SUMMA HEALTH SYSTEM

# Internal Medicine Center Resident Handbook

2018

Internal Medicine Center

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FIRST THINGS FIRST/FAQ

- Residents should check their EPIC **Provider Calendar** (scheduling/templates/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 a variety of experiences that assures that each trainee sees a broad range of medical problems, assumes the primary responsibility for the care of the patients, and acquires skills necessary to practice internal medicine at a high level of expertise.

**Overview**

Internal medicine residents receive their ambulatory education in the Internal Medicine Center (IMC) and in community-based private practices.

As a hospital-based continuity clinic, the IMC provides the backbone for ambulatory education. Residents serve as primary care physicians and are responsible for the ongoing care of their own group of patients. Direct supervision and teaching of residents is available at all times by on-site teaching faculty.

The Community Based Teaching program (CBT) was instituted in 1995 to supplement the ambulatory care experience by providing exposure to off-site outpatient practices. Each second year resident is assigned to work with an internist who is known for teaching ability, quality patient care, and managing a successful office practice.

The ambulatory care program was designed to give the resident the experience of being a primary care provider. Residents are able to assume the responsibility of evaluating and managing their own patients, supervising their inpatient care, and serving as the primary point of referral to other healthcare

providers. The experience reinforces the professional behaviors required in modern ambulatory medicine.

**Goals for residents:**

- Master techniques of 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

**Structure of ambulatory medicine experience:**

- PGY-1 residents: one half day per week in the IMC (up to 6 patients per half day)
- 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.
- PGY-3 residents: two half days in the IMC (up to 8 patients per half day)
- No IMC sessions are scheduled for residents on ICU

Over the course of three years, residents establish their own panel of approximately 200 patients for whom they serve as their primary care physician. 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:**

Faculty physicians precept patients with the residents while the patients are still in the examination room. They are also available to see patients with the residents and use their observations of resident interaction with the patients as part of the evaluation process.

The primary role of the preceptor is to provide guidance and supervision to optimize patient care and resident learning. Residents present patients to preceptors and are encouraged to develop their own conclusions and management plans. Preceptors may 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 twice a week address common primary care issues and current evidence-based treatment. Ultimately, residents are given sufficient autonomy to adapt to their roles as primary caregivers, with easy access to experienced faculty guidance.

**Guidelines for supervision:**

- Interns present every case to a preceptor before patients have left the exam room. During the first 6 months, attending preceptors will directly observe parts of the patient encounter until the resident has achieved their indirect supervision milestones.
- PGY-2 and PGY-3 residents present every case to a preceptor.
- An attending physician cosigns all resident charts.
- Each categorical medicine resident has a formal chart review once a year. Charts are reviewed informally on a regular basis as part of the supervision process.
- When problems/questions arise outside of regular clinic hours, residents may contact a faculty physician to discuss these issues.

**Resident responsibilities:**

In all continuity sites, the resident physician acts as the primary care physician for his/her patients. While responsibilities on the inpatient service may seem more pressing, the experience gained in the outpatient setting provides the foundation for office practice in any specialty. Preceptors will provide the supervision and assistance required by each resident.

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

- 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:
    - 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
    - completion of notes and billing for each patient visit on the same day as the visit
    - checking EPIC daily for messages and lab results, and cover for other residents as assigned
- 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 resident responsibilities in 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 managing other tasks under the guidance of more experienced physicians. As this is also a learning center, residents will have the unique opportunity to actively participate in quality improvement and develop innovations in new models of patient care.

**The IMC Staff**

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

Administrative staff:

Director: Michael Rich

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.

Other leadership: Stephanie Tan, Michelle Cudnik

Members of the leadership team with assorted informal 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.

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)

Schedule tests and referrals

Phlebotomy when lab person is not on site

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

Providers: Anyone who sees patients for the bulk of the visit is considered a provider.
Includes physicians, nurse practitioners, pharmacist

Behavioral Health specialists:
Screen for mental health disorders
On the spot counseling
Assist in obtaining psychological services and coordinating care

Pharmacy:
All aspects of medication education from provider to patient
Medication reconciliation
Investigate conflicting medication lists from multiple sources
Investigate drug interactions
Research assistance

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. In general, there is a "triage nurse" who is assigned to the phone and a "floor nurse" who is assigned to assist with patients in the IMC.

**Patient Appointment Schedule**

The office schedule includes approximately 70 provider schedules, and as a result, is complicated to manage in combination with call coverage, rotations and time away. It is imperative that all providers check their schedules for conflicts on a regular basis, especially if changes to calls or coverage arise.

All appointment units are 30 minutes long, but can be extended to 60 minutes by request 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 later appointment that day 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 personal schedule view:**

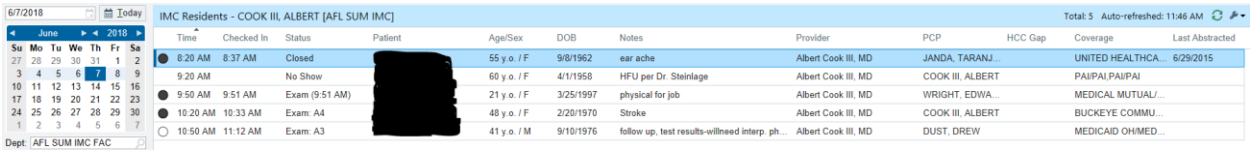
Click on Schedule and go to the list on the left side column
Highlight name
Click on the gears in the bar above the schedule lists

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

Add:
- Status (7601731901)
- PCP (17316)
- DOB (17341)
- HCC gap

Place in this order:
- Appt time
- Checked in
- Status
- Patient
- Age/sex
- DOB
- Notes
- Provider
- HCC gap
- PCP
- Last abstracted

Most of the schedule is self-explanatory except for Status and HCC gap. 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 |
| Present | the patient has **arrived** and signed in |
| Arrived (time) | the patient has **completed registration** at the time listed |
| Exam (room #) | the patient is in the room |
| Comp (time) | patient's encounter is complete and chart is closed |
| No Show | no show |
| Can | cancellation |
| LEFT | patient left after registration or rooming |

**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 by them) |
| 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. The Expeditor predates the electronic record and was originally used to assign residents rooms and let them know which patients should be seen next. **Providers now only have to 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 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)**

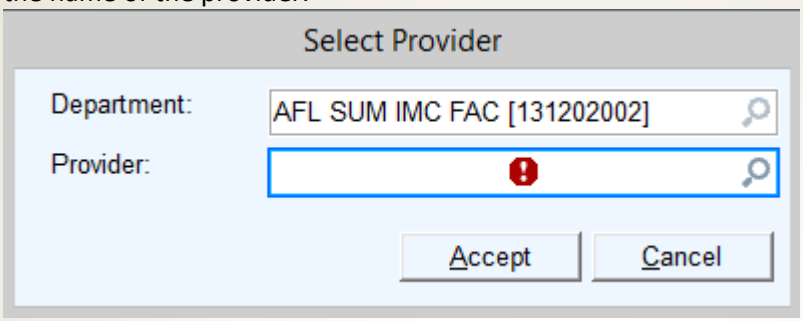
Every provider in Carepath has a personal provider schedule that is updated as soon as changes are made. It should be part of every provider's daily routine to check this schedule for anticipated conflicts or errors. Providers can also use the provider schedule to look at other providers' schedules, 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.

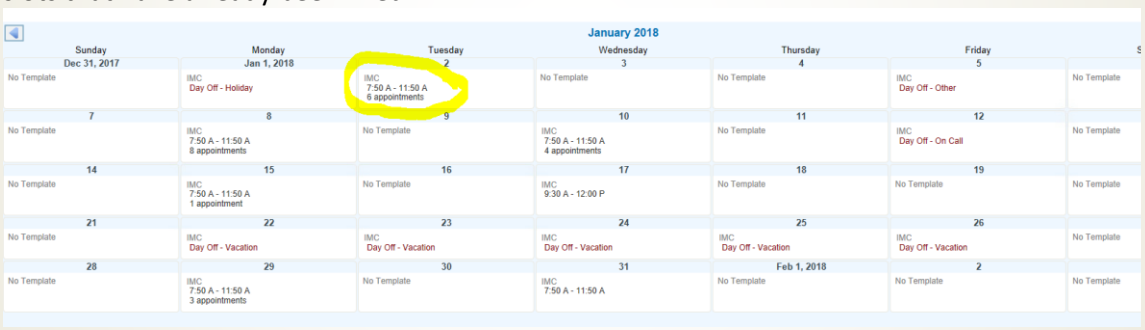
Checking and maintaining your schedule is an important professional responsibility which is evaluated by your advisor and residency director.

# EPIC HINT: CHECKING A PROVIDER'S SCHEDULE

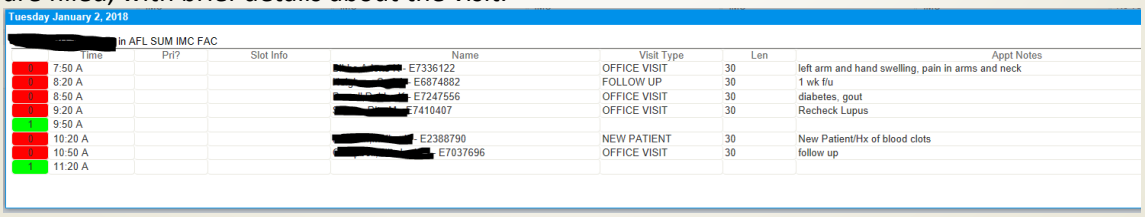
To check an individual provider's schedule, go to the Epic dropdown menu on the left side, select "scheduling" then "provider calendar." You will then see a box prompting you to put in the name of the provider.




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.

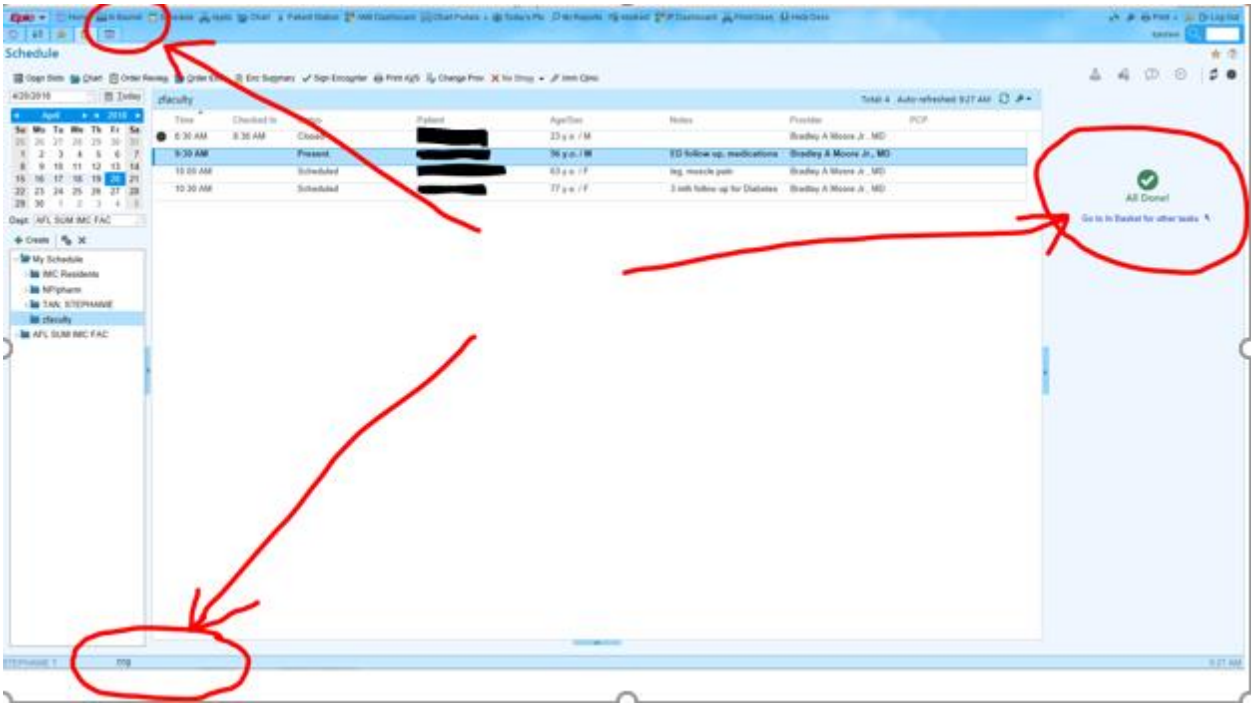



When you click on the individual day, you will be able to see which slots are open and which are filled, with brief details about the visit.

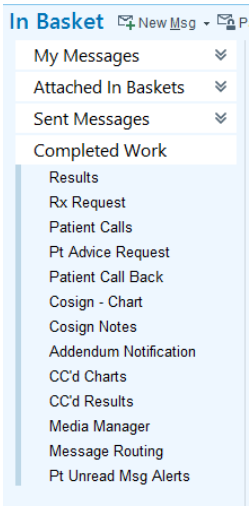


**Tackling the In Basket**

The In Basket can be accessed from several different places: the top toolbar, the bottom toolbar (in the form of alerts), or a very complicated view on the right side of the screen. It is thus unavoidable.




When you click on the In Basket on the top toolbar, 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.




Keep an eye on the bottom toolbar because that will show alerts. 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
- Check anything marked in red, **bold** or "**!**" to determine acuity
- Do patient calls next
- Review results last unless marked as above
- Ask preceptors for help

**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 strive to give the paperwork to the correct physician based on the patient's PCP of record or the name listed 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 discarded by the staff member who sent the fax. 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. **Fax for misdirected results: 234-312-6461**

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 cosignature.
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 do think it is useful, 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. **Cosignatures:** If an attending cosignature 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 and it will be difficult 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 clicked the accompanying star to yellow.

**Smartphrases**

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 dropdown menu/Tools/Smartphrase manager
Select a known user of the phrase you want
Select the phrase
Select the "Owners and Users" tab
Click the "Add myself" button found below the column of users

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**

When you've finished your history and physical, you will let your patient know that you will discuss the plan with the supervising physician. All interns are expected to staff each patient while the patient is still in the room. The precepting attending will listen to your presentation and findings and 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. Your attending physicians are there to assist in any way needed.

Document which person you staffed with and select that physician when you are required to select a supervising physician upon closing the note. 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 are complicated by the presence or absence of staff on your clinic day. Generally, there is a phlebotomist, social worker, behavioral health specialists 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

The IMC currently bills based on facility fees; therefore, we try to capture how much time we spent and how many services we provided to the patient, from the moment they step into the door to the moment they leave. Most medical practices bill based on professional fees which are based on the

complexity of the information managed and the extent of the evaluation. Documentation is not as simple as writing down what you happened during the visit, there also should be a prior awareness of what is required in documenting specific problems. Learn the box below:

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.

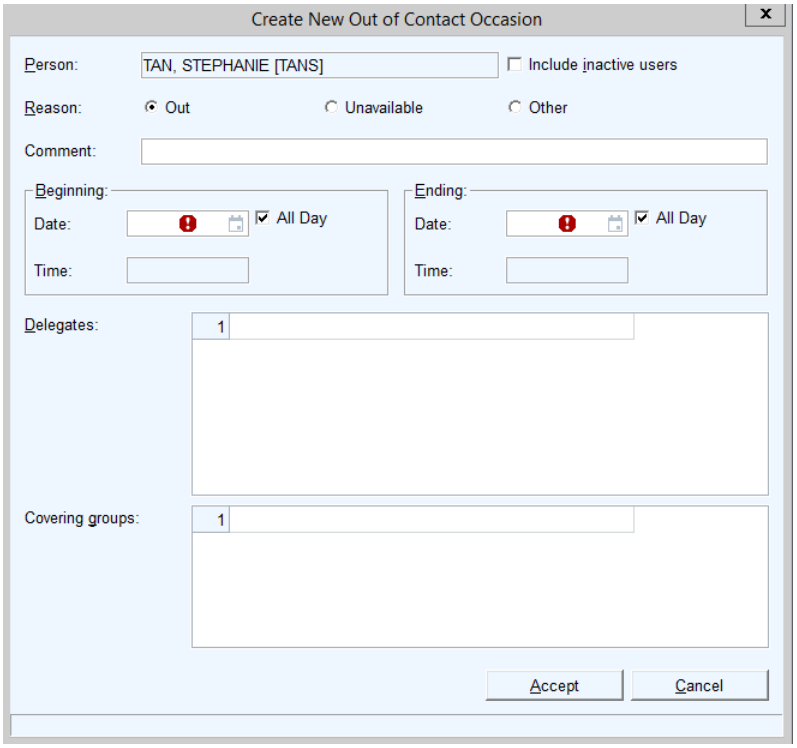
EPIC will automatically generate a professional code for you based on your documentation. It is unable to capture the complexity of free-text, but it is good at capturing data points from your use of pre-formatted note tools. Billing is an evolving process here at the IMC since we will eventually be shifting to professional fees. Your attendings will show you how to do this when you start seeing patients and will always be prepared to help you.

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, your notes that are not closed on time means work that you will not receive payment for.

**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 conflicts arise, 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" which is the farthest option to the right of the In Basket top toolbar. 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**



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