The Reading Hospital
and Medical Center

PART IV

Program Information

The Reading Hospital
and Medical Center

Family Health Care Center

Family Medicine Residency Program

Policies and Procedures Manual

Interns and Residents

2012 – 2013

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FAMILY HEALTH CARE CENTER
FAMILY MEDICINE RESIDENCY PROGRAM

Policies and Procedures Manual

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Overview and Statement of Purpose

Introduction

This manual complements the basic orientation of the residents and staff of the Family Health Care Center (FHCC) and Family Medicine Residency Program (FMRP), and it is a source of first reference for policy clarification. Although every attempt is made to make it as current and complete as possible, situations will undoubtedly arise which are not included in the manual. Faculty, residents, and staff will be notified by email of any changes. If a situation is not covered by a policy delineated in the manual, or if the interpretation is ambiguous, the Program Director, in consultation with appropriate administrators, managers, faculty, and/or Chief Residents, will make the necessary decision or interpretation.

Purpose of the Family Health Care Center

The FHCC represents the clinical site of TRHMC's FMRP. It functions as the out-patient office setting in which a full range of services are provided by physicians who are trained or are training in the specialty of family medicine. The center provides general medical care for patients of all ages and either sex. The FHCC consists of Suites 120 and 200 in the Doctors' Office Building, but may change pending renovations approved in 2012.

The services include preventive, diagnostic, and therapeutic services which are within the range of competence of well-trained family physicians, including counseling services, and those services that are provided by other health professionals who assist the family physician.

The center is staffed by physicians who are engaged in an academic program. These physicians are assisted by a full range of ancillary personnel, including psychologists, nurses (registered nurses and licensed practical nurses), administrators, secretaries, and clerical staff.

Goal of the Residency

The primary purpose of the FMRP is to provide an educational environment that fosters personal and professional growth. The program aims to graduate physicians who are well-trained, competent, and caring clinicians and who are able to effectively practice the specialty of family medicine. A graduate of the program should be able to enter the community not only as a skilled physician, but also as an advocate, an advisor, and a manager of the family's healthcare needs.

The program aspires to teach the knowledge, attitudes, and skills necessary to provide the competent practice of family medicine in local, national, and/or international communities. The program aims to model the attitudes, behavior, and skills necessary for collecting, assimilating, and articulating the vast amounts of information required to practice as a competent and sensitive office and hospital-based family physician. In addition, graduate will be able to accommodate and, in some cases, lead the complex changing nature of healthcare delivery.

Continuity of Care

Along with being a specialty in breadth which provides comprehensive medical care to all members of the family, family medicine is also characterized by being a specialty that emphasizes continuity of patient care.

To maintain appropriate continuity of care, the following guidelines have been developed:

- Each patient at the FHCC will be assigned to a primary physician. Every effort will be made to have the patient seen by the primary physician. New patients will be assigned to specific residents according to patient requests, reassignment recommendations of graduating residents,

or on a random basis. Efforts will be made to provide residents with a diverse patient panel. Residents' patient schedules will reflect the guidelines set forth by the Accreditation Council for Graduate Medical Education (ACGME) for family medicine residency training. Residents are expected to provide continuity of care to their panel of patients in both the in-patient and out-patient settings.

- The practice is organized into five teams, each typically composed of three to four residents, a faculty member, and a nurse. When the primary physician is unavailable, especially in an acute situation, a patient should be seen by a team member, and then referred back to the primary physician. Thus, continuity is also provided via teams.
- Families need to be provided with continuity of care as much as possible.
- Willingness to communicate is essential. Whenever possible, the primary resident should talk with his/her own patients when they have questions or need to discuss test results.

The primary resident is responsible for following the care rendered to his or her patients. While the in-patient care is the responsibility of the residents on the family medicine in-patient service, there should be a note on the chart by the primary physician within 48 hours of admission. In addition, the primary physician must, whenever possible, make "social rounds" during the admission and regularly discuss the patient's progress with the residents on the service.

Resident Competencies

In 2007, the ACGME, which accredits all U.S. residency programs, established a set of "General Competencies" that must guide curriculum development and resident evaluation. All residents must demonstrate competency in each of six areas (seven for osteopathic residents) in order to graduate from the residency program. These competencies form the basic tenets on which our program is structured. Rotation goals/objectives and resident evaluations are centered on these competencies:

Patient care – Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical Knowledge – Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

Practice-Based Learning and Improvement – Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals: identify strengths, deficiencies, and limits in one's knowledge and expertise; set learning and improvement goals; identify and perform appropriate learning activities; systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; incorporate formative evaluation feedback into daily practice; locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; use information technology to optimize learning; and participate in the education of patients, families, students, residents, and other health professionals.

Interpersonal and Communication Skills – Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to: communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; communicate effectively with physicians, other health professionals, and health-related agencies; work effectively as a member or leader of a health care team or other professional group; act in a consultative role to other physicians and health professionals; and maintain comprehensive, timely, and legible medical records, if applicable.

Professionalism – Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate: compassion, integrity, and respect for others; responsiveness to patient needs that supersedes self-interest; respect for patient privacy and autonomy; accountability to patients, society, and the profession; and sensitivity and

responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Systems-Based Practice – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to: work effectively in various health care delivery settings and systems relevant to their clinical specialty; coordinate patient care within the health care system relevant to their clinical specialty; incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; advocate for quality patient care and optimal patient care systems; work in interprofessional teams to enhance patient safety and improve patient care quality; and participate in identifying system errors and implementing potential systems solutions.

Osteopathic Philosophy and Osteopathic Manipulative Medicine (for osteopathic residents only) – Residents must demonstrate a knowledge of the principles of osteopathic medicine and be able to demonstrate osteopathic manipulative techniques.

FMRP and FHCC Organizational Structure and Personnel

Administrative Structure of the FMRP

The Chair of the Department of Family and Community Medicine reports to the Vice President.

The Director of the FMRP reports to the Chair of the Department of Family and Community Medicine, but may report directly to the Vice-President for day to day operational concerns (staffing, budgets, etc.). In conjunction with hospital Administration, the FHCC is responsible for its own operating budget.

Statement as to the Program Director's Responsibility

The Program Director of the FMRP and the FHCC has administrative and educational responsibility for all activities having to do with the residency program, the FHCC, residency training, faculty development, and research. He/she oversees the faculty, residents, administrative staff, and FHCC nurses and staff. In conjunction with the Practice Manager, he/she oversees the residency and practice budgets.

Family Medicine Faculty Associates

The Program Director, Associate Director, and faculty must assume the roles of teacher, supervisor, clinician, administrator, and advisor. They must develop and demonstrate the skills and expertise necessary to meet the training and supervisory responsibilities of the program. They are responsible for implementation of the policies and procedures of the residency program, the practice, and the sponsoring institution as they apply to the residency.

Faculty Advisors

Each resident will be assigned to a faculty advisor. The faculty advisor should be consulted first regarding any questions or concerns that the resident has prior to presenting them to the Program Director. The advisor also monitors the evaluations and progress of the assigned residents and reports any concerns to the Program Director. The advisor helps insure that each advisee is on the path to meeting RRC/ACGME requirements. Note that separately there are available incentive plans that specifically delineate their responsibilities.

Residency Teams and Cross Coverage

Because neither residents nor faculty members can be present in the FHCC at all times, cross coverage is necessary. During scheduled absences, the resident must designate a specific team member to contact. In acute situations, any member of the team, the resident on call, or any available physician may be asked to help. The list of teams is distributed to the residents and faculty at the beginning of the academic year. Teams are led by a faculty physician.

Chief Residents

Each year, residents will be asked to vote for a Chief Resident(s). The individual(s) selected will be responsible for maintaining the schedules for resident night call, specialty clinics, and community clinics. They will attend FHCC staff meetings, serving as the liaison between the residents, faculty, and staff, and will represent resident interests at other committees and meetings within the hospital. Elections and eligibility for Chief Resident selection is available under separate policy.

Problems concerning resident coverage, problems between residents, etc., should be discussed with the Chief Resident(s) first. If the issue is not satisfactorily resolved, then the problem should be taken to the Program Director.

The Chief Resident(s) are provided a stipend in addition to the contracted residents' salary. They are expected to perform their duties in a reliable, timely, and professional fashion.

Program Coordinator

The Program Coordinator assists the Program Director in structuring and implementing all operations of the FMRP and in performing administrative responsibilities.

Education and Curriculum Coordinator/Faculty Secretary

The Education and Curriculum Coordinator/Faculty Secretary coordinates the rotation schedules, the curriculum, and conference schedule. He/she also supports the faculty members in carrying out their clinical, teaching, and administrative duties and responsibilities.

Residency Secretary

The Residency Secretary assists the Program Coordinator with all administrative aspects of the FMRP, as well as supports the mission of the program by assisting the staff, faculty, and Program Director with projects and ongoing endeavors. She is also responsible for maintaining the office schedules in the appropriate software (i.e., Centricity PM).

Administrative and Research Assistant

This individual coordinates the Department of Family and Community Medicine's Continuing Medical Educational conferences, the medical student schedules, and all research associated with the residency program. Though this individual reports to the Department Chair in the Department of Family and Community Medicine, he/she also assists with the ongoing educational missions.

FHCC Practice Manager and Clerical Staff

The Practice Manager oversees the daily operations of the office and supervises the clerical staff. This person is accountable for organizing and coordinating office personnel schedules to assure adequate office coverage. This person is responsible for ordering the supplies and operational materials needed for efficient patient flow. In conjunction with the Chair and the Program Director, this person prepares the budgets for the FHCC and the residency program and prepares financial reports for Administration. This person is responsible for preparing reports regarding patient statistics, office visits, and revenue.

The clerical staff assumes various responsibilities regarding patient care in the FHCC. The clerks welcome the patients and guests; receive in-coming telephone calls; relay messages to the physicians and staff as appropriate; assist the patients in scheduling doctor appointments, laboratory studies, x-rays, and consultations. They prepare necessary referrals and insurance certifications.

FHCC Nurse Manager and Nursing Staff

The Nurse Manager is responsible for the clinical nursing operations of the office and provides supervisory and educational opportunities for nursing personnel. The Nurse Manager evaluates the quality of patient care. The Nurse Manager oversees the Care Manager.

The nursing staff is responsible for providing direct patient care to patients at the FHCC, including assessing, planning, providing, and evaluating care. They perform all standard office nursing procedures, and assist and direct the resident physicians in patient care.

FHCC Care Manager

The Care Manager assists the FHCC staff and physicians with regard to care management. He/she will oversee population management, maintain certain registries, oversee transitional care, assist with QI of FHCC, etc. See separate job description for details.

Job Descriptions

Job descriptions for all personnel are maintained in SuccessFactors on the hospital's intranet. All descriptions are in accordance with TRHMC Human Resources Policies and Procedures.

General FHCC Administrative Policies and Procedures

Orientation of New Personnel

All new employees will receive computer training by the Information Management Systems department. The Practice Manager will coordinate this training.

The Practice Manager and Nurse Manager will train the new employee as to the operations of the FHCC. They will assign existing staff members to teach specific job functions to new employees, and work closely with the new employee during the training period. No one employee will be responsible for complete training of a new employee.

During the orientation, the Practice Manager/Nurse Manager will periodically check with each staff member to see how the new employee is progressing. The new employee will also be encouraged to ask questions for clarification on any task that is unclear. An information booklet will be given to each new employee that will list the job duties at each “station” in the front office.

The new employee will receive official feedback from the Practice Manager or the Nurse Manager after the first month, the third month, and the sixth month, in accordance with hospital policies.

All residents of the FMRP will be required to complete hospital and department orientation prior to beginning their residency training. Details will be appropriately revised and distributed on a yearly basis. Also, all faculty will complete orientation in accordance with policies; see separate document.

Dress and Demeanor

All staff must wear the hospital ID badge at all times per hospital policies.

Residents and staff are expected to act and dress in a manner consistent with their profession or position. All clothing should be neat, clean, and professional looking. Clothing should match and fit. Short dresses, shorts, jeans, jumpsuits, tee shirts, and tank tops should not be worn. Sheer clothing, tight, clinging, or revealing garments, low necklines, extreme or conspicuous styles, colors, or prints should be avoided. Sweaters worn with uniforms must not clash with uniform color. Soiled or untidy uniforms should never be worn on duty.

White coats are provided to residents and faculty and should be worn where appropriate. With rare exceptions, scrub suits should not be worn in the office. Men are expected to wear neckties in most situations, and women are to dress appropriately. Proper personal hygiene and grooming are expected.

Some personnel are required to wear uniforms as specified by the department. The department chooses what color uniforms to wear. The hospital may purchase two lab jackets for each employee yearly. Uniforms purchased by employees must comply with departmental requirements and be consistent with the guidelines above.

Leisure sandals or slippers are not acceptable footwear. Open-toed or heeled shoes are not allowed in areas where heavy equipment, such as carts, beds, or litters, are regularly moved.

Hairstyles should be simple and clean. Make-up, if worn, should be natural-looking and not theatrical.

Pins with the employee’s name, job title, or department, and TRHMC service award pins are acceptable to wear while on duty. Other pins, badges, and insignias, slogans or other items which could possibly be deemed as controversial, annoying, or offensive to patients, visitors, and/or other employees cannot be worn while on duty.

Professional Standards and Ethics

Mature interactions are expected with patients as well as with office and hospital personnel at all times. Patient confidentiality must be guarded at all times. In clinical settings, physicians and staff should avoid noise and laughter, refrain from open discussion of sensitive issues, and be mindful of any information that may be overheard, again respecting patient confidentiality.

Use of property and equipment of the FHCC for personal use is not permitted. Physicians and staff are to use phones assigned to their areas and not in the space designated for others in the office. All physicians, residents, and employees are expected to keep their designated areas within the FHCC reasonably neat and clean.

Smoking, alcoholic beverages, and illicit substances are prohibited on the premises and during hours of work-related duties and responsibilities. Violation of this ordinance will result in disciplinary actions. Eating and snacking in the patient area are violations of Pennsylvania law. Physicians, residents, and employees' personal health must be maintained in accordance with the employee health policies of the hospital.

Residents and faculty should conform to the code of ethics set forth by organized medicine. They must maintain a professional code of conduct and means of communication appropriate to a professional person. They must demonstrate responsibility and integrity by reporting to duties on time, adhering to schedules, and cooperating with their colleagues.

Removal of Materials from the FHCC

No material or equipment that is the property of the FHCC or TRHMC may be removed from the premises without permission of the Program Director or designee.

Vacation Policy and Cross Coverage for Residency and FHCC Personnel

All FHCC employees are required to adhere to the vacation/holiday policies as indicated in TRHMC Policy Manual.

During hospital orientation, Paid Time Off (PTO) and the Income Protection Account (IPA) for each position and how that time is earned are explained to the new employee. Paid vacation benefits are provided only to full-time and part-time employees in accordance with hospital policy. Vacation relief and benefits are not provided to temporary employees.

The front office staff employees will indicate their vacation/holiday preference on a "Request for Time Off" form and submit it to the Practice Manager. Approval will be considered usually on a "first come-first serve" and seniority basis. However, first consideration must always be given to the departmental requirements. Generally, no more than one employee per job title may be on vacation at one time unless the second employee requesting time off finds appropriate coverage for the hours scheduled to work.

In scheduling vacations, the Practice Manager shall give as much consideration as possible to the personal preferences of employees, taking into consideration seniority and rank. When vacation time is approved, the Practice Manager will notify the employee in writing, and also document the time off on the calendar located in the front office. The Practice Manager will make the necessary arrangements for staff coverage. All employees are expected to make every effort to help out and cross cover during the vacations of other employees—full time and/or part time.

Nursing staff will follow a similar policy submitting requests to the Nurse Manager. Other staff will submit requests through the Residency Coordinator.

Resident and faculty vacation requests will be per current policies and by approval of the Program Director.

Policy Regarding Sick Time

All employees, including managers, clerks, nurses, administrative staff, residents, and faculty must call the Program Coordinator at 610-988-8855 to report off sick. A message may be left if the Program Coordinator is not available. Employees should notify the Program Coordinator of the illness as soon as possible so the necessary arrangements for adequate office and/or residency coverage can be made in advance and not inconvenience other employees or cause unnecessary chaos in the office. Residents also need to notify their rotation attending about their sick time.

Full-time employees are to report off sick at least one hour prior to scheduled starting time.

Part-time employees are to report off sick as soon as it is known they are unable to work.

Those who become sick while at work must report to their manager, and, when appropriate, they may be permitted to leave. Hours missed will be recorded per hospital policy.

Other employees (full-time and part-time) are expected to help cover the ill employee's shift.

Policy Regarding Missed Work Hours

If an employee is late for work, or if the office closes early (e.g., due to inclement weather), the employee may choose one of the following options:

- The time may be made up during the lunch hour, or before or after regular working hours, depending on departmental needs, within the same pay period.
- Employees may choose not to make up the time, thereby reducing the amount in their paycheck.
- If the office closes early or opens late due to the weather, employees may use their own judgment to determine safe travel. They certainly may opt to work their normal hours that day and, therefore, no hours need to be made up.

The Practice Manager or Nurse Manager must be notified the same day as to how the employee wishes to be compensated. If nothing is mentioned and it is the end of the pay period, the Practice Manager or Nurse Manager cannot submit the hours. The employee(s), therefore, will not be paid for the time missed.

FHCC Snow and Inclement Weather Policy and Policy for Unscheduled or Unanticipated FHCC Closure

All functions of the hospital will be continued during periods of inclement weather unless approval is given by hospital administration to curtail services or change work schedules.

All employees scheduled to work are expected to report to work on time during unusually bad weather. Employees should leave home earlier than usual to provide needed travel time.

ALL EMPLOYEES ARE EXPECTED TO BE AT WORK AT THEIR DESIGNATED STARTING TIME UNLESS A WEATHER EMERGENCY HAS BEEN DECLARED BY THE HOSPITAL.

If the weather is bad, and it is anticipated by hospital administration that employees will have difficulty reporting to work on time, the Program Director, Nurse Manager, or Practice Manager will be notified, and will re-record the message on the voice mail to alert patients of the procedures for the day.

The Practice Manager or Nurse Manager will call the office staff and nurses who are scheduled to work and relay the message to them.

The Director will call the residency administrative staff and notify them of the delay. The phone message chains will be followed.

Safety Policies and Practices
(Emergencies in Office)

The Environment of Care (EOC) Satellite Safety Program Manual is located in the FHCC Utility Room. This Manual contains the hazardous chemicals information, emergency operations information, safety information, security management, and fire information,

Role of the FHCC in the Disaster Plan

In the event there is a disaster, the FHCC's responsibility is listed in the Disaster Plan Policy Book. Current hospital policies will be followed.

Additional Personnel Policies for Residents and Faculty

In addition to policies addressed in the previous section, further personnel-related policies apply to residents and faculty. The residency program and patient practice must operate in compliance with standard patient care responsibilities, requirements of the ACGME-RRC in Family Medicine, hospital requirements, and other contractual obligations. Salaried residents and faculty are not compensated by the hour and must collectively provide FHCC administrative and clinical coverage 24 hours a day year round.

Holidays

Holidays for residents and faculty are consistent with the employee personnel policies of TRHMC. Coverage during holidays will be scheduled in a fair and equitable manner among all residents and faculty.

Vacation Considerations for Residents and Faculty

Because educational, supervisory, and patient care requirements are a priority, it is required that a minimum number of faculty and residents are scheduled to be at work and available each day that the FHCC is opened. As general policy, at least three faculty (full-time and/or part-time in aggregate) should be available each half-day. Under usual circumstances, no more than one first-year resident and three upper-year residents will be approved to be off or away (including away rotations) on any given day.

The first-year resident is allotted two weeks of vacation while the second-year and third-year residents are entitled to three weeks vacation per year. In addition, residents are granted additional time off around the Christmas/New Year holidays. At least one week of vacation must be taken in the first six months of the academic year.

Vacation time is not allowed during in-patient family medicine and first-year pediatrics. Residents must notify preceptors of vacation that affects their rotation. Time away will not be approved if a continuity OB patient is 38 weeks or greater. No vacation time should be scheduled in the last two weeks of June or the first two weeks of July.

All resident vacations must be approved first by the Chief Resident. The resident will complete the time off request form and submit it to the Chief Resident. When approved, the resident will request the time off via New Innovations. The Education and Curriculum Coordinator will approve the request, and it will be entered in New Innovations.

Vacation requests of three days or more by faculty and residents must have the approval process completed and approved at least 90 days in advance in order to assure adequate coverage in the FHCC. One or two-day vacations may possibly be approved less than one month in advance (for valid reasons as determined by the Program Director) if they do not involve a change in patient care hours. If any time off is approved less than 30 days prior to the requested date(s) and it affects patient hours, the faculty/resident is required to call and reschedule his or her own patients.

Exceptions to the above rules will be examined on an individual basis.

Conference and Educational Time Away for Residents and Faculty

Exclusive of vacation time and salary, each second-year and third-year resident and each faculty member are allowed up to five working days away to attend educational meetings. Residents receive $1,500 for tuition and travel per year to attend a CME conference in accordance with the hospital resident education policy (the “Ed Fund”). At times, the resident’s faculty advisor, along with the Program Director, may require that the resident utilize their funds to attend a specific conference, such as a Board Review

Course. All courses must meet AAFP approval. This will be in accordance with current Ed Fund policies. See separate document for details.

This time away must be approved according to the process described in “Vacation Considerations.” In addition, before registering for a conference, a request for approval must be submitted to Administration via the Program Director. A request can be made for partial reimbursement in advance if necessary. A request for reimbursement must be submitted after attending the conference. These forms are available from the Program Coordinator. When submitting an application for conference time and funds, a descriptive brochure of the conference should be included.

In an effort to meet requirements placed upon the residency program, additional educational time away, coupled with residency recruitment activities, faculty and/or resident presentations, and/or research, may be granted by the Program Director.

Residents are encouraged to attend a formal CME activity. CME funds should not be used for the purchase of text books or reference books in place of conference time.

All conference leave must be used by the first week of June for the year that the funds are available, with rare exceptions.

Management of Health Systems Conferences

All residents will be provided with a series of Practice Management seminars throughout their training. Some are didactic; others self-directed. Some are during specific rotations; others are longitudinal.

Maternity/Paternity Leave

Leave for all employees is outlined in the hospital benefits packet. Residents who require maternity or paternity leave will be allowed to use accumulated sick leave and vacation up to 30 days. Additional leave will have to be taken without pay and will necessitate extension of the residency training. The details of the leave and the schedule of rotations will be worked out on an individual basis with the Program Director.

In general, efforts will be made to schedule rotations in which the resident is non-essential just prior to the estimated due date (EDD) and to avoid call during the month prior to EDD or while on leave. However, the resident will be expected to make up call either prior to or after the leave.

The resident should notify the Program Director as soon as the pregnancy is confirmed. Paternity leave will be granted in compliance with established hospital policy. All leave must comply with the continuity of care and other requirements established by the ACGME-RRC in Family Medicine.

Salary and Benefits

Family Medicine residents have the same salary and benefits for a year of training as all other residents in the hospital. Please refer to the Residency Manual from Academic Affairs for these items.

FHCC Patient Care and Clinically-Related Policies

Core Principles of Family Medicine and Delivery of Care

Family Medicine is a comprehensive specialty which builds upon a core of knowledge derived from several disciplines — drawing most heavily on Internal Medicine, Pediatrics, Obstetrics/Gynecology, Surgery, and Psychiatry — and which establishes a cohesive unit, combining the clinical sciences. The core of knowledge encompassed by the discipline of Family Medicine prepares the family physician for a unique role in patient management, problem solving, counseling, and coordinating total healthcare delivery. The training and experience of the family physician qualify him or her to practice in several fields of medicine and surgery.

The family physician is educated and trained to develop and put forth unique attitudes and skills which qualify him or her to provide continuing, comprehensive health maintenance and medical care to the entire family regardless of sex, age, or type of problem, be it biological, behavioral, or social. The physician serves as the patient or family advocate in health-related matters, including the appropriate use of consultants and community resources. The family physician assumes a key role in the total health care of the individual and family, taking into account the social, physiological, economic, cultural, and biologic dimensions.

Family Medicine offers comprehensive medical care with particular emphasis upon the family unit. The responsibility to provide health care to families is a fundamental concept of the FHCC.

The office experience in the FHCC is a unique part of the FMRP because it emphasizes the concept of longitudinal care. This concept differs from the in-patient model where level of acuity of illness and the uncertainty of prescribed follow-up results in a more episodic and urgent management approach.

Scope of Services in the FHCC

The FHCC provides general medical care for patients of all ages and both sexes. The services include preventive, diagnostic, and therapeutic services within the range of competence of a well-trained family physician.

These ambulatory procedures in the FHCC's scope of services include those which may be carried out without the administration of an anesthetic agent, or those which are carried out under anesthesia provided by a local anesthetic with minimal reliance on regional anesthesia. These procedures include but are not restricted to: repair of minor to moderate lacerations; removal and/or biopsy of skin and subcutaneous lesions; treatment of skin lesions with cautery or cryosurgery techniques; use of such instruments as the flexible sigmoidoscope, nasolaryngoscope, colposcope, spirometer; catheterization of the lower urinary tract; minor office gynecologic procedures, arthrocentesis, etc. In addition, certain investigative procedures may be carried out, including the withdrawal of blood samples, the performance of electrocardiograms, and certain other specialized investigations such as tympanometry and simple audiograms. Each resident must demonstrate competence in a core list of procedures reviewed by the faculty and Program Director and are in accordance with ACGME-RRC requirements.

Consent forms are to be obtained for all invasive procedures, such as biopsies, sigmoidoscopies, etc.

FHCC Clinical Providers

The FHCC is staffed by board-certified family physicians who are members of the Active Staff of TRHMC. These physicians are engaged in both clinical practice and in an academic program educating residents, medical students, and other learners.

Family Medicine resident physicians, who are family physicians training for board certification, manage their own panel of patients under the supervision of the board-certified attending staff. They are assisted by a full range of ancillary personnel, including registered nurses, licensed practical nurses,

psychologists, clerical staff, secretaries, and administrators. In addition, other healthcare personnel may see FHCC patients on-site for clinical and/or educational benefits.

Residency Supervision in the Office

During each office session, at least one faculty preceptor or supervisor is scheduled. Faculty will be responsible for supervising no more than four residents during a given office session. This faculty supervisor is to be present in person during the scheduled office hours for the residents. The faculty is responsible for directly supervising any procedures for which consent has been obtained. The faculty supervisor is responsible not only for supervising the residents during their office hours, but also for auditing the charts of patients seen during that office session according to FMRP general policy.

To insure consistency in precepting, for patient safety/oversight and for educational excellence, following is the precepting policy:

- All first-year residents, for the first six months of residency, will precept every patient before the patient leaves, and the preceptor will see every one of those patients.
- After the first six months for first-year residents, the preceptor does not necessarily need to see every patient, but first years need to precept every patient before the patients leaves.
- All upper-year residents should review their schedules with the preceptor at the beginning of the session (basically, “check in” with the preceptor).
- All second-year residents should formally precept every patient with the preceptor, though it can be after the patient leaves.
- All third-year residents should check in with the preceptor at the end of the session. The preceptor can ask if there were any concerns, etc., but not every patient needs to be formally precepted.
- Note – these requirements are a minimum. Of course, every resident is expected to precept ANY questions, etc.
- The preceptor is to attend at least the “key portion” of any procedure (joint injection, skin biopsy, non-Pap GYN procedure, etc.).
- After signing the note, all residents must route all notes to the session preceptor. The preceptor will review the notes for major issues. The preceptor will give written (or electronic) feedback on at least one note for every first-year resident’s session. The preceptor will periodically give feedback to the upper-year residents.
- Following afternoon office sessions, there are sit-down rounds for 10 to 20 minutes beginning at 4:50/5:00/5:10 p.m. This is for education and will usually be in the format of each resident presenting one interesting case/learning point. On occasion, this may include other formats, such as a more didactic session based on a case.

Office Hours

Office hours are:

Morning.....0820-1130 hours
Afternoon .....1320-1700 hours
Monday and Wednesday Evenings.....1800-2100 hours

Monthly schedules are posted in New Innovations. All reasonable attempts are made to accommodate urgent or semi-urgent patient requests on the same day in accordance with the “open access” policy.

Answering Service

The FHCC uses an answering service during lunch and after hours. At the present time, the FHCC uses Advantage Telemessaging, a full service telemessaging business that operates 365 days a year, 7 days a week, 24 hours a day. The answering service provides digital paging, alpha paging/text messaging, patched calls, tracer calls, recording of messages, and faxing of call logs. Advantage TeleMessaging will attempt to archive messages indefinitely.

There are two separate accounts--one for Suite 120 and one for Suite 200. For Suite 120, the calls go to the faculty member who is on call. For Suite 200, the calls will go to the on-call beeper. The beeper is passed to the resident who is on call. Faculty will be the back-up number. All pagers are through Schuylkill Mobile Fone.

Suite 120 and Suite 200 turn the phones over to the answering service from 11:30 a.m. to 1:00 p.m. Emergencies that cannot wait until 1:00 PM will be put through to 610-988-8199. The front office staff will field calls and contact a nurse if necessary for a call that cannot wait.

At the end of the day, the office will once again turn the phones over to the answering service. Routine messages can be saved for the daily office fax. The caller will be asked if they need to speak to the doctor and if they so indicate, the doctor will receive a text message on the beeper. The caller will be told that if they do not hear back from the doctor in 20 minutes to call the answering service again. If this occurs, the answering service will attempt to page the doctor and have the doctor call the answering service to retrieve the message. The doctor will be paged for all prescription refills unless the patient states that they can wait until the next day. Regarding referrals, the service will take a message and hold it, unless there is a problem in which case the doctor on call will get a page. Any consults are sent to the doctor on call.

Whenever the answering service takes over, at the conclusion of the time period, the service will fax a log of calls and what transpired. The front office follows up on these calls by making sure the doctor on call talked to the patient and made a note in the chart. The front office handles routine messages listed on the fax. All information about the answering service is stored in the Practice Manager's office.

FHCC Clinical Provider Sessions and Schedules

Residents must see continuity patients at least 40 weeks per year per RRC requirements.

The number of sessions per week for resident physicians is determined by their year of residency and their specific rotation. First-year residents generally have one or two sessions per week in the FHCC. At the beginning of the year, established patients are scheduled every twenty to forty minutes, and new patients are allotted 40 minutes. The resident should be able to see three to four patients. As the resident becomes more adept at office flow, time allotted per patient should generally decrease and the resident should be able to see four to six patients per session.

Each first-year resident must have at least 150 patient encounters by the end of the intern year per RRC requirements.

Second-year residents usually have three sessions per week, including one evening. Established patients are scheduled about every 20 minutes, and new patients are given 40 minutes. Second-year residents should strive for six to seven patients per session. Annual patient encounters should range between 500 and 800.

During the third year, residents are usually given four sessions per week, including one evening. Established patients are scheduled every 20 minutes, and new patients are given approximately 40 minutes. Under normal conditions, third-year residents should be able to see approximately nine patients per session. Annual patient encounters should range between 800 and 1,100. Total encounters over the three years must equal or exceed 1,650, and schedules will be altered, if necessary, to achieve this.

The full-time faculty physicians are expected to have regularly scheduled hours during which they will see patients at either FHCC Suite 120 or 200, sometimes accompanied by a medical student.

Faculty hours may be altered depending on the demands of clinical volume, teaching responsibilities, and other residency-related duties. The number and frequency of these sessions will be in accordance with current department incentive plans.

Altering Provider Schedules

Except in an emergency, office hours may not be cancelled or altered by a faculty or resident without authorization from the Program Director or the resident's advisor. Once authorized, the Residency Secretary will direct the front office staff to cancel and reschedule patient appointments. The front office staff will enter changes in the Practice Manager Scheduler. Medical providers are not permitted to physically alter the patient schedule. All vacation, conference time, and paid time off that affect patient care must be approved with at least 90 days' notice. (For more information on vacation and conference time, see "Additional Personnel Policies for Residents and Faculty")

Scheduling FHCC Personnel and Notifying Staff of Appointments

Scheduling adequate support staff and nursing personnel for multiple physicians is the most challenging part of running the clinical office. Therefore, it becomes extremely important to consider the following:

- Office personnel must be notified ahead of time about patients who need to be scheduled, even if the patient speaks directly to one of the family medicine physicians. In this case, the physician should tell the patient to call the office. In the meantime, the physician should notify the office of the nature of the problem, how emergent the problem is, and whether or not that resident wishes to see the patient. This allows the office to be prepared to deal with the problem most efficiently.
- The current pediatrics policy is to re-examine newborns who have been discharged from the nursery less than 48 hours after birth. Please notify the staff when you plan to see these babies.
- After seeing a patient in the FHCC, the resident should specify on the instruction sheet if extra time is needed on the next visit for such things as minor surgery.

Open Access Policy

The FHCC has instituted an "Open Access Policy". The goal is to decrease wait times for a routine appointment. When patients request an acute visit, they are instantly offered one that day or the next working day. Formal audits are conducted examining numbers of appointments done, no-shows, appointment types, requests for appointments, etc.

All appointments will be in twenty minute increments. The following appointments will take two blocks (40 minutes) by default:

- Routine GYN exams/well-woman
- Well-child checks
- New Patients "to establish" (age 40 or greater)
- Annual CPE (age 40 or greater)
- Procedures
- Other as directed by the physician

Pre-booked appointments are limited. Diligent tracking of supply and demand over time will identify the optimal ratio, and this will vary by day of week, for example.

The following appointments may be pre-booked up to two weeks in advance: well child checks, GYN checks, hospital follow ups and new patient examinations. There are designated slots for these types of appointments. Any patient who has extenuating circumstances should be given the option to pre-book.

There are Open Access appointments which are available for booking appointments a few days in advance.

There are Same Day appointments which should only be used for appointments which would be scheduled on the same day that the patient calls. Some Same Day appointments can be used for the

following day. There a few Same Day appointments which are designated for the first appointment of the morning for those patients who call late in the day on the previous day.

Front Office Staff and Triage Nurse protocols for appointment scheduling will be:

- When an appointment is requested, they ask: "Would you like to be seen today?"
- Patients will be offered an appointment within a week. (This is subject to change according to supply and demand.)
- In all cases, patients will be offered an appointment with their PCP (primary care physician).
    - If based on the above, that is not possible, attempts will be made to see a team member utilizing the same criteria.
    - If that is not possible and this is a non-acute issue, a phone note would be routed to the PCP to determine the best course of action. Sometimes a phone call to the patient is all that is needed.
    - If the PCP is out of the office and will be unavailable for more than one day, the nurse manager, (in consultation with program director, if appropriate) will assist in scheduling this patient. It should be a rare occurrence that a patient would be send to urgent care.

Office staff will make use of a function in the Electronic Medical Record called "recall flags". This is a method of following up on a patient in a predetermined amount of time. This method uses a type of mailbox where a date for a follow-up call to schedule an appointment for the patient is stored. The Office staff monitors the Recall Mailbox daily and makes timely phone calls to schedule patients for the follow-up appointment. This appointment should be scheduled within a week of the reminder phone call.

Call Pointe, an automated telephone reminder/call system integrated with our practice management software, is utilized in FHCC.

Acute Care Appointment Policy for Patients who Call the Office

A patient who calls and needs to be treated the same day due to the nature of the problem is considered an "acute care." The acute care policy is as follows:

- A nurse will triage any person who might need an acute visit.
- If the primary physician is in the office, the patient will ideally be scheduled in a same day appointment slot.
- If the primary physician is not in the office, the patient will ideally be seen by a member of the primary physician's team.
- If no one from the team is available, the patient will be seen by any physician who has an available slot.

Assigning a Physician for "Walk-In" Patients

When an unscheduled established patient arrives at the office requesting to be seen by a physician, the following protocol is used. The receptionist will access the patient's chart, and ask the nature of the problem. The receptionist will relay this information to the nursing staff. The nurse will speak to the patient and determine the severity of the problem. The nurse, possibly in consultation with a physician, will determine whether or not an acute visit is warranted, and if the FHCC can accommodate the patient at that time. If a visit is warranted, the patient will be worked into a medically appropriate time slot, or the patient may be referred to the ED. If the patient can be seen at the FHCC, the nurse will follow these steps:

- The patient is worked into or added at the end of the primary physician's schedule.
- If the primary physician is not scheduled for office hours, the patient is worked into or added at the end of a team member's schedule.
- If the above steps do not apply, the patient is scheduled according to physician availability.

New patients who walk into the office requesting to be seen by a physician are scheduled according to physician availability and the nature of the problem. Unfortunately, the type of insurance a patient has may dictate whether we are listed as the PCP and thus that would determine if a physician from FHCC would actually be able to treat a particular patient. A sick patient may be seen prior to our office receiving their old medical records, but it is always to the patient's advantage to be able to refer to medical records from a previous physician. This should be emphasized to the patient at the time the appointment is made.

Policy for Patients Who Arrive Late

Doctors' schedules are sometimes interrupted by patients who arrive late, who cancel just before the time of the appointment, or who fail to keep their appointments. Patients who arrive at the office more than 20 to 30 minutes late (depending upon circumstances) for a routine visit will be rescheduled for another session providing the physician determines this is acceptable. If the patient arrives late and is ill, or if the physician decides the patient should be seen, the patient will be seen at the end of the schedule or in a slot that is determined to be a "no show" (has not arrived or called after 30 minutes have elapsed). If the "no show" patient eventually arrives, unless the problem is urgent, that patient should be rescheduled. This policy allows the doctor to be fair to patients who arrive on time and to also accommodate some patients who are late. If the patient travels by public transportation (BARTA bus or taxi), we will accommodate the patient as much as possible and still remain on schedule for the patients who arrive on time for their appointments. The office staff should always check with the nurse who in turn will check with the physician to determine if the patient should be rescheduled.

Missed Appointments and Dismissal Policy

When a patient fails to keep an appointment without notifying the office or cancels the appointment at the last minute, the patient will be given a verbal warning regarding the ability to schedule appointments in advance. The physician should document the discussion in the EMR.

The office attempts to contact by telephone each patient who misses an appointment. If we are unable to contact the patient at the time of the missed appointment, we will review the situation with the patient the next time the patient calls the office. This discussion should be documented in the EMR.
Any patient who fails to keep an appointment will be advised that if this occurs one more time, they may no longer be able to schedule an appointment in advance. The patient will need to call for an appointment the patient wants an office visit. This discussion should be documented in the EMR.

A patient who misses two appointments may not be allowed to make a pre-booked appointment. If a patient misses three appointments in 12 months, the patient may receive a warning letter advising them of possible dismissal from the practice. If there is a fourth missed appointment within 18 months, the patient may be dismissed from the practice, unless there are extenuating circumstances (which will be determined by the Program Director). This discussion should be documented in the EMR.

The FHCC will continue to render care to patients dismissed from the practice for up to 30 days after the patient is notified by Registered Letter, Return Receipt requested. Records will be transferred at the request of the patient.

Once patients have been dismissed from the practice for any reason and had records transferred to another physician, they will generally not be permitted to return to the practice at a later date. However, if patients in good standing transfer from the Reading area and later return, they may return to this office for medical care.

Continuity of Care

Residents as Primary Doctors
In keeping with the goal of providing family-oriented primary care, we believe that patients and families should be provided with continuity of care as much as possible. Therefore, each FHCC patient will be assigned to a particular resident or faculty identified as his or her primary doctor. Patients who are

members of the same family will be followed by the same primary doctor whenever possible. This assures continuity of care that benefits both patient and provider.

When scheduling patients in the FHCC, every effort is made to allow a given patient to see the primary doctor consistently. There will, however, be circumstances that will make that impossible. Therefore, a team system has been developed at the FHCC. If the primary doctor is not available, the patient will be scheduled to see a resident from the primary doctor's team.

Residents are expected to provide continuity of care to their panel of patients in both the in-patient and out-patient settings.

Clinical Teams

The practice is organized into five teams, each typically composed of four to five residents, a faculty member, and a nurse. When the primary physician is unavailable, especially in an acute situation, a patient should be seen by a team member, and then referred back to the primary physician.

Communication and Continuity of Care

Good communication is essential. Whenever possible, the primary doctor should talk with his or her own patients when they have questions or need to discuss test results. The primary doctor is responsible for following the care rendered to his or her patients.

Continuity of In-Patient Care

While in-patient care is the responsibility of the residents and faculty on the family medicine in-patient service, there must be regular contact between the primary physician and the in-patient team and, ideally, a note on the chart by the primary physician within 48 hours of admission. In addition, the primary physician must, whenever possible, make social rounds during the admission and regularly discuss the patient's progress with the residents on the service.

Assignment of New Patients

If a new patient comes to the FHCC requesting a particular physician, the patient's request will be met whenever possible. Otherwise, new patients coming to the FHCC will be assigned to a first- or second-year resident who has available openings. When assigning patients to residents, the FHCC must consider ACGME-RRC Requirements regarding the required number of annual patient visits per resident.

Transferring Care Within the FHCC

When a resident leaves the residency program, care of the resident's FHCC patients will be transferred to another resident, preferably on the resident's same team. Graduating residents are encouraged to notify patients well in advance that they will be leaving the FHCC and what arrangements will be made for the patient's care. Residents who transfer to a practice in the Reading area may give patients the option of following up in their new practice.

Occasionally, a patient requests a different resident as his or her primary doctor. When this occurs, we encourage the resident to view it as an opportunity to learn about patient satisfaction and to receive feedback about why the patient wishes to transfer. The resident should discuss with the patient the reasons for the request, and a mutual decision about what is best for the patient should be reached. A resident may arrange to have the patient's care transferred to a colleague.

Occasionally, there is conflict between a resident and a patient which may make discussion of other care arrangements difficult or strained. If a patient is unwilling to discuss a request for transfer of care, or if a resident feels that he or she can no longer be an effective caregiver for a specific patient, or if there is another source of conflict which has the potential to interfere with the patient's care, the resident should discuss the case with the faculty advisor to get guidance and perspective and to assist in resolving the

conflict. Because the FMRP and the FHCC function as a group practice, it may, at times, be best that the patient transfer to a different practice.

The Medical Record

Patient information is stored in an Electronic Medical Record, herein referred to as “EMR”. There are several features to help manage workflow and quickly update patient records. Currently, we utilize GE’s Centricity, and some of the following are specific to this:

- The desktop allows review of current appointments, messages from other users called Flags, and pending chart documents requiring review or action.
- Chart Summary provides a snapshot of the patient’s medical status and tabs for accessing and managing detailed chart information.
- The electronic chart is tabbed so that one can access chart documents and clinical lists that include problems, medications, alerts and flow-sheet observations.
- The following modules are included in the EMR: desktop, chart, appointments, registration, inquiry/reports, setup and linklogic.
- There are safeguards in place to complete an audit trail of chart changes. Once signed, information in an electronic chart cannot be erased or altered.
- The EMR protects patient privacy, providing security features that ensure user’s access to patient health information is appropriate to their role in providing health care services.

As with paper charts, the EMR includes the following information: patient demographic data; list of problems and health maintenance profile; list of medications; list of known allergies; list of immunizations; progress notes; diagnostic data (labs, x-rays, etc.); flow sheets; referral information to and from outside agencies; and patient health history.

Scanning

When test results, specialist letters, or any type of correspondence concerning a particular patient are received in the FHCC, these documents should be “scanned” into the EMR. The computer system is designed such that any scanned documents automatically get routed to the inbox of the “responsible provider” (PCP), not the ordering doctor. When this occurs, the document should be routed to the ordering doctor who can follow up on the test and the patient should be notified. If the test was clearly ordered by an outside physician, and the patient is followed by that physician, then the document just needs to be signed. Front office follow policies to maximize the “discreet data” concepts of an EMR.

EMR Downtime Procedures

There may be times when the EMR system is unavailable. This may be due to internal (FHCC) equipment problems, networking problems, power failure, etc.

- Ascertain what the problem may be and call the appropriate help line, i.e. IMS or maintenance.
- Attempt to get patient information for that day printed elsewhere and hand delivered or faxed.
- Get the “downtime box” which contains documents needed to get through office visits (blank paper progress notes, blank paper prescriptions, paper lab and radiology slips, etc.) In Suite 120, this box is located in the accordion file in the room with the printers. In Suite 200, it is located in the front office accordion file.
- Use the old paper phone message forms for any phone calls. These will then be manually typed into the patient’s record later (or, in rare cases, scanned).
- The nurse should handwrite the vitals and the providers write their progress notes on the SOAP note template.
- The provider should have for each office visit the downtime checklist that will communicate to the front office what items/information should be scanned/manually entered into the EMR later when available.
- The yellow super bill from the old paper system, prescriptions, blue x-ray forms and green lab slips will all be used.

- Non-emergent referrals can probably be delayed until the system is up and ready.

Documentation Guidelines

All patient interactions by faculty, residents, nurses, and office staff must be documented in the patient record. These include: telephone calls from patients; calling lab and test results to patients; patient visits; recommendations for referral; emergency visits; hospital discharge summaries; home visits; nursing home visits; and interactions with patients for any reason.

Resident documentation must accurately reflect the preceptor's level of involvement in the care of the patient.

All documentation by nurses and clerical staff related to clinical activity must be documented in the medical record. All nurses who provide patients with clinical services, advice, medication refills, or other administrative issues need to document these interactions in the patient record. All other personnel must document significant patient interactions, such as referrals for specialists, labs, and x-rays, in the patient record. In instances where staff is uncertain of the significance of an interaction, clarification may be obtained from the Practice Manager, Nurse Manager, or the Program Director.

Documentation is completed by using the update button in the EMR. There are many categories to choose from such as phone note, chart note, prescription refill, document vital signs, review problem list, assess a problem, review medication list, find/add a medication, and define the medication prescription. In addition, one can review protocols, order tests and services, order a referral, sign orders and end the visit. The physician can document history of present illness, review past medical history, family history, and social history, document review of systems, document physical exam, and document assessment and plan.

The physician should document the patient's active problems and dates of onset as they arise. It should also include pertinent allergies and past surgeries. The problem list shall be maintained and updated at each visit. Minor or acute problems, (example, pharyngitis, gastroenteritis, etc.,) should not be included unless pertinent to a chronic pattern of illness, such as otitis media in children.

The resident should not label a patient with a diagnosis (example, hypertension or diabetes mellitus) without having satisfactory evidence to support the diagnosis. Obtaining a routine life insurance policy, for example, can become quite problematic if a lab error is diagnosed as a disease or if one spurious examination finding is diagnosed as a disease. Once a label gets in an insurance computer, it may be with that person for life.

Likewise, the medication list should also be kept up to date. Discontinued drugs should have the "stop" date filled in. This allows a fellow physician seeing the patient to know which medications have been used in the past to avoid unnecessarily restarting a drug that perhaps caused a side effect or was ineffective in the past.

When updating medications, always note the number of pills prescribed and the number of refills to be given. This is helpful in avoiding abuse of medications. It also gives a fellow physician the precise treatment should the patient return without relief. Generic prescription writing should be preferred. Exceptions may include drugs for which blood level monitoring is used (anticonvulsant, theophylline, digoxin, thyroid).

In the situation when stimulants (methylphenidate) are prescribed, requirements of Pennsylvania laws must be followed.

Any controlled drug requires a DEA number on the prescription. Until the resident has a DEA number, he or she should discuss the use of a controlled drug with a preceptor, and, if approved, use the preceptor's DEA number. The preceptor must then co-sign the prescription. See current policies regarding prescriptions/refills, opiates, etc.

Confidentiality of Medical Records

THE PATIENT'S OLD PAPER CHART SHOULD NOT BE REMOVED FROM THE FHCC. If it is necessary for the care of a hospitalized patient that the patient's office record data be available on the hospital floor, it should be photocopied and the original left in the office. When appropriate, records may be temporarily sent to the copy service and returned to the office. The hospital Medical Records department oversees copying/releasing of any records.

The medical record is the property of the FHCC. NEVER RELEASE RECORDS WITHOUT AN APPROPRIATE AUTHORIZED SIGNATURE FROM THE PATIENT (OR THE PATIENT'S LEGAL GUARDIAN IN THE CASE OF A MINOR OR INCOMPETENT PATIENT). Never release information to insurance companies, lawyers, or other third parties without appropriate authorizations. Records will be released to other agencies if there is a signed release from the patient. The only exception is Workers Compensation, in which case records must be released when requested by an insurance carrier. Information should not be released to the employer without patient authorization.

NEVER RELEASE A SPOUSE'S RECORDS TO THE SPOUSE WITHOUT WRITTEN AUTHORIZATION. This caveat applies to telephone requests for information unless the physician has clarified with the parties involved that such release is acceptable. For example, a husband phoning for his wife's pregnancy test result technically has no right to that information. Remember, he may suspect that his wife is pregnant by someone other than himself.

If a patient wants copies of labs, these may be provided free of charge. However, if the patient wants a copy of the entire chart, he/she will be billed for duplicating costs by EHI.

Patient Confidentiality

Any information regarding a patient is never given to anyone—verbally or written—without the patient's written permission.

Remember that you need to have the patient's special permission to release information about sexually transmitted diseases (STDs), pregnancy, diseases reported to the Centers for Disease Control, mental health (14 years of age or older), drug and alcohol, and HIV.

Discussion of a patient's medical condition in public or to unauthorized persons may be cause for employment termination per hospital policies.

If the patient is a minor (under 18 years of age), information may not be released without written permission from the parent. Information regarding non-emancipated minors may be released to the parent or legal guardian by the FHCC's clinical staff. Per Pennsylvania law, however, certain issues can be addressed with parent consent.

Parents or guardians may not be given information about emancipated minors without their consent.

Patient Rights and Responsibilities

The FHCC is committed to providing patients with information about their rights as patients of the hospital, the hospital's responsibilities to them as patients, and their responsibilities to the hospital as patients. The department will support the doctrine which the hospital has established. The FHCC will post a notice in the patient waiting room area. Patient Rights and Responsibilities, the hospital-printed document RH3079, will be made available for all patients to take with them. Spanish and English versions are available. Brochures are placed in the literature rack near the entrance door at Suite 200 of the Doctors' Office Building.

Informed Consent

Informed consent refers to the process in which a patient's permission for a procedure, test, treatment, or other intervention is obtained by a caregiver after careful discussion which clearly describes to the patient the nature, risks, benefits, and alternatives to what they are giving permission for. Informed consent refers to the discussion itself, not the piece of paper. The paper that the patient signs provides documentation that the discussion took place. In addition to whatever form is used, the resident should reference any standard or procedure-specific guidelines used and provide brief documentation in the EMR chart note as well. Some procedure-specific guidelines are located in the Procedure Room in the FHCC.

The resident should develop and practice communication skills that maximize ability to discuss the details of a proposed treatment or intervention with a patient. Depending on the nature of the treatment for which consent is sought, the informed consent discussion may range from serious to routine. There are several common circumstances in which informed consent is required in the FHCC. These include, but may not be limited to, consent for procedures, HIV testing, drug screening, and treatment of minors.

Provision of Care and Consent for Treatment of a Minor

Permission to treat any patient under the age of 18 must be obtained from a parent or legal guardian, except in an emergency. Consent may be given verbally but preferably in writing. The provisions of the law within the state of Pennsylvania must be fully complied with.

There are exceptions in which a minor may be treated without parental consent:

- Emergency: If emergency conditions require immediate treatment, treatment may be given without parental consent. In minor emergencies, such as slight lacerations, etc., the treatment will be given to a minor after a reasonable effort is made to obtain appropriate consent.
- Emancipation: Under some circumstances, a minor is considered to have adult status and may consent to his or her own treatment. A person under 18 years of age may consent to his or her own treatment if any one of the following conditions have been met:
    - Graduated from high school
    - Has been married
    - Has been pregnant
    - Seeking treatment for an STD or reproductive health concern

A statement must be added to the consent form showing which condition is met by the individual. When seeking treatment for STD or reproductive health concern, minors should be encouraged to discuss these issues with their parent/guardian when appropriate.

Consent for Immunizations and Immunization Policies

All immunizations require informed consent. Appropriate forms are available in the pediatric examination rooms and from the nursing staff. The physician is responsible for obtaining consent. The nursing staff is responsible for documenting consent and recording the immunization. As in all cases of informed consent, the physician should document the occurrence, content, and outcome of the discussion in EMR.

Immunizations are stored and given in accordance with CDC guidelines. Immunizations should be recorded immediately in the patient's chart on the immunization record in accordance with Pennsylvania law. In the event that a physician authorizes that a patient returns to the office at another time to receive immunizations, the physician must sign the immunization record or record a note that authorizes that the immunization may be administered.

Consent for Videotaping and Live Observation

The FHCC is equipped with video cameras and two rooms with one-way glass windows that allow taping of patient visits as well as direct observation by preceptors. All new patients who enter the practice are informed of this and are asked for their consent to be taped and/or observed in order to assist our

physicians to continuously improve their communications skills. Signed consent forms are kept in the chart. Before a patient is taped, permission to be taped will be verified again just prior to the visit. Residents should familiarize themselves with the “consent for videotaping” form so that they will be prepared to answer questions their patients may have.

Non-Physician Delivery of Patient Care

The care described below may be performed by a physician or by a member of the nursing staff. When required by law, care delivered by non-physicians will be provided only with the approval of a physician.

Telephone Triage Policy

Medical and nursing personnel of the FHCC may provide telephone advice only to established patients of the practice. Patients who seek telephone medical advice should speak with a physician or designee. If a physician is not readily available or if a nurse feels comfortable managing the call, the nurse may question the patient regarding the character and duration of symptoms and other medical problems. If at any time the nurse feels uncertain or uncomfortable with providing advice, the nurse shall then confer with the physician.

New patients seeking telephone advice should be offered an appointment or appropriately referred.

Non-medical personnel are not permitted to formulate and offer medical advice to patients. Therefore, if the message seems to be an emergency, the call is to be immediately transferred to a nurse or physician. The following conditions could be considered emergencies:

- Chest pain
- Shortness of breath
- Loss of consciousness
- Paralysis, partial paralysis, or numbness
- Significant trauma
- Severe headache or stiff neck
- Seizure
- Active bleeding from any site
- Fever of 40 C˚/104 F˚, or a child less than three months old with any fever
- Fever with a rash
- Severe abdominal pain
- Pregnancy-related problems generally considered to be urgent
- Any other problem that the patient believes to be an emergency

Patients should be offered an appointment whenever a visit is believed to be in the best interest of patient care. Whenever a patient declines a recommended visit or “no shows” for a recommended visit, the patient’s decision/behavior needs to be documented.

The telephone protocols from the American Academy of Pediatrics 8th Edition of “Pediatric Telephone Protocols” offer sound, standard information, and may be used as guidelines in providing telephone recommendations to patients. Regarding fever, patients should be encouraged to use the most accurate means available for taking a temperature. It may be appropriate, at times, for patients to be seen to establish the presence or absence of fever.

Rendering appropriate telephone advice is highly dependent upon the accuracy of data gathered by healthcare personnel. The patient or his/her designee is responsible for providing honest, accurate data to FHCC personnel. If, for any reason, it is believed that information received is inaccurate and that the patient may have a condition requiring an urgent or non-urgent face-to-face evaluation, then the patient must be offered an office visit or urgent care/emergency evaluation.

Over-the-Telephone Confidentiality

Maintaining confidentiality of medical information is of utmost importance. FHCC staff will make every effort to comply with established confidentiality laws and guidelines, including HIPAA regulations. FHCC

personnel must not disclose patient information to any person or organization without the consent of the patient or his/her legal guardian.

Documentation

A summary of telephone conversations must be documented in EMR in the patient record as soon as possible. Documentation should include:

- The time and date
- Pertinent details of the telephone interaction
- Signature of the nurse or FHCC personnel
- The physician's signature, when required

Over-the-Telephone Prescriptions and Verbal Orders

Prescriptions called to a licensed pharmacist must be authorized by the prescribing physician.

If a verbal prescription order is obtained by a registered nurse, she/he shall repeat the prescription order back to the physician for purposes of clarification. The nurse shall record the prescription in the medical record with the name of the prescribing physician. The verbal order must be authenticated and initialed by the prescribing practitioner within 24 hours. The telephone number and name of the pharmacy receiving the prescription order must be recorded in the medical record. There is a more detailed description of the prescription policy later in this document. The FHCC will adhere to laws and standards regarding prescription faxing and e-Rx.

Allergy Injections

Prior to administration of an allergy injection, the patient, solution, and dosage must be correctly identified by a registered nurse or a physician. Signature is required by personnel. A physician must be present in the FHCC at the time and one half-hour after the injection is administered. The patient must remain on-site at least 15 minutes after the injection has been given.

Medication and Vaccination Administration

All medications and vaccinations should be administered by, or under the supervision of, appropriately licensed personnel in accordance with laws and governmental rules and regulations governing such acts and in accordance with approved medical procedures as stated in the Medication System Manual. A written or dictated physician authorization is required for administration of medications and/or vaccines.

Antibiotic injections shall be administered by or under the direct personal supervision of the prescribing physician.

Guidelines for preparation and administration of medications and vaccinations are to be followed as stated in the Nursing Manual and Medication Manual.

Emergency and Other Stock Drugs

Drugs approved for use during an emergency are provided by TRHMC Pharmacy. These drugs are kept in the FHCC Clinical Storage area. They are replaced routinely by The Reading Hospital Pharmacy following use or upon expiration.

Drugs found to be acceptable for use by the Program Director can be routinely stocked and procured from TRHMC by completing a requisition. This requisition should include date, signature, name, and amount of drug requested. Drugs are to be checked on a monthly basis for expiration date. This is to be done by the Nurse Manager or her designee.

Administration of Drugs within the FHCC

Drugs shall be administered only on the order of a faculty member or a resident of the FHCC. Verbal orders for drugs may only be accepted by personnel so designated in the Medication System Manual, and must be authenticated by the prescribing practitioner within 24 hours. All medication shall be administered by, or under the supervision of, appropriately licensed personnel in accordance with the laws and governmental rules and regulations governing such acts and in accordance with approved medical staff procedures in the Nursing Manual and Medication System Manual.

Controlled Drugs

Administration of controlled drugs shall be documented by the physician or nurse in accordance with the Nursing and Medication System Manual.

Guidelines for obtaining narcotics and barbiturates from the Pharmacy are to be followed as stated in the Nursing Manual.

Medication Errors

Medication errors and adverse drug reactions are to be reported immediately in accordance with the Nursing Manual and hospital policies.

Emergency Drugs

A Medical Staff-approved stock of emergency drugs and antidotes will be available in the FHCC.
The emergency drug supply will be checked at least daily and after each use to assure that all items are immediately available in useable condition.

Poison Control

The Poison Control Center telephone number (1-800-722-7112) and current authoritative antidote information will be readily available within the FHCC.

Discontinued and Outdated Drugs

Discontinued and outdated drugs and containers with worn, illegible, or missing labels will be returned to the Pharmacy for proper disposition.

Policy for Pharmaceutical Representatives

The FHCC does not allow pharmaceutical representatives to meet with any physician or staff during regular business hours on hospital property.

Location, Procurement, and Storage of Medical Supplies and Equipment

Due to minimal storage availability, needed medical supplies are procured on a weekly basis. Requests for medical supplies must be given to the Practice Manager for ordering. The Practice Manager will order all supplies for the nursing and clerical staff, and complete required forms for the Accounts Payable Department.

Infection Control Policies

The Infection Control Manual is located in the FHCC Utility Room. All infection control policies that are acceptable at TRHMC are explained in detail within that manual.

Surveillance of Infections

Nursing personnel are responsible for reporting highly contagious infections or reportable diseases to the Infection Surveillance Nurse, using Form 3.21—Infection and Communicable Disease Report. This includes infections among patients and personnel.

Personnel

- All personnel will wear clean attire and shoes.
- All personnel are subject to Employee Health policies as described in the Personnel Policy Manual and Infection Control Manual.
- All personnel should carry out aseptic hand-washing technique as described in the Infection Control Manual.

Nursing Personnel

Nursing personnel should be aware of and carry out the following aseptic techniques as described in the Nursing Manual or Infection Control Manual.

- Medication administration
- Urinary catheterization
- Thermometer procedures
- Sterile re-dressings
- Isolation precautions

Education

All nursing staff will complete the Health Streams educational courses on infection control.

Reporting Communicable Diseases

The Pennsylvania Department of Health has compiled a list of disease or disease entities that must be reported. Guidelines for this process are found in the Infection Control Manual.
It is the examining physician's responsibility to report all communicable diseases to the Department of Health. STD forms can be obtained from the nursing staff. Note that TRHMC Laboratory automatically reports many positives.

Legal Obligations and Reporting Laws

For questions concerning legal obligations, the resident should consult the Program Director, Medical Director's office, or hospital attorney.

Prescription Policies

Prescriptions given over the telephone or in person are to be recorded in the EMR without exception. Nurses are allowed to phone in or fax prescriptions for patients with physician approval. The physician is to sign the EMR as soon as possible regarding any prescription refills.

Controlled substances are not to be prescribed over the telephone. Only in the rare circumstance of terminally ill patients on hospice unable to come to the FHCC may prescriptions for controlled substances be mailed to the patient.

Prescription Refills

At an office visit, every attempt will be made to synchronize/"harmonize" all of the patient's chronic medications. In this way, refills will be on the same cycle, thus limiting separate needs for refill requests.

All medications, for chronic illnesses (with exceptions as noted below) such as cardiac conditions, HTN, DM, hypothyroid, GI issues, allergies, etc., will be prescribed with a ninety day supply with one refill or thirty day supply with five refills.

If it is noted that the patient has not been in to the office within one year:

- The nurse will contact the patient to schedule them for a visit.
- The patient will be prescribed one month's worth of medications with no refills.
- It will be documented that the patient was informed of our policy that no refills will be provided after that.

Whenever refills are prescribed, the nurse will check protocols to see if any testing is due.

- For example, our protocols may suggest that any patient on Synthroid (or equivalent) needs a TSH at least annually, patients on diabetes medications have an HA1C at least every 6 months, patients on cholesterol medications get a fasting lipid panel and AST and ALT annually, etc. This should, of course, be ordered without needed input from physicians.
- If the nurse at the time of a refill request notes other tests/services due, those are also to be ordered per protocol. This may include mammograms, scheduling patient for a PAP, etc.

Medications to which this policy doesn't apply include:

- Coumadin - only refilled six months at a time, and only if INR has been done in the last six weeks. (This is for stable patients; newly started patients need more intensive monitoring.)
- Antidepressants/Anxiolytics - only refilled six months at a time; needs office visit at least every six months for refill.
- Chronic narcotics
    - If nurse cannot find the pain contract, office visit is made to address this
    - Needs office visit at least every six months for refill
    - Except in unusual circumstances (patient on hospice, patient lives far away and makes arrangements with PCP, etc.), these prescriptions should not be mailed.
    - Schedule II drugs
        - A physician is allowed only to prescribe a one-month supply with no refills
        - Examples Percocet, morphine, Oxycontin
        - Cannot be faxed/called in, only written allowed
    - Schedule III-V drugs
        - Can be faxed/called in, refills allowed
        - Examples: Vicodin (Schedule III), Ambien (Schedule IV), Darvocet (Schedule IV)
- Stimulants/ADHD medications - Schedule II drugs (Ritalin); only refilled one month at a time; needs office visit at least every six months.

Every request for a refill/every refill needs to be documented clearly.

Chronic Opioid Registry

The FHCC has created a patient registry to keep track of patients who are on chronic opiates and will enable physicians to better take care of these patients. This registry is not meant to replace documentation in the chart. This is not part of the patient record. It is meant for the physician to be able to, at a glance, see where the practice and individual physicians stand on patients who are on chronic narcotics. The registry will be kept on an Excel spreadsheet on the Q-drive of the computer system. The registry should contain the patient name, medical record number, responsible provider, indication, date of last office visit, date of last toxicology screen, date of signed pain contract, other specialists seen, type of opioid, break-through opioid, date evaluated for co-morbid mental health issues, other pain or related medications, and comments. This registry will be reviewed periodically by the Program Director and/or designated faculty to see how physicians and patients are doing. Feedback will be provided. This registry is password-protected.

Mechanisms for Timely Review of Laboratory and X-Ray Results

Laboratory and x-ray reports are routed to the EMR in Centricity document. "Panic values" are to be called by the lab to the appropriate physician or expedited to the lab printer for the physician. Any abnormal critical lab values are communicated to the nurse, then to either the primary care physician or

faculty preceptor to determine if immediate action is required. There are appropriate policies and procedures in place from the Department of Pathology.

Residents and faculty are to regularly check (at least every 24 hours during workdays) their EMR desktop for in-coming diagnostic testing. If a faculty or resident physician is to be away for more than 24 hours, a team member is to review his or her desktop for laboratory and x-ray reports.

Reports for x-ray, labs and some cardiology studies are interfaced through the computer system into the FHCC EMR. These reports will appear on the appropriate physician's desktop. Written x-ray and laboratory reports which are mailed or faxed to FHCC from an outside facility are scanned into the EMR and appear in the appropriate physician's desktop. Abnormal test results are immediately scanned for physician review or are taken to the physician in the office. Once the physician reviews the test results, the document should be electronically signed and the patient should be notified. Lab and x-ray reports are available on Physician View on hospital and office computer terminals. Each resident is assigned a code to access these results.

Patient Recall Mechanism for Additional Studies or Consultation

The patient is responsible for following instructions and/or recommendations for follow-up, undergoing further studies, and seeing specialists and consultants. Individual physicians may develop their own personal system to check on patient adherence.

Incident Report Mechanisms

The Nurse Manager of the FHCC is responsible for filing incident reports on any patient care-related problem. If any incidents occur in the area of the reception area or business office, then it is the responsibility of the Practice Manager to coordinate the incident report filing. A physician may need to be notified to examine the individual and complete the incident form. The incident report must be filed online. The proper location of the incident report can be found on the homepage of the hospital intranet under E-Apps, Incident Reporting.

Quality Assurance

Quality assurance activities for the FHCC consist of monitoring out-patient care via ongoing patient satisfaction surveys and retrospective chart reviews in addition to other monitors which are developed based on important aspects of care.

The Practice Manager is responsible for tallying patient satisfaction surveys.

The Associate Director, residents, and office personnel are responsible for reviewing charts and tallying the results. These activities are frequently coupled with disease management educational sessions. The chart audit information is then reviewed by the Program Director, and action is taken dependent on the results. Feedback is given to all office providers. Deficiencies are brought to the attention of residents, faculty, and nurses via memo and/or discussion. The overall monitoring results are discussed quarterly at resident conferences.

At the FHCC, obstetrical patients are followed, and prenatal and postnatal care is supervised by a board-certified obstetrician. Labor and delivery are currently supervised by the obstetrician. There is an OB chart audit form currently in place for the FHCC which delineates aspects of prenatal care, such as glucose screening, hepatitis screening, etc.

The FHCC Quality Improvement (QI) Committee meets weekly and is an outgrowth of FHCC's involvement with the Governor's Office of Health Care Reform Chronic Care Initiative. Members include, but are not limited to, the FHCC Medical Director, Practice Manager, Nurse Manager, Care Managers, and others.

QA files are maintained in the FHCC, and annual reports are sent to the Medical Director's office and the Hospital's QA Coordinator.

The Service Form

The Service Form, formerly known as the “superbill,” is used with each patient visit. This form provides the base for patient registration, patient billing, and documenting diagnoses for billing. Thus, it is extremely important that the physician understand what is expected in completing the “orders section” in the EMR. The test form lists x-rays, labs, referrals, medications and advice for follow-up.

Visit Charges

Charge codes are divided into two categories — established patient and new patient. Each category is subdivided into sections based on the complexity of the history, physical exam, and diagnostic management. How professional services should be coded and billed is covered in the Practice Management curriculum of the residency program.

What to charge for a visit is often difficult for the resident to decide. Regardless of the amount of clinical experience, doctors charge for their expertise, medical care delivered, and procedures performed. Because the concept of charging a patient is new to the resident, residents should discuss questions or concerns with the preceptor, the Front Office, or the Practice Manager.

Office Revenue

Revenue generated from the FHCC is the property of TRHMC and assures that needed personnel, equipment, and educational materials and experiences are available for the residency program. Learning to bill appropriately should be a personal concern of each resident to prepare for the future.

There can be complex legal ramifications when patients are not charged. Please remember that residents are not only charging for their time but also for nursing staff and office staff time. Here are three areas of frequently lost revenue:

- Undercharges
  A simple ear recheck or wound check is an office visit, and a charge should be indicated on the charge sheet.
- Failing to bill for office surgery and procedures
- No-charge (“courtesy”) visits; these should be rare and financial hardship should be documented.

Coding

All services performed should be indicated on the Service form. Place the billing codes and orders in the order section of the EMR. Proper coding is essential to the management of the office. It is extremely important that thorough documentation is in place to back up any procedure or E/M code. From both a legal and insurer standpoint, if a procedure was not documented, it was not completed. The Billing and Practice Analyst will review all charge codes and submit these codes to the hospital billing system through the registrations system known as OAS Gold.

Immunization and Procedure Charges

Specific coded charges are to be used for immunizations and procedures.

In-Office Laboratory Charges

Specific coded charges are to be checked for in-office laboratory-related services (i.e., KOH prep, wet mount, pregnancy test, etc.).

Diagnosis

The physician should always provide the diagnosis for each patient. The office staff will look up the appropriate ICD-9 code. Indicate diagnoses for all problems treated during an office visit. This will promote accurate billing and processing. Number diagnoses in order of priority for that office visit.

Return Appointment

Follow up appointments are not usually scheduled on the same day the patient is being seen for a problem. With the Open Access scheduling system in place, a recall flag is placed in the patient chart for the office staff to call the patient a few days before the physician would like the patient to follow-up. This system is similar to a “tickler file”.

Ordering Studies

The physician can order labs, x-rays, EKG’s, etc., in the Orders Section of the EMR. The physician prints this form and hands it to the patient. The patient turns the form into the office staff. If the test is ordered STAT, staff will make the necessary arrangements at the time of the visit. Staff will make any necessary appointments for the patient either at the time of the visit or at a later date. The Insurance Coordinator will make arrangements for the test and obtain any required authorizations from the insurers.

Consultation and Referral Appointments

When the physician wishes the patient to be seen by a specialist, a referral form should be completed in the orders section of the EMR. Some specialties will have a corresponding form to attach to the referral. Depending upon the urgency of the consultation, the physician may wish to call the consultant directly, since this is the most expedient way of getting an urgent consultation. The Insurance Coordinator will schedule all necessary appointments and obtain authorizations from the proper insurer.

It is proper to send a letter about the patient, including a summary or copies of studies already performed and background information, to aid the consultant. The resident should also make clear the purpose of the consultation.

Many consultants welcome the resident’s accompanying the patient for the consultation, so the resident may want to make a note of the date and place of the consultation if he/she wishes to attend.

It is very important for the physician to set up a return appointment for a short time after the scheduled consultation. This assures the resident that the patient kept the appointment with the consultant and that follow-up occurs in case there is a communication breakdown between the consultant and patient.

A CONSULTATION SHEET OR LETTER IS REQUIRED FOR ALL REFERRALS TO THE OUT-PATIENT SERVICES CLINIC.

Health Maintenance Organizations (HMOs) require that properly completed referral forms be submitted prior to patients seeing a specialist.

A patient referred to Physical Therapy must be given a prescription which includes the written diagnosis and instructions (“evaluate and treat”).

A patient referred to the dietitian must also be given a prescription which includes the diagnosis and the type of diet which should be reviewed (i.e., ADA, cardiac prudent, 2 gram Na, etc.).

Return to Work/School Excuses

Excuses may be written by the physician, nurse, or receptionist. This task can be easily accomplished using the EMR. The note should specify the date(s) the patient is to be excused, when he/she should return to school/work, and any restrictions that may apply. This information should also be noted in the patient’s EMR chart.

Patient Forms

Some patient visits (for example, school physicals, pre-operative clearance physicals, permission to engage in sports, driver’s physicals, work physicals, disability forms, etc.) require that related forms be completed. The FHCC policy is that if the form can be completed at the time of the visit, a copy is

scanned in the chart and the original returned to the patient. If the form is extensive, the patient should be advised to return in a reasonable amount of time (usually 48 hours) to pick it up. This form can be mailed or faxed at the patient's request.

The physician who provided the service should fill out the form. When a patient drops off a form, office staff will make sure the patient's name and date of birth are on the form. Other FHCC demographic information should be completed the Front Office Staff. The patient will be informed that the form will be completed within one week. The office staff will also verify that the patient has had a physical exam within one year. The form cannot be completed if it has been over one year since a physical exam was performed.

The form is placed in the doctor's chart garage and noted in the EMR. If the physician believes it to be reasonable to complete the form without an additional exam, and if the form does not require any further testing (i.e., U/A, PPD, hematocrit, vision screening, etc.,) the physician may sign the form. If the physician is away, the designated team member may complete the form using information gathered from the provider's notes. If, in the providing physician's absence, the form is unable to be adequately or accurately completed, the patient must be notified in a timely fashion, and given an approximate date to check back with the office. It is the responsibility of the team member to communicate to the primary physician that a form is in his or her chart garage and that it needs to be completed.

PPDs cannot be placed on a Thursday because the patient would need to return to have it read on a day when the office is closed.

When the physician has completed the form, he/she will return it to the Front Office. The patient is notified that the form is ready for pick up. The form can also be mailed or faxed at the patient's request. A copy of the form is scanned into the EMR.

Health Maintenance Organizations (HMO)

The FHCC physicians participate in several HMO/managed care insurance companies. Family physicians will be following the HMO patients as their primary care physician (PCP) and coordinating their care with other specialty physicians. As the PCP, physicians must authorize all referrals needed for consultations with participating specialists, OB/GYN consults, x-ray studies, laboratory studies, emergency visits, etc. Each insurance organization has their own guidelines, and the front office staff has been trained to know what each insurer requires regarding referrals and authorizations. Many of the guidelines can be found on the individual insurer's website.

As PCP providers, the FHCC is responsible for providing 24-hour coverage seven days a week. It is important to remember that if a resident authorizes a patient to be seen in the Emergency Department at TRHMC, he/she must give this information to the receptionist the next business day so the staff can call the HMO and authorize the ED visit. If these arrangements are not made with the staff, the HMO may not pay for the ED visit and the patient may have to pay the bill.

If the patient's problem does not warrant emergency care, the resident can ask the patient to call the FHCC the next morning and be seen in the office instead.

Nutrition Assessment Protocol

Each patient seen at the FHCC is weighed at each visit. The weight is recorded in the patient's chart. All new patients have height recorded at the initial visit and yearly after that.

All children are weighed at each visit and during a well-child exam. Height and weight are plotted on the growth chart as appropriate for age. The FHCC has a variety of specific age-related material for each well-child visit.

In the case of a weight change (decrease of more than 10 pounds in a period of three months), the Nutrition Assessment Tool will be utilized. This weight change will be discussed with the resident seeing

the patient, and the appropriate referrals will be made to either the Nutrition Counseling Service at TRHMC or the provider required by the patient's insurance program.

Pain Management Protocol

Each patient seen at the FHCC will be asked a "chief complaint." During the process, the nurse will ask, in most cases, "Are you having pain today, or are you in any discomfort?" If the answer to this question is yes, the nurse will then ask, on a scale of 1 (being the least) to 10 (being the worst), the number the patient would assign to the pain or discomfort. In the case of a small child or mentally challenged adult, the smile faces will be used. This response will be documented on the Patient Assessment Flowsheet.

The patient's physician would determine the intervention utilizing all areas available by TRHMC and other modalities.

Assessment of Function Protocol

Each patient seen at the FHCC will have functional needs assessed as indicated. Upon entering the room, the nurse will ask a series of questions:

1. Have you seen a decline or loss in your ability to care for yourself in the last three to six months (dress, bathe, cook, etc.)?

2. Have you seen a decline or loss in your ability to walk in the last three to six months (walk in the house, walk in the store, or mall, or neighborhood)?

3. Have you fallen more than two times in the last three to six months?

4. If there are changes, are you currently receiving treatment to improve these changes?

The response will be documented in the Patient Assessment Flowsheet. If a referral to OT/PT is needed, the physician will discuss this with the patient and make the appropriate referral.

Assessment of Learning Needs and Interpreter Protocol

If, at the time of a patient office visit, it is determined that the patient has special learning needs, all resources in the TRHMC will be utilized:

- A language or sign language interpreter: Contact Interpreting Services or use the language-line phone system.
- Patient resources will be utilized. All able and permitted caretakers will be involved.
- All efforts will be used to stay within the boundaries of the patient's insurance plan.

Medical Equipment Protocol

All medical equipment used in the FHCC by or on patients will be inspected and maintained by TRHMC Biomedical Department. This will be in accordance with that department's standards.

If a patient is in need of equipment for use at home, the resident physician will make arrangements either by a referral or directly in conjunction with the nurse working at that session. This will be documented in the patient's record.

Medication/Patient Information Protocol

When needed, the FHCC will use Micromedex on TRHMC Intranet. Formularies for the various insurance providers can be found on the individual insurance websites.

Community Referral Protocol

In the event that any FHCC patient needs a referral to a community agency, the nurse and/or physician will utilize the referral book located in the Care Manager's Office. These are community programs that are available, usually FREE of charge, to the patient.

If a formal referral is required due to special circumstances, the front office staff will handle the referral. This referral must be documented in the patient's chart.

All referrals will be carried out with the patient's insurance in mind.

The FHCC Care Manager should be involved in most cases of patients needing ongoing community resource involvement.

Residency Curriculum and Policies

Residency Curriculum

Introduction
Family Medicine requires knowledge and skills in both the out-patient and in-patient settings. During the first year, training is predominantly in the hospital. By the third year, rotations are largely out-patient based.

Curricula are posted on the New Innovations website. Residents should review this prior to beginning each rotation. Residents who show initiative and interest in learning are more likely to be allowed by attending physicians to participate in specialized procedures.

At the beginning of each rotation, the resident will discuss the schedule and the goals of the rotation with the preceptor.

First-Year Rotations

Night Float
Five 2-week blocks; this rotation is really an extension of the Family Medicine (FM) inpatient experience and a replacement for traditional intern overnight call. Resident physicians will manage the care of patients on the FM inpatient and Children's Health Center (CHC) services, evaluate patients in the ER for possible admission, and participate in other educational activities. Schedule will be determined per policy, but will generally be Sunday through Friday nights (overnight). By the end of the rotation, residents should be able to handle patient care responsibilities on the inpatient service and CHC services in an organized, efficient, compassionate manner and communicate effectively with patients, families, physicians, and staff.

In-Patient Family Medicine
Two four-week blocks are devoted to the Family Medicine in-patient service. This usually consists of a Family Medicine faculty, one resident from each year of residency, and occasionally a medical student. We care for all FHCC patients (Suites 120 & 200) who are hospitalized as well as others based on current policies. First-year residents are expected to manage on average at least five patients per day. Second-year residents usually care for consults, newborns, and others on the service, and carry the upper-year pager. Third years take overall responsibility for the clinical and educational demands of the service.

Pediatrics
Two four-week rotations are supervised by the full-time hospital pediatric staff and involve both in-patient and out-patient pediatrics. The resident is responsible for all Children's Health Center (CHC) newborns, all CHC pediatric patients, and unassigned pediatric patients who are admitted. The resident may also be involved in writing orders for sedation prior to out-patient procedures, such as CT scans and EEGs. The out-patient experience includes time at the CHC and examination of patients in the ED upon the request of the ED physician.

Emergency Medicine
This rotation provides experience in the evaluation and management of emergency medicine patients under the supervision of an assigned ED teaching attending. The resident's goals should be discussed with that individual. The rotation includes one day with a paramedic/EMT crew in the community. [njs1]

Cardiology
The resident will work with Cardiology Associates of West Reading for four weeks, primarily caring for patients in the Medical Intensive Care Unit, Surgical Intensive Care Unit, and telemetry units. One or two residents from Internal Medicine may also be on the service. Dr. Peter Will currently coordinates this rotation.

Obstetrics
This four-week rotation is supervised by the OB senior residents and attendings under the guidance of

the Director of the Obstetrics and Gynecology Residency. The resident may also interact with the private OB attending staff. Interns must contact the OB chief resident two to three weeks prior to the rotation to set up time for an orientation period.

Prior to the rotation, all residents will be given a series of OB core content lectures to familiarize themselves with the essentials of perinatal care. This will allow them to have a more meaningful experience on the OB floor.

Residents may, if the OB floor is quiet, return for Morning Report at the FHCC provided they promptly return to the OB floor following report. They should first ask permission from the Chief of the OB service before taking advantage of this privilege.

Surgery
This four-week rotation involves in-patient care on a general surgery service, currently Spring Ridge Surgical Specialists. Responsibilities include pre-op evaluation, assisting during surgical procedures (as a first assistant), and post-op management. The resident may attend surgery clinic in Out-Patient Services on Monday and Thursday afternoons.

Psychiatry
The two-week general psychiatry rotation provides experiences in out-patient, in-patient, and partial hospital settings. It provides a broad overview of psychiatric evaluation and treatment for children, adolescents, and adults. Four mornings per week are spent on a four-bed adolescent in-patient psychiatry unit. Afternoons include mental health evaluations with the ACT Program and Partners Program, introduction to drug and alcohol services, participation in “dual diagnosis” group therapy, and supervised practice in out-patient medication management for common psychiatric disorders. Dr. Kolin Good is the attending psychiatrist who oversees the rotation.

ENT
One week will be spent learning the principles of a problem-focused head and neck history and physical exam, as well as the management of common conditions in Otolaryngology.

Urology
One week will focus upon the evaluation, examination, and management of common genito-urinary disorders.

Physical Medicine and Rehabilitation
This is a one-week rotation with the PM&R staff. The resident will learn the principles and practices of physical medicine and rehabilitation, including the use of occupational, physical, and speech therapies. Drs. Paul Brockman and Kelley Crozier coordinate this rotation.

Ophthalmology
This is a one-week rotation with a private ophthalmology group, traditionally Eye Consultants of Pennsylvania. The resident will learn the principles and practices of eye exams and pathologies. They will be exposed to varied sub-specialties such as cataract, strabismus/pediatric, etc.

Second-Year Rotations

Beginning in the second year, there is increasing emphasis on out-patient medicine. At the beginning of each rotation, the resident is encouraged to discuss with the attending physician the areas desired for further exposure.

In-Patient Family Medicine
Two four-week blocks are devoted to the Family Medicine in-patient service. This usually consists of a Family Medicine faculty, one resident from each year of residency, and occasionally a medical student. We care for all FHCC patients (Suites 120 & 200) who are hospitalized as well as others based on current policies. First-year residents are expected to manage on average at least five patients per day. Second-year residents usually care for consults, newborns, and others on the service, and carry the upper-year pager. Third years take overall responsibility for the clinical and educational demands of the service.

Pediatrics
Second-year residents will be assigned to the CHC Pediatric Service. In addition to the duties specified under the PGY-1 rotation, the resident has additional supervisory responsibilities for the PGY-1 resident and medical students.

Geriatrics
The resident will work at the nursing home during this month under the direction of one of the geriatricians. Also, time may be spent at other venues, such as the Geriatric Assessment Center, with other offices/agencies, etc. At the beginning of the second year, the resident will be assigned patients in local nursing homes to follow longitudinally. Residents will be responsible for seeing their patients every 30 days and for attending monthly didactic rounds.

Obstetrics
The PGY-2 rotation is considered a Maternal Health rotation. This will consist of more time with the Reading Hospital OB/GYN Residency, but will also include time at Berks Women in Crisis (BWIC), the Children's Alliance Center (CAC), and the Reading Birth and Women's Center. The time with the OB/GYN Residency will include some time on the labor floor. However, residents will have significantly more time in the low risk/high risk OB clinics, as well as time observing genetic counseling. Time at BWIC and CAC will allow the resident to gain a fuller understanding of the problems that affect women and children. The experience will provide them with the tools to identify at-risk families and refer them to the community-based resources that are best able to care for them. The Family Medicine Faculty Associate for Obstetrics (Dr. Tom Raff) oversees this.

Behavioral Medicine
This rotation focuses on understanding personality, human behavior and interaction, and emotional concerns relevant to the primary care medical setting. Residents will practice and refine advanced communication skills used to facilitate patients' behavior change, deliver treatment options and general patient education, provide brief focused counseling, maximize compliance with a medical regimen, and diagnose and manage common psychiatric disorders, such as anxiety and depression. This rotation includes live observation and videotape review of regular FHCC patients. Also, residents will spend a week at the Caron Foundation. Supervision is by the Behavioral Medicine faculty, Deborah Bevvino, PhD, who coordinates this rotation.

Sports Medicine
This is an out-patient rotation. The emphasis will be on the non-surgical aspects of sports medicine with emphasis on care of athletes of all ages, performance of pre-participation sports physicals, assessment of common injuries, knowledge of treatment, and rehabilitation. The rotation is coordinated by Dr. Cory Keller.

Surgery
Emphasis will be on out-patient skills, such as removing skin lesions and evaluating patients from the medical perspective preoperatively. The preceptor is Dr. Louis Mancano.

Critical Care
This is a four-week rotation focusing primarily on the delivery of care in the Medical Intensive Care Unit. Residents receive formal training in the use of ventilators. Residents must manage at least 15 critically ill patients. Most importantly, residents need to identify "sick" from "not sick" patients.

Critical Appraisal Skills
Second-year residents will be exposed to the basics of critical appraisal skills during this month. As medical knowledge increases at an exponential rate, it becomes increasingly difficult to keep up and use the latest information in the care of patients. Therefore, it is imperative that physicians have the skills to access high quality, relevant information quickly, efficiently, and evaluate the information as to its validity. Knowing how to obtain and interpret medical literature is now an essential skill, one that graduates of this program should possess. This rotation will provide the fundamentals with regard to medical literature. Residents will gain insight into the research process, thereby allowing them to develop critical appraisal skills. This will occur through checklists, directed readings, etc.

Psychiatry
The two-week general psychiatry rotation provides experiences in out-patient, in-patient, and partial hospital settings. It provides a broad overview of psychiatric evaluation and treatment for children, adolescents, and adults. Four mornings per week are spent on a four-bed adolescent in-patient psychiatry unit. Afternoons include mental health evaluations with the ACT Program and Partners Program, introduction to drug and alcohol services, participation in "dual diagnosis" group therapy, and supervised practice in out-patient medication management for common psychiatric disorders. Dr. Kolin Good is the attending psychiatrist who oversees the rotation.

Medical Subspecialty
This two-week rotation will expose residents to varied specialties based on the resident's previous experiences and current and future needs.

Allergy
Residents will spend one week with a local allergist. They will identify indications for referral and current standards of work-up and treatment.

Rheumatology
Residents will spend one week with a local rheumatologist. They will identify indications for referral and current standards of work-up and treatment.

Electives
Second-year residents will have 1 month for an elective during the PGY-2 year. Plans for all electives should be finalized with the resident's faculty advisor at least three months in advance. Residents are to contact the practice with which they plan to rotate. Once approval is granted, they must inform the Curriculum and Education Coordinator who maintains the residency rotation schedule.

Third-Year Rotations

In-Patient Family Medicine
Two four-week blocks are devoted to the Family Medicine in-patient service. This usually consists of a Family Medicine faculty, one resident from each year of residency, and occasionally a medical student. We care for all FHCC patients (Suites 120 & 200) who are hospitalized as well as others based on current policies. First-year residents are expected to manage on average at least five patients per day. Second-year residents usually care for consults, newborns, and others on the service, and carry the upper-year pager. Third years take overall responsibility for the clinical and educational demands of the service.

Emergency Medicine
This rotation provides experience in the evaluation and management of emergency medicine patients under the supervision of an assigned ED teaching attending. The resident's goals should be discussed with that individual. The rotation includes one day with a paramedic/EMT crew in the community. [njs2]

Community Medicine
The resident will learn about multiple agencies in the community which are available to provide support services. Responsibilities include staffing the student health clinics at the Pennsylvania State University Berks Campus and Alvernia University. Residents are also scheduled to work one evening in the Western Berks Free Medical Clinic. There is also an opportunity to learn about the workings of the State Health Department. This rotation is coordinated by Dr. Michael Baxter.

Gynecology
To gain experience in out-patient gynecology, the resident will work in a variety of settings, including the Gynecology Clinic in Out-Patient Services and the private office of Dr. Nabil Muallem, Family Medicine faculty OB/GYN preceptor.

Dermatology
Diseases of the skin are some of the most common disorders presenting to a family physician. Therefore, diagnostic and management skills of basic dermatologic disorders are an essential part of residency training. In addition to a longitudinal hospital-based Dermatology Clinic, third-year residents rotate with a group of board-certified dermatologists. Residents are exposed to a wide array of dermatologic diagnoses and learn practical treatment strategies.

Ambulatory Medicine/Management of Health Systems/Practice Management
The ambulatory medicine rotation is a one-month experience in the FHCC in the third year. The resident will gain additional experience in the work-up and management of common conditions encountered in Family Medicine. Practice management training, as well as specific assignments, will also be emphasized during this rotation. This occurs through face-to-face time with the Practice Manager as well as directed by readings and checklists.

Office-Based Cardiology
This rotation is designed to enhance the skills developed on the PGY-1 in-patient cardiology rotation but with an out-patient focus. The resident is assigned to the local cardiology group. Patients are evaluated in the office setting. Residents are familiarized with an assortment of non-invasive cardiac diagnostic procedures.

Out-Patient Pediatrics
The resident will work in the office of a local pediatrician or another out-patient setting for two weeks. Arrangements should be made by the resident at least three months before the beginning of the rotation.

Neonatalogy
During this two-week rotation, residents will learn to diagnose and manage the more common neonatal complications and illnesses by participating on rounds in the Neonatal Intensive Care Unit (NICU) and by attending deliveries with the NICU staff. The Neonatal Advanced Life Support course will be completed during this rotation.

Orthopedics
This is a combined in-patient and out-patient rotation. The resident will improve skills in the musculoskeletal physical exam and will learn to diagnose and manage common orthopedic problems. Physicians from Orthopedic Associates of Reading supervise this rotation.

Radiology
[njs3]Residents will spend two weeks identifying indicators for varied tests. This rotation can be customized. Dr. Michael Feightner oversees this rotation.

Pediatric Subspecialty
This two-week[njs4] rotation enables residents to identify normal from abnormal. Residents will rotate in various areas, such as pediatric speech therapy and nutrition.

Electives
Third-year residents will have two months for electives. These should be selected based on the resident's interests and needs in practice later. Away rotations must be approved at least three months before the rotation begins. (Otherwise, it may not be possible to accommodate the resident's plans.) In order to provide continuity of care to patients in the FHCC, a resident may not be away for more than two months and not in consecutive months. Away electives must be approved by the Program Director. An information form and goals and objectives must be completed.

Responsibilities on Call

Responsibilities
Residents provide night call coverage for the Family Medicine in-patient service and the CHC patients. During the first year, interns are scheduled for night float from Sunday through Friday. During the second and third years, residents take call for the Family Medicine in-patient service, including babies delivered by the FMRP and individuals admitted to the service from the Emergency Department, the FHCC, admissions for offices with whom the FMRP has agreements to perform in-patient services, and CHC pediatric patients. PGY-2 and PGY-3 residents will also take phone calls for FHCC and FMRP nursing home patients.

The resident is responsible to perform a complete History and Physical, including a detailed Assessment and Plan and admission orders. The resident is responsible for all calls related to patients that are admitted until sign-out the following day. The Family Medicine resident on call is responsible for

evaluating CHC pediatric patients when asked by the ED physicians and admitting if necessary. The CHC pediatric on-call attending must be notified of all ED accommodations or admissions.

When writing admission orders, STANDING ORDERS are available for a variety of in-patient units and protocols. These must be used for the following diagnoses: COPD, CHF, pneumonia, acute myocardial infarction, and acute stroke.

Sign Out
Evening call begins at 1700[njs5] hours. The resident(s) on the Family Medicine in-patient service and the resident on Pediatrics are responsible to sign out to the resident on night call and the intern on night float. This process should include pending lab studies, potential problems, and patients in the ED Observation Unit.

Telephone Calls
Handling phone calls from patients is a very important skill for the family physician. This can be very challenging on call, because the resident may receive calls from FHCC patients, nursing homes, pregnant women in our practice, and CHC pediatric patients. All calls must be documented in the EMR.

Seeing Patients Outside Office Hours
Patients who need to be seen after hours or on weekends should be seen in the Emergency Department, rather than in the FHCC. This policy assures that ancillary help is available if needed and simplifies billing. The resident must notify the ED triage nurse that the patient is coming and what is to be done.

If the patient's problem does not warrant emergency care, the resident should offer advice and recommend that the individual call the next morning for an appointment to be seen in the office.

An Observation Unit is available to observe patients for up to 23 hours for evaluation and treatment. All admitted patients and observed patients should be reviewed at sign outs. The final decision about disposition should be made as soon as possible.

Weekend Call
To assure continuity of patient care for hospitalized patients, the residents on the Family Medicine in-patient service share on-call coverage throughout each weekend of their in-patient month. The senior resident on the Family Medicine in-patient service is typically on call Friday night. If for any reason no one on the Saturday team is familiar with the in-patient service, it is his or her responsibility on Saturday morning to round with the faculty and resident(s) coming on call and be available until rounds are completed. It is imperative that accurate information about patients and their treatment plans be transmitted to the oncoming residents on Saturday and Sunday.

Weekend call — Friday 1700 hours through Monday 0730 hours — includes admission coverage for patients of the FHCC, the Second Street Dispensary, Dr. Lazaro Pepen, CHC pediatric patients, and pediatric patients of Family Medicine practices in Berks County. Residents will be periodically updated regarding current admission coverage.

The resident on call on Saturdays, Sundays, and holidays will round on all in-patients. Holiday call is similar to that for weekend call.

For billing purposes, report all patients seen at home, nursing homes, ED, or ED Observation Unit to the FHCC office staff on the next business day.

Back-Up Coverage
There is a designated faculty person on call each night as found in New Innovations. All admissions to the hospital or the Observation Unit must be discussed with the faculty attending on call. Faculty must also be notified of any significant change in the condition of a patient on the in-patient service. Any other patient care questions related to patients seen in the ED, contacted through telephone, or handled as after-hour office visits may be discussed at the discretion of the resident. Although residents are expected to function more independently as they progress through their residency training, PLEASE DO NOT HESITATE TO CALL THE ATTENDING at any time if you are uncertain about any patient's problem.

The resident on the Family Medicine in-patient service must be available within beeper range on nights and weekends to back up the resident on call, or this resident must obtain back-up coverage and then notify the resident on call of this change in coverage.

If a resident becomes ill or has other unforeseen conflicts with being on call, IT IS THE RESIDENT'S RESPONSIBILITY TO OBTAIN ALTERNATE COVERAGE. The Program Coordinator should be notified of the change as soon as possible. The Chief Residents have policies and plans to address this.

OB Call
Each resident is required to follow and participate in the delivery of at least 10 continuity FHCC OB patients throughout their pregnancies. At least 10 patients will be assigned, with none having a due date during the last month of residency. Although each resident is expected to deliver his or her own patients, circumstances may warrant coverage by a team member.

Residents must be available within beeper range for their OB patients beginning at 37 weeks. If alternate coverage has been arranged, the senior resident on call must be informed.

Ideally, each OB patient will contact her primary physician before coming to the hospital so that appropriate arrangements can be initiated. However, if a patient presents to the hospital (either in the ED or L&D) without prior notification, she should be evaluated initially on the OB Triage Unit. If it is evident that the patient needs to be admitted or will require an extended evaluation, the primary physician should be contacted to assume care.

The Berks Community Health Center's OB patients will be taken care of by the assigned resident, and Drs. Raff, Muallem, and Strieb. When these patients come to the Labor and Delivery floor, they will initially be evaluated on the OB Triage Unit. A call will be placed to whichever Family Medicine/OB or OB attending is covering that night, as well as to the resident who may be assigned to that patient. That attending and resident will then come in to manage the patient.

Hospital Dictation

Every hospitalized patient must have an H&P dictated within 24 hours. A brief admit note should also be written in the chart.

The Discharge Summary should be dictated at the time of discharge. It is easier to dictate about a patient recently seen! The discharge diagnoses should correlate as much as possible with the diagnoses listed on the Summary Sheet. For hospital billing procedures, the Summary Sheet must be filled out completely at the time of discharge, and the discharge summary should be available as soon as possible. Discharge Summaries for patients discharged to nursing homes or rehabilitation facilities must be dictated 24 hours prior to discharge so that it can accompany the patient. When discharging an FHCC patient, a brief note should be entered in the HER at the time of discharge (ex, a "chart note" in Centricity).

H&Ps and Discharge Summaries are dictated to assure legibility. These must be proofread before signing.

Medication Reconciliation – Accurately updating all medication changes at the time of patient discharge is essential using the appropriate forms. This must be carefully reviewed with patient and family. Whenever a patient is admitted outside office hours, it is the responsibility of the admitting resident to dictate the H&P. If the patient is admitted through the office, there should be a mutual decision between the admitting physician and the resident on the in-patient service as to who writes the orders and does the H&P.

When dictating, spell the name of the patient and list the medical record number. Always speak clearly. Also identify which full-time Family Medicine faculty person is in charge of the service — not just who is on call for that date.

At the conclusion of the dictation of H&Ps and Discharge Summaries, always request a copy for the FHCC as well as for the referring physician if the patient was referred from a community physician.

Policy for Supervision of Residents

Residency Supervision in the FHCC
During each office session, a faculty supervisor is scheduled.

Faculty will be responsible for supervising no more than four residents during an office session. This faculty supervisor is to be present during the scheduled office hours for the residents. The faculty supervisor is responsible not only for supervising the residents during office hours, but also for auditing the charts of patients seen during that office session and reviewing notes.

First-year residents must review each patient with a faculty preceptor prior to discharging the patient from the office. Senior residents must review with the preceptor only those patients about whom they have questions. All residents will have their charts reviewed and evaluated on a rotating schedule. The preceptor should complete at least one evaluation form for each resident seeing patients during the session . These will be given to the Residency Secretary who will keep a log of the completed forms. She will put the forms in the resident's mailbox. After signing the completed form, the resident will return it to the Residency Secretary and it will be placed in the resident's portfolio.

Resident Supervision on the Family Medicine In-Patient Service
A faculty attending is scheduled for supervising the Family Medicine in-patient service. The faculty attending is responsible for overseeing clinical activities on the Family Medicine in-patient service for a designated period of time, with the exception of weekend call schedules and night call schedules which are handled on a rotating basis by full-time and part-time faculty. Faculty call begins at 1700 hours each evening and ends at 0800 hours the next morning. The residents on call the previous night sign out activities of the previous evening to the Family Medicine in-patient service.

Resident Supervision on Rotations Not Supervised by FMRP Faculty
The attending physicians directly working with the residents are responsible for overseeing clinical activities of residents assigned to them. These attending physicians must complete an evaluation form at the end of the rotation. While most evaluations are completed electronically in New Innovations, some attendings still complete a paper evaluation.

Use of Consultants
Consultation should be obtained on patients at the discretion of the residents with the approval of faculty. This includes both patients seen in the FHCC and on the in-patient service.

OB in the FHCC
The FHCC obstetrical patients are followed with their prenatal and postnatal care supervised by the Family Medicine obstetrical faculty and a board-certified obstetrician. Labor and delivery are also supervised by the FM/OB faculty, with OB backup or by the obstetrician. There is a monthly OB chart audit form currently in place for the FHCC which delineates aspects of prenatal care, such as glucose screening, hepatitis screening, etc.

Effective Use of Preceptors

A preceptor will be assigned to every office session in the FHCC. The purpose of a preceptor is to be an effective teacher for residents and medical students and is responsible for overseeing patient management in a particular session. The preceptor may be either a full-time or a part-time faculty person.

Effective precepting involves two-way communication between the teacher and the learner. The preceptor may organize an informal Ambulatory Care Conference at the end of each session to give residents the opportunity to review all cases with the preceptor.

To enhance communication and education, residents should:

- Present cases to the preceptor that are concise and contain pertinent information.
- Accept responsibility and be receptive to constructive feedback.
- Develop ability to make decisions on his/her own but recognize when help is needed.

- Arrive on time.
- Demonstrate good organizational skills.
- Avoid projecting his/her own values onto patients.

Importance of Documenting Resident Experiences

It is essential for each resident to document procedures performed and quantities of patients treated with different conditions. Performing or assisting in surgical procedures, such as minor surgical procedures, colposcopies, obstetrical deliveries, and so forth, must be recorded. Patients cared for in the MICU, SICU, NICU, and Pediatrics Unit should have their Medical Record Numbers and diagnoses recorded. This information will become essential in the future as physicians apply for clinical privileges in hospitals and for credentialing information and medical insurance organizations.

When graduates apply for privileges, (such as procedures, ability to interpret tests, or admitting privileges for critical care, cardiac care, pediatric, or obstetrical units), they may be required to document the quantity, the dates, the degree of involvement, and the experience in the related procedures or with special patients. This process will be expedited if residents keep a running documentation of experiences and procedures encountered during residency.

For both out-patient and in-patient procedures, residents are responsible for documenting their own experience in the New Innovations database in real time. As a backup to the system, it is strongly suggested that residents keep the same information in their personal possession, along with supporting documentation, such as copies of operative reports, pathology reports, discharge summaries, and preceptor evaluations. This is especially important for those privileges which may be difficult to obtain, such as ICU/CCU privileges, endoscopies, deliveries, and surgical procedures/line placements. What is not learned with proficiency during residency is more difficult to become proficient in once the resident has finished formal training.

Medical Students

Medical students frequently participate in third-year or fourth-year clerkships in Family Medicine or first or second-year observerships at the FHCC. These students from a variety of university medical schools have specific goals and objectives to be learned during their clerkships.

During each session in the office, students will always be assigned to a resident or preceptor. Depending on the level of training, students should be allowed to participate in the diagnosis and management of FHCC patients. They are also expected to participate in conferences and other community activities.

The residents and faculty are responsible for completing evaluation forms of each student's performance and attitudes during the rotation in the FHCC. One form is for abbreviated assessment of the student's daily encounters with patients. A second, more detailed form should be completed near the end of the rotation, and will be a summary of the student's progress and performance. The curricular documentation is available from the Administrative and Research Assistant.

Medical students will be assigned on-call time. It is the resident's responsibility to call the student for any admissions prior to midnight. After midnight, the student should be contacted by phone for interesting cases only.

Please remember that the medical students provide a tremendous recruitment opportunity for our residency program.

Areas of Special Interest

All second-year and third-year residents are encouraged to participate in an area of special interest, such as sports medicine, advanced obstetrics or geriatrics, community health, or clinical research. Residents are expected to identify this area and discuss plans with their faculty advisor. Residents may then designate one office session per month during which they will be freed from office responsibilities in order

to explore this area of clinical interest. This absence from the FHCC must be cleared with the Curriculum Coordinator at least two months in advance.

Research/Scholarly Activity

Each resident is required to complete a scholarly activity project per current policy.

These activities are to be discussed with the faculty advisor.

Resident Computers

Computers intended for resident use are located in the FHCC. The primary function is to allow residents access to EBSCO literature searching, the Physician View Lab System (NetAccess), New Innovations, and computerized patient management problems. They may also be used for personal word processing, spreadsheet applications, or other personal use.

Computer policies follow:

- Assistance is available from faculty and the residency administrative staff.
- Do not enter any personal files onto the hard disk, or modify the autoexec.bat file or any other hard disk file.
- Code numbers and passwords for database access are meant for official residency use only. Any personal, non-residency related use of these codes is unethical conduct.
- Please do not enter any programs on the desktop other than those you have been instructed to enter. Entering into unfamiliar programs can cause serious computer problems.

Residency Education Requirements

All requirements of the ACGME-RRC are adhered to at the FHCC. Specific regulations can be obtained in the appropriate RRC publications.

Osteopathic residents during their PGY1 year (AOA dual-accredited internship) have the following requirements in addition to their assigned clinical rotations:

- They are required to see continuity patients specifically for Osteopathic Manipulation in the monthly Osteopathic Manipulative Medicine (OMM) Clinic held in the FHCC;
- They are required to attend at least 60% of monthly lectures specifically on topics related to Osteopathic Manipulative Medicine.

Conferences

Noon Conferences

These conferences are coordinated by the FMRP specifically for residency purposes. The curriculum covers topics relevant to in-patient and out-patient primary care. Emphasis is placed on commonly seen diseases and practical management. Resident involvement, informal group interaction, case presentations, and questions are encouraged. The Monday and Tuesday conferences generally involve Internal Medicine residents also. Thursday and Friday conferences generally deal with Family Medicine issues. Journal Club and other recurring series may occur here.

Friday 0800 Conference

This conference is organized by the Department of Family and Community Medicine, and, accordingly, is geared toward the office practitioner. Because family physicians are largely out-patient based, these are extremely useful conferences for residents.

Medical Grand Rounds

Two Wednesday mornings a month from 0730 to 0830 are reserved for Grand Rounds, coordinated through the Department of Medicine with input from other departments. Residents are expected to attend unless a specific rotation or FHCC responsibilities preclude this.

Morning Report
Morning report is held Monday through Thursday from 0730 to 0800. It is a required meeting for all residents unless otherwise excused. The format may include discussion of patients admitted overnight, review of patients on the in-patient service, resident presentations, topics of interest, and “Team Time” where residents participate in QI activities with their teams.

Wednesday AM Conference
Wednesday mornings are protected teaching time. Activities scheduled may include procedure workshops, Balint group, etc.

Wednesday Noon Meetings
The Resident/Faculty meeting is held monthly, usually the third Wednesday of the month from 1200 to1300 hours.

On the second and fourth Wednesdays at noon, residents meet with the Chief Resident(s) to discuss issues of mutual interest.

The first Wednesday will be reserved for nursing home rounds and geriatrics education.

Other Conferences and Meetings
The resident is encouraged to attend other departmental conferences whenever feasible. A weekly list is available.

Occasionally, additional conferences, workshops, or residency-related educational functions will be held. Residents will be informed in advance whether these are optional or mandatory.

Conferences are offered for the educational benefit of the residents. Attendance will be monitored. The standards are 70% attendance at conferences and 70% attendance at morning report.

Power Point presentations and other materials from didactics are available for all in the department on the Q drive in the “Presentations for Self-Study” folder.

Videotaping and Live Reviews

Some exam rooms in the FHCC are equipped with video cameras or one-way glass windows. This makes it possible to videotape visits and for preceptors to observe residents on the monitors in the Behavioral Medicine room. In this way, residents receive supervised practice and coaching in specialized skills for rapport building, history taking, physical exam, medication instruction, and patient education.

Preceptors may observe visits at any time. Patients will always be notified that a faculty would like to observe the resident — not the patient — and will be asked for consent. Similarly, if a visit is to be taped, the patient’s consent will be obtained.

Each resident will be videotaped at least twice each year. The resident, with one or two faculty members, will review the tape. The review is an opportunity for residents to objectively view themselves and to receive constructive feedback and guidance. In addition to observations and verbal feedback provided during the review, residents will receive written feedback as well.

Video reviews will be incorporated into specific rotations.

Other Residency Issues

Nursing Home
The objective of this experience is to develop skill in managing patients longitudinally in extended care facilities (ECF). Second-year and third-year residents are assigned up to four nursing home patients at a time.

Nursing home rounds are made every month with faculty supervision. Geriatric conferences are held monthly. Patients are seen sooner if necessary. All patients must be discussed with the faculty team leader.

All ECFs are governed by federal and state regulations. Failure on the part of the physician to comply with timely visits and adequate documentation may jeopardize the license of the facility. All deficiencies must be corrected immediately.

Admission Procedures

- The physician will be contacted for verbal verification of admission orders when the patient arrives.
- The patient must be seen within 48 hours of admission. At that visit, the physician should sign the orders, fill out the H&P, and write a progress note, including all pertinent diagnoses. There should be a diagnosis for each routine medication.
- Each new admission must have an H&P, and usually a CBC, UA, and CXR within the last 30 days. Otherwise, they must be done within two days after admission. It is also advised that the patient's Pneumovax status be documented and PPD be placed (if not contraindicated).
- Upon admission to the ECF, the resident should discuss with the patient and family, as appropriate, orders regarding the patient's wishes for resuscitation, re-hospitalization, artificial feeding, and so on. These discussions should be documented carefully in the record.

Monthly Visits

- The physician is required to visit each patient every 30 days if skilled care or intermediate care.
- At each visit, a progress note should be written in S-O-A-P format. This note should include a response to recommendations from the pharmacist.
- All order sheets and reports of diagnostic studies must be signed and dated. New and changed orders should be done on telephone order forms, NOT on the computerized order sheets.
- If new diagnoses should be added to the problem list (e.g., MI 6/02), please indicate on a verbal order sheet.

Other Requirements

- Annual PE: the annual examination usually includes a PE, CBC, UA, and CXR or PPD. Patients on certain routine medications should also have blood levels checked periodically, e.g., theophylline, digoxin, and potassium.
- Charges are the responsibility of the faculty supervisor.
- Verbal orders must be signed and returned as soon as possible. The order should be dated the date it is signed.
- When notified that a patient has died, the resident may either pronounce the patient and complete the paperwork at that time or give the nurse permission to pronounce the patient. If the nurse pronounces the patient, the nurse will notify the coroner's office. The death certificate will be brought to the FHCC by funeral home personnel where a fully licensed physician should fill out the diagnoses and sign as certifying physician.
- Whenever a patient is discharged or dies, the medical records librarian will organize the chart. The Discharge Summary and all needed signatures should be completed within two weeks after notification that the chart is ready.

Home Visits

Each resident is required to make and document at least two home visits on continuity patients at some time throughout residency training.

Out-Patient Clinic: Dermatology

Dermatology Clinic is held on the first and third Wednesday afternoon of each month. Residents are assigned to Dermatology Clinic on a rotating basis. This assignment list is a list of residents who MUST attend. All other residents are welcome and encouraged to attend.

RESIDENTS ARE REQUIRED TO "COVER" THEIR ASSIGNED CLINICS BY FINDING ANOTHER RESIDENT TO FILL IN FOR TIME THEY MISS DUE TO VACATION, MEETINGS, ILLNESS, OR OTHER ABSENCES. Anyone who misses a clinic without making prior coverage arrangements will be required to make up two clinics for every one missed. Because these are busy clinics, lateness cannot be tolerated.

Out-Patient Clinic: GI
GI Clinic is held on the second, third and fourth Monday morning of each month. Residents are assigned to GI Clinic on a rotating basis. This assignment list is a list of residents who MUST attend. All other residents are welcome and encouraged to attend.

RESIDENTS ARE REQUIRED TO "COVER" THEIR ASSIGNED CLINICS BY FINDING ANOTHER RESIDENT TO FILL IN FOR TIME THEY MISS DUE TO VACATION, MEETINGS, ILLNESS, OR OTHER ABSENCES. Anyone who misses a clinic without making prior coverage arrangements will be required to make up two clinics for every one missed.

Because these are busy clinics, lateness cannot be tolerated.

Advanced Directives/DNR Orders/Pronouncement of Death

- Whenever admitted to the hospital, a patient must be asked, by law, if he or she has advanced directives or desires information on the subject. The admitting nurse and physician must sign the order sheet as confirmation.
- "DNR" status will be addressed and documented per current hospital policies.
- Any resident can pronounce a patient and sign the death certificate as the pronouncing physician. Fill out only the section under pronouncing physician. Although anyone with an unrestricted Pennsylvania license can sign as certifying physician, in general, the attending physician should sign as the certifying physician. Residents should always discuss the certificate with the attending prior to completing cause of death sections.

    If a patient dies in a nursing home or at home, even if the death is expected, either the physician must go and pronounce the patient, or the Coroner's office must be notified. If a death certificate is not signed immediately, it will be brought to the FHCC office if the patient died outside the hospital or to the Medical Records Department if the patient was hospitalized at the time. The funeral director is responsible for completing the remainder of the certificate, and forwarding it to the proper agency.

    The certificate should never be given to the family or to an insurance company.
- If the physician feels that an autopsy is indicated, — and the death is not a coroner's case — the pathologists of TRHMC will perform the autopsy free of charge. It is imperative that the permission form be signed by the family before notifying the pathologist. Physicians should discuss the case with the pathologist prior to speaking with the family.
- At the time of death, a note should be placed in the patient's chart indicating whether an autopsy was requested and whether the patient was a candidate for organ/tissue donation.
- In general, when a patient dies, family members should be notified by the attending physician unless the on call or continuity resident has an especially close relationship with the family. Circumstances should first always be discussed with the attending physician.

Library Services
The medical library on E-Ground is open from 0800 to 1700 hours.

Residents may access the library at all other times through use of their hospital ID badges once they have been electronically coded to this access. Residents are not to loan their ID badges to anyone.

Reference services are available from the Medical Librarian during working hours. There are approximately 200 journals and serials available along with the latest editions of standard medical texts.

Reference materials may be signed out for two days, and other materials may be signed out for two weeks. Renewals may be made by telephone or in person. Failure to return materials on a timely basis may result in fines and/or loss of library privileges.

There is also a library in the FHCC. These books CANNOT be removed from the FHCC.

Policy for Selection of Residents
See TRHMC Resident Manual.

Evaluations

Evaluation is valuable and necessary to provide feedback to residents, faculty, and external agencies. Such feedback can enhance planning on both personal and program levels.

In-Training Exam
This exam is given yearly in October or November. All residents are required to take this exam as it is the prototype of the American Board of Family Medicine Certification Exam. Residents will be notified in advance of the date and time of the exam.

Rotation Evaluations
Each attending physician to whom the resident is assigned fills out an ACGME competency-based evaluation form in New Innovations. As compiled, these forms will be reviewed with the individual resident as a means of feedback.

Resident Evaluations of Preceptors and Faculty
Each resident completes an evaluation form in New Innovations after each rotation to evaluate the preceptor and the overall rotation. Family Medicine faculty are also evaluated at least annually by residents in New Innovations.

These evaluations will be reviewed at resident conference meetings as a means of improving the program. Residents should promptly fill out these forms using New Innovations.

360˚ Evaluations
The FHCC clinical and clerical staff will complete a semi-annual evaluation on each resident.

Patient Satisfaction Surveys
New patients at the FHCC are asked to complete a survey to provide feedback on their impressions of the center's operations and staff, including their physician. In addition, patients are given the opportunity to complete surveys, approximately annually, reflecting their perceptions of FHCC physicians.

Advisory Reviews
At least twice a year, the faculty advisor formally meets with each resident to review rotation evaluations received for the previous time period, performance in the FHCC, conference attendance, and all other pertinent issues.

Program Director Evaluation of Faculty
Evaluation of faculty is the responsibility of the Program Director, who may seek input from a variety of sources, including residents and staff.

Disciplinary Measures for Residents

See TRHMC Resident Manual.

If any discrepancies exist between the Family Medicine manual and TRHMC Resident Manual, TRHMC Manual materials will be followed.

Resident Responsibilities
The "Essentials of Accredited Residencies" of the ACGME lists the following responsibilities of residents:

- To develop a personal program of self-study and professional growth with guidance from the teaching staff;
- To participate in safe, effective, and compassionate patient care under supervision, commensurate with their level of advancement and responsibility;
- To participate fully in the educational activities of their program, and, as required, assume responsibility for teaching and supervising other residents and students;
- To participate in institutional programs and activities involving the Medical Staff and adhere to established practices, procedures, and policies of the institutions;

- To participate in institutional committees and councils, especially those that relate to patient care review activities;
- To apply cost containment measures in the provision of patient care.

Not included in ACGME essentials but also considered essential to satisfactory resident performance are the following:

- Attendance on all rotations unless otherwise excused;
- Being on time for office hours and scheduled events unless otherwise excused;
- Reliability of service to patients and families;
- Responsive attitude toward assigned duties;
- Maintenance of rapport toward other professionals and staff within the hospital and FHCC;
- Constructive use of feedback from evaluations and counseling.

Probation
Consistent failure to meet responsibilities in the above areas will be grounds for placement on probation. The conditions of probation will be outlined in writing at the time the probation begins.

There are two types of probation which exist in the FMRP. The first is “line” probation which can be exercised by the Program Director for violation of performance duties outlined in this section.

The second type of probation is “academic” probation which can be exercised by the Program Director for academic or clinical deficiencies.

However, every effort will first be made to identify residents who are having difficulty and address issues prior to disciplinary action being taken (see appropriate policy).

Both types of probation require the Program Director, in conjunction with the faculty, to document in writing the remedial actions to be taken by the resident on probation.

Probationary periods may vary in length depending on the type of problem requiring remediation. There may be consequences to a resident’s career, licensing, and credentialing if they are placed on probation.

Suspension and Termination
See TRHMC Residency Manual

Selected Requirements of the American Board of Family Medicine

Limitation on Absence
Family Medicine residents must have a deep feeling of personal responsibility for the continuing, comprehensive care of the patient. Outside activities that interfere with the proper discharge of this responsibility should not be permitted.

Residents are expected to perform their duties as resident physicians for a minimum period of 11 months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed one month per calendar year. One month is interpreted as 21 calendar days.

Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the limitation on absences, but should not exceed five days annually.

Third-year residents are allowed three personal days to interview for prospective jobs in addition to their regular vacation and educational leave.

Time off from the residency in excess of one month within the academic year (first, second, or third year) must be made up before the resident advances to the next training level. The time must be added to the projected date of completion of the required 36 months of training.

In cases where a resident leaves the program for whatever reason and such absence EXCEEDS one month, the Program Director must inform the American Board of Family Medicine in writing of the resident's departure and return. Absences which EXCEED three months violate the continuity of care requirement. Thus, the Program Director may utilize various criteria to judge the point at which the resident may re-enter the program provided that:

- The resident NOT be readmitted to the program at a level beyond that which was attained at the time of previous departure;
- Approval of the Board similar to that for any admission at an advanced level is obtained prior to reentry;
- And requests for authorization for readmission provide a detailed description of the evaluation used to determine the level at which the resident is to be readmitted.

Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of second year and first month of third year in sequence). A resident does not have the option of reducing the total time required for the residency (36 calendar months) by forgoing vacation time.

"Away rotations" must be approved by the Program Director, and may not exceed two months during the second year and two months during the third year. An "away rotation" form, which lists the site, preceptor, dates, and goals and objectives, must be submitted prior to approval. This form is to be submitted as early as possible but at least three months prior to the rotation. International experiences are governed by the hospital's International Rotations policy.

The Board recognizes that vacation/leave policy varies with programs and is the prerogative of the Program Director so long as it does not exceed the Board's time restriction.

Deadline for Satisfactory Completion of Residency
Residents who are expected to complete training by June 30 are automatically provided the application link for the April certification examination. Residents who are expected to complete training between July 1 and October 31 may be declared eligible to apply for the April examination based on a recommendation from their residency program director. Residents who are expected to complete after October 31 and before December 31 will be permitted to apply for the November exam.

Reference: American Board of Family Medicine Requirements for Certification and Institutional Requirements and Program Requirements for Residency Education in Family Medicine

Policy for Resident Promotion and Graduation/Criteria for Advancement

All residents must demonstrate reasonable skills in the following areas. The second and third years of residency require many abilities that are more complex than that of the first-year resident. Some of these are:

- Multi-tasking (patient care)
- Independence (systems-based practice, responsibility)
- Sound clinical judgment (patient care, professionalism, medical knowledge)
- Ability to interact professionally with other attendings, patients, and ancillary staff (interpersonal and communication skills, respect, compassion, ethical principles)
- Ability to lead the clinical team (systems-based practice management, interdisciplinary approach to care)
- Prioritizing (professionalism, patient care)
- Working efficiently and expeditiously (patient care)

In order to assure that residents are ready for these responsibilities, they will be required to:

- Score a passing grade on all licensure exams required for a given level of training.
- Score no less than the lowest 10% on the in-training examination in two areas (patient care, medical knowledge)
    - Scoring less than 10% in any one area will require remediation in that area tailored to the individual resident's needs in discussion with his/her advisor. Examples of such a remediation program would be studying the Core Content Review.
    - If, in that given area, the resident scores less than 30% on the subsequent in-training examination, the applicable rotation will be repeated (medical knowledge).
- Pass all of his/her rotations (professionalism, systems-based care, medical knowledge).
- Satisfactorily complete the required days and/or hours of all required and elective rotations as established by the ACGME, the ABFM, AOA, and TRHMC's FMRP.
- Achieve satisfactory performance during each and every completed rotation as indicated through the evaluations completed by the appropriate preceptors/course evaluators. Any residents receiving an unsatisfactory final evaluation during any rotation (required or elective) will be required to complete a remedial assignment as determined by the course preceptor and the faculty of the FMRP. Only after satisfactory completion of all remediation, may a resident be promoted to a level of higher responsibility. Remediation may include repeating a rotation in place of elective time.
- Comply with "continuity of care" requirements for resident education in Family Medicine.
- Document procedural skills performed and requested clinical experiences during residency training.
- Comply with terms of the yearly resident's contract.
- Comply with policies and procedures established by TRHMC.
- Satisfactorily complete all medical records and related patient care responsibilities.
- Comply with the normal and ethical standards of care established by TRHMC and the FMRP.
- Perform well (meet competencies) on a standardized patient care test, such as CES (medical knowledge and all other competencies).
- Have the confidence of the faculty in his/her abilities.
    - The faculty recognizes that, as part of the learning process, residents will make errors of various degrees. If a resident has an established pattern of making serious errors and this pattern is not significantly improved upon, then the faculty may not advance the resident to a higher level of independence and responsibility until safe residency performance has been demonstrated.

The following list of errors gives a sense of the severity of different mistakes that may occur:

- Error of minimal clinical impact (e.g., wrong date)
- Error of potential serious impact (e.g., failure to pick up red flags in history/physical)
- Error that violates HIPAA regulations or major omission of obvious clinical finding (e.g., 3/6 heart murmur)
- Error of high potential to adversely harm patient if not caught by other personnel (e.g., wrong medication)
- Error that may inflict harm to the patient and be reportable under hospital policy

The resident should not raise significant issues in regard to professionalism, as gauged by the faculty or staff that would prevent him/her from working in a professional, collegial manner with other healthcare professionals in the institution, or that would prevent him/her from managing patients safely (e.g. untreated substance abuse).

Professional Matters

Licensure

Training Licenses
In order to participate in this residency program, or any graduate medical education program in Pennsylvania, during the PGY-1, PGY-2, and PGY-3 years, the resident must have a graduate license with a number in the format of MT-000000 or OT-000000 from the Commonwealth of Pennsylvania.

- In order to advance from one year to the next in the residency program, documentation of training requirements must be on file in Harrisburg.

- In order to participate in graduate medical training at a second-year level (PGY2), a resident must first have passed Parts 1 and 2 (CK and CS) of the United States Medical Licensing Examination (USMLE) or a similar examination acceptable to the Pennsylvania State Board of Medicine.

- To participate in graduate medical training at a third-year level or higher, a resident must pass all three parts of the United States Medical Licensing Examination (USMLE) or a licensing examination acceptable to the Pennsylvania State Board of Medicine.

- If a resident has not met the criteria to advance to the next year's level of training, he/she will continue with the duties and responsibilities of the current year of training. The resident must, however, complete all requirements at the earliest possible date. Total residency training cannot exceed 48 months.

For more information, contact the Program Coordinator to review the Rules and Regulations of the State Board of Medicine.

Unrestricted Licenses

- Accredited Allopathic Medical Schools
- At the end of the PGY-2 year (no sooner than 15 days prior to completion of the PGY-2 year), the resident may apply for an unrestricted license, provided he/she has passed all parts of the United States Medical Licensing Examination (USMLE). This license number will be in the format of MD-000000-L or E.
  NOTE: If a resident did additional training elsewhere at the PGY-1 level, he/she must still complete the PGY-2 year before applying for the unrestricted license.
- Unaccredited Allopathic Medical Schools (IMGs). The resident must complete three years of approved graduate training, one each at the PGY-1, PGY-2, and PGY-3, before applying for an unrestricted license. The resident must also pass all parts of the United States Medical Licensing Examination (USMLE).
- Osteopathic Medical Schools. The Osteopathic Practical component is included in COMLEX-USA Level 2-PE exam as of 2005. It is taken along with the written section for the COMLEX Level 2 exam. This exam is generally taken in medical school, and the COMLEX Level 3 exam is taken at the end of the PGY-1 year. For more information, residents can refer to the National Board of Osteopathic Medical Examiners website at:
  www.nbome.org/examiners.htm

DEA Licenses
A resident may apply for a DEA number once he/she has applied for an unrestricted license.
If there are any questions, contact the Residency Coordinator OR the following agencies:

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649
Telephone: 717-783-1400

State Board of Osteopathic Medicine
PO Box 2649
Harrisburg, PA 17105-2649
Telephone: 717-783-4858

Moonlighting

- Please refer to Guidelines in TRHMC Residents' Manual.

FAMILY HEALTH CARE CENTER
FAMILY MEDICINE RESIDENCY PROGRAM

Staff Directory
2012-2013

D. Michael Baxter, MD	Chair, Department of Family and Community Medicine
Lee Radosh, MD	Director, Family Medicine Residency Program
Deborah Bevvino, PhD, CRNP	Faculty Associate
Mary Brigandi, DO	Faculty Associate
Nipa Doshi, MD	Faculty Associate
William Lovett, MD	Faculty Associate
Thomas Raff, MD	Faculty Associate
Jane Weida	Faculty Associate
Louis Mancano, MD	Part-time Faculty
Nabil Muallem, MD	Part-time Faculty
Deloris Carlson, RN	Nurse Manager
Cindy Harris	Administrative and Research Assistant
Donna Lonaberger	Residency Secretary
Rose Reeser	Curriculum and Education Coordinator
Nancy Schearer	Residency Coordinator
Susan Sullivan	Practice Manager

Nursing Staff:
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Sheila Faust, LPN
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Lori Kuhn, RN
Nancy Martinez-King, RN
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Linda Brown
Diane Crosby
Evette Diaby
Lina Hernandez
Carolyn Kaufman
Yadira Sotelo
Yvonne Weaver
Elizabeth Weidner
Cynthia Weinhold
Peggy Wise
Patti Zook