and submitted to the ME department before the rotation is scheduled. All forms must be submitted at least thirty (30) days prior to the start of the rotation or the resident will be assigned an attending by the DME. All electives shall be within the FH system. Elective III and IV are in any area of medicine the resident chooses. Elective III and IV are for four (4) weeks each. There must be a signed Off-Site Agreement form in the ME department with the elective attending.

Rotation sites must be approved by the DME prior to completion of the *Elective Rotation Form*. All rotation sites must be within the FH system.

The resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation.

OGME-4 Residents

Each OGME-4 resident will have three elective rotations consisting of four (4) weeks each. The resident will arrange the rotation. The *Elective Rotation Form* (available in the Department of Medical Education) must be completed and submitted to the ME department before the rotation is scheduled. All forms must be submitted at least thirty (30) days prior to the start of the rotation or the resident will be assigned an attending by the DME. All electives shall be within the FH system. There must be a signed Off-Site Agreement form in the ME department with the elective attending.

Rotation sites must be approved by the DME prior to completion of the *Elective Rotation Form*. All rotation sites must be within the FH system.

The resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation.

Elective Options

Allergy and Immunology

Objectives: The resident will demonstrate competency in his/her ability to:

1. Understand the physiology of the allergic response.
2. Understand immunosuppression.
3. Understand the mechanism of desensitization.
4. Care for the allergic patient.
5. Understand the role of somatic dysfunction and the relationship of osteopathic principles and treatment on the immune system.

Community Medicine

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will enhance his/her knowledge and skills in health promotion disease prevention, including appropriate strategies such as immunizations, healthful lifestyle changes, and other community related programs.

Objectives

The resident will demonstrate competency in his/her ability to:

1. Utilize community resources to assist in the management of patients.
2. Understand the role of local health departments in the management of patients.
3. Utilize evidence-based principles to determine appropriate strategies for care.
4. Identify modifiable risk factors for the prevention of disease.
5. Understand how physicians' personal behavior affects the patient's perception of them as a role model for responsibility in their own health.
6. Understand the importance of patient education in the area of injury prevention, especially motor vehicle accidents, accidents in the home, sports injuries, and domestic violence.
7. Understand the role of and utilize Hospice in the care of the dying patient.
8. Understand the importance of recognizing cultural diversity among the patient population and within the community.

Endocrinology

Objectives: The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage uncomplicated endocrine disorders.
2. Understand the indications for surgery in the management of endocrine disorders.

Hematology

Objectives: The resident will demonstrate competency in his/her ability to:

1. Manage common hematologic disorders.
2. Understand hematopoiesis.
3. Understand the diagnosis and management of coagulopathies.

Infectious Disease

Objectives: The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage common infectious diseases.
2. Understand the epidemiology of infectious diseases.
3. Appreciate the role of the health care team in the control of infectious disease.
4. Understand the role of the immune system in health and disease.
5. Understand the role of antibacterial, anti-fungal, and anti-viral agents in the management of infectious disease.

Nephrology

Objectives: The resident will demonstrate competency in his/her ability to:

1. Understand electrolyte and acid-base disturbances.
2. Understand the etiology and diagnosis of nephrotic diseases.
3. Diagnose and manage common medical disorders of the kidney.
4. Utilize pharmacologic agents appropriately in patients with renal disease.

Neurology

This is an elective rotation under the supervision of a neurologist, which is primarily an outpatient rotation with some hospital rounds. The resident will be responsible for:

- Attending all scheduled rounds, meetings and conferences
- Writing notes and orders as directed
- Evaluating and consulting on assigned patients
- Completing assigned readings
- Observing and discussing cases with attending
- Taking call as assigned
- Attending lectures

Objectives: The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage common disorders of the nervous system.
2. Understand the role osteopathic manipulation plays in the management of neurologic disorders.

Clinical Competencies Neurology

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
<p>Medical Knowledge:</p> <p>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care</p>	<ul style="list-style-type: none"> • Acquire clinically applicable knowledge base of the basic and clinical sciences underlying the care of patients with neurological illness • Know the appropriate indications for commonly ordered neurology tests and procedures, including: EEG, EMG/NCV, evoked potentials, lumbar puncture, 	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation

	<p>CT and MR imaging of brain and spinal cord</p> <p><i>See list of common problems in Neurology</i></p>		
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</p>	<ul style="list-style-type: none"> Effectively obtain an accurate neurological history Effectively perform and interpret a neurological examination Appropriately select and interpret neurology lab and imaging studies Effectively evaluate and manage common inpatient neurology problems, including headache, dizziness, back and neck pain, and peripheral neuropathies Perform lumbar puncture with proper technique 	<ul style="list-style-type: none"> Morning Report Didactic Programs Bedside teaching 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Record Review Case Logs Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> Demonstrate effective listening and communication skills Effectively appraise the neurological conditions of given patients regardless of age, sex, ethnicity, or race Protect patients' right to confidentiality Identify support networks and exchange appropriate information following prescribed procedures, with family members and professional associates Emphasize the role of the patient on the treatment team 	<ul style="list-style-type: none"> Bedside and Outpatient teaching and modeling Videos / Movies Workshops Medical Spanish classes Whole Person Care conference 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Monthly Service Evaluation
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> Identify the major sources of neurological information Identify and acknowledge gaps in personal knowledge and skills in the care of the patients with neurological illness and complaints Identify and utilize resources related to evidence-based guidelines and routine neurological care 	<ul style="list-style-type: none"> Use of "virtual library" QA / PI data Journal Club EBM workshops Use of EBM order sets 	<ul style="list-style-type: none"> AOA CAP program QA / PI reports OSCE 360 Degree Evaluation Portfolios Monthly Service Evaluation

<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> • Understand and utilize the multidisciplinary resources necessary to care optimally for patients with neurological illness and complaints • Collaborate with other members of the health care team to assure comprehensive care for patients with neurological illness and complaints • Be cognizant of the health care financing issues affecting the delivery of neurological health services 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Community service (Shepherd's Hope) • Involvement in Discharge planning 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> • Combine scientific curiosity with respect for the patient regardless of age, sex, ethnicity or race • Demonstrate an empathic relationship with patients while obtaining information needed to participate in the development and utilization of treatment plans • Adhere to the AOA ethics and parameters of confidentiality 	<ul style="list-style-type: none"> • End of Life Care Training (EPEC) • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities</p>	<ul style="list-style-type: none"> • Be cognizant of a holistic approach to mental health problems • Assess for and administer adjuvant OMT to aid in the lessening of suffering caused by concomitant medical illnesses that may be impacting, or are impacted by, mental health issues 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly Distance Learning • OMT Clinics • Computer Modules 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • Inpatient Credentialing • OSCE • Monthly Service Evaluation

Common Problems in Neurology

- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis
- Ataxia
- Autonomic Nervous System
- Cerebral Palsy
- Chronic Fatigue Syndrome
- Chronic Pain Syndromes
- Congenital Anomalies
- Cranial Nerve Diseases

- Delirium
- Dementia
- Demyelinating Diseases
- Dysautonomia
- Epilepsy
- Headaches
- Huntington's Disease
- Hydrocephalus
- Hyperventilation
- Infections
- Meningitis
- Movement Disorders
- Muscle Diseases
- Neoplasms
- Neurodegenerative Diseases
- Neurotoxicity Syndromes
- Ocular Motility Disorders
- Parkinson's Disease
- Peripheral Nervous System
- Pituitary Disorders
- Sleep Disorders
- Spinal Cord
- Stroke
- Tourette Syndrome
- Trauma and Injuries
- Tumors

Oncology

Objectives: The resident will demonstrate competency in his/her ability to:

1. Screen for and diagnose common cancers.
2. Participate with the oncologist in the care of cancer patients.
3. Utilize a team approach for the care of cancer patients.
4. Utilize Hospice in the management of the terminally ill patient.

Ophthalmology

Objectives: The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage common ophthalmologic conditions that may present to the family physician's office.

Otolaryngology

Objectives: The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage common otolaryngologic conditions that may present to the family physician's office.
2. Integrate osteopathic principles and manipulative treatment into the management of disorders of the ear, nose, and throat.

Radiology

Goal

To provide the resident, through didactic and clinical experiences, with an educational experience that will expand his/her knowledge and skills in the utilization and interpretation of appropriate imaging techniques.

Objectives

The resident will demonstrate competency in his/her ability to:

1. Utilize appropriate studies to appropriately diagnose and manage common medical and surgical diseases.

This rotation is completed at VINCON Diagnostic Center. It is under the direction of Vincent Giuliano, MD and Concetta Giuliano, DO at 5732 Canton Cove, Winter Springs, Florida, 32708. Phone 407-699-7787.

DIRECTIONS TO CLINIC: Take 417 to Red Bug Lake Road. Make a left off the ramp. Go pass the Oviedo Mall for about three or four miles. Make the first right after Rising Sun. Turn left into Plaza. VINCON is the last office on right.

Rheumatology

Objectives: The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage common disorders of the musculoskeletal system.
2. Diagnose diffuse connective tissue disease.
3. Understand the role osteopathic manipulation plays in the management of patients with rheumatologic disease.

Sports Medicine

Synopsis

Training in sports medicine shall include clinical and didactic experiences in pre-participation assessment, injury prevention, evaluation, management and rehabilitation related to athletic and recreational injuries. The orthopedic portion of sports medicine training may be integrated into the orthopedic portion of the curriculum; however, time devoted to sports medicine should be in addition to the minimum requirement for orthopedics.

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will expand his/her knowledge and skills in the management of athletic and recreational injuries.

Objectives

The resident will demonstrate competency in his/her ability to:

1. Evaluate individuals for athletic participation clearance.
2. Manage uncomplicated injuries sustained in sports related activities.

Emergency Medicine/Radiology I (also see Radiology)

Synopsis

Training in emergency medicine shall be a minimum of three (3) months duration and include both didactic and clinical experiences. These shall consist of four (4) week blocks with a minimum of thirty-six hours per week. During OGME-1 the resident will spend 1 month in the emergency room treating patients under direct supervision.

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will expand his/her knowledge and skills in the management of emergency medical and surgical problems.

Objectives

The resident will demonstrate competency in his/her ability to:

1. Demonstrate the appropriate triage of emergency patients.
2. Provide emergency care for stabilization and initial treatment of emergency patients.
3. Successfully pass ACLS.

This rotation will be conducted in the Florida Hospital East Orlando ED unless another campus is designated and approved by the DME. The residents are required to work a minimum of forty (40) hours each week in the ED. Residents may also have the option to work in Express Care at FHEO. The DME may request a copy of the hours worked per day to verify the 40-hour requirement has been met.

OGME-1 Residents must do two nights and two weekend days during their four-week rotation. **All residents are to coordinate their schedule with Dr. Joseph Zarlengo or Dr. Regan Schwartz on the first day of the ED rotation.**

The residents will be scheduled for one clinic session each week at FHCE during this rotation.

OGME-1 Residents are required to spend one day a week at the VINCON Diagnostic Center with Drs. Concetta Giuliano and Vincenzo Giuliano.

Clinical Competencies Emergency Medicine

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
Medical Knowledge: Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care	<ul style="list-style-type: none"> • Describe the relevant anatomy, pathophysiology, investigative modalities, and management of acute disorders of body systems. These systems include: <ul style="list-style-type: none"> ○ Acute medical emergencies ○ Trauma patients ○ Abdominal pain ○ Ill infants / children ○ OB/ GYN problems ○ Poisoning / overdoses ○ Epistaxis ○ Acute psychosis ○ Substance abuse ○ Seizures • Interpret data obtained during patient assessment in order to construct a differential diagnosis and arrive at the more common potential etiologies • Develop rational, relevant, practical, and comprehensive management plan including the need for further diagnostic studies • Distinguish the seriously ill patient from the patient with minor illness or injury • Recognize, evaluate and initiate management in all life-threatening conditions • Understand the Baker Act and the Marchman Act and the appropriate use of 	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation

	<p>these</p> <ul style="list-style-type: none"> • Define advance directive, living will, power of attorney, guardianship, and trusteeship • Explain protocols for reporting sexual assault, rape, child abuse and elder abuse <p><i>See list of common problems in Emergency Medicine</i></p>		
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</p>	<ul style="list-style-type: none"> • Balance proper use of investigations and treatment for patients with a social obligation to control health care costs • Develop appropriate documentation skills – written and verbal • Discuss and/or perform the following procedures: <ul style="list-style-type: none"> ○ Laceration repair ○ Regional anesthesia / digital blocks ○ Casting / splinting ○ Reduction of uncomplicated dislocations ○ Removal of foreign bodies ○ Interpretation of diagnostic imaging ○ Gastric lavage ○ Nasal packing / cautery ○ I & D of abscesses ○ Indications for tetanus prophylaxis 	<ul style="list-style-type: none"> • Morning Report • Didactic Programs • EBM Guidelines and Procedural Workshops • Procedural Models • Procedural Credentialing • Bedside teaching 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Record Review • Procedural Models • Procedure and Case Logs • Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Demonstrate willingness to receive and act upon feedback from peers, faculty, other healthcare workers, and patients and their families • Develop communication skills with peers, faculty, consultants, and ancillary personnel necessary to run the emergency department • Communicate directly with attending emergency physicians regarding problems or concerns that may arise regarding medical education and patient care • Demonstrate the ability to convey bad news to patients and their families 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation

<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> • Illustrate issues of QA/PI and risk management in the emergency department • Incorporate validated research findings into clinical practice of emergency medicine • Refine and improve the knowledge skills and attitudes of prior training • Appraise various emergency medical texts, including evidence-based evaluations of proposed treatments 	<ul style="list-style-type: none"> • Use of “virtual library” • QA / PI data • Journal Club • EBM workshops • Use of EBM order sets 	<ul style="list-style-type: none"> • QA / PI reports • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> • Describe and identify emergency medical services for pre-hospital care within the community • Recognize and respond to those issues where advocacy is important • Discuss the relationships between the emergency room physician and primary care physicians, as well as the consultants. 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Involvement in Discharge planning • Community service (Shepherd’s Hope) 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> • Identify the ethical issues in the clinical practice of emergency medicine • Manifest a commitment to lifelong learning and the desire to improve skills and provide better care • Protect information provided by or about patients by keeping it confidential and divulging it only with the patient’s permission, except when otherwise required by law • Treat all patients with dignity and respect their privacy 	<ul style="list-style-type: none"> • End of Life Care Training (EPEC) • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient</p>	<ul style="list-style-type: none"> • Identify and treat those emergency medical conditions that may be effectively managed by OMT • Understand the indications and contraindications of the use of OMT in the emergency department setting • Correlate osteopathic philosophy into various disease entities • Apply the neuromusculoskeletal basis of homeostasis into the practice of emergency medicine 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly Distance Learning • OMT Clinics • Computer Modules 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • Inpatient Credentialing • OSCE • Monthly Service Evaluation

care activities			
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Common Problems in Emergency Medicine

Undifferentiated Symptoms

- Shortness of Breath
- Chest Pain
- Shock
- Altered Mental Status
- Headache
- Syncope
- Abdominal Pain
- Fever
- “unwell” patient
- GI Bleeding
- Vaginal Bleeding
- Abnormal Behavior
- Seizure

Respiratory

- Asthma and COPD
- Pulmonary Embolism
- Airway Obstruction
- Pneumothorax
- Pneumonia

Cardiovascular

- Acute Coronary Syndromes
- Congestive Heart Failure
- Cardiac Dysrhythmias
- Hypertensive Emergency
- Aortic Dissection and Aneurysm

Neurological

- Stroke/Transient Ischemic Attack
- Seizure
- Meningitis
- Cerebral Hemorrhage

HEENT

- Corneal Abrasion/Foreign Body
- Epiglottitis
- Epistaxis

Gastrointestinal Disorders

- Gastritis/Peptic Ulcer Disease
- GI Bleed (upper and lower)
- Acute cholecystitis
- Bowel Obstruction
- Appendicitis

Genitourinary Disorders

- UTI
- STD
- Vaginal Bleeding
- Ectopic Pregnancy
- Nephrolithiasis
- Testicular torsion
- Acute Urinary Retention

Musculoskeletal

- Ankle sprain/strain

- Common fractures
- Common dislocations

Trauma

ENT

No more than one-week of personal leave can be taken during this rotation.

This is a two week rotation in which the OGME-1 resident will be assigned to Michael Bibliowicz, DO, David Rabaja, DO, and Dale Harrington, DO. The OGME-1 resident will assist Drs. Bibliowicz, Rabaja and Harrington with all pre-op, post-op and ENT surgery. The OGME-1 resident will attend outpatient clinic with Drs. Bibliowicz, Rabaja and Harrington as permitted.

The OGME-1 resident will be assigned H&P's and attempts will be made to perform these on patients seen by the ENT service. Weekends may be assigned for hospital coverage by the surgeon.

The OGME-1 resident is required to attend all didactic sessions. The OGME-1 resident may be assigned to present a lecture each month based on a case or topic relating to this rotation.

The OGME-1 resident will complete their one-half day clinic assignment at the FHCE.

Geriatrics

No personal leave is allowed during this rotation.

Synopsis

It is incumbent on each resident to recognize the special needs of the geriatric patient. As aging is a normal physiologic process, so the care of the elderly patient is an increasingly essential skill for family physicians. Training shall take place at the continuity of care training site, hospital, long-term care facility, patient's home, geriatric assessment unit, or in any other site appropriate for the care of elderly individuals.

Goal

To provide the resident with didactic and clinical exposure to the care of elderly patients.

Objectives

The resident will demonstrate competency in his/her ability to:

1. Understand the physiologic changes that occur with aging.
2. Differentiate between normal age-related changes and disease pathology.
3. Recognize atypical presentations of diseases in elderly individuals.
4. Utilize basic geriatric assessment tools in clinical practice.
5. Assess and assign appropriate levels of long-term care for elderly persons.
6. Understand the differences among the continuum of care for elders.
7. Manage the elderly patient in various levels of care.
8. Understand the role of the family in the care of the elderly.
9. Perform a functional assessment of elderly.
10. Understand the role of a multidisciplinary team in the care of the elderly.
11. Access available community resources to care for frail and/or homebound elderly patients.
12. Utilize Osteopathic Manipulative Treatment (with special attention to myofascial release, strain counter strain, and muscle energy) in the treatment of the elderly patient.
13. Understand the role of and utilize hospice in the care of the dying patient.

14. Understand the use of appropriate immunizations in the elderly patient
15. Understand the issue of self-determination including advanced directives.
16. Understand strategies to optimize quality of life.
17. Understand appropriate pain management in the elderly.
18. Understand pharmacokinetics in the elderly.
19. Recognize the importance of being an advocate for accessibility to health care for all elderly patients.

RESIDENT (OGME-2 and OGME-3):

Residents will be assigned to a four-(4) week rotation at:
Sunbelt Health Care Center of East Orlando
250 South Chickasaw Trail
Orlando, Florida 32825 (located behind Florida Hospital East Orlando)
(407) 380-3466

Be sure to schedule an orientation with the head nurse of Sunbelt Health Care Center on the first day of your rotation. Make sure to obtain a copy of all nursing home meetings/activities, as well as a map of the nursing home.

This rotation is under the supervision of Maria Gonzalez, MD, FM/Geriatrics and/or the geriatric fellows. The resident will be responsible for:

- Attending all scheduled rounds, meetings and conferences
- Writing notes and orders as directed
- Evaluating and consulting on assigned patients, including nursing home, clinic and hospital patients if necessary (for follow-up)
- Maintaining the nursing home patient list which needs to be updated on a continuous basis
- Complete assigned readings (be sure to pick up required reading articles from the department of Medical Education on the first day of your rotation)
- Observing and discussing cases with attending
- Taking call as assigned
- Attending lectures
- Preparing and presenting Family Medicine Board Review, as well as case presentations on Tuesdays and Fridays

The resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation. The resident will also attend the Geriatric clinic at Family Health Center East on Monday and Wednesday mornings.

Geriatrics Longitudinal

Nursing Home:

All second and third year residents of the Osteopathic Family Medicine program will be assigned to a nursing home patient(s). Those patients must be seen once every month at the day and time that the faculty preceptor is present in the respective nursing home.

Every month, the resident physician will get an e-mail close to the due date of his/ her note, at that point on time, the resident will do in his/her own time the note corresponding to the particular nursing home patient and will report to the resident on Geriatric rotation or the faculty preceptor.

A second e-mail will be send if 10 days later the resident has not seen his/her patient. If after one week of this second remainder the resident physician has not done the evaluation with corresponding note of the Nursing Home patient. The resident will be then, reported to the program director to complete the note in the next 24 hours and to receive an extra call at the hospital

Clinical Competencies Geriatric Medicine

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
<p>Medical Knowledge:</p> <p>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care of all ages and all stages of life.</p>	<ul style="list-style-type: none"> • List the most common acute, chronic and psychological diagnoses that present to the geriatric physician including their main presenting symptoms and physical examination findings • Understand the important alterations in pharmacokinetics and pharmacological effect of medications commonly prescribed for elderly patients • Demonstrate the importance of longitudinal care including growth and development assessments, health screenings and management of commonly seen chronic problems • Demonstrate an understanding of health promotion and disease prevention • Provide a differential diagnosis for common complaints, symptoms and signs that present to the geriatric physician <p><i>See list of common problems in Geriatric Medicine</i></p>	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • EBM Guidelines and Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</p>	<ul style="list-style-type: none"> • Demonstrate the ability to perform a complete medical history and physical examination on an older patient and offer a differential diagnoses and plan for treatment • Perform an accurate geriatric assessment • Demonstrate an ability to develop rapport with patients through effective listening skills, empathy, sensitivity and respect for the patient • Recognize the importance of total patient management including preventative care, patient education, episodic illness care and chronic illness care in a variety of settings including office, hospital, home visits and group visits • Recognize the impact of the disease process on the patient relative to family and other interpersonal relationships • Recognize the bio-psycho-social 	<ul style="list-style-type: none"> • Morning Report • Didactic Programs • EBM Guidelines and Procedural Workshops • Procedural Models • Procedural Credentialing • Bedside teaching 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Record Review • Procedural Models • Procedure and Case Logs • Monthly Service Evaluation

	aspects of family systems and its impact on individual and family health		
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> List and demonstrate the principles of the art of interviewing Demonstrate empathy and cultural sensitivity in patient interactions Present oneself in a professional manner to patients and their families Demonstrate body language that places the patient at ease Relate discussions and explanations in a manner that the geriatric patient can correctly interpret Utilize touch when appropriate and within the boundaries of an appropriate doctor-patient relationship Maintain confidentiality at all times 	<ul style="list-style-type: none"> Bedside and Outpatient teaching and modeling Videos / Movies Workshops Medical Spanish classes Whole Person Care conference 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Monthly Service Evaluation
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> Be cognizant of, and apply, evidence-based medicine as it pertains to geriatric medicine Collect and analyze patterns of medical practice and compare / contrast the individual patterns within the practice with established clinical guidelines and norms Recognize incidence of disease with epidemiologic consequence and know the process of appropriate notification (outbreaks, etc.) 	<ul style="list-style-type: none"> Use of “virtual library” QA / PI data Journal Club EBM workshops Use of EBM order sets 	<ul style="list-style-type: none"> AOA CAP program Videomonitoring QA / PI reports OSCE 360 Degree Evaluation Portfolios Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> Integrate the importance of appropriate referral systems and their use in geriatric medicine Identify health care issues involved in managed care with associated formulary, preventative care and referral pattern issues Understand and use a team approach when delivering healthcare to the geriatric patient 	<ul style="list-style-type: none"> Multidisciplinary rounds Community service (Shepherd’s Hope) Home visits Group visits 	<ul style="list-style-type: none"> OSCE Videomonitoring 360 Degree Evaluation Portfolios Monthly Service Evaluation
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse</p>	<ul style="list-style-type: none"> Act in a professional manner at all times Dress appropriately when working with patients Continually subscribe to changing and advancing medical knowledge Be cognizant of, and sensitive to, cultural diversity Demonstrate respect and professional behavior with other members of the 	<ul style="list-style-type: none"> End of Life Care Training (EPEC) Role Modeling Cultural Diversity Training 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Portfolios Monthly Service Evaluation

patient population	healthcare team		
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care</p>	<ul style="list-style-type: none"> Identify patients in the geriatric medicine setting who would benefit from OMT Skillfully apply appropriate manipulative treatment as part of the overall treatment of the patient's condition 	<ul style="list-style-type: none"> Inpatient Credentialing Weekly Didactic Sessions Monthly Distance Learning OMT Clinics 	<ul style="list-style-type: none"> In-service Exams COMLEX III Inpatient Credentialing OSCE Monthly Service Evaluation

Common Problems in Geriatric Medicine

- Prevention and Health Promotion 4/Geriatric Assessment
- Surgical and Perioperative Care
- Delirium
- Cognitive Impairment and Dementia
- Falls and Mobility Disorders
- Parkinsons and Other Movement Disorders
- Depression and Other Mental Health Issues
- Sleep Disorders
- Visual and Hearing Impairment
- Dizziness and Syncope
- Cerebrovascular Disease
- Cardiac Disease
- Hypertension (in the Older Adult)
- Peripheral Vascular and Thromboembolic Disease
- Respiratory Disease
- Abdominal Complaints and Gastrointestinal Disorders
- Incontinence
- Renal, Fluid and Electrolyte Disorders
- Arthritis and Vasculitis
- Osteoporosis and Hip Fractures
- Pressure Ulcers
- Common Skin Disorders
- Cancers in the Geriatric Population
- Anemia in the Elderly
- Endocrine Disorders
- Diabetes in the Elderly
- Common Infectious Diseases

- Principles of Rehabilitation
- Weight Loss and Other Nutritional Issues
- Elder Mistreatment, Violence, and Self-Neglect
- Principles of Drug Therapy: Changes with Aging, Polypharmacy, and Drug Interaction
- Exercise, Balance and Mobility
- Common Pain Syndromes and Management of Pain
- Palliative Care and Pain Management
- Anti-Aging and Complimentary Therapies

Gastroenterology

Objectives

The resident will demonstrate competency in his/her ability to:

1. Screen appropriately for colorectal cancer.
2. Understand the role of osteopathic principals and treatment in the diagnosis and management of gastrointestinal disease.
3. Understand the indications for surgery in gastrointestinal disease.
4. Manage uncomplicated diseases of the gastrointestinal system.

This two (2) week rotation will be supervised by Dr.'s Robert Shultz, Dr. Keith Moore and Dr. Aniq Shaikh. The resident will be responsible for:

- Writing progress notes on all service patients
- Seeing consults with the Attendings
- Assisting Attendings during procedures
- Following the reading schedule for GI
- Accessing endoscopy video tapes and model to develop an understanding of instruments
- Becoming familiar with endoscopy procedures and indications for it

The Resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation; usually in the afternoons.

Clinical Competencies Gastroenterology

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
Medical Knowledge: Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care	<ul style="list-style-type: none"> • Apply pertinent basic science principles to patients with gastrointestinal problems • Analyze pathophysiological principles to understand why patients develop signs and symptoms from various diseases • Apply basic pharmacological principles to the treatment of common gastrointestinal diseases <p><i>See list of common problems in Gastroenterology</i></p>	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • EBM Guidelines and Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation
Patient Care: Provide patient care that is compassionate, appropriate, and	<ul style="list-style-type: none"> • Demonstrate proficiency in obtaining a history from a patient with GI complaints • Perform a problem focused physical examination on an a patient with GI complaints 	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • EBM Guidelines 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE

effective for the treatment of health problems and the promotion of health	<ul style="list-style-type: none"> • Formulate a differential diagnosis for common presenting symptoms of gastrointestinal disease • Develop specific motor skills necessary to perform procedures on GI patients <ul style="list-style-type: none"> ○ Flexible sigmoidoscopy ○ Colonoscopy ○ Paracentesis • Understand the clinical indications and contraindications of performing: <ul style="list-style-type: none"> ○ GI endoscopy ○ ERCP ○ Needle biopsy of liver ○ Paracentesis ○ Endoscopic measures of controlling GI bleeding 	<ul style="list-style-type: none"> • and Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Develop communication skills that facilitate the transfer of information to persons from a different cultural or socioeconomic background • Utilize communication skills necessary to care for dying patients and their families • Employ sensitivity when dealing with people who are vulnerable or scared • Assess the psychosocial and spiritual needs of the patient 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> • Identify and utilize resources for dissemination of new information regarding the practice of gastroenterology • Identify and utilize evidence-based medicine guidelines in the field of gastroenterology • Apply these principles to regular health maintenance 	<ul style="list-style-type: none"> • Use of “virtual library” • QA / PI data • Journal Club • EBM workshops • Use of EBM order sets 	<ul style="list-style-type: none"> • AOA CAP program • QA / PI reports • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> • Employ a team oriented approach to problem solving in gastroenterology • Consult other physicians and health care providers in a manner that maximizes patient care and minimizes communication barriers • Question the increasing larger role that financial considerations play in medicine • Advocate for the needs of the patient, in light of society’s inability to provide unlimited resources to everyone 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Community service (Shepherd’s Hope) • Involvement in Discharge planning 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
Professionalism:	<ul style="list-style-type: none"> • Exemplify behaviors such as altruism, 	<ul style="list-style-type: none"> • End of Life Care 	<ul style="list-style-type: none"> • OSCE

<p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.</p>	<p>accountability, excellence, duty, honor, integrity, and respect for others</p> <ul style="list-style-type: none"> • Altruism: the best interest of the patient must come before the interests of the doctor • Accountability: accountability to patients, patients' families, peers, faculty and society • Excellence: an effort to exceed ordinary expectations • Duty: a commitment to service • Honor and integrity: a commitment to the highest standards of personal and professional behavior • Respect for others: respect for patients, their families, peers, nurses, faculty, and other medical personnel and ancillary staff 	<p>Training (EPEC)</p> <ul style="list-style-type: none"> • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities.</p>	<ul style="list-style-type: none"> • Apply osteopathic principles to the diagnosis and treatment of the GI patient • Identify specific gastrointestinal conditions where osteopathic manipulative medicine is a component of the treatment plan. Examples: <ul style="list-style-type: none"> ○ Ileus ○ PUD ○ Pancreatitis • Apply holistic approaches to the diagnosis and management of gastrointestinal conditions 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly Distance Learning • OMT Clinics 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • Inpatient Credentialing • OSCE • Monthly Service Evaluation

Common Problems in Gastroenterology

Upper GI tract disorders:

- Barrett's Esophagus
- Dysphagia
- Esophageal cancer
- Esophageal strictures
- Esophageal varicies
- Esophagitis
- Gastroesophageal Reflux Disease (GERD)
- Hiatal hernia
- Peptic Ulcers
- Stomach cancer

Liver Disorders:

- Cirrhosis
- Fatty liver disease
- Hemochromatosis
- Viral hepatitis (hepatitis A, B & C)
- Non-Viral hepatitis

- Alcoholic hepatitis
- Auto-immune hepatitis
- Nonalcoholic Steatohepatitis
- Liver Cancer

Bowel Disorders:

- Abdominal pain
- Anal disorders
- Appendicitis
- Bowel obstruction
- Celiac Disease
- Colorectal Cancer
- Crohn's Disease
- Diarrhea
- Diverticular Disease
- Fecal Incontinence
- Gastritis
- Gastroenteritis
- Gastroparesis
- GI bleeding
- Hemorrhoids
- Inflammatory Bowel Disease (IBD)
- Irritable Bowel Syndrome (IBS)
- Ulcerative Colitis

Pancreobiliary disorders:

- Bile duct disease
- Gallbladder disease
- Gallbladder and bile duct cancer
- Gallstones
- Hyperinsulinemia
- Pancreatitis
- Pancreatic cancer
- Sphincter of Oddi dysfunction

Gynecology I and III

Synopsis

The minimum duration of this portion of the curriculum shall be four (4) months. Four (4) weeks must be completed during OGME-1. Residency training in obstetrics and gynecology should consist of a minimum of one-month maternity care and a minimum of two months in gynecology. This shall be in addition to the routine care of patients in the continuity of care training site. Pre and postnatal care should be stressed along with office gynecology. All residents must perform a sufficient number of deliveries to assure competency expected of a family physician. A portion of the resident's maternity care experience should be derived from the resident's panel of patients from the continuity of care training site. Supervision of labor and delivery must be immediately available. Advanced obstetrical training, for those residents interested, shall be arranged. For those residents who desire to develop technical proficiency in appropriate operative procedures that may form a part of their future practice, additional training in obstetrics must be made available as an elective within the last 24 months of the residency. The gynecologic portion of this experience should be primarily ambulatory, but residents must participate in the management of gynecologic/surgical emergencies. The training should include some inpatient care, preoperative care, assisting in surgery, and postoperative management. Procedures appropriate to the family physician shall be stressed.

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will expand his/her knowledge and skills in the management of obstetrical patients and patients with gynecologic problems.

Objectives

The resident will demonstrate competency in his/her ability to:

1. Manage low risk obstetrical patients in the in-patient and outpatient setting.
2. Recognize early signs and symptoms of fetal and/or maternal distress during pregnancy.
3. Seek appropriate preventive or corrective measures to insure the health and safety of both the fetus and the mother.
4. Recognize medical and surgical problems in the obstetrical patient.
5. Manage common gynecologic problems.
6. Integrate the use of osteopathic manipulative treatment in the management of obstetrics and gynecologic disorders.
7. Obtain appropriate consultation.

Gynecology I

No more than one-week of personal leave can be taken during this rotation.

This is a two (2) week rotation for OGME-1 residents completed at the Central Health Center. The Central Health Center is located at 832 West Central Boulevard, Orlando, Florida 32805. Before beginning this rotation, the resident is required to complete a confidentiality statement located in the department of medical education.

The Resident will be scheduled for one clinic session each week at FHCE during this rotation.

Gynecology III

No more than one-week of personal leave can be taken during this rotation.

This is a four (4) week rotation for OGME-3 residents completed at the Central Florida Family Health Center. The Health Center is located at 5449 S. Semoran Blvd., Suite 14. The Resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation.

Gynecology/Oncology I and II

No more than one-week of personal leave can be taken during this rotation.

This is a two (2) week rotation supervised by Dr.'s Neil Finkler, Robert Holloway and Hannah Ortiz. The Resident will be responsible for:

- Attending GYN/ONC clinic at 2501 North Orange Avenue, Suite 689 (303-2422). The scheduling nurse is Debbie Dennison.
- Following assigned GYN reading program
- Attending lectures

The Resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation on varying days.

FM/NMM Residency (FM Requirements as per FM Manual) Neuromusculoskeletal Medicine (NMM) Requirements

Resident Responsibilities

Residents will be held to the same standards as directed in the FM manual with the following additions to include but are not limited to:

1. The resident shall develop skills in palpatory diagnosis and technique in order to competently perform osteopathic manipulative treatments. A full understanding of the physiology, indications for use, and the technical proficiency is required for each treatment modality. These shall include but are not limited to: HVLA, Muscle energy, soft tissue technique, myofascial release, strain-counterstrain, osteopathy in the cranial field, facilitated positional release, functional and articulatory technique.
2. The resident shall manage NMM patients in the hospital and clinics under faculty supervision. Proper documentation on each patient will be required and reviewed according to current standards.
3. The resident shall be required to maintain a daily log of NMM activities including patients observed/treated, condition, progress, type of treatment and level of involvement.
4. The resident shall be required to maintain a current log of NMM meetings, CME programs attended, reading materials beyond the assigned curriculum and teaching involvement.
5. The resident shall not assume any responsibility outside the Department of Medical Education without approval from the directors of Family Medicine and NMM and the Director of Medical Education.
6. The resident shall participate in the teaching of house staff members when assigned. This may include NMM scheduled lectures, programs, and presenting rounds or labs.
7. The resident shall assume increasing patient care responsibility, commensurate with his/her ability as (s)he progresses in the residency.
8. The resident shall attend all NMM lectures and the didactic sessions unless excused by the NMM faculty or DME.
9. The resident will be required to provide constructive evaluations of other residents, externs and faculty members associated with the NMM program.
10. The resident shall be familiar with and abide by the AOA Code of Ethics.

Resident Supervision

Every patient must be seen or reviewed by the proctor for each encounter. The duration and type of training and supervision by the proctor will vary based on the resident's skill and patient's needs. The resident will notify the proctor when supervision is needed. A NMM proctor must be in the department circulating between rooms throughout the NMM outpatient clinic. Inpatient supervision will be provided during daily hospital rounds by the NMM attending. Immediate supervision is always available in the clinic and hospital at other times.

Inpatient Consultation OMM service

Residents assigned to a NMM rotation will be required to fulfill all administrative and clinical responsibilities for the Inpatient OMM consultation service. These include but are not limited to:

- ◆ Holding the OMM beeper
- ◆ Track current OMM patient lists
- ◆ Inform attendings of new consults
- ◆ Review case with attending prior to initiating NMM
- ◆ Perform initial and follow up NMM consults
- ◆ Document patient care according to consultation standards
- ◆ Supervise other residents and externs while on the NMM service
- ◆ Weekend call will include 50% of weekend days while on an NMM rotation

Documentation

Residents will be required to document all patient encounters according to current standards. All documentation will be reviewed by a supervising physician.

NMM Continuity Clinic

During OGME-2, residents will initially be closely supervised by NMM faculty at Family Health Center East. OGME 3-4 residents will have separate NMM continuity clinics at the Family Health Center East supervised by NMM faculty. All visits will be reviewed by an attending physician. New patients will have a 45-minute comprehensive NMM evaluation performed which will include history, physical, differential diagnosis, prognosis

and treatment plan. Established patients should be seen in 45 minutes for OGME-2, 30 minutes for OGME 3 and 4 unless varied by the NMM clinic attending.

Neuromusculoskeletal Medicine Requirements

		OGME 2	OGME 3	OGME 4
4	Internal Medicine	*	1	1
	Surgery	*	1	1
	Neuromusculoskeletal (3)	3		
	Consult and Training			
4	Pediatrics		1	1
	OB/Gyn		1	1
	Elective (with NMM Practice) (2)	1		1

**fulfilled by patient consults on inpatient OMM service*

The three neuromusculoskeletal rotations may include Orthopedics, Rheumatology, Neurology, Physical Medicine, or others deemed appropriate and approved by the program directors and DME. The elective rotations will be with physicians who use NMM in their practice extensively or exclusively. Continuity training will occur in the NMM and FM clinics. Inpatient and outpatient training in Peds, OB/GYN, Surgery and Internal Medicine rotations meet the NMM certification requirements. Inpatient NMM consults will be done by the residents assigned to these rotations, or on a rotating basis of other residents.

Neuromusculoskeletal Medicine Schedule

Residents in the Family Medicine/NMM Residency program have four rotations of four weeks in each of the OGME 2 and 3 years. OGME-4 has five 4-week rotations. These rotations fulfill the neuromusculoskeletal requirements for certification eligibility and will be scheduled according to Item 7. One week of allowed vacation or CME may be taken during one of these rotations each year.

OGME-2

Rotation	Length
Administrative Resident	4 weeks
Behavioral Medicine	2 weeks
Emergency Medicine	4 weeks
FMRS	4 weeks
Geriatrics	4 weeks
Gynecology	4 weeks
NMM (Rampil)	4 weeks
NMM/Gynecology Obstetrics	4 weeks
NMM/Orthopedics	4 weeks
Pediatrics	4 weeks
Pharmacy	2 weeks
Practice Management/Radiology	4 weeks
Surgery (Colorectal)	4 weeks

OGME-3

Rotation	Length
Administrative Resident	4 weeks
Behavioral Medicine	2 weeks
Elective	8 weeks
Emergency Medicine	4 weeks

FMRS	4 weeks
FM/OMM	2 weeks
Geriatrics	4 weeks
GI	2 weeks
Gynecology/Oncology	4 weeks
NMM (Rampil)	4 weeks
NMM/Radiology	4 weeks
Obstetrics	4 weeks
Pediatrics	4 weeks
Surgery (ENT)	4 weeks

OGME-4

Rotation	Length
Administrative Resident	2 weeks
Dermatology	4 weeks
Elective	12 weeks
Emergency Medicine	4 weeks
FMRS	4 weeks
FM/OMM	2 weeks
NMM (Rampil)	4 weeks
NMM Elective	4 weeks
NMM/Gynecology Obstetrics	4 weeks
NMM/Rheumatology	4 weeks
Pediatrics	4 weeks
Surgery (Urology)	4 weeks

Scientific Clinical Investigation

A scientific clinical investigation paper in NMM is required to graduate from the FM/NMM residency program. Graduation is required for eligibility to sit for NMM certification board. Topics must be approved by the NMM faculty members and submitted to the program director by July 1 of OGME-3. The paper outline is due by September 1 of OGME-3; the first draft by May 1 of OGME-3; the final draft is due September 1 of OGME-4. Design and statistical support are available through Medical Education.

Logs

Logs must be kept on all patients seen in the clinic, hospital and on elective rotations. All procedures and reading must be logged. All lectures given and labs taught by the resident will be recorded by the resident. Examples of logs forms are provided in both paper and computer formats. Hard copies of updated logs are due 1 week after the end of each rotation. One copy needs to be turned into medical education and one copy needs to be retained by the resident.

Didactic Sessions

The resident is required to attend a weekly NMM morning didactic seminar unless excused by the NMM faculty or DME. All residents will be required to read the materials prior to topic discussions. The curriculum will be provided and updated by the NMM faculty. Residents will be progressively responsible to present material, select topics, demonstrate technique, and be active in all discussions. Two questions per reading will be written and turned in weekly to a NMM faculty member at the didactic seminar by the resident.

Lectures & Presentations

Residents will be required to assist in all NMM labs and NMM lectures. All NMM lectures/presentations will be discussed and approved at an appointment with NMM faculty prior to the date of presentation. OGME-2's will be required to present 1 NMM lecture to the Residents and the seminar session. A Power Point presentation is required unless waived by NMM faculty. OGME-3 and 4 will be required to perform a formal lecture every other month to the residents as directed by the NMM faculty. This same topic will then be presented to the didactic seminar in a more comprehensive and detailed fashion.

Nights/IM/FMRS/Pediatrics

No personal leave is allowed during this rotation.

OGME-1 Residents

The OGME-1 resident assigned to the Nights/IM/FMRS/Pediatric rotation will be responsible for the medical coverage of all patients in-house on approved services and for participating volunteer faculty. The OGME-1 resident will respond to other attendings patients for emergencies and life-threatening situations. Any non-emergency procedures of orders shall be approved by the attending in advance. Attendings of emergently cared for patients must be contacted as soon as possible and sign all related orders and notes.

The OGME-1 resident will be responsible for the admission of patients to the following services in order of importance:

1. FMRS
2. Pediatrics
3. General Internal Medicine (Weekend, Holiday OGME-1 Resident)
4. Other approved Family Physicians, medicine specialists and surgeons involved with the education program

All orders written at admission shall be approved by an Attending or call resident.

The OGME-1 resident will be required to report all changes in patients conditions to the call resident or the Attending of a patient on a particular service. The OGME-1 resident may be requested to assist with surgery and deliveries during the night hours; however, the OGME-1 resident must be prepared to break scrub and return to the medical floors to provide urgent or emergent medical coverage as needed. The OGME-1 resident on surgery or OB should be called first.

The OGME-1 resident will give a morning report on all activity through the night to the FMRS resident after the 7:15 am morning report meeting. The OGME-1 resident is required to perform H&P's on patients admitted through the night. The OGME-1 resident is exempt from Family Health Center East (FHCE) duty. The OGME-1 resident will be NOT be responsible to attend Clinic while on this rotation.

This rotation is six weeks and is divided into two-week segments throughout the year.

The rotation will be thirteen (13) days. If a change in the schedule is desired they may trade with an OGME-1 classmate after completing and submitting the appropriate *Time Off/Scheduling Change* form for approval.

Residents

On occasions out of necessity or as part of disciplinary action, residents may be assigned to night coverage. All of the above information then applies.

Obstetrics/Gynecology

Synopsis

The minimum duration of this portion of the curriculum shall be four (4) months. Four (4) weeks must be completed during OGME-1. Residency training in obstetrics and gynecology should consist of a minimum of one month maternity care and a minimum of two months in gynecology. This shall be in addition to the routine care of patients in the continuity of care training site. Pre and postnatal care should be stressed along with office gynecology. All residents must perform a sufficient number of deliveries to assure competency expected of a family physician. A portion of the resident's maternity care experience should be derived from the resident's panel of patients from the continuity of care training site. Supervision of labor and delivery must be immediately available. Advanced obstetrical training, for those residents interested, shall be arranged. For those residents who desire to develop technical proficiency in appropriate operative procedures that may form a part of their future practice, additional training in obstetrics must be made available as an elective within the last 24 months of the residency. The gynecologic portion of this experience should be primarily ambulatory, but residents must participate in the management of gynecologic/surgical emergencies. The training should include some inpatient care, preoperative care, assisting in surgery, and postoperative management. Procedures appropriate to the family physician shall be stressed.

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will expand his/her knowledge and skills in the management of obstetrical patients and patients with gynecologic problems.

Objectives

The resident will demonstrate competency in his/her ability to:

- Manage low risk obstetrical patients in the in-patient and outpatient setting.
- Recognize early signs and symptoms of fetal and/or maternal distress during pregnancy.
- Seek appropriate preventive or corrective measures to insure the health and safety of both the fetus and the mother.
- Recognize medical and surgical problems in the obstetrical patient.
- Manage common gynecologic problems.
- Integrate the use of osteopathic manipulative treatment in the management of obstetrics and gynecologic disorders.
- Obtain appropriate consultation.

This rotation is completed at Florida Hospital Orlando in the labor and delivery unit. This rotation is coordinated by D. Ashley Hill, MD. Before the rotation, the OGME-1 resident needs to pick up the required articles and yellow OB handbook from the department of Medical Education. Arrive at the labor unit on the first day of the rotation and ask to page the senior resident. (The labor unit number is 407-303-1606.) The senior resident will assign responsibilities, including patient rounds, triage, etc. The senior should assign a call day once a week.

The OGME-1 resident is responsible for assisting with the coordinating externs on the rotation.

The OGME-1 resident is required to attend didactic sessions by OB/GYN unless excused by the attending.

The OGME-1 resident will complete one-half (1/2) day clinic assignment at the FHCE during this rotation, usually Thursday p.m

The OGME-1 resident may be assigned to present at least one lecture and/or case to the department each month based on a case or topic relating to this rotation.

Refer to Gynecology section of manual for additional information.

Clinical Competencies OB/GYN

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
<p>Medical Knowledge:</p> <p>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care</p>	<ul style="list-style-type: none"> • Apply the relevant genetics, physiology, embryology, anatomy, pharmacology and microbiology to obstetrical and gynecological patients • Understand normal obstetrical care including physiological changes in pregnancy, normal labor and delivery, and postpartum care <ul style="list-style-type: none"> ○ Fetal development ○ Prenatal care ○ Antepartum fetal monitoring ○ Labor and delivery ○ Induction of labor ○ Operative vaginal delivery and C-section ○ VBAC ○ Postpartum hemorrhage ○ Postpartum infection ○ Lactation • List in linear fashion the cardinal movements of labor <ul style="list-style-type: none"> ○ List the three stages of labor and the associated phases ○ Discuss the relationship between the cardinal movements and the stages of labor • Understand how to assess and manage the medical complications of pregnancy including early pregnancy loss, multifetal pregnancy, early or uncomplicated labor <ul style="list-style-type: none"> ○ Diabetes mellitus ○ UTI ○ Medical illnesses complicating pregnancy ○ Psychiatric illnesses complicating pregnancy ○ Drug use in pregnancy ○ Preterm labor ○ Bleeding in third trimester ○ Hypertension in pregnancy ○ Fetal growth retardation ○ Post term pregnancy ○ PROM ○ Fetal death • Provide comprehensive routine gynecologic care including preventative care and family planning advice <ul style="list-style-type: none"> ○ Abnormal uterine bleeding ○ Vulvar and vaginal infections ○ STDs ○ Pelvic masses ○ Chronic pelvic pain ○ Endometriosis ○ Urogynecologic disorders ○ Benign breast disease ○ Contraception counseling 	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation

	<ul style="list-style-type: none"> Recognize the indications for and the technical aspects of GYN surgery Understand the endocrinologic issues women face throughout their cycle such as menarche, infertility and menopause Understand the epidemiology, screening, diagnosis, and management of common GYN malignancies including breast, uterine, cervical, and ovarian cancers <p><i>See list of common problems in OB/GYN</i></p>		
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</p>	<ul style="list-style-type: none"> Demonstrate proficiency in obtaining an obstetrical and gynecological history Perform a gynecological exam on a non-pregnant and a prenatal exam on a pregnant patient Develop differential diagnoses, and evaluation and management plans for common presenting GYN symptoms <ul style="list-style-type: none"> Abdominal pain Pelvic pain Dysmenorrhea Vaginal discharge Dyspareunia Incontinence Amenorrhea Abnormal uterine bleeding Endometriosis Demonstrate how to conduct a routine prenatal visit Demonstrate obstetrical expertise <ul style="list-style-type: none"> List and explain abnormalities of labor Assist in deliveries, both vaginal and caesarian Conduct post-partum rounds Demonstrate surgical expertise <ul style="list-style-type: none"> Knowledge and identification of anatomical structures and relationships Proper surgical instrument use Conduct post-operative rounds demonstrating an understanding of important physical findings and potential complications 	<ul style="list-style-type: none"> Morning Report Didactic Programs EBM Guidelines and Procedural Workshops Bedside teaching 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Record Review Procedure and Case Logs Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> Gain a sympathetic understanding of the problems encountered by females of all ages Demonstrate comfort with the sexual history and examination Demonstrate counseling skills with respect to problems such as contraception, antepartum care and gynecologic malignancy 	<ul style="list-style-type: none"> Bedside and Outpatient teaching and modeling Workshops Medical Spanish classes Whole Person Care conference 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Monthly Service Evaluation

<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> • Become aware of the sources for dissemination of new information regarding the practice of OB/GYN • Gain familiarity with the evidence-based guidelines for routine obstetric and gynecologic care including aspects of regular health maintenance 		
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> • Gain an appreciation with respect to indications for referral and transfer of care from the primary care physician • Demonstrate what information to provide to the OB/GYN consultant and how to provide appropriate communication regarding urgency of issues 		
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> • Appreciate the privacy, autonomy and comfort of the female patient 	<ul style="list-style-type: none"> • End of Life Care Training (EPEC) • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities</p>	<ul style="list-style-type: none"> • Identify those obstetrical and gynecological conditions that are most effectively managed by OMT (e.g. postural discomforts of pregnancy, pelvic pain, pre-menstrual syndrome, dysmenorrhea) • Apply holistic approaches to the diagnosis and management of OB/GYN conditions 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly Distance Learning • OMT Clinics • Computer Modules 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Inpatient Credentialing • Monthly Service Evaluation

Common Problems in Obstetrics/Gynecology

Normal Pregnancy

- Prenatal and Antepartum Care

- Normal Labor and Delivery patterns
- Caesarian Section
- Postpartum hemorrhage
- Postpartum infection

Complications of Pregnancy

- Diabetes Mellitus
- UTI
- Pre-term labor
- Third trimester bleeding
- Hypertension, pre-eclampsia and eclampsia
- Multiple Gestations
- Premature Rupture of Membranes
- Post-term pregnancy

Gynecology

- Abnormal and Dysfunctional Uterine Bleeding
- Vaginal Infections
- Pelvic Masses
- Endometriosis
- Benign and Malignant Breast Disease
- Contraceptive counseling
- Hormonal Replacement
- Cervical Dysplasia and Cancer

OMM

Synopsis

This component of the curriculum shall be taught in a longitudinal fashion in all patient care settings. This may be accomplished through didactic lectures, one-on-one tutorial instruction, direct application of osteopathic manipulative treatment or other appropriate formats.

The continuity of care training site is key to the development of good skills in osteopathic manipulative treatment. Appropriate supervision shall be provided so that the resident will integrate these skills into the daily care of his/her patients. This shall be documented in the medical record.

Goals

1. To teach the resident, through didactic as well as clinical settings, the application of osteopathic principles and osteopathic manipulative treatment in all patient care settings.
2. To expose the resident to multiple treatment techniques so he/she may choose the most appropriate method of treating any patient.

Objectives

The resident will demonstrate competence in his/her ability to:

1. Describe the philosophy behind osteopathic manipulative treatment.
2. Describe the role of the musculoskeletal system in disease, including somato/visceral reflexes, alterations in body framework, and trauma.
3. Describe contraindications to osteopathic manipulative treatment.
4. Utilize multiple methods of treatment including, but not limited to, high-velocity/low amplitude (HVLA), strain/counter strain, and muscle energy.
5. Demonstrate, as documented in the medical record, his/her use of osteopathic principles and osteopathic manipulative treatment in the continuity of care training site in an integrated fashion. It is understood that integration implies the use of OMT in such conditions as, (but not limited to) respiratory, cardiac, and gastrointestinal disorders, as well as musculoskeletal disorders.

The resident assigned to the OMM rotation will be required to fulfill all administrative and clinical responsibilities for the following including but not limited to:

- Inpatient OMM Service
- Carry the OMM Beeper for 50% of the week days while on the OMM rotation
- Keep track of current OMM patient list & give proper sign out to covering residents
- Inform attending of new OMM consults
- Review case with attending prior to initiating OMM
- Perform initial and follow up OMM consults
- Document patient care according to consultation standards
- Supervise externs while on the OMM service

The resident assigned to the OMM rotation is required to attend a weekly OMM morning didactic seminar unless excused by the NMM faculty or DME. The residents will be required to read the materials prior to topic discussions. The curriculum will be provided and updated by the NMM faculty. Residents will be progressively responsible to present material, select topics, demonstrate technique, and be active in all discussions. Two questions per reading will be written and turned in weekly to a NMM faculty member at the didactic seminar by the resident.

The resident will attend and assist the OT & P committee meeting and all OMM lectures during the rotation.

The resident will be assigned to a community physician who is strong in OMM and will be expected to assist, perform, and document OMT as requested by the physician.

1. **Didactic Sessions:** held Thursdays from 8:15 a.m. – 12:00 p.m. (usually in the 3rd floor conference room of FHEO, check with Medical Education department for exact location)
 - Get calendar of assignments from Dr. Rampil or Soraya Valcourt.
 - Sign out books or make copies to complete the reading assignments.
 - Write a multiple choice question from each reading – include the page number, answer, and reference information.
2. Interns/residents must attend OMM clinic on Thursday afternoons.
3. Fill out “expectation form” (available from Residency Coordinator) and return ASAP to Dr. Crow.
4. Around 8:15 a.m., Dr. Crow will page the OMM beeper to get the daily inpatient census and assign patients. Residents/interns are **required** to maintain an accurate patient list. (No “list” can be retrieved from the computer.)
5. Interns/residents must **carry** OMM beeper at all times during the workweek. On Fridays at 5:00 p.m., hand off the beeper to the FMRS resident. Discuss the patient list and inform the FMRS resident of any NMM resident rounding for that weekend. Weekend OMM rounds will be supervised by Dr. Crow, Dr. Allgeier or other attending.
6. On Monday at 7:00 a.m., pick up OMM beeper and list from FMRS resident.
7. Residents will go to community physicians’ office after rounds are completed on the day that he/she is not assigned to the Family Health Center East clinic. Interns will get assignments from Dr. Rampil.
8. Format for completing consults for OMM: *Give a copy to Dr. Crow. Call Dr. Crow to discuss case **PRIOR** to treating. Inpatient consultations must be completed within 24 hours from initial call.*

Assessment:

1. Reason for hospitalization/OMM consult
2. Somatic dysfunction (anatomic regions) head, cervical, thoracic, ribs, lumbar, sacral, visceral, pelvis, other (write out – no abbreviations)
3. Other contributing medical conditions

Plan:

1. Medical management as per attending
2. OMT X ____ regions (count the total of SD above)
3. Other suggestions

CC: Reason for hospitalization and/or reason for OMM consultation

HPI: PSHx:

PMHx: SOCHx: ALL:

PE: must include: vitals

Neuro exam

PT/INR

Musculoskeletal

Platelet Count

Osteopathic Exam

Exam pertinent for Dx

Write out relevant somatic dysfunctions (i.e. OAESIRr, restricted respiratory diaphragm, 1st rib restricted in inhalation, LLQ fascial strain with tissue congestion).

Please write a statement describing the goals of Osteopathic treatment.

Ileus example: Treatment goals are to stimulate bowel peristalsis by balancing the autonomics, decrease somatic dysfunction, decrease tissue congestion to increase healing time, increase lymphatic drainage.

Pneumonia example: Treatment goals are to increase sputum expectoration. Decrease somatic dysfunction. Decrease work of breathing to increase overall O₂ availability. Balance autonomics. Decrease sympathetic input to the lungs by breaking the visceral-somatic reflex, this will thin sputum consistency.

Orthopedics / Sports Medicine

Objectives: The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage common orthopedic conditions that patients may present to the family physician's office.
2. Integrate osteopathic manipulative treatment into the management of orthopedic disorders.

The OGME-1 resident will be assigned for two (2) weeks to the Orthopedic service at FHEO. The OGME-1 resident's time and responsibilities will be with Dr. Sean McFadden.

The OGME-1 resident is to accompany the orthopedic surgeon for all inpatient and outpatient surgeries, procedures, and patient care. Assisting with after-hours surgeries for orthopedic cases will be expected.

Weekends may be assigned for hospital coverage by the surgeon.

The OGME-1 resident is required to attend all didactic sessions unless excused for surgeries. The OGME-1 resident may be assigned to present at least one lecture and/or case to the department each month based on a case or topic relating to this rotation.

The OGME-1 resident will complete their one-half (1/2) day clinic assignment at the FHCE.

Clinical Competencies Orthopedics

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
Medical Knowledge: Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral)	<ul style="list-style-type: none">• List differential diagnoses for:<ul style="list-style-type: none">○ Acute and chronic knee pain○ Acute and chronic hip pain○ Acute and chronic shoulder pain○ Acute and chronic back and neck pain○ Painful extremity including	<ul style="list-style-type: none">• Didactic Conferences• Sports Medicine Journal Club• Procedure Workshops• Board Review	<ul style="list-style-type: none">• In-service Exams• COMLEX III• OSCE• Monthly Service Evaluation

sciences and the application of this knowledge to patient care	<p style="text-align: center;">joints</p> <ul style="list-style-type: none"> • Understand the normal and pathologic anatomy of the vertebral column and large joints • Understand the natural history of a healing fracture, ligament and tendon injury • Understand the principles and basic techniques of casting, splinting, and strapping • Understand the role of physical therapy in rehabilitation of orthopedic injuries • Describe the risks and benefits of diagnostic and therapeutic strategies, including surgery, for common orthopedic conditions <p style="text-align: center;"><i>See list of common problems in Orthopedics</i></p>		
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</p>	<ul style="list-style-type: none"> • Learn a focused approach to performing a musculoskeletal history and physical examination • Gain skills in identifying fractures and dislocations on radiographs • Learn the technique of joint aspiration and injection • Gain skills in assisting at orthopedic surgeries • Know how to measure and record joint motion using the American Academy of Orthopedic Surgeons' criteria • Diagnose and manage musculoskeletal disorders and injury, including: <ul style="list-style-type: none"> ○ Bursitis ○ Tendonitis ○ Osteoarthritis ○ Low back pain ○ Neck pain 	<ul style="list-style-type: none"> • Morning Report • Didactic Programs • EBM Guidelines and Procedural Workshops • Procedural Models • Procedural Credentialing • Bedside teaching 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Record Review • Procedural Models • Procedure and Case Logs • Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Communicate effectively with patients, their families and members of the healthcare team • Consider the psychological ramifications of orthopedic diagnoses on patients and their families when communicating • Avoid use of technical surgical jargon when communicating with patients, families and other physicians and staff who are involved in the care of the patient 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation
<p>Practice-Based Learning and</p>	<ul style="list-style-type: none"> • Identify and utilize sources of content that allow for the provision of the most updated 	<ul style="list-style-type: none"> • Use of "virtual library" 	<ul style="list-style-type: none"> • AOA CAP program

<p>Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<p>standards of care in orthopedic practice</p> <ul style="list-style-type: none"> • Utilize evidence-based medicine whenever appropriate to the care of the patient • Be able to critically evaluate literature about orthopedic care • Develop means for practicing and refining orthopedic skills that will be needed over time • Recognize and accept limitations in one's knowledge and clinical skills as a means for continuously improving 	<ul style="list-style-type: none"> • QA / PI data • Journal Club • EBM workshops • Use of EBM order sets 	<ul style="list-style-type: none"> • QA / PI reports • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> • Develop and demonstrate respect and honor for the roles of many health care professionals required for collaborative surgical care <ul style="list-style-type: none"> ○ Primary care, emergency and attending physicians ○ Operative and nursing personnel ○ Social workers and discharge planning personnel ○ Pain management specialists ○ Nutritionists ○ Therapists- physical and occupational ○ Hospice ○ Pastoral care • Develop an awareness of the payment issues involved in orthopedic care <ul style="list-style-type: none"> ○ Managed care requirements for pre-operative clearance ○ Issues regarding length of stay ○ Cost of surgical supplies and their impact on hospital operating budgets 	<ul style="list-style-type: none"> • Multidisciplinary rounds • Community service (Shepherd's Hope) • Involvement in Discharge planning 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> • Apply ethical and legal standards to orthopedic surgical decision making • Practice with compassion <ul style="list-style-type: none"> ○ Respect the privacy and dignity of patients and their families ○ Respect confidentiality ○ Effectively communicate bad news to the patient and family ○ Demonstrate tolerance for issues related to cultural, religious, spiritual and socioeconomic diversity • Maintain honesty and integrity in all relationships centered on the provision of surgical care 	<ul style="list-style-type: none"> • End of Life Care Training (EPEC) • Role Modeling • Cultural Diversity Training 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Portfolios • Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p>	<ul style="list-style-type: none"> • Comprehend and apply osteopathic medical concepts in the diagnosis and treatment of the orthopedic patient • Utilize OMT skills to aid in pre-surgical diagnosis 	<ul style="list-style-type: none"> • Inpatient Credentialing • Weekly Didactic Sessions • Monthly 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • Inpatient

<p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities</p>	<ul style="list-style-type: none"> • Utilize OMT skills as appropriate in the management of orthopedic disease • Utilize OMT skills as appropriate in the management of orthopedic surgical complications(e.g. ileus, pneumonia, wound infections) 	<p>Distance Learning</p> <ul style="list-style-type: none"> • OMT Clinics • Computer Modules 	<p>Credentialing</p> <ul style="list-style-type: none"> • OSCE • Monthly Service Evaluation
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Common Problems in Orthopedics

- Common fractures
- Osteoarthritis and rheumatoid arthritis
- Compartment syndrome
- Fat embolus
- Adult respiratory distress
- Open fractures and joints
- Bite injuries
- Pediatric hip conditions
- Common benign and malignant bone tumors
- Knee ligament injuries
- Low back pain including spondylolisthesis
- Scoliosis
- Spinal cord injuries
- Carpal and cubital tunnel syndromes
- Dupuytren's contractures
- Bone disorders including achondroplasia, osteogenesis imperfecta, and osteoporosis

Pediatrics

No personal leave is allowed during this rotation.

Synopsis

Pediatrics is a critical component of osteopathic family medicine. There shall be a structured educational experience consisting of a minimum of four and one half months (18 weeks). One and one half months (6 weeks) shall be completed during OGME-1 and include at least 25% of the time being dedicated to neonatal nursery and at least 50% of the time being dedicated to the care of the ambulatory or hospitalized patient between 2 and 16 years of age. Years two and three shall include the ambulatory and inpatient settings. There will be clinical experience in the newborn nursery, and the neonatal intensive care nursery.

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will expand his/her knowledge and skills in the management of pediatric and adolescent patients.

Objectives

The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage pediatric problems encountered in family medicine.
2. Manage pediatric emergencies.
3. Provide general care of the newborn in the hospital and office setting.
4. Provide well child care up to and including adolescence.

This is a rotation totaling eight (8) weeks for OGME-1, eight (8) weeks for OGME-2 and (6) weeks for OGME-3 which may be divided into four (4) and two (2) week blocks.

Hours

The pediatric clinic runs from 8:30 am through 12:00 noon and from 1:30 p.m. through 5:00 p.m.. Residents and externs will be expected to be at the clinic at the start of these sessions and to remain until the session is over, or until released by the attending, unless otherwise instructed by the attending on-call. Excessive tardiness will be reflected in your grade.

The senior Resident on service will be responsible for developing and turning in a schedule for all of the externs and residents which will divide their time between the clinic and the hospital. This schedule is to be discussed with one of the attendings for approval and then submitted to the DME for final approval.

Hospital Rounds

The attending on call will advise you as to the time of morning rounds.* Work rounds should be completed before attending rounds (i.e.: patients should be examined, lab studies obtained and reviewed, necessary orders written, etc.). Externs will be involved in the care of the patients, but the resident or OGME-1 resident in the hospital MUST supervise the extern, be familiar with all of the patients, and review the exam prior to attending rounds. Externs assigned for the inpatient rotation should be responsible for one patient at Winter Park Memorial *and* Florida Hospital East Orlando.

Other responsibilities include:

- One resident or OGME-1 resident for each hospital. If three available – third goes to busiest location as assigned.
- Start attending rounds as directed.
- Start I/R patient care early enough to be ready for attending rounds. (1st hospital 7 am or earlier) as needed to complete both hospital rounds by noon – everyone attends 12:30 lectures
- Residents on rounds at WP excused from 7:15 am lecture except residents for FM Lectures (should be scheduled for FHEO)
- Residents on rounds at FHEO are not excused from 7:15 lecture
- All Peds Residents are expected to attend 12:30 lectures
- AM Mandatory meetings may be given excused absence on an individual basis

Hospital Responsibilities

As part of the Pediatric Rotation requirement, OGME-1 residents will complete two (2) weeks of newborn / neonatal medicine at Winter Park Hospital. They will be assigned one (1) call night of Peds per week during this block. Residents will examine all newborns assigned to the practice each morning before attending rounds and write the History and Physical or a Progress note as necessary for the status of the patient.

*Additionally, discharge orders should be written on infants ready for discharge. On the Pediatric ward, all patients should be examined prior to attending rounds, and all outstanding lab tests or radiographic studies checked and evaluated. Necessary orders are to be written and ready for review. Admission History and Physical are to be dictated at the time of admission by the admitting resident.

At the time of discharge, a discharge summary should be dictated by the resident on service and all prescriptions and discharge instructions are to be written for the family. The resident who has examined the patient should discuss the care with the family (including nursery patients).

Residents are expected to round on patients, even when scheduled for the continuity of care clinic. Failure to do so may result in disciplinary action including but not limited to extra call.

Clinic Responsibilities

Residents report to the clinic at 8:30 am and begin seeing patients. The charts will be in the holder outside the door of the exam room. After completing your exam and assessment, present the patient to the attending listed on the front of the chart. Prior to presentation to the attending, you should formulate a diagnosis and plan of management for the patient.

Further disposition will depend on the patient's needs. If nurse care is needed, place the chart back in the door and pull the appropriate flag. If any laboratory studies are performed on patients whom you have seen please make a note of them and be sure to follow up on the results.

NOTE: When seeing patients in Clinic, please attempt to see them in the order in which they arrived (numbers at top of encounter form indicate order).

Extern Responsibilities

Externs will examine patients in the hospital under the supervision of the resident on service. During the first rotation of pediatrics, externs will see only well babies in the clinic until notified by the attendings that they may see sick children as well. Externs will also assist residents as requested with obtaining lab studies or reports, etc.

Additional Responsibilities for Externs and Residents

Resident will be expected to guide OGME-1 residents and externs as much as possible to make patient care run smoothly. OGME-1 Residents will instruct and guide externs. All residents and externs will be expected to research and present one topic during the rotation. This may be based on a patient you have seen or on a common pediatric condition. Please clear the topic with one of the attendings.

Ambulatory Call – Residents

Many of the calls on ambulatory service will be Pediatric calls. You should try to handle these calls to the best of your ability, utilizing your telephone triage guideline (Barton Schmitt -- copy in the Department of Medical Education). However, if you encounter a situation which is problematic (i.e.. A prescription is called for and you are not licensed yet or you are not sure of the best course to take; or you encounter a particularly difficult or irate parent), you have two options:

1. Speak to the resident on call for pediatrics that can then assist you in the management (since they often will have been involved with the patient in one of the offices or s/he may call the attending on call for assistance).
2. Page the attending on-call yourself to discuss the case and develop a plan for care.

Additionally, you will, on occasion, be notified of lab results on pediatric patients. Please be sure to inform the resident on call for pediatrics of the result, as they will usually be waiting for that result to establish a care plan or to discuss it with the patient's family.

OGME-1 Residents

This is an eight (8) week (4 and 4) Primary Care Pediatric rotation under the supervision of Dr.'s Sonia Rico, Hera Nahar, Pallavi Deliwala, and Lisa Ramey where the bulk of your experience will take place in the clinic. There is a significant amount of newborn nursery care as well, and admits for any patients who require hospital care at Florida Hospital East and Winter Park Memorial Hospital.

A book entitled *Instructions for Pediatrics Patients* by Barton D. Schmitt is kept at the Department of Medical Education. The OGME-1 Resident is encouraged to check out this book when they have Pediatric or Ambulatory call.

OGME-1 Residents will be scheduled for one (1) family medicine clinic session a week at FHCE during this rotation on varying days. No vacation or CME days may be taken during this rotation.

OGME-1 Resident Responsibilities

The OGME-1 resident on service is the primary care physician for all patients in the hospital. As such, the OGME-1 resident is primarily responsible to follow the patients' course during the hospital stay and be familiar with the hospital care. All patients on the pediatric ward are to be seen at least twice daily--once at work rounds in the morning and again in the afternoon to determine the progress and need for change in management. At afternoon rounds you are to follow up on all labs and tests or procedures performed during the day and review them with the Attending on call. (Always check in with the attending, even if there are no problems, to review the patients' status.)

You should attend morning lecture/report and noon conferences.

Daily work rounds are to be completed prior to morning lecture/report and Attending rounds.

Work rounds should include:

- Examine all patients on service and all newborns in the nursery and write a progress note.
- If a extern examines the patient, you **MUST** be present to review the exam and cosign the note. (ALL OGME-1 resident and extern progress notes must also be cosigned by the attending physician.)
- Notes should be in problem-oriented form.
- Obtain all outstanding lab reports and place on chart.
- Review dosages (consult standard texts) and fluid orders.
- Review Consultant's notes.
- Please develop a flow sheet for patients who have had a long stay with many studies, or a complicated course.
- Develop a plan of care for the day, including changes in management, need for consults, etc. (All requests for consults must first be discussed with the attending.)
- Stamp one billing form for each patient with the hospital nameplate for the attending to complete (this is only done once for each hospital stay).
- Make brief notes on each patient summarizing the stay to be given to the attending and the on call resident. (The flow sheet may substitute for this if it is complete.)

Additional responsibilities include:

- Round in a.m. as assigned FHEO and WP
- Clinic p.m.
- Call at FHEO for Peds admits on Tuesday nights
- Weekends
 - 2 twenty-four hour days out of 2 week block
 - 4 twenty-four hour days out of 4 week block
 - 6 twenty-four hour days out of 6 week block

You should supervise the medical externs in all of their patient encounters and review all of their notes.

You are responsible for all diagnostic procedures and treatments performed on your patients (with the assistance of the attending or senior resident), as well as arranging for follow-up after the patient is discharged.

OGME-1 Residents will also have to complete the dictation of the H&P at the time of admission and the discharge summary or a transfer summary if the patient is transferred.

With the assistance of the second year residents, OGME-1 residents will be expected to teach the externs basic skills such as the normal newborn exam, etc.

During the Pediatric section meeting at Florida Hospital East, the OGME-1 resident will present a case, obtaining the old records, and x-rays as needed. A typed summary of the case presentation is to be given to Medical Education within two days of the meeting.

Residents

- Rounds a.m. as assigned FHEO and WP
- Clinic a.m./p.m. – FHCE/Oviedo as assigned
- Peds admit call will be combined with Ambulatory and FMRS

OGME-2 Resident Responsibilities

The second year Resident will function as a supervisory Resident for the first year OGME-1 Resident and the externs on service. You will supervise the OGME-1 resident and externs in their examination of patients and charting. When you are on call, you will be responsible for all of the same functions which the OGME-1 resident performs (i.e.: H&P's, writing orders, supervising extern exams, follow up on lab work, etc.). The H&P must be completed at the time of admission.

You are to do work rounds with OGME-1 residents and externs, making sure all of the work is completed and well organized. In the nursery, all parents of well babies should be spoken to BEFORE attending rounds. If there is a question or problem that you cannot handle, advise the parents that the attending will be in to speak to them later (and let the attending know that the parents have questions).

When in the Clinic be aware of the patient flow. Make sure the externs and OGME-1 residents are seeing patients and reviewing them with the attendings appropriately and in a timely manner.

Make yourself available to the OGME-1 resident and externs to review questions and problems they may have regarding patient management. You will be responsible to teach the OGME-1 resident necessary basic skills, such as normal newborn exam and discerning abnormal findings. You should also guide the OGME-1 resident with routine workups of commonly found problems (i.e.: the newborn whose mother had no prenatal care, group B strep evals, sepsis workup etc.).

Prepare a lecture on a pertinent pediatric topic during the rotation (this may be on a general pediatric topic or specific topic relevant to the patient seen in the clinic or on the ward -- discuss with one of the Attendings prior to presentation). **NOTE:** PowerPoint is available in the library and at the Clinic to assist you in preparing a professional and interesting presentation. Any PowerPoint program 7.0 or lower is compatible with the lap top computer and LCD equipment available in Medical Education.

The resident will be scheduled for three clinic sessions each week at FHCE during this rotation.

OGME-3 and OGME-4 Resident Responsibilities

The third and fourth year Resident will primarily be responsible for organizing and supervising the rest of the resident/extern team on Pediatrics. You will also be responsible for teaching the externs, OGME-1 residents and second year Residents. Make yourself available to answer questions during the work day if your assistance is needed, (i.e.: with writing orders, calculating dosages or IV fluids, etc.).

You will also be responsible for assisting in the development of a schedule for all of the residents and externs, dividing your time between the clinic and the hospital. The resident on call should stay at the hospital to make attending rounds along with one or more externs (depending on the number on service). The other residents and externs are to go to clinic after helping with work rounds. A second or third year Resident may be assigned to go to Oviedo if there is sufficient coverage at FHCE (at least one resident must be at FHCE at each session). Review this schedule with the attending and distribute it to all of the attending, residents, and externs on service after approval by the DME.

You should make work rounds with the other residents in the morning and be sure the work is fully completed BEFORE attending rounds. **NOTE:** This needs to be done around Morning Lecture/Report. You should get your team to the 7:15 Lecture/Report. (If there is a second year on service, you may alternate this function with him/her.) If the second year is covering the hospital on a given day, you are to report to clinic by 8:30 am to see patients.

When you are on call for the hospital, you will perform the same duties as the OGME-1 resident would (i.e.: H&P's, writing orders, following up on lab studies, etc.). You are to do the H&P on an admission at the time of admission.

If you have a extern working with you, s/he may help with the H&P, however, you need to be present to supervise and cosign the final note. (Attending must also cosign ALL orders and progress notes.)

Prepare a lecture on a pertinent pediatric topic during the rotation (this may be on a general pediatric topic or specific topic relevant to the patient seen in the clinic or on the ward -- discuss with one of the attendings prior to presentation).

NOTE: PowerPoint is available in the computer room to assist you in preparing a professional and interesting presentation. Any PowerPoint program 7.0 or lower is compatible with the lap top computer and LCD equipment available in Medical Education.

You should be aware of the responsibilities of the OGME-1 residents and second year Residents and supervise their functioning as well as fill in when they are unable to perform their duties (due to absence or excessive workload). You should be familiar with all patients.

The resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation.

Clinical Competencies Pediatrics

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
<p>Medical Knowledge:</p> <p>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care</p>	<ul style="list-style-type: none"> • Identify the common acute and chronic medical conditions for which children visit pediatricians <ul style="list-style-type: none"> ○ Develop a reasonable differential diagnosis and treatment plan for common pediatric clinical problems ○ List and identify those conditions that require immediate recognition and management in children (e.g. meningitis, epiglottitis, appendicitis, etc) ○ Demonstrate an awareness of the unique pharmacological concerns involved with prescribing medication for children • Assess for failure to thrive and identify its major causes • Assess for developmental delay and identify its major causes • Describe the fundamental aspects of health maintenance in children • Delineate the various immunizations for children • Describe the methods for evaluating the nutritional condition of children • Define normal ranges in children for commonly ordered laboratory studies <ul style="list-style-type: none"> ○ Identify the most likely and most serious possible causes for abnormal laboratory studies <p><i>See list of common problems in Pediatrics</i></p>	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • Procedure Workshops • Board Review 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation • Written Exam

<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</p>	<ul style="list-style-type: none"> • Demonstrate history and physical exam skills for: <ul style="list-style-type: none"> ○ Newborns ○ Infants and toddlers ○ Children ○ Adolescents • Demonstrate the appropriate involvement of parents and other caregivers in the assessment of the well and sick child • Order laboratory tests as indicated for both health maintenance and illness assessment • Plot growth and development for children and interpret the results • Conduct developmental assessments on children and interpret the results • Perform procedures such as: <ul style="list-style-type: none"> ○ IV line placement ○ Phlebotomy ○ Audiometry ○ Tympanometry ○ Testing for Strep pharyngitis ○ Giving immunizations ○ Circumcision • Effectively differentiate between the sick child who needs immediate attention and the sick child who can be managed less acutely 	<ul style="list-style-type: none"> • Morning meeting • Didactic Programs • EBM Guidelines and Procedural Workshops • Bedside teaching 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Record Review • Procedure and Case Logs • Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates</p>	<ul style="list-style-type: none"> • Recognize and address the needs of both the child and the parent or caretaker during the visit • Utilize appropriate techniques in interviewing children and their parents or caretakers <ul style="list-style-type: none"> ○ Communicate the diagnosis in lay language and assure comprehension • Provide effective patient education <ul style="list-style-type: none"> ○ Educate regarding indications for calling the doctor or returning to the office for follow-up • Provide anticipatory guidance on: <ul style="list-style-type: none"> ○ Normal growth and development concerns ○ Issues related to puberty and adolescence ○ Issues related to family dynamics • Consider confidentiality issues and the rights of parents and minor children around health care issues 	<ul style="list-style-type: none"> • Bedside and Outpatient teaching and modeling • Videos / Movies • Workshops • Medical Spanish classes • Whole Person Care conference 	<ul style="list-style-type: none"> • OSCE • 360 Degree Evaluation • Monthly Service Evaluation
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate</p>	<ul style="list-style-type: none"> • Identify and utilize virtual library for use in diagnosis and therapeutics • Whenever possible, apply evidence-based medicine to clinical decision-making processes • Utilize clinical guidelines and best practice standards in an effort to minimize unexpected and unnecessary clinical variation 		

scientific evidence, and improve their patient care practices			
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> Formulate diagnostic and therapeutic plans based upon medical, psychosocial, spiritual, socioeconomic and ethical factors Utilize community agencies and resources Apply ethical and legal boundaries with regard to the interaction with and treatment of children and their parents or caretakers Educate parents or caretakers on safety issues specifically regarding recreational activities, exercise, diet, drugs and alcohol, sexual activity, STDs and pregnancy 		
<p>Professionalism:</p> <p>Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> Communicate cases to colleagues, supervisors and consultants clearly and succinctly Employ effective and proper strategies when confronted with problems relative to patient care responsibilities Use appropriate dress, behavior and language in dealing with children, parents or caretakers, staff, peers and other health care workers Acknowledge and demonstrate respect for the child and their parents or caretakers throughout the interaction Honor the principles of compassion, empathy, and respect for modesty, privacy and confidentiality Demonstrate tolerance of family attitudes, beliefs, cultural and socioeconomic influences 	<ul style="list-style-type: none"> Role Modeling Cultural Diversity Training 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Portfolios Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities</p>	<ul style="list-style-type: none"> Recognize the differences in osteopathic approaches to the child versus the adult Perform osteopathic evaluation and treatment to newborns, children and adolescents <ul style="list-style-type: none"> Condylar assessment and decompression Occipital to sacral fascial unwinding Leg length discrepancy Scoliosis 	<ul style="list-style-type: none"> Inpatient Credentialing Weekly Didactic Sessions Monthly Distance Learning OMT Clinics Computer Modules 	<ul style="list-style-type: none"> In-service Exams COMLEX III Inpatient Credentialing OSCE Monthly Service Evaluation

Common Problems in Pediatrics

Health Maintenance

- Immunizations
- Normal Growth and Development

Cough and/or Wheeze

- URI
- Asthma
- Pneumonia
- Bronchiolitis
- Allergic Rhinitis

Fever

- Common Viral Illnesses
- UTI
- Occult Bacteremia
- Meningitis
- Febrile Seizures

Sore Throat

- Group A Beta-Hemolytic Streptococcal Pharyngitis
- Mononucleosis

Ear Pain

- Otitis Media
- Otitis Externa

Abdominal Pain

- Gastroenteritis
- UTI
- PID
- Functional Abdominal Pain

Dermatitis or Rash

- Atopic Dermatitis
- Viral Exanthems
- Impetigo
- Monilial and Tinea Infections
- Scabies

Heart Murmurs

- Innocent Murmurs
- Septal Defects

Developmental Delay

Failure to Thrive

Common Hemoglobinopathies

- Sickle Cell Disease
- Thalassemias

Nephrology

- UTI
- Nephrotic/Nephritic Syndromes
- Proteinuria

Common Chronic Conditions of Childhood

- Allergies
- Asthma
- Cerebral Palsy
- Cystic Fibrosis
- Diabetes Mellitus
- Seizure Disorders

Common Conditions in the Nursery

- Hypoglycemia
- Jaundice

Pharmacotherapy

This is a required two (2) week rotation for OGME-1 residents at Family Health Center East. Coumadin clinic and Diabetic patient education will be included in this rotation. Following the rotations, the Resident is expected to regularly present and discuss appropriate cases with Shannon Miller, Pharm.D., attending coordinator.

Goals

1. Apply a step-wise literature-based approach to the management of core ambulatory diseases whose therapy is largely based on drug therapy which include but are not limited to: congestive heart failure, hypertension, asthma, COPD, diabetes, lipid management, depression, CAD, and anticoagulation.
2. Define a rational approach to case-specific management of drug therapy for select diagnoses as determined by Resident choice from list of available topics provided by the preceptor. (see attached topics list)
3. Introduce clinical investigative opportunities and methodology.
4. Experience the Diabetic patient group education and training.
5. Participate in the Coumadin clinic.

Process

The seven half-days blocks are divided as follows:

1. *Consult Service* (1-2 half days): Consisting of participation in the Coumadin clinic, Hypertension clinic, and any other disease state management clinics which may be instituted
2. *Information Exchange* (2 half days): Residents will choose identified areas of interest of diseases to concentrate on. These sessions will consist of dialogue and didactic teaching with regard to pharmacotherapy for these selected disease states. Emphasis will be placed on obtain detailed patient medication histories, patient disease education, screening for drug-drug and drug-disease interactions and patient medication adherence reviews. The rotation will concentrate on core ambulatory disease states which include but are not limited to: congestive heart failure, hypertension, asthma, COPD, diabetes, lipid management, depression, CAD and anticoagulation.
3. *Clinical Application* (1-2 half days): Residents are asked to select a few of their patients with multiple problems. These patients' charts will be reviewed thoroughly for optimization of drug therapy together with the Resident. The goal is to guide the Resident to manage drug therapy in the most efficacious manner considering compliance, cost, drug-drug and drug-disease interactions. This type of case based practice should provide the Resident practice in working through multiple drug-related problems.
4. *Participate in disease specific education and monitoring* (Diabetic patient education and Coumadin clinic)

The resident will be scheduled for one clinic sessions each week at FHCE during this rotation.

Objectives

1. The Resident shall demonstrate a working knowledge of the following disease state management covered during the rotation:
 - 1.1 Available agents for treating the given disease
 - 1.2 The important factors to consider when selecting from among the available agents for patient subsets or individual patients
 - 1.3 Appropriate monitoring parameters for efficacy and toxicity of agents involved in the treatment of the disease
 - 1.4 The common and/or more serious adverse effects that may result from specific pharmacological intervention and the appropriate parameters to monitor for assessing the occurrence of these reactions

- 1.5 A logical method of choosing alternative drug agents when a change is necessitated by either therapeutic failure or adverse drug reactions
 - 1.6 A reasonable approach to making the appropriate dose changes at correct intervals during the time-course of therapy for given patients
2. The Resident shall be exposed to the following basic principles, but may require consultation in:
- 2.1 Pharmacokinetic evaluation for the purpose of therapeutic drug monitoring and dosage prediction
 - 2.2 Evaluation of complex multiple regimens especially as it related to drug synergy, antagonism, or effects upon concurrent disease process, and the likely results of proposed changes in those regimens.
 - 2.3 Drug information retrieval sources for unusual situations
 - 2.4 Relative cost of specific agents within the therapeutic classes to treat selected disease states
3. Residents will be introduced to research as it pertains to ongoing clinical trials and Residency research requirements.
- 3.1 Present methods available to seek research opportunities.
 - 1.2 Introduce format of clinical research studies.
 - 1.3 Extrapolate Resident research ideas to meet research requirements.
 - 1.4 Introduce preparation necessary for research publication.

Evaluation

Standard evaluation form by the preceptor will be used with emphasis placed upon the active aspects of the rotation as performed by the Resident. Written exam covering drug therapy for core ambulatory disease states. The resident will be scheduled for clinic sessions at FHCE each week.

Recommended Reading/References

1. Dipro (et al). Pharmacotherapy, A Pathophysiological Approach, 3rd edition. Appleton and Lange, 1997.
2. Evans, (et al.). Applied Pharmacokinetics, 3rd edition. Applied Therapeutics, 1992.
3. Koda-Kimble (et al). Applied Therapeutics: The Clinical Use of Drugs, 7th edition. Applied Therapeutics, 1997.
4. Supplementary materials specific to selected disease, distributed by preceptor.

Practice Management/Radiology

No personal leave is allowed during this rotation.

This is a required four (4) week rotation for OGME-2 residents. Three clinic days per week will be included on Monday morning, Tuesday morning and Friday morning at Family Health Center East Clinic. This rotation is held in the Family Health Center (FHO), Family Health Center East (FHEO), Conference Rooms and offices and is coordinated by Dr. Neal Smith and Dr. Steve Meyer (Radiology).

Process

The rotation consists of didactic lectures/discussions in a small group format with Dr Smith, Valarie Prusia, a practice management coordinator, Sue Wuertz, Practice Coordinator, and Cathy Spohr, Practice Manager.

In addition to the 4-week full time rotation, the following learning resources will be used:

1. *Conferences*: There are several practice management noon conference lectures lasting approximately one hour each.
2. *Seminar*: There is a required formal two-day practice management seminar with various speakers such as lawyers, CPAs, Practice Management Consultants, etc. given on an annual basis.

3. *Longitudinal program in OGME-2 and OGME-3 years:* Within the framework of the FHC block rotation, the residents will learn to manage and adjust patient flow and resources. Within the framework of teams, and with the help of advisors, the residents will learn to track and analyze production figures.

Topics (of the rotation and 1 and 2 above) include:

- A. Choosing a practice and different practice types
- B. Practice facilities and office organization
- C. Medical records and business records
- D. Personal and professional financial planning
- E. Computer utilization
- F. Personnel management
- G. Patient flow management
- H. Medical legal issues
- I. Marketing
- J. Hospital staff issues
- K. Managed care

Evaluation

1. Written post-test after completion of 2-week rotation
2. Written evaluation of seminar by residents
3. Written personal mission statement

Goal

The resident shall obtain the body of knowledge and skills necessary to choose a practice location, evaluate a contract, efficiently manage a physician's practice, and negotiate with managed care organizations.

Objectives

Core of Knowledge

- I. Procedures for establishing a practice
 - A. Developing a personal mission statement
 - B. Preparing a CV
 - C. Choosing a partner or practice mode
 - D. Choosing a community (personal and professional)
 - E. Interviewing
 - F. Purchasing an established practice
 - G. Checklist and general timetable of application and forms to be completed prior to entering practice, i.e., privileges, business cards, Medicare provider number, etc.
 - H. Negotiating with managed care organizations for employment
 - I. Evaluating a contract
- II. Practice Facilities
 - A. Location
 - B. Design and cost
 - C. Equipment
 - D. Inventories and supplies
- III. Office Organization
 - A. Types of practice, i.e., solo, corporation, partnership, association, pre-paid plans
 - B. Other systems of health care delivery
 - C. Forms
 - D. Inventories and supplies
 - E. Assignment of duties
- IV. Office and business management

- A. Practice accounting
 - 1. Reading/Understanding Financial Statements
 - 2. General understanding of two column accounting
 - B. Monitoring profitability
 - 1. Cash flow
 - 2. Cost analysis
 - 3. Financing
 - 4. Operating practices
 - 5. Accounts receivable
 - 6. Income Splitting
 - C. Ancillary Services
 - D. Personal financial planning
 - 1. Retirement planning and savings
 - 2. Insurance issues-Life, disability, overhead, umbrella etc.
 - 3. Budget
 - 4. Investing
- V. Computer utilization
- A. Clinical applications
 - B. Business
 - C. Practice analysis (QM) and research
- VI. Personnel management
- A. Employee relationships
 - 1. Salaries
 - 2. Benefits
 - 3. Employee motivation
 - 4. Employee recruitment, retention and discharge
 - 5. Accountability
 - B. Job descriptions
 - C. Labor laws and Federal regulations
 - D. Personnel records
- VII. Patient management
- A. Scheduling
 - B. Patient education
 - C. Consultation and referrals
 - D. Processing patients - ICD-9-CM and CPT Coding
 - E. Building a practice
- VIII. Medical-legal aspects of practice
- A. Professional liability insurance
 - B. Relationships with legal profession
 - C. Giving a deposition
 - D. Governmental Regulations
 - 1. CLIA
 - 2. OSHA
 - 3. ADA
 - 4. Medicare fraud and abuse rules
- IX. Hospital issues
- A. Selection of hospitals
 - B. Staff appointment and privileges
 - C. Medical staff and departmental responsibilities
- X. Marketing
- A. Overview of medical marketing
 - 1. Definitions of marketing
 - 2. Need for marketing and changes in marketing with managed care
 - 3. Misunderstandings about marketing
 - B. Development of the marketing concept

1. Setting personal and professional goals
2. Marketing audit, analysis and research
3. Market focus
- C. Marketing strategy: Ethical marketing goals
 1. Product/service
 2. Price
 3. Place/location
 4. Promotion/communication
- D. Patient retention techniques
- E. Clinical applications of marketing principles
 1. Services, i.e., hypertension, diabetes, obesity care
 2. Benefits achieved

- XI. Inter-professional relations
- A. Professional associations
 - B. Professional organizations

- XII. Managed Care
- A. Contracting
 - B. Cost of care
 - C. QM/UM
 - D. Risk sharing

- XIII. Community Resources

Skills

The resident should develop skills in:

- I. Selection of practice type (involves decisions on life-style, residence location and professional interrelationships)
- II. Prudent selection and utilization of advisors and vendors
- III. Personnel management and delegation of responsibilities
- IV. Computer competency
- V. Time management
- VI. Personal and public (oral and written) communication
- II. Resources management
- III. Income splitting and expense allocation

The resident will be scheduled for regular clinic session times each week.

Required Reading

1. The New Practice Handbook, McGraw Hill.
2. Personnel Management, McGraw Hill.
3. The Medical marketing Handbook, McGraw Hill.
4. Prepared syllabus

Recommended Reading

1. Practice Management for the Physician, Winer.
2. Making the Most of Your Money, Jane Bryant Quinn.
3. 7 Habits of Highly Effective People, Stephen R. Covey.
4. Legal Guide for Physicians, J. Taraska
5. Family Physicians and Managed Care, David Vogel, AAFM.

Pulmonology/Critical Care

No more than one-week of personal leave can be taken during this rotation.

Objectives

The resident will demonstrate competency in his/her ability to:

1. Perform a preoperative pulmonary assessment.
2. Diagnose and manage common pulmonary diseases.
3. Understand the role of osteopathic manipulation in the treatment of pulmonary disease.

This is a two (2) week rotation.

The OGME-1 resident will be scheduled for one (1) clinic session each week at FHCE during this rotation. If a one-week vacation is taken during this rotation, the combined week schedule is followed.

Week 1

MONDAY	Didactic on ventilator management (1-2 hours)
TUESDAY	Rounds with the critical care therapist (1-2 hours)
WEDNESDAY	Rounds with the critical care therapist (1-2 hours)
THURSDAY	Rounds with the critical care therapist (1-2 hours)
FRIDAY	Rounds with the critical care therapist (1-2 hours)

Week 2

MONDAY	Didactic on spirometry performance/ABG performance (1-2 hours)
TUESDAY	Interpretation of spirometry studies/ABG studies (1-2 hours)
WEDNESDAY	Interpretation of spirometry studies (1-2 hours)

Combined Schedule

MONDAY	Didactic on ventilator management (1-2 hours) Didactic on spirometry performance/ABG performance (1-2 hours)
TUESDAY	Rounds with the critical care therapist (1-2 hours) Interpretation of spirometry studies/ABG studies (1-2 hours)
WEDNESDAY	Rounds with the critical care therapist (1-2 hours) Interpretation of spirometry studies (1-2 hours)
THURSDAY	Rounds with the critical care therapist (1-2 hours)
FRIDAY	Rounds with the critical care therapist (1-2 hours)

The remainder of time on this service will be spent on rounds with Dr. Barroso and Attermann, managing Dr. Barroso's patient's and teaching the externs on rotation.

Learning Resources

- Modes of Ventilation Tape
- Modes of Ventilation Article
- Spirometry Interpretation Article
- ABG Interpretation literature

Surgery

No personal leave is allowed during this rotation.

Synopsis

The minimum duration of this portion of the curriculum shall be five (5) months with at least one (1) month being completed during each of the three (3) years. Emphasis will be placed on the ambulatory management of surgical

problems in the specific subspecialty areas listed below. Procedures appropriate to osteopathic family medicine shall be emphasized. Pre and postoperative diagnosis and management of all types of surgical patients will be stressed.

Goal

To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, educational experiences that will expand his/her knowledge and skills in the management of surgical diseases.

Objectives

The resident will demonstrate competency in his/her ability to:

- a. Diagnose and manage surgical disorders and surgical emergencies.
- b. Refer patients with surgical problems, in a timely and appropriate fashion, to the appropriate surgical specialist.
- c. Assist the surgeon in the operating room
- d. Perform those specific surgical procedures that family physicians may be called on to perform.
- e. Manage, in conjunction with the surgeon, the surgical patient during the preoperative and postoperative period.
- f. Understand basic surgical principles, of asepsis, handling of tissue, and assisting in the operating room.

This is an eight-week rotation with the general surgery group contracted with FHEO Family Medicine Residency.

Education opportunities and experiences are numerous. They involve seeing surgical patients and consultations independently. The information, findings, work up, differential diagnosis and treatment plans are discussed with the attendings. Case and topical discussions are ongoing throughout the patient's stay. Anatomy, pathology, anesthetic and surgical procedures are reviewed, presented and discussed during surgery and rounds. Involvement progresses from discussions and observation through assisting to possibly doing the surgery and managing the cases. This depends on the interest, competency and confidence demonstrated by the OGME-1 residents.

The OGME-1 resident will be responsible to assist the general surgeons (primarily Robert Frilen, DO, Joseph Bennett, DO, Malcolm McDonald, DO and Victor Modesto, MD) with all surgical admissions and H&P's, presurgical workup and evaluation, surgical procedures, and postoperative care. The OGME-1 resident's time will be divided among the surgeons equitably as available.

The OGME-1 resident will be responsible for assisting with surgeries after 7:00 p.m. if requested by the surgeons and not exceeding the work hours requirement.

The OGME-1 resident will be expected to complete a reasonable number of assigned H&P's. The majority will be on patients who are on the surgical service.

The OGME-1 resident is required to attend all didactic sessions unless excused for surgeries.

Weekends will be assigned for hospital coverage while on the Surgery service. The OGME-1 resident will complete their one-half (1/2) day clinic assignment at the FHCE on either Wednesday or Friday afternoon.

The OGME-1 resident may be assigned to present at least one lecture and/or case based on cases or topics relating to this rotation; to the monthly surgery department section meeting.

It is the extern and OGME-1 resident's service and responsibility to make sure all surgeries are covered and all patients seen. Your objective is to follow each patient you work with from admission to discharge. On patients you work-up, attend their surgical procedures in the operating room. Take daily notes and dictate the discharge summary on the patients whose surgery you observed and participated in. OGME-1 Residents need to spend more time in the operating room (you will be evaluated and 25% of it depends on your operating room performance). ICU notes should only be written by the OGME-1 residents as they are complicated patients. There is a weekly General Surgery House Staff meeting on Friday in the Doctor's Lounge. Each of the house staff during the monthly rotation is required to present at this meeting on an assigned topic, at a time to be assigned. Each OGME-1 resident on service is required to present a 10-minute educational presentation at the quarterly General Surgery Department meeting. The presenting person will be notified by Medical Education.

Clinical Competencies Surgery

Goals: Realm of Competency	Objectives	Teaching Methods	Evaluation
<p>Medical Knowledge:</p> <p>Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care</p>	<ul style="list-style-type: none"> • Possess knowledge of anatomical, molecular, biochemical and cellular mechanisms underlying the pathology of disease <ul style="list-style-type: none"> ○ Shock – hypovolemic, septic and cardiogenic ○ Trauma – penetrating, blunt and chemical ○ Acute abdomen ○ Hernias ○ GI hemorrhage – upper and lower ○ Peptic ulcer disease ○ Biliary tract disease ○ Pancreatitis – acute and chronic ○ Portal hypertension ○ Appendicitis ○ Abdominal masses ○ Colonic and ano-rectal diseases ○ Arterial occlusive disease ○ Venous disease, including DVT prophylaxis ○ Endocrine gland diseases ○ Breast masses and disease ○ Cancer – especially breast, colon, gastric, pancreatic, lung and skin • Possess knowledge of essential characteristics of surgical practice <ul style="list-style-type: none"> ○ Examination of the patient from the surgical viewpoint ○ Evaluation and care of the pre-operative and post-operative patient, including appropriate orders ○ Sterile technique including scrubbing, gowning, gloving, prepping and draping a field ○ Fluid resuscitation and therapy ○ Basic wound evaluation and care ○ Hemostasis and anticoagulation including DVT prophylaxis and treatment ○ Nutritional support – enteral and parenteral 	<ul style="list-style-type: none"> • Morning Report • Didactic Conferences • Journal Club • Procedure Workshops • Board Review • Tumor Board 	<ul style="list-style-type: none"> • In-service Exams • COMLEX III • OSCE • Monthly Service Evaluation

	<ul style="list-style-type: none"> ○ Malignant neoplasia and its effect on body systems ○ Infections and appropriate prophylactic and therapeutic antibiotic use ○ Basic principles of minimally invasive surgery ○ Effective management of pain <p><i>See list of common problems in Surgery</i></p>		
<p>Patient Care:</p> <p>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</p>	<ul style="list-style-type: none"> ● Elicit thorough and pertinent patient histories ● Perform a comprehensive and organ system specific examination ● Write pertinent surgical notes <ul style="list-style-type: none"> ○ Pre-operative notes ○ Operative notes ○ Post-operative checks ○ Progress notes ○ Consultation notes ● Interpret results of commonly used diagnostic tests with recognition of their limitations ● Engage in effective surgical decision making including timing, need for surgery, assessment of surgical risk / benefit ratios ● Perform basic surgical skills <ul style="list-style-type: none"> ○ Nasogastric tube insertion ○ Venipuncture ○ IV catheterization ○ Arterial puncture ○ Urinary catheterization ○ Suturing ○ Skin stapling ○ Drainage of abscesses ○ Surgical assisting 	<ul style="list-style-type: none"> ● Morning Report ● Didactic Programs ● EBM Guidelines and Procedural Workshops ● Procedural Models ● Procedural Credentialing ● Bedside teaching 	<ul style="list-style-type: none"> ● OSCE ● 360 Degree Evaluation ● Record Review ● Procedural Models ● Procedure and Case Logs ● Monthly Service Evaluation
<p>Interpersonal and Communication Skills:</p> <p>Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with</p>	<ul style="list-style-type: none"> ● Communicate effectively with patients, their families and members of the healthcare team ● Consider the psychological ramifications of surgical diagnoses on patients and their families when communicating ● Avoid use of technical surgical jargon when communicating with patients, families and other physicians and staff who are involved in the care of the patient 	<ul style="list-style-type: none"> ● Bedside and Outpatient teaching and modeling ● Videos / Movies ● Workshops ● Medical Spanish classes ● Whole Person Care conference 	<ul style="list-style-type: none"> ● OSCE ● 360 Degree Evaluation ● Monthly Service Evaluation

patients, their patients families, and professional associates			
<p>Practice-Based Learning and Improvement:</p> <p>Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices</p>	<ul style="list-style-type: none"> Identify and utilize sources of content that allow for the provision of the most updated standards of care in surgical practice Utilize evidence-based medicine whenever appropriate to the care of the patient Develop means for practicing and refining surgical skills that will be needed over time Recognize and accept limitations in one's knowledge and clinical skills as a means for continuously improving 	<ul style="list-style-type: none"> Use of "virtual library" QA / PI data Journal Club EBM workshops Use of EBM order sets 	<ul style="list-style-type: none"> AOA CAP program QA / PI reports OSCE 360 Degree Evaluation Portfolios Monthly Service Evaluation
<p>Systems-Based Practice:</p> <p>Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value</p>	<ul style="list-style-type: none"> Develop and demonstrate respect and honor for the roles of many health care professionals required for collaborative surgical care <ul style="list-style-type: none"> Primary care, emergency and attending physicians Operative and nursing personnel Social workers and discharge planning personnel Pain management specialists Nutritionists Therapists- physical and occupational Hospice Pastoral care Develop an awareness of the payment issues involved I surgical care <ul style="list-style-type: none"> Managed care requirements for pre-operative clearance Issues regarding length of stay Cost of surgical supplies and their impact on hospital operating budgets 	<ul style="list-style-type: none"> Multidisciplinary rounds Community service (Shepherd's Hope) Involvement in Discharge planning 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation Portfolios Monthly Service Evaluation
<p>Professionalism:</p> <p>Demonstrate a commitment to</p>	<ul style="list-style-type: none"> Apply ethical and legal standards to surgical decision making Practice with compassion 	<ul style="list-style-type: none"> End of Life Care Training (EPEC) Role Modeling 	<ul style="list-style-type: none"> OSCE 360 Degree Evaluation

<p>carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> ○ Respect the privacy and dignity of patients and their families ○ Respect confidentiality ○ Effectively communicate bad news to the patient and family ○ Demonstrate tolerance for issues related to cultural, religious, spiritual and socioeconomic diversity <ul style="list-style-type: none"> ● Maintain honesty and integrity in all relationships centered on the provision of surgical care 	<ul style="list-style-type: none"> ● Cultural Diversity Training 	<ul style="list-style-type: none"> ● Portfolios ● Monthly Service Evaluation
<p>Osteopathic Philosophy and Osteopathic Manipulative Medicine:</p> <p>Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate. Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities</p>	<ul style="list-style-type: none"> ● Comprehend and apply osteopathic medical concepts in the diagnosis and treatment of the surgical patient ● Utilize OMT skills to aid in pre-surgical diagnosis ● Utilize OMT skills as appropriate in the management of surgical disease ● Utilize OMT skills as appropriate in the management of surgical complications(e.g. ileus, pneumonia, wound infections) 	<ul style="list-style-type: none"> ● Inpatient Credentialing ● Weekly Didactic Sessions ● Monthly Distance Learning ● OMT Clinics ● Computer Modules 	<ul style="list-style-type: none"> ● In-service Exams ● COMLEX III ● Inpatient Credentialing ● OSCE ● Monthly Service Evaluation

Common Problems in Surgery

- Shock
- Trauma
- Acute Abdomen and Appendicitis
- Hernia
- Gastrointestinal Hemorrhage
- Peptic Ulcer Disease
- Biliary Tract Disease
- Pancreatitis
- Abdominal Masses
- Colonic and Ano-rectal Disease
- Arterial Occlusive Disease
- Breast Masses
- Surgical Endocrine Disease
 - Thyroid, parathyroid, adrenal, pancreas, testicle, ovary
- Cancer
 - Breast, colon, gastric, pancreatic, lung, skin

Surgery Elective

This is a four-week rotation in which the Resident selects a surgical or subspecialty rotation from the following services with the approval of the DME:

- General Surgery
- ENT
- Urology
- Others (ortho, plastics, ophthalmology, colorectal etc.) as approved by the DME

The Resident must select a service and complete the Elective Rotation Assignment form to confirm the rotation with the attending and the ME department. The rotation will not be scheduled until the attending and the DME have signed the form. All forms must be completed and submitted to the office thirty (30) days prior to the rotation or the Resident will be assigned an attending by the DME. All rotations shall be within the FH system.

The Resident will be responsible for:

- Attending all outpatient sessions with the attending(s)
- Assisting with surgery of interest
- Writing daily progress notes on patients
- Assisting Attendings with all special procedures
- Examining and assessing consults under the direct supervision of the Attendings
- Following the reading program
- Assisting with supervision of OGME-1 residents and externs on the service
- Providing a daily education component for OGME-1 residents and externs
- Attending Surgery Department section meetings (one surgery Resident will be asked to present a case at this meeting; however, all residents on the rotation are to attend the meeting)

The Resident will be scheduled for three (3) clinic sessions each week at FHCE during this rotation on various days.

Urology

Objectives

The resident will demonstrate competency in his/her ability to:

1. Diagnose and manage common urologic conditions that may present to the family physician's office.
2. Integrate osteopathic principles and manipulative treatment into the management of urologic disorders.

Residents:

This four (4) week rotation will be supervised by Dr. Albers. The resident will be responsible for:

- ✓ Accompany attending while caring for patients in his office.
- ✓ Assist and observe attending during procedures.
- ✓ See consults with attendings.
- ✓ Become familiar with endoscopy indications complications, and procedures.
- ✓ Follow the reading schedule and assignments for urology.

The resident will be scheduled for three (3) clinic sessions each week at FHCE during the rotation on varying days.

Procedures

Synopsis

To be able to provide comprehensive care, the family physician should be competent to perform certain procedures.

Goal

To provide the resident, through observed clinical training, educational experiences that will prepare him/her to perform procedures necessary to provide comprehensive care.

Objectives

The resident will demonstrate competency in his/her ability to perform as a minimum the following procedures:

1. Punch Biopsy of Skin
2. Excision Of Skin Lesion
3. Incision And Drainage Of Abscess
4. Toenail Removal
5. Suturing/Laceration Repair
6. Spirometry
7. Interpret A Resting EKG
8. Flexible Sigmoidoscopy
9. Circumcision
10. Colposcopy With Cervical Biopsy
11. Endometrial Biopsy
12. Lumbar Puncture
13. Vaginal Delivery
14. Episiotomy Repair
15. Casting
16. Taping Of Ankles And Other Joints
17. Joint/Bursa Aspiration/Injection
18. Removal Of Cerumen From Ear Canal
19. Epistaxis Management (Nasal Packing)
20. Intubation
21. Central Line Placement
22. Suprapubic Tap
23. Allergy Testing
24. Insertion Of Urethral Catheter
25. Defibrillation

RESEARCH AND SCHOLARLY ACTIVITY REQUIREMENTS

AOA / ACOFP: The AOA / ACOFP guidelines state that the program must provide opportunity for residents to participate in research or scholarly activities.

The residents will be required to participate in the following:

- 1) QI Projects
→ 1 QI Project/ year/ Practice Group
- 2) Patient Orientated Evidence that Matters (POEMS)
→ OGME-1 = 2 (1 in Emergency Medicine; 1 in Pharmacology)
→ OGME-2 = 2 (1 in Emergency Medicine; 1 in Behavioral Med)
→ OGME-3 = 3 (1 in Emergency Medicine; 1 in Behavioral Med; 1 in Geriatrics)
- 3) Scholarly projects
Conduct research project (elective time given) - investigator initiated, *or*
→ Present a case report, a poster or an oral presentation at a regional or national conference,
or
→ Write a case report submitted for publication in peer review journal, *or*
→ Prepare literature review article submitted for publication in peer review journal
- 4) IRB certifications (NIH, Research HIPAA & CV)
→ OGME-1 will complete this requirement following EPIC training or within the first 3 months of residency.

I. QI projects

Resident involvement in quality improvement projects results in healthcare excellence with reduction in risk and cost. As frontline physicians, residents can recognize when problems in quality, safety, and efficiency occur.

QI projects are important to resident education:

- a) Fulfills AOA /ACOFP criteria for practice-based learning and improvement competency
- b) Allows residents to become active participants in our residency practice – improving healthcare, delivery and outcomes
- c) Increased awareness in methods for performance improvement leading to increased re-imbursement (P4P)
- d) To learn the skills required for future re-licensure requirements

Quality improvement projects are not intended to be “generalizable” to outside practices, or to be published. IRB approval is not needed.

Pre-requisite knowledge for faculty:

- 1) Strategies to recognize clinical management issues
- 2) Skills to assess the issue
- 3) Knowledge of how to implement a practice change
- 4) Skills to analyze the project impact

Resident Goals:

- 1) Understanding quality improvement in the clinical setting from the stakeholder’s perspective.
- 2) Identify a clinical management issue
- 3) Analyze the issue
- 4) Research the current guidelines/evidence for standard practice or alternative practice
- 5) Develop a plan to improve patient care
- 6) Implement the project
- 7) Analyze the impact of change
- 8) Project presentation

II. Patient Oriented Evidence that Matters (POEMS)

Residents will learn the skills to answer questions which occur in everyday practice via efficient, evidence-based methods. Through explicit review of selected resources, they will learn to quickly review literature for strengths, weaknesses and take-home messages. They will integrate this information and develop a bottom-line answer to their clinical question.

POEMS are important to resident education:

- a. Fulfills AOA / ACOFP criteria for critical review of the literature
- b. Enables the resident to answer Clinical questions at the point of care
- c. Improves the resident’s ability to provide EBM care

Pre-requisite knowledge for faculty:

- 1) Knowledge of resources to rapidly retrieve the evidence
- 2) Skills to appraise the evidence
- 3) Knowledge of the POEMS format

Resident Goals:

- 1. Identify clinical questions which occur in regular practice
- 2. Efficiently search and find resources to answer clinical questions
- 3. Rapidly retrieve (& appraise as necessary) evidence
- 4. Gain awareness of some of the available resources (& use more than 1-2)
- 5. Enhance the skills and comfort in presentation.

III. Scholarly projects

Scholarly activity is important to resident education:

- a. Fulfills AOA / ACOFP requirements for opportunities for research in principles of research design, performance, and analysis and encourage research participation.
- b. Fulfills AOA / ACOFP recommendations that faculty must demonstrate broad involvement in scholarly activity.

Scholarly project options

- 1) Conduct research project (elective time given) - investigator initiated
Project leaders – Crow, Allgeier, Spruill, Lukman
- 2) Present a case report, a poster or an oral presentation at a regional or national conference
Project leaders – individual mentors
- 3) Write a case report submitted for publication in peer review journal
Project leaders – individual mentors
- 4) Prepare literature review article submitted for publication in peer review journal
Project leaders – individual mentors

Pre-requisite knowledge for faculty:

- a. Overview of scholarly activity: what is it, how can we incorporate it into our current load and where can we present, submit, etc
- b. Learn all of the components of preparing a manuscript, case study, or review article for a peer-reviewed journal.
- c. Key concepts and basic rules of good grammar
- d. Writing in the “active voice”

Resident Goals:

- a. Develop skills that encompass the ability to: perform literature searches using MEDLINE and other resources
- b. Ability to critically evaluate research articles
- c. Utilize evidence-based medical information resources
- d. Interpret and apply clinical decision rules; and appropriately apply evidence in clinical decision-making

RELATED NONCLINICAL AREAS

The following is an outline of the non-clinical areas relevant to the family physician as presented in the family medicine residency. These areas include, but are not limited to, epidemiology, sociologic aspects of health, economics of health care delivery, etc.

Economics

Educational Objective

The Resident will demonstrate understanding and knowledge of the skills of practice setting, organization, and management. These will include (all mandatory)

1. Types of medical practice settings
2. Use of professional advisors
3. Development of office floor plans
4. Office equipment and furnishings
5. Office communications systems
6. Budget development
7. Credit and collection procedures
8. Billing and bookkeeping systems
9. Fee development
10. Sources medical payments and insurance billing
11. Appointment scheduling
12. Personnel hiring, procedures, and policies
13. Awareness of organizational medicine, i.e. AOA and ACOFM

Epidemiology

Educational Objectives

To increase Resident ability to identify, evaluate, analyze and to take action with epidemiologic problems. The goal is to provide Resident with a basic understanding of the principles and practice of Epidemiology (recommended).

Category II and III

Concepts

1. Introduction to Epidemiologic practice (recommended)
 - a. Agent-Host Environment model
2. Epidemiologic Methods (recommended)
 - a. Agent-Host Environmental model
 - b. formulating the hypotheses
 - c. Analytical studies
 1. Cause-effect relationships
 2. Statistical associations
 - d. Experimental Studies
3. Retrospective and Prospective Studies (recommended)
 - a. Case-history studies
 - b. Cohort studies
4. Selected infectious disease case studies (recommended)
 - a. Occurrence
 - b. Incubation periods
 - c. Methods of spread
 - d. Periods of contagion
 - e. Clinical picture of disease process
 - f. Methods of control
5. Community diagnosis (recommended)
6. The working of health services (recommended)
7. Specific disease control programs (recommended)
 - a. Hospital infections control
 - b. Immunity-types and methods
 - c. International immunity requirements

Sociological Concepts in Health

I. Educational Objectives

1. Present the socioeconomic factors as related to illness and “wellness” in modern society (recommended)
2. Present the societal roles of health care physicians, including physicians, nurses, paramedical personnel and health care administrators (recommended)
3. Present the societal role of patients in the community and the health care institution (recommended)
4. Explore the various organizational aspects of health care services in society (e.g. acute care hospitals, long term care, public health , private practices, voluntary services and governmental agencies) (recommended)
5. The goal is to provide Residents with a working knowledge of the sociological aspects of health and illness; health care; and the organization of health care services (recommended).

Computers in Medicine

I. Educational Objectives

To assist the Resident in developing a sense of computer functioning and its application to the practice of medicine.

Category I, II, and III

A. Concepts

Each Resident should be instructed in the use of state of the art computer systems, be given the opportunity for hands-on exposure and be expected to become “computer literate” over the course of the residency program (recommended)

B. Skills

Computer instruction is divided into three segments: (recommended)

1. Educational, which consists of an array of interactive software;
2. Patient information, which consists of those functions of or pertaining to information transfer; and
3. Accessing national databases.

PROTOCOL FOR CONFERENCES AND PAPERS

1. Weekly seminars on various pertinent subjects will be conducted by members of the Family Medicine Residency faculty and the Residents (recommended).
2. Each Resident will be expected to participate as a member of the medical review audit/quality assurance committee of the Department of Family Medicine and present on retrospective audit to the Department of Family Medicine at one of its monthly meetings (recommended).
3. Each Resident will be expected to present at least one formal lecture, on a topic germane to family medicine, at the lecture series which is conducted primarily for the Housestaff (recommended).
4. Each Resident will be expected to prepare and present a research paper in a form acceptable for publication in the Journal of Osteopathic Medicine (mandatory)