SUMMA HEALTH SYSTEM

Internal Medicine Center Resident Handbook

2019

Internal Medicine Center

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FIRST THINGS FIRST/FAQ

- Residents should check their EPIC **Provider Calendar** (EPIC/scheduling/provider calendar) to see which days they are assigned IMC
- When assigned an IMC session, residents are expected to be on site in the IMC from **8:00-11:30 am** for morning sessions and **1:00-4:30 pm** for afternoon sessions. Senior patient appointments start at 7:50 and 12:50. Residents should stay until they discharge their final patient of the session.
- All schedule changes/requests should go to the **chief resident**.
- **Interns are required to staff every patient with a faculty attending**.
- Messages, labs, and reports should be checked **daily** unless the resident is on an excused rotation.
- Residents should ensure the coverage of their patients before signing out for any period longer than a weekend.

INTRODUCTION

Background

Training in the care of ambulatory patients is an essential part of the Internal Medicine residency. Since 1974, our program has emphasized training of all residents in the provision of longitudinal, preventive, and comprehensive care. The program includes experiences that assure that each trainee sees a broad range of medical problems and acquires skills necessary to practice internal medicine at a high level of expertise.

Overview

Internal medicine residents receive their ambulatory experiences in the Internal Medicine Center (IMC) and in community-based private practices (CBT). IMC is a continuity clinic and serves as the residents' outpatient office practice for the duration of their residency. CBT is a one year experience which gives residents the opportunity to work one-on-one with an internist at their private office.

In the IMC, residents are the primary care physicians for their own panel of patients; therefore, they are given the responsibility of evaluating and managing their own patients, directing their inpatient care, and serving as the primary point of referral to other healthcare providers. This experience reinforces the professional behaviors required in modern outpatient medicine, supervised by on-site faculty.

Community Based Teaching (CBT) supplements the ambulatory care program by providing experience in off-site outpatient practices. Each second year resident has the option to work with an internist who has a reputation for teaching ability, quality patient care, and managing a successful office practice. CBT gives residents an opportunity to see what office practice is like outside of the hospital.

Ambulatory training goals:

- Master techniques of efficient interviewing and physical examination
- Develop procedural skills pertinent to ambulatory care

- Learn the natural history of disease, management of acute and chronic medical problems, and assessment of disability
- Learn to prioritize problems in developing care plans
- Communicate health promotion, disease prevention, and lifestyle intervention
- Develop skills as an accessible counselor, coordinator, and patient advocate
- Participate in care teams and identify quality improvement goals
- Master professional behaviors including: managing coverage, patient phone calls, document management, patient and staff communication
- Master medical chart documentation
- Master outpatient consult skills, including pre-operative assessments

Format of ambulatory medicine experience:

- PGY-1 residents: one half day per week in the IMC (up to 6 patients per half day)
    - 1 assigned morning per week during elective rotations
    - 1 afternoon per week during med teams
    - Every Friday morning during ER rotation
- PGY-2 residents: one half day per week in the IMC and one half day per week at CBT (up to 7 patients per half day). Residents who are not in CBT will have two half days in the IMC per week.
    - 1 assigned morning per week during elective rotations
    - 1 afternoon per week during med teams
- PGY-3 residents: two half days in the IMC (up to 8 patients per half day)
    - 2 assigned mornings per week during elective rotations
    - 1 assigned afternoons per week during med teams
    - 1 session per month dropped for long term care (LTC)
- Transitional/preliminary residents:
    - 1 afternoon per week during med teams (up to 4 hospital and ER follow-ups only)
- IMC rotation: 6-8 half days per week
- No IMC sessions are scheduled for residents on ICU or CCU

Over the course of three years, residents establish their own panel of approximately 200 primary care patients. New post-hospital patients continue their care in the IMC with the resident who managed their hospital care, linking inpatient and outpatient services. Ideally, hospitalized IMC patients are followed by their resident primary care physician.

Preceptors (aka attendings, supervisors, faculty)

Faculty physicians staff patients with the residents while the patients are still in the examination room. They may also see patients with the residents and use their observations of residents' interactions as part of their evaluation process.

The preceptor's role is guiding patient care and resident learning. Residents present patients to staffing preceptors, but are encouraged to develop their own conclusions and management plans. Preceptors will examine and interview patients to verify or clarify findings, teach techniques, model communication skills, or assist in determining the best course of treatment. Didactic sessions three times a week address common primary care issues and current evidence-based treatment.

Supervision:

- All residents present every case to a preceptor
- All intern/patient encounters for the first 6 months of training will have direct supervision of a preceptor
- Every patient at a level 4 or 5 complexity requires direct observation by a preceptor.
- Attending physician preceptors cosign all resident charts.
- Each categorical medicine resident has an extensive formal chart review and medication chart review once a year. Charts are reviewed by faculty physicians on a regular basis as part of the supervision process.
- Faculty physicians are available to assist with all problems/questions related to patient care and the residency.

Resident responsibilities:

Resident responsibilities in the IMC reflect the demands of a traditional office practice adapted to a supervised setting. Residents gain experience in clinical care, professional behavior, cross-coverage, and practice management by acting as primary care physicians for their own panel of patients. Preceptors provide the supervision, experience and assistance as required by each resident. As this is also a learning center, residents have the unique opportunity to actively participate in quality improvement and develop innovations in new models of patient care.

The following are basic expectations for residents in the outpatient setting. Residents will:

- Review their schedule weekly to check for conflicts
- Report to the office promptly for all sessions and be available by pager daily (7:30-5 pm)
- Participate in IMC didactic sessions during their IMC rotation (Tuesdays, Wednesdays, and Thursdays, 8:00-8:30 am)
- Participate in the daily huddle at 8:30 am when scheduled for morning clinic
- Provide all aspects of primary care including:
    - reviewing patient charts ahead of appointment times
    - routine health maintenance and preventive care
    - management of medical problems, including acute care and assisting patient triage
    - reviewing all test results and communicating findings with patients
    - case managing and coordinating care given by subspecialists and other providers
- Master professional behaviors including:
    - clear documentation of all clinical encounters, refills, and telephone consultations
    - prompt completion of notes and billing for each patient visit (within 24 hours)
    - addressing messages and lab results daily
    - providing coverage of work colleagues
- Coordinate changes in their IMC schedule with the Chief Resident and the IMC manager
- Ask questions and ask for help when needed. Learning to communicate and work with all members of the team is key to a physician's success in an office practice.

The IMC Staff

The IMC staff includes administrative staff, clerical staff, and clinical staff. Their roles (as it pertains to residents) are described briefly below.

Administrative staff:

Director: Michael Rich MD

Directs the IMC and manages provider-related issues.

Practice manager: Lisa Geer

Directly supervises the clerical staff, oversees the scheduling, handles all business aspects of the IMC. All office concerns should be directed to the practice manager.

Clinical coordinator: Dave Conrad

Oversees the clinical staff. All clinical issues which are not provider-related should be brought to the clinical coordinator.

Resident Schedule coordinator: CJ Deem

Liaison between residency program scheduling and IMC scheduling.

Schedules most of the post-hospital and transitional care visits.

Managing directors: Stephanie Tan MD, Michelle Cudnik PharmD, Stephanie Zaugg DO

Members of the leadership team with assorted responsibilities related to the day-to-day operation of the IMC.

Clerical staff and their responsibilities:

Practice manager: Lisa Geer

Oversees all aspects of the office.

Serves as the primary resource for questions regarding insurance, coding, scheduling, office processes, and document management.

Medical office associates (aka secretaries, MOAs):

Registration

Appointment scheduling

Incoming phone calls

Message sorting and routing

Document preparation, including scanning and faxing

Billing: Wendy Myers

Reviews documentation to submit for compensation.

Social worker: Elizabeth Puckett

Screens patients for nonmedical issues affecting health and care.

Assists patients who have difficulty accessing medical care due to social circumstances, limited resources, and low health literacy. Assesses possible resources for patient and assists in obtaining them.

QI Program Coordinator: Rose Penix

Provides practice performance information

Assists with QI project direction and management

Clinical staff and their responsibilities:

Medical assistants (aka MAs):

Work directly with the physicians and the patients

Manage patient flow through the clinic

Rooming and initial intake (vitals, chief complaint, vaccine consent forms)

Flu shots

Assists providers with physical exams

Perform most POC testing (EKG, HBa1c, hemoccult, UA, preg test)

Nurses:

Nurse visits (BP checks, suture removal, ear irrigation)

Walk-in triage, phone triage and clinical phone calls
Pyxis access
Vaccinations
Patient care which requires ongoing assessment (IVs, aerosols, medication administration)
Assist care coordination

Lab phlebotomist: Jillian Johnson

Referral coordinator:
Schedules tests and referrals
Communicates between offices to facilitate the completion of authorizations and tests

Behavioral Health specialist: Stephanie Petersen LISW
Screens for mental health disorders
On the spot counseling
Assists in obtaining psychological services and coordinating care

Pharmacist: Michelle Cudnik PharmD
All aspects of medication education from provider to patient
Medication reconciliation and resident pharmacy chart review
Investigate conflicting medication lists from multiple sources
Investigate drug interactions
Research assistance
Supervises pharmacy education

Nurse Practitioner: Maria Lorenzo

The office is divided loosely into two sides (A and B) to facilitate workflow. At least one MA is assigned per side and providers are generally assigned to one side for the session. Nurses work from a central location. A "triage nurse" is assigned to the phone and a "floor nurse" is assigned to assist with patients in the IMC. Cross-coverage between clinical duties is common when the clinic is busy.

Patient Appointment Schedule

The office schedule includes approximately 70 provider schedules, and is complicated by call coverage, rotations and time away. All providers should check their schedules for conflicts at least weekly and whenever changes in their own schedules are made (switching calls, vacations, interviews, etc).

All appointment units are 30 minutes long, but can be extended to 60 minutes for certain conditions (ex: communication difficulties, multiple services required, high complexity). If it is apparent that the patient requires a longer appointment time, make the request at the time of scheduling so enough time can be allotted.

All patients are asked to arrive at least 10 minutes early to complete registration prior to their appointment time. New patients are expected to bring in any medications they are currently being prescribed.

Late patients are patients who arrive more than 10 minutes past their scheduled appointment time. They are informed that they have missed their appointment and are offered a same day later appointment or rescheduled for another day. Any appointment given on the same day should allow enough time for the patient to be registered and in the room by the appointed time. An MOA should

ask a nurse to triage a late patient if the patient appears ill or complains of any potentially emergent problems (ie, high fever, chest pain, shortness of breath, dizziness).

Interpreting the daily schedule

The schedule view can be configured in multiple ways, so the IMC has a preferred template for the schedule which corresponds better with our needs. This is reviewed and customized with every new provider upon orientation. The text box below details how to format the schedule view.

To format the daily schedule view:

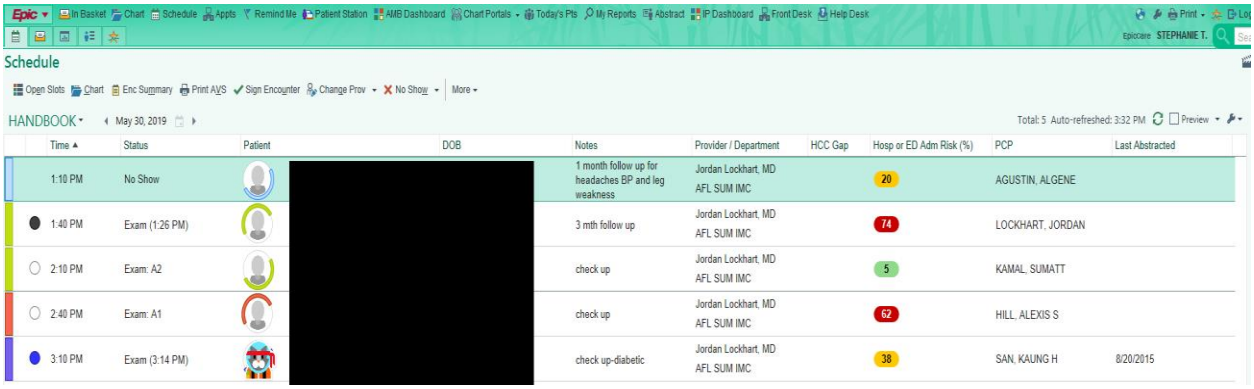
Click on My Schedule
Highlight your name
Click on the gears in the bar above the schedule lists

Remove:
- Status
- Controlled substance monitoring
- My chart
- Referring provider cred
- CSN

Add:
- Status (17306)
- PCP (17316)
- DOB (17341)
- HCC gap
- Hospital or ED adm risk (%)

Place in this order:
- Appt time
- Status (17306)
- Patient
- Age/sex
- DOB
- Notes
- Provider
- HCC gap
- Hospital or ED adm risk (%)
- PCP
- Last abstracted

Most of the schedule is self-explanatory except for HCC gap and status. The HCC gap pertains to certain patients who have a yearly documentation requirement which can be fulfilled on any visit in a given year. Most patients will not have anything listed in this column, but if they do, any preceptor will be able to assist in addressing this.



Status shows where the patient is in the IMC registration and rooming process:

Scheduled	the patient has an appointment
Arrived (time)	the patient has **completed registration** at the time listed
Exam (room #)	the patient is in the room
Exam (time)	(this was added in the last upgrade and no one knows what it means)
Comp (time)	patient's encounter is complete
Closed	patient's chart is closed
No Show	no show
Can	cancellation
LEFT	patient left after registration or rooming

(Note that "Arrived" does not capture the actual arrival time)

Colored circles on the left side of the schedule is an indicator of room status.

Green:	MA is rooming patient
White:	ready for provider or provider in room
Blue:	nursing orders
Red:	pharmacy review
Orange:	behavioral health (rarely used)
Black:	patient encounter complete

In addition to checking the daily schedule, the clinic providers should keep track of the **Expeditor** panel. These lighted panels are in the bullpen and in front of the MA station, and are used to show where patients are and give a general idea of what's going on in the room. **Providers should remember to press the white button outside of the room when going in to see the patient, and press it again to clear the light when discharging the patient.** Note that most of the lights correspond to the colored circles in the EPIC schedule.

EXPEDITOR LIGHTS	
Green light:	MA rooming
White light:	no blink—patient in room
	Rapid blink—see this patient next
	Slow blink—provider in the room
Blue light:	Nurse or nursing procedure
Yellow light:	Seldom used, but mostly to get attention for something specific
ALL LIGHTS ON:	it usually means that the room should not be used

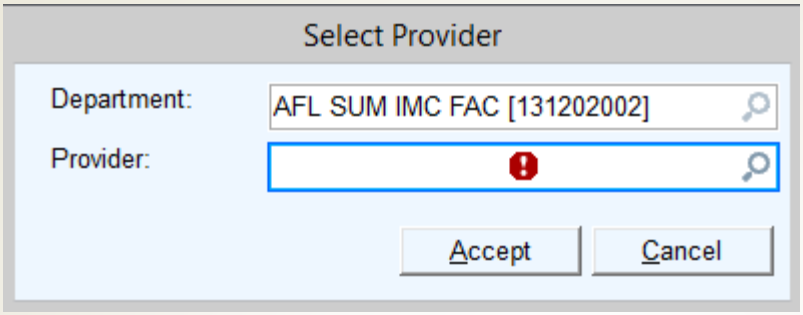
Provider schedule (or your personal schedule, not daily schedule)

Every provider in Carepath has a personal provider schedule that is updated as soon as changes are made. It should be part of every provider's daily routine to check this schedule for anticipated conflicts or errors. Providers can also use the provider schedule to look at other providers' schedules, check which appointments and days they have free, and see which patients are scheduled on any given day.

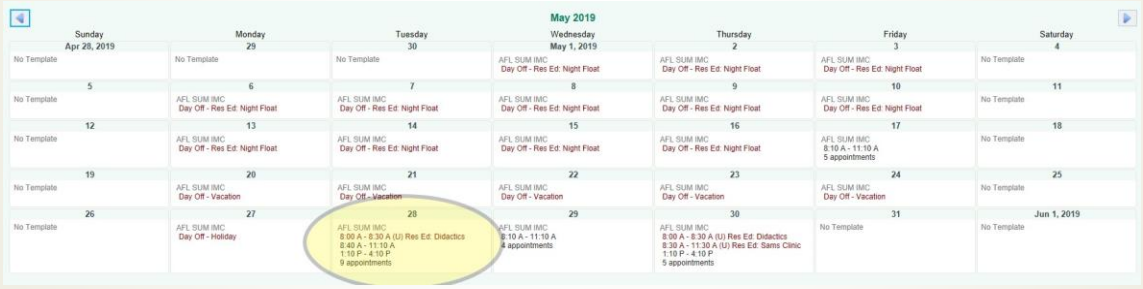
Schedule changes must be approved by the chief resident and will be directed to the IMC residency coordinator to change the EPIC schedule. Checking and maintaining your schedule is an important professional responsibility which is evaluated by your advisor and residency director.

EPIC HINT: CHECKING A PROVIDER'S SCHEDULE

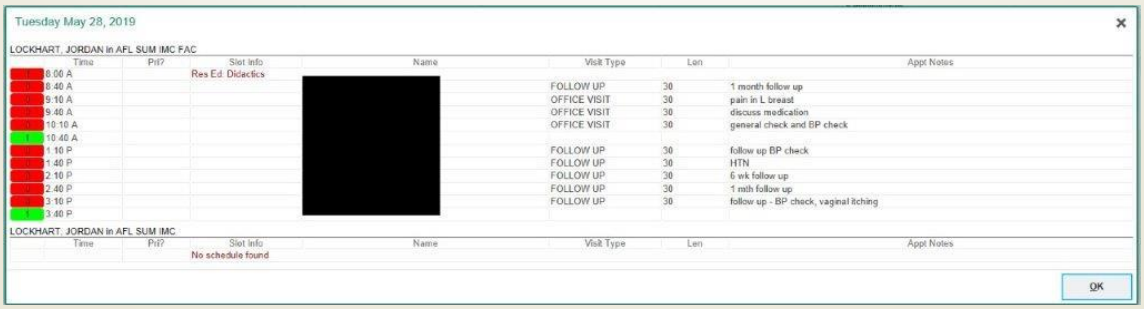
To check an individual provider's schedule, go to the Epic dropdown menu on the left side, select "scheduling" then "provider calendar." You will then see a box prompting you to put in the name of the provider.



Once you select the provider, you will see a calendar of the current month, but can easily click to future months. From this schedule, you will be able to see designated clinic times and the slots that have already been filled.



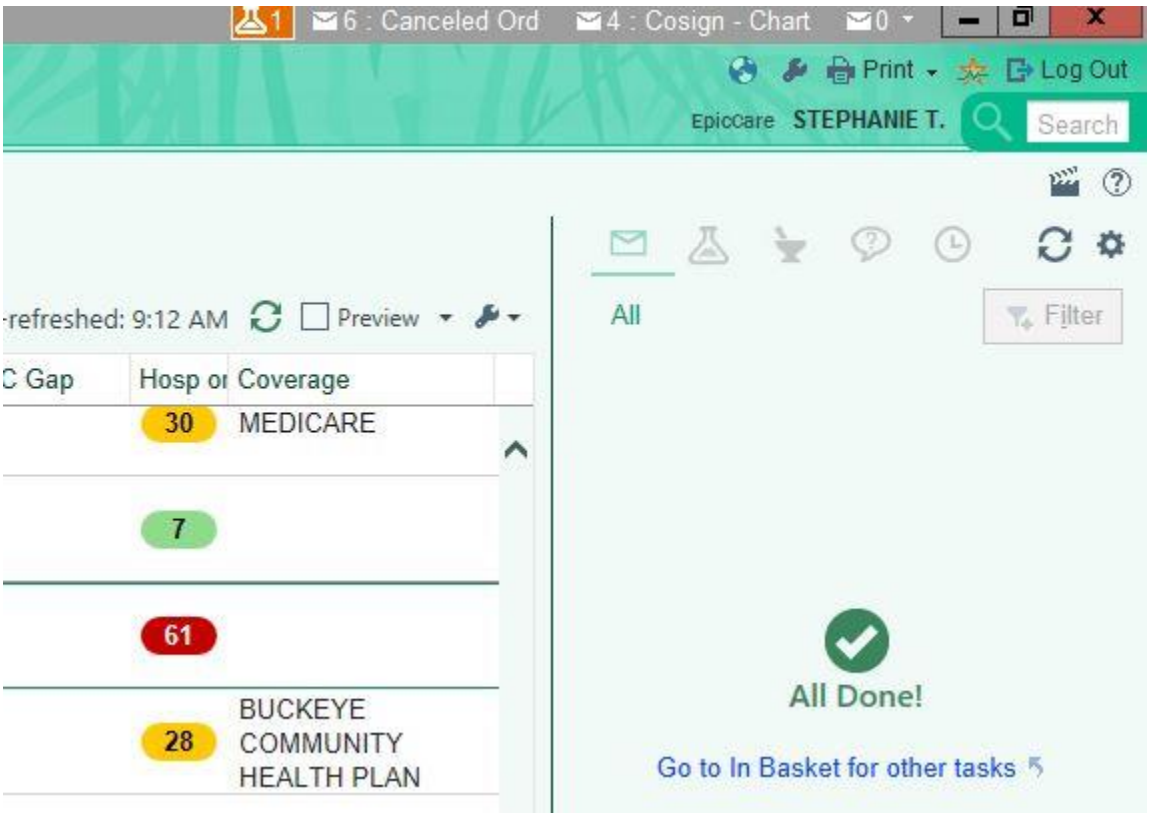
When you click on the individual day, you will be able to see which slots are open and which are filled, with brief details about the visit.



Tackling the In Basket

The In Basket can be accessed from the EPIC dropdown, the top toolbar, and the right side column where a mini form of the messages will show.

When you click on the In Basket, a drop down menu appears of all the things you have to do. It also shows work for cross coverage if you are assigned as a delegate, and you can access any work you've already done. Below, it shows tasks in the top toolbar but not in the right-side task list because I was cross-covering another doctor.



Keep an eye on the numbers on the right side of the top toolbar because that will show alerts (example above). The specific task will be listed with a number next to it indicating how many items are in the folder. Take care of prescription requests first because they are quick to do. Your next priority should be patient calls and advice requests because these have been screened by a nurse and are usually high acuity. Anything red, with "!", or bold should be prioritized. Most of these will be results that fall out of the reference range and are automatically flagged, but some will be high priority messages that need to be addressed quickly.

Please ask your preceptors how to manage your messages as you begin to get them. The material is too complicated to explain in text and is easier to demonstrate with actual examples.

Addressing tasks within your In Basket promptly is an expected and required professional behavior. With few exceptions, it should be cleared each business day.

IN BASKET TIPS

- Clear daily
- Do prescriptions first
- Do anything marked in red, **bold** or "**!**" next (these markings imply urgency)
- Do patient calls next
- Review results last unless marked as above
- Ask preceptors for help
- **Fax for misdirected results: 234-312-6461 (primarily for EPIC documents)**

Paper, more paper, and the occasional disk

There is also a box assigned to you for physical items such as medical charts on disk or paper, forms, prior authorizations, results and other paperwork. Most things that arrive to the IMC in paper form are scanned, labeled and directed to the appropriate provider electronically. The items that land in the physical inboxes are usually too unwieldy to handle electronically and require completion or sorting before scanning. The staff will distribute the paperwork based on the patient's PCP or the name on the paperwork. For many reasons, paperwork could be mistakenly assigned to you, so every reasonable attempt should be made to get it to the right person in a timely matter. Do not discard anything until it is properly handled.

First, check to see if this is an IMC patient or a pending IMC patient by looking up the patient in EPIC. Check the PCP and the encounters, past and pending. If this is not an IMC patient, we will send notice to the source that the fax was misdirected. Once it is sent back, it will be shredded. If the document requires urgent action (for example, you receive a biopsy result intended for another office and it shows a malignancy), please attempt to locate the correct physician and contact them about the results before sending it.

WHAT TO DO WITH "MYSTERY PAPERS"

1. Look up patient
2. Check PCP
3. Check past and pending encounters
4. If no previous or future IMC visits, bring to attending or practice manager

Second, the physical inbox has already been screened by the staff for "scanworthy" items. If it is an actual paper, then it generally will require a physical action before processing. Refer to the box below for tips. Detailed information about home health certifications will be provided by the practice manager at orientation. The entire staff is available to assist you with any questions about document handling.

WHAT TO DO WITH PAPER DOCUMENTS

1. **Prescriptions**: there should not be any of these. Let the practice manager or attending know if you receive any on paper.
2. **Orders requiring signature only**: if it can be entered as an EPIC order, open the patient chart and place it electronically before sending. Shred the paper copy once completed.
3. **Home Health new orders and recertifications**: review and complete them to the best of your ability. Sign, date, and place in Dr Rich's inbox for co-signature.
4. **Durable medical equipment and all orders requiring specific paperwork**: complete the paperwork, sign, date, write "fax then scan" on the first page, then place in TO BE FAXED box.
5. **FMLA, Disability**: complete the paperwork, sign, date, write "fax then scan" on the first page, then place in TO BE FAXED box. If you have reviewed something and require more time or additional information to complete the forms, place them in your personal "reviewed pending action) folder in your inbox.
6. **Information only**: (labs, medical records, consult notes, discharge summaries, etc) Carefully consider whether you need this information. We often receive hundreds of pages of junk. If it is not useful, put it in the secure shredding bin**. If you think it is useful, then sign and date it, label it, write "scan" on it and put in the scan box.** Please do not expect 100 pages of medical record to be useful because once it is scanned, it will be very hard to find what you want in the document. Take out the useful pages and have them scanned and labeled individually so they can be searched and retrieved. Shred anything that is not useful for the medical record (ask yourself if you or anyone else would ever want this information)
7. **Co-signatures:** If an attending co-signature is required, you should give the signed paperwork to your faculty advisor (part of your professionalism evaluation). If your faculty advisor is not on-site or the paperwork is urgent, you may ask a bullpen attending to cosign.

YOU WILL HAVE A FOLDER WITHIN YOUR BOX TO PLACE THINGS THAT WILL NEED ACTION THAT YOU CAN'T COMPLETE RIGHT AWAY.

Anything that has been reviewed should have your signature, date and action written on it.

THE PHYSICAL INBOX SHOULD BE CHECKED DAILY.

Seeing patients

This handbook will not teach you how to see patients. The expectation is that you will report to work on time and stay until your last patient has left or the end of your session (whichever comes last). The attending physicians assigned to staff in the clinic are there to teach you, help you, coach you, and guide you. You will review your patients ahead of time, see them, staff them with your attendings, and then go over discharge plans with them.

Clinic can be challenging for many reasons. There will be patients who will have communication difficulties due to limited English proficiency, low literacy, hearing and speech deficits, and lack of education. There will be patients who have experienced extreme hardship, violence, and poverty.

There will be patients who have so many problems that it will seem impossible to know where to start. But mostly, there are patients who need you and appreciate your expertise.

Prepping for your patients when you have down time waiting will help direct your visit and improve efficiency. You are able to enter the patient's chart ahead of their visit and write preliminary notes and place orders which will disappear in 2 weeks if your patient does not show. Helpful things to preview are: the patient's medical history and problem list, current medications (making note of possible refill needs or monitoring tests), health maintenance needs, reason for appointment, previous visit and continuity questions for ER and hospital follow up. Anticipate which questions patients may have. A little preparation ahead of the visit will save you time, improve your clinical ability, and make you look like a star.

PRE-VISIT CHECKLIST

- Reason for visit
- Medical history/problem list
- Last encounter
- Medications:
  - Need refills?
  - Need monitoring tests?
  - Medications from other sources?
- Lab results since last visit (result review)
- Requests:
  - Did the patient ask you to do something that you haven't yet done?
- Health maintenance:
  - Due for screening?
  - Immunizations?
- Enter the expected documentation, smartsets and orders

Writing notes

No single style of writing notes works for everyone. There are two suggested templates that will be given to you during your orientation. Become familiar with them and decide which one better reflects your workflow.

.imcgennoteftv1	for providers who like to free text the H and P
.imcgennotepbpapv1	for providers who like to write the assessment and plan under specific problems

Remember that the notes you write are open to any provider with EPIC access and the involved patient through MyChart by default. When you are creating a note, do not check the box marked "sensitive"

because it hides your note from everyone and it will be impossible to review it. If you do not want the patient to read the note, **uncheck** the box marked "Share with Patient."

Preference lists

During orientation, you will have an outpatient preference list loaded onto your profile. The preference list contains groupings of test orders and hard to find test orders for your convenience. It is updated periodically to reflect the current orders accepted by our hospital system. To get the most recent preference list, go to the EPIC dropdown menu in the upper left corner of the screen. **Go to tools/preference list composer, select user, and copy Stephanie Tan's outpatient preference list.** You will have the option to merge lists; however, if you merge, your list may contain obsolete tests that were intentionally removed.

When you are creating orders, you can limit the tests to items on your preference list by selecting the "browse" tab and clicking "favorites only." That will pull up the preference list and any previous items that you added a gold star.

Smartphrases (aka dotphrase)

Smartphrases are quick and useful links to prewritten text. Smartphrases have "owners" (the people who wrote them and make changes to them) and "users" (the people who can use them). To access your list of smartphrases, go to the EPIC dropdown menu, **select tools/My Smartphrases.** From this menu, you can add new phrases, edit existing ones (if you own them), or give access to your phrases to other users. To look at other smartphrases, **select tools/Smartphrase Manager**, then select your source. You will already have a list of useful phrases shared with you. Anything on the list can be accessed by typing a period followed by the smartphrase name (ex: .smartphrase).

Unlike preference list items, smartphrases are dynamic, so any changes made to the smartphrases will pass to all users of the phrase going forward. You will not receive any notice if the owners of the smartphrases have changed the content of them. Always review the text in your smartphrases before your sign your notes.

To add a smartphrase to your list:

- EPIC/Tools/Smartphrase manager
- Select a known user of the phrase you want
- Select the phrase and double click to review
- In the lower right box marked "Sharing," select **+Add me**

If you would like to use the content of a particular smartphrase and you are not an owner, you can copy the phrase and create your own smartphrase to edit as you like. The advantage of creating your own phrase is that your new phrase will not be modified by anyone except people you designate as an owner.

Staffing with Preceptors

Attendings are required to see every intern's patients first 6 months, and any resident's patients who will be a level 4 or 5 (more on that later). All patients must be staffed while the patients are still on site. Before you see your patients, you will prestaff with your assigned attending to plan your approach and to determine if and when the attending should step in during your visit. For most, it will be during the physical exam or after staffing in the bullpen.

Generally, when you've finished your history and physical, you will let your patient know that you will discuss the plan with the supervising physician. The precepting attending will listen to your presentation and findings, then discuss the case with you. Teaching will be interactive and informal. Further evaluation after discussion with the attending may include involvement of social work, behavioral health, pharmacist, or nursing staff.

When you return to the room, you will be able to complete the interaction with the patient based on your discussion with the attending. Document which person you staffed with, and select that physician when you are required to select a supervising physician upon closing the encounter. Unlike the hospital, it is not necessary to route the note itself to the preceptor.

Labs/Tests

We are able to do some point of care testing. These orders are labeled POC or POCT in EPIC.

POC tests available:
- Urine pregnancy
- Urine dipstick without micro
- HbA1c (fingerstick for diagnosed diabetics only)
- Glucose
- Fecal occult blood
- EKG (clinic performed)

Discharging Patients

Wrapping up visits can be complicated by the presence or absence of staff on your clinic day. Generally, there is a phlebotomist, social worker, behavioral health specialist and a scheduler available. The staffing attendings will guide you through the patient discharge process since it may vary.

Do before completing each visit:
- **medication** reconciliation and refills of all current meds
- review of **labs/tests** done since last visit
- plan for **follow up**
- **AFTER VISIT SUMMARY** printed and given to patient

Charge Capture and Billing

You will hear a lot of alphabet soup related to billing, and it will cause unnecessary confusion.

Know these:
- CPT codes used for billing procedures
- E/M codes used for billing evaluation and management (professional fees)
- ICD-10 codes used to define the patient's problems and needs

Below is a very basic quicksheet to help you decide how complex your documentation is or should be.

BILLING 101

3 basic **components** to each note:

--history (including ROS, PMH, FMH, social, etc)
--physical
--medical decision-making

4 basic degrees of **complexity** to each component (which corresponds with billing levels):

Level	History	Physical	Medical Decision-making
2	Problem-focused	Problem-focused	straightforward
3	Expanded problem-focused	Exp problem-focused	low complexity
4	Detailed	Detailed	moderate complexity
5	Comprehensive	Comprehensive	high complexity

New patients require all three components to meet a level of complexity to be billed at that level. For example, if the history and the physical are both comprehensive but the decision-making is low complexity, it can only be billed as a new level 3.

Established patients (patients who have been seen here in the past 3 years) require only 2 out of 3 components to meet the level of complexity billed. For example, if the history and the physical are both detailed and the decision-making is only low complexity, the patient can still be billed at established level 4.

Based on this, about 2/3 of your patients will be level 4 (most of the established patients follow-ups) and about 1/3 will be level 3 (mostly the work-ins).
What defines **problem-focused**?
You stick to the one chief complaint, limit the ROS to the problem and don't update any of the other history. You only examine the location in question. Example: Suture removal, cerumen impaction, skin laceration.

What defines **expanded problem-focused**?
You consider the chief complaint and ask related review of systems and you examine other areas that may be relevant. Example: sore throat (fever, chills, cough, headache, myalgias, appetite), examination includes ear, nose, throat, neck for lymph nodes, and one other system such as abdomen for hepatosplenomegaly, skin for rash, lungs and heart.

What defines defines **detailed**?
In the sore throat patient above you would do all of the exam listed and ask questions pertaining to additional past history, family history, or social history. You might also address other medical problems, refills, or chronic issues. It is expanded problem-focused plus additional information (but not so much information that you could call it comprehensive).

What defines **comprehensive**?
Comprehensive is doing everything short of admitting the patient. You will seldom use this level unless you have a very sick patient who is refusing admission.

EPIC will automatically generate a professional code for you based on your documentation. It is unable to capture the complexity of free-text, but it is good at capturing data points from your use of pre-

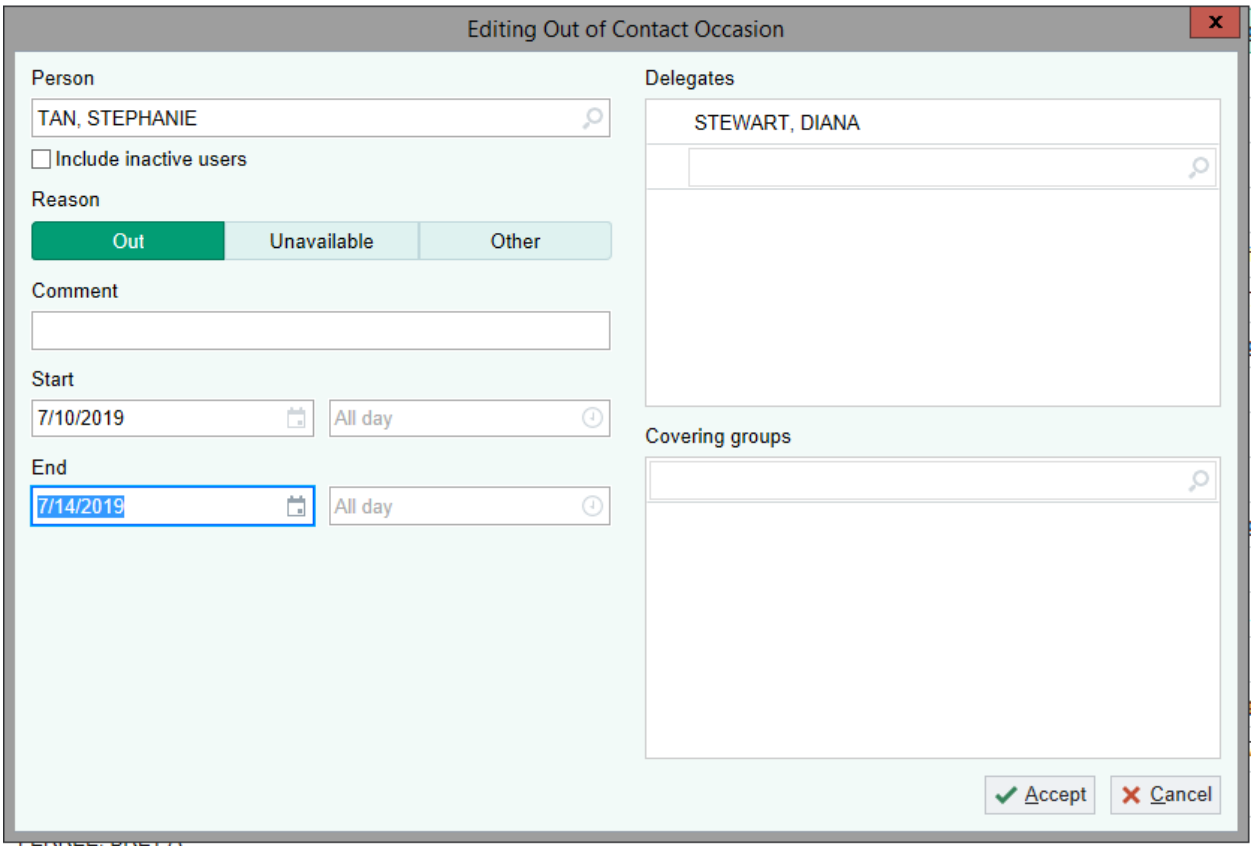
formatted note tools. Customizing macros for your ROS and physical exam will capture data points for you and save you a lot of work later.

Your documentation should be concise, accurate and reflect the amount of work you did. Notes should be completed within 24 hours of the patient encounter. In real life, encounters left open represent unpaid work.

Covering for yourself and others

You will be assigned another resident as a work partner or "buddy" to help each other in coverage throughout your residency. Ideally, your buddy should be someone who generally shares your practice style and work philosophy but is not your best friend, spouse or significant other (i.e. not someone who might join you on vacation) because they will be expected to cover you when you are out, and you will cover them when they are out. When necessary, different residents can be assigned to cover your work. When you cover another resident, you should check their physical mailbox and their EPIC mailbox.

The simplest way to ensure that your EPIC inbox is covered is by assigning a delegate. To do this, select "In Basket" then select "Out." A box should pop up labeled "Out of contact." In the lower left corner there is a button labeled "+New."
Click on this and a box will come up which allows you to put in the days you are out and who is delegated to cover in that time period (below). Your delegate will automatically receive your results and messages while you are out. **Action: In Basket/Out/New/Create New Out of Contact Occasion/Accept**



INDEX