I. **Educational Purpose**

The Primary Care (PC) Internal Medicine Residency Program was started as a separate track within the UC Davis Internal Medicine Residency Training Program in 1979. As categorical medicine residency programs are traditionally quite adept at training residents for subspecialty and inpatient medicine, the initial goal of the PC Program was, and remains today, to train physicians to provide comprehensive inpatient and outpatient primary care. It accomplishes this goal through combining the strengths of the categorical training program with an intensified and diverse ambulatory care experience. A second major goal is give residents a solid clinical and didactic background in evidence-based general internal medicine.

II. **Structure of the Primary Care Track**

a. The PGY1 year is identical to that of the Categorical Residents.

b. Over the PGY2 and PGY3 years, the PC residents spend approximately ½ of their time on Outpatient Block (OPT) time, and the other ½ on traditional internal medicine rotations, which will include General Medicine Wards, Emergency Medicine, General Medicine Consultations (GenPro), CCU (year 2), MICU (year 3), Night Float, and 2 electives. During those rotations, their experiences are dictated by the specific curricula for those rotations, and they are not addressed in this document. An example of this structure is outlined below.

### 2005 - 2006

<table>
<thead>
<tr>
<th>Blocks 1-3</th>
<th>Blocks 4-6.5</th>
<th>Blocks 6.5-10</th>
<th>Blocks 11-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC Outpatient Clinics</td>
<td>Inpatient Ward, CIS, Consult Elective</td>
<td>PC Outpatient Clinics</td>
<td>Inpatient Ward, Medicine Consults, ER 2 wk</td>
</tr>
</tbody>
</table>

### 2006-2007

<table>
<thead>
<tr>
<th>Blocks 1-3</th>
<th>Blocks 4-6.5</th>
<th>Blocks 6.5-10</th>
<th>Blocks 11-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC Outpatient Clinics</td>
<td>Inpatient Ward, MICU, Consult Elective</td>
<td>PC Outpatient Clinics</td>
<td>Inpatient Ward, Medicine Consult, NF, ER</td>
</tr>
</tbody>
</table>

III. **Principal Teaching Methods**

During the OPT time of the PC track, the following are the principal teaching methods:
a. **Directly Supervised Patient Care Activities.** Residents will rotate through a variety of clinics. In these clinics, they will see patients independently, come up with their own assessment and plan, then present these patients to their faculty supervisor and a final plan will be determined. Physical examination findings will be taught by supervisors as dictated by the case.

b. **Didactic Education:** During their OPT time, each Tuesday AM from 8 to noon is dedicated to small group, seminar based education. The following experiences are included:

**Psychiatry in Primary Care Seminar Series (monthly)**  
This seminar series is run in concert with faculty from the Department of Psychiatry, with Dr. James Bourgeois assisting with its coordination. It includes a series of seminars covering common psychosocial topics pertinent to primary care. Topics include: somatization disorder, depression, anxiety disorders, eating disorders, psychiatric emergencies, elder abuse, the psychotic patient, personality disorders, sexual dysfunction, and dementia.

**Medical Interviewing and Communication Skills Seminar (monthly)**  
This seminar series entails reviewing videotaped patient encounters. Each resident videotapes patient encounters in the clinic, and the tape is then reviewed as a group. We concentrate on interview techniques, patient-physician communication skills, and psychosocial aspects of patient care. It is an eye-opening and valuable experience for the residents and is a great hands-on opportunity to discuss these important topics.

**PC Resident Journal Club (weekly)**  
Residents meet together with a faculty member and critically review articles from the medical literature with their colleagues, applying the basic tenets of Evidence Based Medicine. All medicine interns have an intensive research block during their ambulatory have an 8-week Evidence-Based Medicine course that is taught during the internship year.

**Resident Research Seminars (approximately four times per year)**  
All UC Davis interns participate in the Intern Research Block during the second half of their internship year. This is an excellent introduction to assist in the annual Scholarly Project that each PC resident completes each year. These seminars are used to share progress on the scholarly project for each resident. Research technique and resources are reviewed, and problem-solving on individual projects allow group learning.

**Outpatient Morning Report (weekly)**  
PC residents attend UC Davis morning report and present educational cases from clinic, to allow focused discussion on common outpatient problems.

**Resident Teaching Seminars (monthly)**  
Residents are taught by faculty skills and techniques for more effective teaching of fellow residents and students.

**Health Care Policy Seminars (monthly)**  
We are discussing the basics of how health care policy are developed and how we as physicians can affect health care policy and be true advocates in our current health care system. We also discuss issues of population health and medical financing.

**Clinical Reasoning/EBM Seminars (monthly)**  
This seminar series expands upon the basics of EBM supplied in the intern seminar series. PC residents run these interactive seminars to elucidate the fine points of clinical reasoning, with the help of faculty facilitators.
Other Topics: We also have residents teach their colleagues with Teaching Points seminars; we have Current Events in Medicine, where we discuss recent advances in the news for medicine; we teach musculoskeletal exam skills in small groups; we do a finding a job seminar; we cover important skills in billing and documentation.

Other Conferences that PC residents attend during OPT time include the following:

**General Medicine Pre-Clinic Conference (weekly)**
Case-based discussions with accompanying articles addressing common ambulatory care topics. This includes a monthly Pre-Clinic Journal Club prepared by one of the categorical residents each month.

Academic Conference (weekly). Held each Monday from 1:30 to 4 pm for the entire Medicine Residency program.

c. **Scholarly Project:** Each resident is expected to complete a scholarly project in each of the PGY2 and PGY3 years. The scope and content of the project can be quite variable. In the past, projects have ranged from scholarly literature reviews to clinical research studies. Residents are required to work with faculty mentors (many are available, especially from our Center for Health Services Research in Primary Care) who will assist with their projects. Research seminars are held several times during the year where each resident updates the group on his/her project, giving an opportunity for group feedback, group problem solving, and project improvement. Each resident is expected to present his or her project to their resident colleagues at a Monday Academic Conference session during the academic year. Residents are encouraged to submit their research project for publication and/or for presentation at regional and national meetings. Residents are prepared for this by completing the intern IRB rotation.

**IV. Educational Content**

a. **Venues and Clinic Experiences:** Residents rotate through clinics at multiple sites. This includes the UC Davis General Medicine Clinic where they have 2 half-days of clinic per week during OPT time, and ½ day per week on average during non-OPT time; UCD Geriatrics Clinic ½ day per week. All residents also attend CARES clinic (HIV clinic) approximately every 2 days; attend at least 8 half-days of UCD Neurology Clinic; and 8 half-days of Medicine-Psychiatry Clinic. Residents also choose from the following list of clinics before each 3 month OPT block, and an individualized schedule, based on preferences, is created for each resident. Residents rotate through most or all of these clinics at some point in their 2 years in the PC track.

- UC Cardiology (Thurs AM)
- UC Treadmill (Thurs AM)
- CHF (Tues PM) Dr. Lewis
- Breast Cancer Clinic (Tues PM) Dr. Chew
- Dermatology—Elk Grove (Mon AM) R2 only
- Dermatology—VA (Mon AM)
- UC GI (Fri AM) Dr. Leung (biliary)
- UC GI (Fri PM) Dr. Terrado (general)
- UC Liver (Thurs PM)
- UC Pulmonary (Fri PM)
- UC Rheum Dr. Cheema (Thurs PM)
b. **Patient characteristics:** Patients come from a variety of health systems (UCD, Mercy Medical Group, UC Davis, the Sacramento VA health system, and the Sacramento County health system. As such, there is a massive variety of age, ethnicity, and socioeconomic status.

c. **Procedures:** Residents may be able to perform procedures in many of the above clinics, the most common being skin biopsies, arthrocentesis and therapeutic joint injections, exercise treadmill testing, pap smears, incision and drainage, endometrial biopsy.

d. The PC Geriatrics component has a separate curriculum that the reader is referred to for further details.

V. **Educational Goals and Objectives**

Please see the continuity clinic and ambulatory care curricula for expectations for the PTY1 years. For the PGY2 and PGY3 years, these competencies are progressive, i.e. PGY3 should be added to PGY2 (and PGY1) competencies.

Please also refer to specific Geriatrics Curriculum for PC program for specifics on Geriatric care competencies.

1. **PGY1 YEAR** – by the end of the PGY1 Year, interns are expected to have the following competencies:

**Patient Care**

PGY1 residents are expected to be able to the following by the end of the PGY1 year:
- Take a complete history, perform a complete physical exam, and develop a preliminary management plan within the 1 hour time allotment for new patients
- Perform a problem-specific history and physical on follow-up patients with common acute and chronic diseases, and develop a preliminary management plan, within the 30 minute time allotment for follow-up patients
- Document a clinic or telephone note appropriately in the EMR
- Review and update the problem list at each encounter
- Review and update the medication list, and give appropriate refills, at each encounter
• Demonstrate integrity, respect, compassion and empathy for patients and their families, including respect for personal preferences and patient rights.
• Perform a Pap smear and breast exam

PGY2 residents are expected to be able to the following by the end of the PGY2 year:

• Send prescriptions electronically to pharmacies using their own license and DEA number (via the EMR).
• Implement chronic pain medication contracts for patients taking controlled substances
• Be able to care for patients with common neurologic complaints (as seen in the Neurology Clinic), including seizure disorder, peripheral neuropathy, headache, and chronic care of stroke patients.
• Be able to describe dermatologic lesions and describe and implement care for common problems in dermatology, including eczema, seborrheic dermatitis, rosacea, squamous cell and basal cell cancers of the skin, and acne.
• Be able to structure a medical interview appropriately (asking for full spectrum of complaints up front, negotiating an agenda, using open ended questions, appropriate closure), and demonstrate this via videotaped or observed encounters.

PGY3 residents are expected to be able to the following by the end of the PGY3 year:

• Perform a simple joint injection (shoulder, knee)
• Perform an appropriate history and physical exam and develop an appropriate management plan with minimal supervision for patients in ambulatory settings with most acute and chronic medical problems.
• Be able to perform an appropriate physical exam for patients with shoulder, knee, back, and neck complaints.
• Demonstrate appropriate clinical reasoning in ambiguous situations.
• Use patient education as a form of intervention and partnering.
• Be able to handle patients with complex psychosocial situations with minimal assistance from attendings.
• Be able to lead an advanced directives discussion with patients in clinic, and demonstrate this through videotaped or observed encounters.
• Will be able to manage patients with common subspecialty-related problems in the ambulatory setting with minimal assistance, including fibromyalgia, osteoarthritis, hypertension, chronic renal failure, diabetes, hypothyroidism, CAD, valvular disease, depression, anxiety, hyperlipidemia, migraine headache, GERD, PUD, hepatitis C, COPD, asthma, post-stroke disease, TIA, constipation, IBS, venous insufficiency, peripheral vascular disease.

Medical Knowledge

PGY1 residents are expected to be able to the following by the end of the PGY1 year:

• Know the indications and contraindications for general preventive health measures, including colon cancer screening, breast cancer screening, cervical cancer screening, Pneumovax vaccine, influenza vaccine, and tetanus vaccine
• Know the indications for, and goals of treatment for hyperlipidemia screening and treatment
• Know the appropriate health care maintenance for patients with diabetes, including eye screening, neuropathy screening (monofilament), lipid screening, nephropathy screening (urinary microalbumin to creatinine ratio), HgA1c monitoring and goals, and immunizations.
• Know the JNC guidelines for management and treatment of hypertension
• Know the care guidelines for patients with atherosclerosis.
• Know differential diagnoses for common acute complaints seen in general internal medicine clinics.

PGY2 residents are expected to be able to the following by the end of the PGY2 year:
• Regularly display self-initiative in filling knowledge gaps on conditions encountered in clinic.
• Demonstrate knowledge of study design on validity or applicability to practice.
• Develop well-formulated differential diagnoses for patients with multiple problems.
• Know the benefits and side effects of oral diabetes and lipid-lowering therapies
• Select appropriate antihypertensive and CHF medications based upon evidence-based guidelines
• Discuss the potential benefits and risks of prostate cancer screening with their patients.
• Create an Asthma Action plan with their patients
• Know the pharmacology of commonly used anti-seizure medications and commonly used topical steroids.
• Share knowledge on common ambulatory topics with residents through the Teaching Points portion of the seminars.
• Will complete scholarly project, as described above.

PGY3 residents are expected to be able to the following by the end of the PGY3 year:
• Independently present up-to-date scientific evidence to support clinical hypotheses.
• Demonstrate basic knowledge of statistical principles when reviewing scientific literature.
• Will complete scholarly project, as described above.

Practice Based Learning and Improvement

PGY1 residents are expected to be able to the following by the end of the PGY1 year:
• Participate in quality improvement projects in clinic and use their panel-specific data to guide the improvement in the care of their own patients (using system resources).
• Use the EMR decision support tools to improve delivery of healthcare to their patients (e.g. HM alerts in EMR).
• Identify areas of weakness for self-directed learning and for seeking help when needed.
• Admit to errors and rapidly seek assistance in remedying them.
• Deliver care that reflects learning from previous experiences.

PGY2 residents are expected to be able to the following by the end of the PGY2 year:
- Participate in developing the annual clinic quality improvement project.
- Understand core quality improvement measures and what pay-for-performance entails
- Be able to discuss articles and lead journal club for seminar series, with use of the Users Guides to the Medical Literature as guidance.

PGY3 residents are expected to be able to the following by the end of the PGY3 year:
• Demonstrate the teaching skills that are covered in resident as teacher seminars held in didactic component of rotation.

Professionalism
• Answer pages from all clinic personnel in a timely manner
• Check their EMR inbox daily
• Address messages and abnormal test results in an appropriate timeline.
• Return patient calls in a timely manner (within 24 hours of initial call)
• Treat all clinic staff with respect
• Assess and use informed consent
• Maintain patient confidentiality
• Arrange patient coverage for all issues (i.e. transfer care to a colleague) before leaving on vacation.
• Demonstrate intellectual curiosity, by looking up clinical questions both in clinic and between sessions.

Interpersonal and Communication Skills

PGY1 residents are expected to be able to the following by the end of the PGY1 year:

• Organize a clinic visit during which the resident gets a list of all of the complaints up front, and then negotiates an agenda with the patient, appropriately prioritizing potentially dangerous conditions for evaluation.
• Develop therapeutic doctor-patient relationships with patients from a variety of socio-cultural backgrounds in a culturally sensitive manner.
• Effectively communicate treatment plans to patients and families
• Use telephone interpreting services to communicate with their patients whenever appropriate.
• Type in instructions into the Patient Instructions section of the EMR whenever necessary.
• Provide patient centered counseling on medical problems, and specifically counsel patients about lifestyle behaviors.
• Be able to clearly and concisely present patients to attendings in clinic.

PGY2 residents are expected to be able to the following by the end of the PGY2 year:

• Successfully negotiate most “difficult” patient encounters (e.g. irate patients or substance abuse issues)
• Maintain successful inpatient-outpatient provider communication to ensure continuity of care for clinic patients.
• Sign off their Geriatrics patients to their partners when they switch from outpatient to inpatient medicine rotations.
• Appropriately handle telephone care calls.
• Dictate appropriate referral letters in consultation clinics that adequately relay the results and recommendations and plans from the consultation visit.

PGY3 residents are expected to be able to the following by the end of the PGY3 year:

• Successfully negotiate all “difficult” patient encounters.
• Perform motivational interviewing techniques (i.e. Action Planning) with their patients, when appropriate.
• Conduct a discussion of advance directives with a patient

Systems Based Practice
PGY1 residents are expected to be able to the following by the end of the PGY1 year:
- Communicate with other PCPs when they have seen that physician’s patient in clinic.
- Work with the pharmacy technicians and ambulatory pharmacists to provide timely refills to all of their patients. Work with staff to assess, coordinate and improve multispecialty care across inpatient and outpatient settings.
- Identify or access resources for ambulatory patients, including home health care agencies, support groups, medication assistance programs, physical therapy programs.
- Guide patients through the complex healthcare environment
- Demonstrate dedication to high quality patient care.

PGY2 residents are expected to be able to the following by the end of the PGY2 year:
- Understand essential elements of the following insurance types: HMO, MediCal, MediCal Managed Care, and Medicare
- Consider cost of medications in prescribing for common ambulatory conditions.
- Will work within system of care for Geriatrics clinic to ensure seamless care for their Geriatrics clinic panel

PGY3 residents are expected to be able to the following by the end of the PGY3 year:
- Understand the principles of E&M Coding of clinic encounters for billing purposes.
- Assume leadership role in management of complex care plans for their patients.
- Complete end-of-residency patient care notes (and clean-up of their patient care list) to facilitate transfer of care to the next resident.

VI. Ancillary Education Materials
Residents have 24 hour online access to the CRC with its access to electronic texts, online resources, and many journals through PubMed. Residents also have access to UpToDate online, and there are many textbooks in the medicine clinic covering diverse, common topics (e.g. Dermatology, Office Orthopedics, Ophthalmology)

VII. Methods of Evaluation

a. Evaluation of Residents: Faculty that supervise residents more than 2-3 sessions are asked to complete an evaluation in E-Value at the end of the resident’s rotation with them. Geriatrics attendings and General Medicine Clinic Firm attendings fill out evaluations in E-Value every 6 months. Patients are asked after each visit to complete 360 evaluations on the residents that they see. Clinic nurses are asked to evaluate residents every 6 months.

b. Evaluation of Faculty and Program: Residents are asked to evaluate key attendings that they work with during their OPT time, using E-Value. Residents are asked to fill out evaluations on the General Medicine Clinic and Geriatrics clinic every 6 months. Dr. Keenan does a separate written survey each year on every experience for each resident and summarizes the findings from that survey in order to make changes. Dr. Keenan solicits regular feedback from the residents during Tuesday morning sessions to improve the clinics and program.

VIII. Schedule, Call, and Work Hours.

a. Residents do not have in-house call during OPT time except for the few times per year that they are scheduled as the night float or called in for backup.
b. Residents take telephone call for their own patients from 5 pm to 8 am each day. On weekends, residents rotate telephone call, such that each resident covers approximately one in 12 weekends for the entire PC program.

c. Residents generally start work at 8 AM and are done by 6 PM. They always have 1 in 7 days off when averaged over 4 week blocks, and never exceed 80 hours per week.

APPENDIX 1 – GERIATRICS CLINIC GUIDELINES

UC DAVIS GERIATRICS CLINIC
PATIENT MANAGEMENT GUIDELINES
Drs. Hirsch and McCloud

- Geriatrics Clinic is not just a primary care clinic for elderly patients. The approach and goals are different. The emphasis is upon FUNCTION, and not just medical diagnosis. Whereas a general internal medicine clinic focuses on disease management, geriatrics focuses on patient management. Indeed, with many of these patients, their medical diagnoses may be of secondary concern, as we address such issues as safety, nutrition, abuse, or medication management.

- All patients in geriatric clinic, unless specifically being seen as a consultation, MUST belong to a designated resident (fellow) and resident (fellow) team.* Please understand that you will be responsible for your patient’s oversight, healthcare maintenance, and medication refills whether or not you were the last to see the patient, or have ever seen the patient. Please be certain the medical record clearly identifies the primary care physician/team. To do this, go to the EMR PROBLEM LIST and enter V70.0 (routine medical exam) in the upper diagnosis box. After you have accepted this diagnosis, go to the free-text diagnosis box (the second text field) and enter:

  GERIATRIC CLINIC PATIENT OF DRS. XXX & YYY

  o Put the HCM stuff below this.

- If one of the medical students sees your patient on a particular visit, please do make your presence and involvement known, to help reinforce that you remain their physician.

- Be certain your patient has your professional card. You might want to write “Geriatric Clinic” above your name, and remind patient/family to identify themselves as a geriatric clinic patient when they call.

- Although not every visit warrants change to exam gown, many visits do. Please do not rely on piecemeal disrobing or “under the shirt” exam. These patients offer an abundance of valuable abnormal physical findings. With proper disrobing, you will discover skin cancers, pressure wounds, signs of abuse, unexpected bruits, and a myriad of helpful findings. Whenever feasible, examine the patient on the exam table and NOT in the chair!
• Remember, the attending may want to verify findings—best not to have them re-
dress until case has been presented.

• Geriatrics Clinic requires that you present your case to the attending physician in the
exam room, unless delicate psychiatric or social issues mandate confidential discussion
prior to bringing attending into the room.

• Please remember to begin your presentations with a summary statement of the patient’s
key functional and psychosocial characteristics, followed by the chief complaint. (I also
recommend to all trainees to identify their main question of management that they may
have right up front – makes sure that they get educated on their needs. “My main
question is how to proceed in managing the psychotic symptoms.” Is great to hear in the
first or second sentence!!) This is helpful to give the attending a context in which to
assess the significance of the medical history that follows. BE DESCRIPTIVE!

o Instead of “This is a 90 year-old man here for hip pain,” say “This is a 90 year-old
retired English professor living at Eskaton Village Carmichael who is fully
independent in his self care and provides much of the personal care for his 87
year old demented wife. His granddaughter, Sue Jones, has brought him to this
visit.”

• CHARTING

Clearly state a presenting complaint at the top of your progress note. Do not state: “here for
refills”, “here to establish” or “for follow-up.” Instead, say “for follow-up of urinary incontinence”
or “for ongoing management of hypertension and memory impairments.”

For consultations and new patients, in the ROS section cover at least 10 systems. For follow-
ups, cover at least 2 sections.

PMH: Use it not only for relevant past medical and surgical problems, but for ACTIVE
problems. THESE INCLUDE KEY FUNCTIONAL AND PSYCHOSOCIAL PROBLEMS.
Separate problems by categories. If you have an up-to-date problem list in the EMR, you can
get by by writing, “See EMR Problem List, reviewed/updated today.”

SOCIAL HISTORY: Document key functional status and psychosocial information. Include key
IADL/ADL dependencies and difficulties, who the caregiver is, and name & phone number of the
facility they are living in, if not own home. DO NOT MERELY STATE “no tobacco or alcohol.”

Your charting should reflect the name and relationship of any collateral historian who
has accompanied the patient. Do not say “son reports…” Say “Son, Bill Blair states
father has been wandering lately…” Remember there is a very good chance we will
need to contact the family or caregiver at some future point. Put the names and
contact information of these collateral historians and caregivers in the problem list.

PHYSICAL EXAM: Be descriptive in charting your physical exam. A general appearance entry
of “N.A.D.” suggests a lack of appreciation of the extraordinary variations in human aging. A
general appearance of “a slightly disheveled and unshaven, underweight, frail-appearing male
in mid-80s who tends to repeat his comments” speaks volumes more than “elderly male, N.A.D.” Comments such as “able to hear normal conversation”, “ambulating with a cane several inches too short”, “impatient and contentious with family” show that you are honing in on the geriatric issues (ie, is good for preceptor evaluations as well as patient care).

ASSESSMENT AND PLANS: These should include not only medical but key functional and psychosocial problems that need action. For example, under “Functional,” you might list: “Impaired mobility due to severe arthritis.” Under “Psychosocial” you might put, “Inadequate caregiver support.”

- LIST PROBLEMS THAT HAVE A MEDICAL ICD-9 CODE FIRST, FOLLOWED BY PSYCH DXS, THEN MISCELLANEOUS FUNCTIONAL AND PSYCHOSOCIAL PROBLEMS. MEDICARE REIMBURSEMENT IS SUBSTANTIALLY LESS FOR PSYCHIATRIC DIAGNOSES.

E.g., if the patient comes in with weight loss due to dementia, list “Weight loss” of “malnutrition” as the diagnosis, and state “due to dementia and inability to prepare food.” “Alzheimer’s disease” and “dementia” are psychiatric dxs, whereas “memory loss” is a medical dx. If the patient has vascular dementia, list “Late effects of stroke” as the diagnosis, followed by “resulting in dementia.”

- SOCIAL SERVICES

  - Many of your patients will benefit from speaking with our social worker, Glenda Till. Please get to know Glenda, and identify those patients you would like her to be aware of. If you look at each clinic’s schedule at the start, you might be able to tip her off such that she can make optimal use of patient’s wait time in exam room. She should touch base routinely with most new patients. She also has her own template into which she can schedule patients.

- PATIENT INSTRUCTIONS

  - With normal aging, older adults have losses in verbal memory more than visual memory. It is more important with this population that you WRITE DOWN medication changes, instructions, other advice that you might verbally give your younger General Medicine clinic patients. Type this into the Patient Instructions section of the EMR visit navigator and it will print out for them.

- EMR

  - The maintenance of up-to-date EMR Problem List and Medications is one of your key responsibilities. The list is invaluable to the triage nurses and your colleagues as we receive requests for refills, durable medical equipment authorization, or other problem solving. And the medication list promotes safe prescribing.

- CONSULTATIONS

  - When patients are seen for geriatric consultation, it is the resident’s responsibility to dictate a report to the referring physician or referral source. That report must include the physician’s address (even if it means a moment of search engine work e.g. Yahoo Yellow Pages), or it cannot be mailed. (Dictation Code

  - You should know that Medicare requires that office visits considered “consultations” (handled differently by our billing department) require the name of
the referring source, the consultation question, and should conclude with “Recommendation:…” rather than “Plan:…”

- **PRESCRIPTIONS**
  - Please remember that one of the most important tenants of geriatric medicine is judicious restraint in prescribing, and minimizing polypharmacy. Each time you prescribe, ask yourself what medication(s) you can also eliminate. Try to address many problems with non-pharmacologic solutions, such as a list of tips for better sleep hygiene in lieu of a sedative-hypnotic drug.
  - All prescriptions, whether written or sent via the EMR, need a license number and DEA number on them. So, if you are an R2 and do not have both of those, your attending will have to cosign your prescriptions. Prescriptions for durable medical equipment (walkers, bedside commodes, etc.) must have the attending’s signature and Medicare “UPIN” number (a number you do not have as a physician-in-training.) Durable medical equipment (DME) prescriptions must be written on separate from medication prescriptions, as they will be filled at medical-surgical supply companies. A duration of need is required (in Medicare lingo, “indefinite” is 99 months). List the diagnosis or diagnoses justifying the DME, with ICD-9 codes whenever possible. Give these DME prescriptions to the clinic RN (Laurie) to get them ordered, unless your patients prefer to handle them on their own.

- **HELPFUL ICD-9 CODES FOR EMR PROBLEM LIST and DME**

  Abnormality of gait (781.2): Great for patients with unsteady gait at risk of falling.
  Adverse effect of medication (995.2): Heading under which to list side-effects of medications, etc.

  Convalescence and palliation (V66)
  Counseling (V65.49)
  Counseling, advance directive (V65.49)
  Fall, one level to another (E884.9): To document history of falls.
  Long-term use of other medication (V58.69): Handy for listing current chronic meds in the “comments” box.
  No family able to care (V60.4)

  Personal history of non-compliance with medical treatment (V15.81): Great for patients who are non-adherent with their meds, diet, etc.
  Routine medical exam (V70.0): Use for identifying clinic and provider (see above). And contact information of care providers…per above. Can also document Healthcare Maintenance issues.
Primary Care residents rotate through the UCD Neurology Clinic, usually the R2s. In order for us to do this, we guarantee them one resident every Wednesday afternoon. The Neurology Clinic has created a small panel of patients that are followed by the PC residents. This clinic is held on Wednesday afternoons, and includes the Neurology Residents’ clinics and our own Primary Care Neurology clinic. There are a total of 9 residents there (one PC) with 2-3 neurology attendings. In general, these attendings are community neurologists who are volunteer clinical faculty.

A. LOCATION and LAYOUT

The Neurology Clinic is in the ACC Building, Suite 0100.

On your first day, ask the receptionist to show you where the physicians’ conference room is. Orient yourself to the room and the clinic:

1. Computers: there are 4 across from the entrance to the room for your use.
2. Conference Table: the volunteer clinical faculty sit around this table and hear presentations here.
3. Boxes: there are 5 boxes on the table -- one for DNKAs, one for Medical Records filing, one for authorizations, one for documents to be faxed, and a To Do box for the nurses.

B. SCHEDULE and VISITS

1. The primary care residents have their own patient panel that has been created for us. Whichever PC resident is in clinic is responsible for following up on PC patient issues.

2. Each half-day, a typical PC resident schedule is as follows:

   Primary Care Resident Template

   1300 to 1400       60 minutes New referral
   1400 to 1500       60 minutes New referral
   1500 to 1530       30 minutes Follow-up
   1530 to 1600       30 minutes Follow-up

   You can find your schedule on the EMR under Schedules/Neuro Clinic ACC, and look under Dr. Dr. Vijayan’s name. Just like GenMed, the Neuro clinic cares for a large number of MediCare and MediCal patients. It is difficult to predict who will show up.

3. If a follow-up patient’s chart does not show, look in the computer for prior dictations plus there are SHADOW BINDERS in the clinic. These are located above the computers. One is designated for Primary Care. You must place the yellow copy of your completed note (with the attending’s note) in the chart prior to giving your original note to the discharge planner. It is also
nice to put in the dictated note after it is transcribed.

4. See your patient and present to an attending. Once you are done, there are 3 DISCHARGE FORMS that you have to fill out. You will need an ICD-9 code and your attending’s name on most of the forms. The forms are:
   a. Laboratory/Order slip
   b. Follow-up form – tells when to return to the clinic
   c. Billing form – you fill it out (see below)

1. Write your note and dictate a letter (see below). Place the yellow copy of your note in the shadow binder.

C. MAILBOX

There is a primary care resident mailbox in the clinic. This is where test results or other messages will go. You are responsible for addressing things in this mailbox, so check it each time you are in clinic. It is located along the wall to your right as you enter the conference room. The clinic checks for critical lab values, but otherwise, the PC resident in neuro clinic is responsible for following up on all of these tests.

D. DICTATION

As a specialty practice, all patients are seen on a referral only basis through the Hospital Physician Referral Center (PRC). In most cases, the referral is for consultation. As a result, every visit should yield a correspondence letter back to the referring physician.

You need to write the consult note AND dictate a consultation letter for each visit.

Access the Hospital Dictation System by calling 4-1000. There are numerous telephones available in the Neurology Conference room in the Clinic. In the event all phones are in use, ask to be directed to the Neurosurgery Conference room in the Clinic.

Patient location code is 22.
Work Type:
11 for internal provider referrals (UCD physician referred)
12 for external provider referrals (non-UCD physician referred)

(For new patients, the referring can be identified on the hard-copy referral form provided at the initial visit)

All dictation should begin with the referring provider’s name and address, then, “Dear Dr. ______. Thank you for referring (patient name) to me for consultation.”

Dictate a line for a co-signature as follows: "Co-sign this report with Dr. _____." or "Also provide a signature block for Dr. _____." or "Provide dual signature with Dr. _____.” In other words, a co-signature block will only be provided if a specific request is made per the examples above. (Dictating "This patient was seen and examined with Dr. _____" WILL NOT suffice).

All patients must have learning needs/barriers assessed and it must be documented that the patient (or caregiver) was educated and how they were educated. This is documented in two ways:

1. “Check” boxes pre-printed on Progress Note (easiest).
2. The statement “I have educated/instructed the patient or caregiver regarding all aspects of the above stated plan of care. The patient or caregiver indicated understanding” can be prompted in transcription by simply stating “patient educated” at the end of your dictation.

If you are having difficulty with the dictation system or have questions, please contact Alicen Arsenault at ext. 8702

E. BILLING

A charge document is provided for every patient visit. You must write your name, PI number, and the name of the referring physician in the appropriate blocks at the top of the charge document. (This is good practice, as most of you will need to learn how to do this to bill after residency...the attendings do it in GenMed Clinic).

Because the majority of resident patients are Medicare/MediCal, you are required to identify the attending to whom you presented and dictate a request to generate the attending signature block.

Neurology Clinic adheres to the documentation billing guidelines established by the UCDHS Compliance Office, as well as any applicable legal and/or payer specific requirements. The physician is responsible for accurate ICD-9 and CPT coding. Remember, the documentation must support the coded level.

The Patient Record Abstractor (PRA or “biller”) is required to verify, using established guidelines, that the documentation supports the coded level. The PRA is empowered to adjust the coding as necessary to align with the documentation. If any of the required documentation is missing, the PRA will issue a Request for Information (RFI). This institution-wide form will identify the needed documentation.

If you have any questions or need clarification regarding the RFI or other billing issues, you may contact Daniel Steinhart (Practice Manager) at ext. 6742, or Dee Larsen (PRA III) at extension 6741.

F. EQUIPMENT

Just because this is a Neurology clinic does not mean that tools are included. Be sure to bring you reflex hammer and tuning fork to the clinic (and any other favorite testing tools).

G. RESOURCES

MOSC-IV Supervisor
Neurology Clinic
916-734-4795

She is the one to contact in the event of any absences, etc. She does your schedules too.

You can always contact the practice manager for help.

Donna Hopkins is the discharge planner and kindly agreed to answer most questions that residents have had so far.
The Neurology Residents are also great resources.

If clinical questions arise between sessions of the clinic, you should contact the Neurology Chief Resident.