INTRODUCTION

Welcome to the Family Medicine Center of Charleston. The purpose of this resident manual is to answer any of the questions, which you may have as you enter our program. Please make yourself very familiar with these policies, as the answers to most of the questions you will have will be contained there. You will find that our faculty is very open to discussions on practically any area of concern, which you may have.

Our purpose is to provide the highest level of training in preparation for a career in family medicine.

Best wishes for success in your years of training - we're glad that we shall play a vital role.

Sincerely,

Andy R. Tanner, DO
Program Director
Family Medicine Center of Charleston
RESIDENT MANUAL 2010 – 2011

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A Brief History

The Charleston Campus of West Virginia University is the oldest regional medical school campus in the United States and has become a prototype for community based training. In the 1960’s, a group of prominent OB-GYN physicians approached leaders at area hospitals to consider consolidation of services that would improve the quality of patient care and that could support an environment for the training of medical students and residents in Charleston. Building upon this groundwork, three area hospitals merged on January 1, 1972 to create Charleston Area Medical Center (CAMC). Funded by an Area Health Education Center grant, CAMC and West Virginia University signed an affiliation agreement on November 14, 1972 to establish a Charleston based campus and partnership that would provide clinical training for physicians and other health professions. While some graduate medical education training previously existed, the merger of hospitals and medical staffs and the affiliation with WVU, allowed for the development of a focused mission of education in the southern region of the State. The satellite campus provided clinical rotations for third and fourth year medical students from WVU. With the establishment of six medical school departments on site, including Family Medicine, we began training medical students from the West Virginia University School of Medicine, requiring third year medical students to complete a one-month Family Practice rotation with the option of an additional month for fourth year students.

In the early 1970’s, the West Virginia Chapter of the AAFP wanted to create a residency-training program. With the cooperation of Charleston Area Medical Center (Hospital #1), Herbert J. Thomas Memorial Hospital (Hospital #2) and West Virginia University, the Kanawha Valley Family Practice Residency Program became a reality. The original office opened on July 1, 1974 and was located behind Thomas Memorial Hospital. This was the first family medicine residency program in West Virginia. The first class of family medicine physicians graduated on June 30, 1977. Later in the 1980’s, two rural satellite offices were established in the communities of Sissonville and Clendenin. These offices were established to provide care in a medically underserved area and provide a diverse population and rural training site for residents and medical students.

In 1993, the residency program expanded its partnership with Charleston Area Medical Center creating a larger Family Medicine Center location in downtown Charleston, adjacent to the General Division of CAMC. The new location served as the hub for the residency program and remained complemented by the rural satellite offices and the site located at Thomas Memorial Hospital (FMC #2). In the late 1990’s, due to economic challenges, the continuity clinics for the residents at the rural sites were discontinued.
In 2004, due to continuing economic realities the rural satellite offices located in Sissonville and Clendenin were sold to Cabin Creek Health Systems, which had another Federally Qualified Health Center (FQHC) in the area. This new arrangement allowed the offices to stay open and continued to provide a training site for medical students from WVU. Our family medicine inpatient service continues to provide inpatient care for the patients from these offices when they require admission at CAMC or Thomas Memorial Hospital. Our faculty members have developed close relationships with many of the patients and families in these rural areas through their care of over many years. Our residents now rotate at these satellite offices as part of their community medicine rotation, which allows them to experience rural health and become familiar with the FQHC model.

In August of 2008, Family Medicine Center #1 moved to the Robert C. Byrd Clinical Teaching Center, located adjacent to the Memorial Division of Charleston Area Medical Center. Located in the 210,000 square foot facility are the outpatient offices for the Departments of Family Medicine, Internal Medicine and Behavioral Medicine. By integrating these offices into one location, CAMC and WVU are able to provide more convenient and efficient health care for the community and to strengthen the clinical education mission.
Jeffrey Ashley, MD – Chairman
Andy Tanner, DO – Program Director
Kathleen Bors, MD – Student Coordinator
Daniel Dickmam, MD – Assistant Professor
Julia Ellison, DO – Assistant Professor
Amy Tickle, MD – Assistant Professor
Molly Johns, DO – Assistant Professor
James Mears, MD – Assistant Professor
Greg Jarrell, DO – Assistant Professor
Chris Terpening, PharmD
Scott Fields, PhD, Clinical Psychologist
Tiffany Edwards, MBA – Administrator
Elizabeth Westfall, C-TAGME – Program Coordinator
Tammy Pauley – WVU Student Program Coordinator

Office Staff
CAMC Family Medicine Center

Nursing: 304-388-4626 or 304-388-4627
Laboratory: 304-388-4631
Front Office: 304-388-4600; 304-388-4676; 304-388-4675; 304-388-4639
Medical Records: 304-388-4659
Patient Billing: 304-388-4641 (CAMC); 304-388-4617 (WVUPC)
Referral Office: 304-388-4638
Administrator: 304-388-4615
Preceptor Room: 304-388-4613
Program Coordinator: 304-388-4620
Student Coordinator: 304-388-4630

Kanawha Valley Practice Center

Front Office: 304-768-3941 or 304-768-3934
Sincerely Yours Answering Service: 304-340-1620
CAMC Hospital Operator: 304-388-5432
Paging Service: 304-388-8250

Office Hours of Operation
Monday – Friday 8:30 am to 4:30 pm

Closed 12 – 1 (lunch)

Closed Major Holidays

Front Office Staff arrive at 7:45 am

If you are unable to make it to a scheduled office day (for emergency only), you are to call the Program Coordinator (304-388-4620) once you know there is a problem. If she is unavailable, please call the front office (304-388-4639) so that patients can be notified

PATIENT ASSIGNMENTS

Each resident is assigned to a panel of patients at the Family Medicine Center. A concerted effort is made to assign entire families to each resident to ensure exposure to an appropriate number of complete families in order to learn family dynamics and the principles of integrated health care. We take effort to see patients are distributed to residents as balanced as possible with regard to age distribution and disease category. Throughout the residency, the front office staff will assign NEW patients to you as well. These patients will continue to see you throughout your time with us. In the event that your patients need to be seen at a time when you are not available, they will be assigned to one of your team members, in an effort to maintain some degree of continuity with your patients.

ASSIGNMENT OF PATIENT APPOINTMENTS

Guidelines used by the front office in assigning patients to residents are outlined below:

<table>
<thead>
<tr>
<th>Residents</th>
<th>New Patients</th>
<th>Complicated RV</th>
<th>Routine RV</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY 1</td>
<td>60 mins.</td>
<td>40 mins.</td>
<td>30 mins*/20 mins.*</td>
</tr>
<tr>
<td>PGY 2</td>
<td>40 mins.</td>
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<td>20 mins*/15 mins.*</td>
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<tr>
<td>PGY 3</td>
<td>30 mins.</td>
<td>30 mins.</td>
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<tr>
<td>Faculty</td>
<td>30 mins.</td>
<td>30 mins.</td>
<td>15 mins.</td>
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*For the first six months residents will be assigned the higher number of minutes per visit, the second six months resident appointment times will be bumped up to the next PGY level.

If you need additional time with a patient for a return visit, please indicate this on the patient’s
fee ticket so the front office staff can schedule the return visit for a longer length of time.

During PGY 1, you will need to see 140 patients in order to meet the minimum number of required patient visits. You will receive monthly updates on the number of patients seen and this is monitored by the Program Director.

**CHART NOTES**

- All progress notes should be completed on the day of the office visit.
- At the end of all progress notes, be sure to write the name of your attending. (for example, “patient seen and discussed with Dr. Ashley.”)
- All progress notes need to be DATED, TIMED and SIGNED.
- All entries in the chart need to be DATED, TIMED and SIGNED.
  - This includes review of laboratory data, medical imaging and hospital records.
- Once you have completed your progress note, please place the chart in your attending’s box for his/her review and signature.

You will be assigned a CHART BOX. This box will contain charts which need your attention, such as review of laboratory data, signatures for medical equipment, record review etc. **IT IS YOUR RESPONSIBILITY TO COMPLETE ALL NECESSARY CHARTS AT THE END OF EACH OFFICE SESSION. FAILURE TO KEEP UP WITH YOUR CHARTS WILL RESULT IN DISCIPLINARY ACTION.**

**MEDICAL RECORDS**

Patient records are to be handled in a confidential manner at ALL times. **At no time is the patient's medical record to physically leave the premises of the Center.** All records of patients seen at the Center are to be reviewed by the attending responsible for the care of the patient. No chart is to be placed back into file after a resident entry is made until counter-signed by a faculty member. This includes telephone messages as well. In the event that the patient leaves the Center and becomes the patient of another physician, proper authorization in writing must be secured before copies of the medical records can be sent to that physician. In some cases a summary letter will need to be dictated. This is the responsibility of the assigned resident. The original record is to always remain at the Center.

The PROBLEM SUMMARY and MEDICATION LIST are a vital part of the medical record. **It is expected that each resident will maintain an up-to-date problem list and medication list on all patients they see.** This is vitally important as other residents or faculty may have to answer medical questions or assist in medical care when the assigned resident is not available. These charts also serve as a source of research in family practice and an up-to-date medical record is essential in assisting this task.

**GUIDELINES FOR RELEASE OF MEDICAL RECORDS**

1. All requests for such information should be routed to the attending
resident of the patient.

2. No information can be released without a signed RELEASE OF MEDICAL INFORMATION FORM from the patient. This RELEASE is then attached to the office record and becomes part of the record.

3. Notification is to be made to the program director if any request is received from a lawyer or legal firm.

4. Any reports that are desired from insurance companies, Workmen's Compensation, disability, etc. are the responsibility of the attending resident. When appropriate, a dictated report can be used.

5. Care must be taken to release only proven diagnoses for which there is corroborative evidence in the record.

6. A copy of any dictated reports should be placed in the office record as a permanent part of the record with the date of the report recorded.

7. An appropriate fee should be billed to the company and attached to the report when sent. At times a charge for copying of the medical record will be sufficient. Any questions on any of the above should be brought to the attention of the director for clarification.

REFERRALS

Many of the patients seen in your continuity clinic will require a REFERRAL to a specialist or for certain testing. All patients requiring referrals should be discussed with your attending physician. The following procedures require completion of a REFERRAL FORM:

- Specialist consultation (Cardiology, Pulmonologist, Neurology etc)
- Medical Imaging
  - CT
  - MRI
  - Ultrasound
  - Barium Swallow/Enema
  - Nuclear Studies
- Vascular Studies
- Specialized Laboratory Studies
- Cardiac Stress Testing
- EEG

If your patient requires STAT testing, please see one of the referral specialists to meet your
NOTIFICATION OF LABORATORY TESTS/MEDICAL IMAGING

You will need to notify ALL patients of the results of laboratory testing (HGBA1C, Lipid Profile, and Chemistry Panel etc) and medical imaging. One of the best ways to do this is use of our Lab Notification Letter. These are available in the office and you can simply fill in the blanks, sign your name and leave in the “Outgoing Mail” box for delivery. Be sure to write clearly and explain results in a way your patients will UNDERSTAND! If you choose to notify your patients with a phone call, be sure to document the conversation in the progress notes or on the lab/x-ray report. You should NOT send Lab Letters to patients for results of STD testing or HIV testing. If your patient has an abnormal result, it is best to call the patient and schedule follow-up. The nursing staff can assist you with this as well.

PRESCRIPTION REFILLS

Many of your patients will be on multiple medications. It is your responsibility to ask each patient at every visit if they need refills on their medications. Be sure your patients have enough refills until the next scheduled appointment. At times, you may not want to give refills on certain controlled medications. Please indicate in your note if the patient can call in for refills before their next scheduled appointment or if you are prescribing for a certain period of time.

You will also need to make yourself familiar with the many medication formularies of the various insurance carriers for our patients. Many of our patients have Medicaid and a list of the medications covered by Medicaid is available in the office. It is recommended that you ask patients how they pay for medications before writing a prescription make yourself aware of the high cost associated with these prescriptions.

PROCEDURE FOR PHONE CALLS AND MESSAGES

All phone messages originate in the front office and are recorded concerning patient's health care or patient's request to talk with a physician. Requests of an urgent nature will be made known to the resident who is to take care of the message in an expedient fashion. The nursing staff will bring messages to you from time to time. All messages need to be taken care of before leaving the office. It will be expected that each resident make sure there are no unanswered messages from patients before leaving the Center. Urgent messages from patient's whose resident is not in the office will be handled by the faculty preceptor.

Do NOT give your personal pager or cell phone number to patients. All phone calls and messages from patients need to be handled through the office in order to assure proper documentation and HIPPA compliance. If you need to call a patient after hours from your home or cell phone, you can call the CAMC operator (304-388-4321) and ask them to patch you through to a patient’s phone. This will assure that a patient does not obtain your number from caller ID.
Outgoing calls are made from any phone in the Family Medicine Center by dialing 9 and then the appropriate number. Long distance phone calls are not to be made without prior consultation with faculty. **At no time are the Center’s telephones to be used for personal calls of a long distance nature.**

- 304-388-4600 - receptionist
- 304-388-4628 - private line for fax transmissions
- 304-388-4646 - private line to FMC nursing staff
- 304-388-4620 - residency coordinator/program director
- 304-388-4621 - residency/departmental fax line

Incoming calls from patients are transmitted through the first line. The line is for use of physicians of the center to call direct from the outside or to call from the center if other lines are busy. Physicians who are expecting phone calls should inform the receptionist so that no hold up is produced when the caller is on the line and his call can be expedited without delay. Likewise, all physicians entering and leaving the center should check in and out with the receptionist. Residents should inform the residency coordinator in writing of their dates for vacation/conference or any other times that appointments need to be canceled or rescheduled.

**FEES**

Fee schedules for the Family Medicine Center will be made available to each resident. The faculty is very committed in teaching the economics of health care delivery as well as the medical aspects of health care delivery. It will be expected that each resident become competent in the appropriate selection of charges for the care rendered by the resident. It is expected that ongoing consultation be obtained for faculty members as to appropriate charges. It is imperative that an attending’s name responsible for oversight of the patient be placed on each fee ticket at the time service is rendered. All patients who are billed CPT codes 99204, 99205, 99214, 99215 have to be seen and evaluated by an attending. No fees can be billed without an attending name. We attempt to keep our fees in the customary and usual range for those found in the community to assist the residents in learning the economics of family practice. The office administrator will be providing you with monthly reports reviewing the economic data of the office and individual financial reports for your review. This data should help you understand the economics of the office and how your individual productivity can impact the practice as a whole.
PATIENTS

- **Scheduling** - Patients are seen at the Family Medicine Center on an appointment basis. All appointments are to be made with the front office staff. Residents are NOT to make any appointments and patients CANNOT be seen in the Center without being registered with the front office. At times, you may need to schedule a patient with you during one of your clinic days and you should call the front office to help facilitate this need. It is the responsibility of the resident to make the receptionist aware of any unusual circumstances or situations which may require more time for scheduling such as unusual procedures or unusually complicated cases which may take more time. **No changes are to be made in the resident’s schedule unless approved by the program director or the program coordinator.**

- **Transfers** - If a patient desires that medical records be sent to another physician, the patient must submit this authorization in writing to the medical records clerk. The resident is responsible for notifying a faculty member any time a patient desires to be transferred from the Center. If the transfer is due to dissatisfaction the patient has experienced in medical care, this is to be brought to immediate attention of a faculty member. In the event that a patient wants to transfer from one resident to another, approval must be obtained by a faculty member. This is generally discouraged but occasionally is allowed in individual circumstances.

- **Hospitalized Patients** - Patients requiring hospitalization become the responsibility of the family practice hospital service. The admitting resident is responsible for notifying the senior resident for the hospital service to which the patient will be admitted. The resident who is seeing the patient in the office may assist in dictating a history and physical, writing an admit note and participate in the writing of admission orders, but final responsibility lies with the resident inpatient team. No patient is to be admitted to the hospital service without the direct involvement of the resident inpatient team and the attending physician. Any patient who is admitted after 6:00 p.m. becomes the responsibility of the resident on call. Discharge summaries are the responsibility of the PGY-1 or PGY-2 resident on the case. The senior resident will notify you if one of your patients is admitted to the hospital. You must remain in contact with the senior resident on the inpatient team during the admission and make arrangements to visit your patient during their hospital stay. The patient will be scheduled to see you in follow-up after discharge.

- **Patient Education** - Education of patients to carry out the physician's instructions is important. A number of resources are available including patient education videotapes, diet classes, patient handouts, as well as a multitude of other outpatient resources. Please consult the clinical nursing staff for this information.
QUALITY ASSURANCE

All charts are reviewed on a 100% basis by faculty on all resident activity in the outpatient and inpatient setting. In addition, all lab results and radiologic reports on patients are reviewed by a faculty member. A quarterly review is done by the clinical staff in accordance with CAMC guidelines. Residents are required to participate in the quality assurance activities of the clinical services to which they are assigned.

SPECIAL PROCEDURES

The Family Medicine Center is equipped with certain specialized instruments to aid in the diagnosis and treatment of patient problems:

1. **Vision Testing** - Is available for the comprehensive testing of vision for refractive errors, astigmatism and color perception.

2. **Tympanometry** - Is available to assist in the management of middle ear disorders.

3. **Proctoscopy** - Is available for examination of the rectum.

4. **Colposcopy** - An Olympus colposcope with video capabilities is available for assistance in examination of the cervix. A complete set of instruments for the biopsy and treatment of cervical diseases is available. A request for colposcopy needs to be placed on a referral form and this procedure is scheduled with the front office.

5. **Endometrial Biopsy** - Pipelle endometrial biopsy instruments are available for the securing of endometrial sampling in indicated patients.

6. **Spirometry** - Is available to assist in the diagnosis of COPD asthma and other pulmonary disorders. The residents are expected to become proficient at the interpretation of spirometry.

7. **Minor Surgery** - A comprehensive array of minor surgery equipment is available to assist in all manners of excisions, incisions, ligations and other minor surgical procedures. In addition, liquid nitrogen and electrical desiccators are available for use when appropriate.
HOUSE CALLS

There will arise an occasion in which a house call should be made. All residents are required to participate in making house calls. There was much more reason to make house calls in years gone by when therapy was based more on clinical impression and when the availability of diagnostic testing was unavailable. The need to practice defensive medicine was likewise not prevalent to the extent that it is today. Even so, there will be instances in which a house call could and will be made. They shall usually fall into the following categories:

- Chronically ill patient being cared for at home and for whom transportation of a reasonable nature is unavailable or economically unfeasible.

- Caretaker in the above situation (family member usually) needs to be reassured that his/her care of the patient is proper under the circumstances.

- Terminally ill patient who has chosen to die at home and where family's need in this situation is the paramount reason to render care.

House calls should be discouraged for the following reasons:

- Acutely ill in otherwise healthy patient.

- Prescribing of narcotics when those in attendance are not trustworthy and may abuse the presence of these drugs.

- Where the risk for malpractice is high and for which a house call cannot lower or nullify this risk and may even intensify the likelihood.

When it is anticipated that a house call is deemed necessary it needs to be approved by a
faculty member, and if the resident is a PGY-1, on initial visits and/or if the resident is uncomfortable, a faculty member should accompany the resident. A prompt progress note detailing the house call should be made and given to a faculty member for review. House calls may be made on the continuity patients in the resident’s panel or as part of the geriatrics rotation.

NURSING HOME PATIENTS

The Family Medicine Center has a number of Nursing Home patients at Oakridge Nursing Home. Each second and third year resident will be assigned a certain number (generally 4-8) of Nursing Home patients and will be scheduled during regular office time to see these nursing home patients with an attending. It is the primary responsibility of the resident to complete all paper work and to answer all phone calls related to nursing home patients. The nursing home is instructed to contact the assigned resident for any information or orders that are needed. This can occur at times you are not scheduled in the Family Medicine Center. **You are expected to return these phone calls even while on a rotation.** If at any time there is a question as to the appropriate medical care to render, please contact an attending physician for guidance. It is expected that the resident see the patient at least once monthly which may mean before or after vacation/conference time which falls during your regularly scheduled nursing home time. Coverage for attending to your nursing home patients needs to be arranged by you for any absences (remote site rotations, maternity leave, extended illnesses, and other extended absences).

ANWERING SERVICE/PERSONAL PAGERS/SERVICE PAGER/CELL PHONE

The Department of Family Medicine utilizes the services of a 24-hr answering service. This service is available when the office is not open and patient phone calls are automatically directed to this service. You will become more familiar with this service in PGY 2 and PGY 3 as patient phone calls are directed to the resident on call after hours. You are required to keep a phone call message sheet with you while on-call and record the directions or advice given to patients after hours. It is important for you to document the patient concerns and advice for medical/legal purposes and to provide the continuity physician with up to date and accurate information. These phone call sheets also need to be signed by the attending physician and are directed to the appropriate office the next business day. Be aware that under NO CIRCUMSTANCES are you to call in controlled substances or antibiotics to patients after hours. Our patients are aware of this policy, but from time to time they may try to persuade a resident to provide them with medications over the phone.

The Department also has a Family Medicine Service Pager (304-340-4017). This number is provided to the ER’s and medical floors at CAMC and Thomas Memorial Hospital. Critical lab values are also called to this number as well. You will become more familiar with the Service
Pager when you rotate on the Inpatient Service.

Your personal pager should be worn at ALL times when on duty. You should answer pages promptly and in a professional manner. Always identify yourself and the service with which you are working with (ie, Pediatrics, Internal Medicine, Family Medicine) when responding to pages.

Your personal cell phone is also an excellent way to communicate with your peers and other members of the department. Be sure the Program Coordinator, Program Director and Chairman have a cell number for you. If you prefer that the OFFICE nursing staff contact you via your personal phone, please let them know. At NO time should you text or email patient information on your personal phone. Also, you should NEVER take photos of patients at ANY time.

**INPATIENT FAMILY MEDICINE SERVICE**

Patients are admitted to one of four hospitals. At Charleston Area Medical Center we admit patients to all three divisions; Memorial, General, and Women & Children's. We also admit to Thomas Hospital. One attending physician will oversee all four hospitals. The resident responsibilities will be divided according to patient location and volume, but, in general, CAMC Memorial and Women and Children’s will be covered by the PGY-1 and PGY-3 residents while Thomas and CAMC General will be handled by the PGY-2 resident. Obstetrics is handled as a special service with its own attending, which could be either a Family Practice faculty or the OB-GYN service with their attending. The CAMC service will consist of one senior level resident, and at least one intern who will be devoted to the service full-time. One PGY 2 resident will responsible for admissions at Thomas and CAMC General. Mandatory check in is at 7:30 a.m. at the Family Medicine Center in the conference room for the CAMC service and the resident on call. On Tuesdays and Thursdays, check-in will be preceded by a resident-run educational conference. All residents on the hospital service as well as the resident (and medical student, where applicable) are expected to attend check-in each day. At the end of each day, approximately 6:00 p.m., it is expected that each resident check out with the resident on call. In the event of admission during the day, notification should be made to the senior resident of the appropriate service. CAMC beepers are assigned to each resident at the beginning of the year and these are to be utilized throughout the entire residency so that you may be contacted as the need arises. In addition, the residents on hospital service will also have a digital pager.

**OBSTETRIC PATIENTS**

The Family Medicine Center encourages the registration of obstetric patients and considers this a vital aspect of family practice training. Continuity obstetric patients are seen and followed by the resident in the office and are delivered by them under appropriate supervision of faculty. The care of an obstetrical patient takes precedence over all other responsibilities including that
of rotations and office appointments. No obstetrical patients will be assigned to residents whose due date falls before anticipated completion of two months of obstetrical service. PGY 2 and PGY 3 residents are expected to have a fellow resident as a co-manager of each continuity OB patient to ensure proper coverage. After 34 weeks, the primary resident responsible for the OB patient will remain in town and available for delivery if needed. The resident will be expected to perform the circumcision on all male infants for whom the parents wish to have this done under the supervision of an attending physician. Drs Mears, Ellison and Johns maintain OB privileges for the department and will be supervising deliveries, prenatal and postnatal care of your patients. The OB call schedule for the department is posted on CAMNET. If one of them is not available, coverage is provided by the Department of OB/GYN through a prior arrangement

MEALS

Meals at Thomas Hospital are free to residents while on duty. At CAMC meals are provided for residents while on call for a hospital service only via the use of meal cards which were provided to you at the Institutional Orientation Program. Please see your CAMC house-staff manual for the details. Lunch is USUALLY provided in the department on Tuesdays and Thursdays.

IMPAIRED RESIDENT POLICY

The impaired resident policy is that described in the most recent edition of the CAMC House Staff Manual. Please refer to that manual for resources available and any questions you may have.
RESIDENT EDUCATION

DIDACTICS

A number of meetings and conferences are held at the Family Medicine Center and elsewhere at which attendance by the family practice resident is expected. Please review the accompanying diagram for lectures and discussions scheduled at the Family Medicine Center.

Monday – Friday 7:30 am  Morning Check in Rounds
Tuesday 7:30 am       Lecture
Tuesday 12:30         Intern Lecture
Thursday 12:30        Grand Rounds
Thursday 1:30         Lecture
Thursday 2:30         Lecture

In addition to lectures and discussions at the Family Medicine Center, there are many conferences ongoing at CAMC. The family practice resident is expected to attend the conferences that fall under the department with whom you would be currently rotating. The senior resident on your service will provide you with a list of lectures to attend during your monthly rotations.

Conference attendance is monitored and a minimum of 75% attendance is expected.

VIDEOTAPING

Dr. Fields, our clinical psychologist, will arrange to have your encounter with a patient at the Family Medicine Center videotaped within the first three months of your residency. He will meet with the patient beforehand and discuss the use of the videotape and obtain consent from the patient. The encounter will be videotaped and he will review the video and provide you with feedback regarding interpersonal and communication skills. The medical content of the video will be reviewed by the attending physician. Dr. Fields will schedule this exercise several times throughout your residency. The information will be utilized as part of your evaluation and
reviewed by the Program Director.

**MINI CLINICAL EXAM**

The attending physician will follow you into an exam room and observe your interaction with a patient. He/she will evaluate your performance based on the 6 core competencies and provide you with immediate feedback. This form will be reviewed by the Program Director and be utilized as part of your overall evaluation.

**JOURNAL CLUB**

Journal Club is held each month, during the allotted lecture time on Thursday afternoon. Dr. James Mears will assign a review article to a PGY 2 or PGY 3 resident. The resident will present the article and be prepared to answer questions related the topic.

**SIMULATION CENTER**

The simulation center will be used for small group discussions and demonstrations at various times in your residency. The center has many resources available which will enhance your education and sessions in the center will be scheduled by the Program Director and Program Coordinator.

**CLINICAL TEACHING**

A number of teaching opportunities arise when seeing patients in the office. The attending physician will discuss cases with you and there is an opportunity to learn from other residents seeing patients in the office with you. The clinical faculty see patients in the center alongside the residents and are available for discussion and demonstration as opportunities arise.

**BOARD REVIEW**

Board review is incorporated into the monthly didactic schedule. The department also recently purchased the Core Content Review for all residents in the department. This online review series should be utilized on a monthly basis and your progress in this series will be monitored by the Program Director and your faculty advisor. The Program Coordinator will provide you with your access codes to the Core Content Review.

**RESIDENT/STUDENT LECTURES**

As part of your medical education, you will be asked to prepare and provide lectures to your peers. You will be assigned topics by the Chief Resident and your lecture will be evaluated by the attending physician assigned to conference. You may also be asked to provide lectures to medical students as well. These lectures will be evaluated by the medical students.
EVALUATION

MONTHLY ROTATION
At the end of each monthly rotation, the Program Coordinator will send out an evaluation form to your attending physician and the residents and students who worked with you during the month. A monthly evaluation of your performance in the office setting is sent to your attending physicians as well. These evaluation forms are sent via the New Innovations Software and returned to the department electronically. You are able to review these evaluations at any time by logging on to the website with your secure password. These monthly evaluations are reviewed by the Program Coordinator, the Program Director and your Faculty Advisor on an ongoing basis. Each quarter, these evaluations are reviewed by the Education Committee and individual resident performance is discussed.

STAFF EVALUATIONS
On a quarterly basis, the Staff at the Family Medicine Center will evaluate your performance on a variety of competencies in the office setting. These evaluations will be reviewed in the same fashion as described above.

QUARTERLY EVALUATIONS
Every 3 months, you will meet with your faculty advisor to review your progress in the program. At this meeting you and your advisor will review the written evaluations available, visit number data, staff evaluations, education committee meeting minutes and other pertinent data points. The written evaluation will also be reviewed by the Program Director.

SEMI-ANNUAL EVALUATION
Every 6 months, you will meet with the Program Director to review your progress and performance in the residency. He will review your quarterly evaluations, visit numbers, procedure logs, staff evaluations, mini-clinical exam forms and monthly evaluations. If available, in-service exams will be reviewed as well.

PATIENT COMMENT CARDS
Patient comment cards and patient surveys are given to all patients at the Family Medicine Center. Positive and negative comments will be reviewed with you on an on-going basis. Patient surveys and comments are also generated on patients admitted to the hospital as well. Many of these comments are sent to Medical Administration for resolution of conflicts.
IN-TRAINING EXAM

The ABFP In-training exam is given November of each year. You are required to take this ½ day exam. The results of the exam are available in early January after the exam and are one measure of your performance within the residency. Any resident scoring below the 10th percentile on the exam will be placed on remediation schedule and be required to attend a board review coarse. If your average score for all three years is at or above the 50th percentile, the Sponsoring Institution will pay for the cost associated with your certifying board exam.

All osteopathic residents are ALSO required to take the ACOFP in-training exam, which is given in early December of each year. The results are used as described above.

CHIEF RESIDENT

The Department of Family Medicine elects a new Chief Resident at the in December of each academic year. The position, which is a year long, runs January through December. A complete job description is available for review. Their primary function is to facilitate resident-faculty interactions, develop call schedules, oversee conferences, and represent the department in interdepartmental resident meetings.
RESIDENT RESPONSIBILITY AND SUPERVISION POLICY

The Department of Family Medicine adheres to the guidelines set forth in the House Staff Handbook for supervision of residents and interns (section II B, page 3). The attending physician supervises all patient care at all times. In the outpatient setting, residents are supervised by an attending physician, who is present in the office during office hours. There is one supervising family physician faculty member for every 4 residents working in the clinic at any given time. In the inpatient setting, interns are supervised by a senior resident and by the attending physician. The attending physician assigned to the inpatient service is available at all times, either by phone or pager, and makes rounds on patients in the hospital daily. The Chairman and Program Director are available by phone or pager at all times should a problem come up in reaching one of the attending physicians. The faculty and residents are trained annually on the recognition of the signs and symptoms of fatigue. If a resident is found to be suffering from severe fatigue, his or her work duties are re-assigned, and they are sent home to rest.

VACATION/SICK LEAVE AND DRESS CODE

- Carry over vacation time from one year to the next is not permitted. The American Board of Family Practice specifically prohibits the transfer of vacation from one year to the next. There are also very strict guidelines as to the amount of time away from the residency for any reason that can be taken within any academic year. **Any time that patient care duties cannot be performed for any reason, the residency coordinator needs to be notified directly.** This includes time spent away from a rotation as well.

- Professional attire is required at all times (sleeveless garments must be covered by a jacket or lab coat, no blue jeans, low cut or revealing blouses/shirts. Skirts and dresses must be fingertip length). Clean lab coats
are the required dress in the clinic area at all times (scrubs are permissible when rotating on the hospital service). **Closed toed shoes are required at all times while in the clinic area, no exceptions.** All tattoos must be covered either with clothing or a bandage. Please keep jewelry to the minimum, body piercings should be covered or removed.

- No vacation time will be granted during the last two weeks of time spent in the residency, during the self-assessment examination in November, and during the annual Family Medicine Center Workshop Day, which is in the first full week of April. No vacation time will be granted for third year residents for graduation.

**MOONLIGHTING POLICY**

The Department of Family Medicine Moonlighting Policy adheres to the policies and procedures set forth by Charleston Area Medical Center, which states:

Moonlighting is defined by the ACGME/AOA as “professional and patient care activities that are external to the educational program”. The ACGME/AOA prohibits any requirement of resident/interns to perform moonlighting services.

Moonlighting is not encouraged but is permitted within parameters of defined institutional policy. The primary responsibility of the resident/intern is to the service or activity to which they are assigned. The resident/intern’s training program must be given priority over any outside activity. Therefore, moonlighting activities must not interfere with clinical and educational performance.

All resident/interns engaged in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. Professional liability coverage is not provided for moonlighting activity. It is the responsibility of the institution hiring the resident/intern to determine whether such licensure is in place, whether adequate liability coverage is provided, and whether the resident/intern has the appropriate training and skills to carry out the assigned duties. Moonlighting outside the scope of the training program may at times be offered to resident/interns at CAMC locations. Resident/interns must follow the same policy, permission process and requirements of moonlighting regardless of whether the moonlighting engagement will be internal or external to CAMC locations. Resident/interns will be responsible for securing confirmation of malpractice coverage and licensing requirements outside the scope of their residency training assignment.

As stated in the resident/intern Contract, resident/intern must obtain prior permission to moonlight and must complete a Request for Permission to Moonlight Form prior to engaging in any moonlighting activity. Failure to do so may lead to immediate revocation of moonlighting
privileges, as well as disciplinary measures, including dismissal. Permission to moonlight does not grant professional liability coverage. Resident/intern’s performance will be monitored for the effect of moonlighting activities upon regular performance. Adverse effects may lead to withdrawal of permission.

Resident/interns should refer to the current Charleston Area Medical Center Resident Moonlighting Policy for guidelines on moonlighting and the moonlighting permission process. The policy will be available to resident/intern through the Office of Graduate Medical Education or the Program Office. A signed statement of receipt of the policy must be placed in the resident/intern’s permanent file before permission to moonlight will be made a part of the resident/intern’s individual record or file.

**DUTY HOUR POLICY**

The Department of Family Medicine adheres to the duty hour’s policy as set forth in the resident handbook. In addition, the program will adhere to the following guidelines regarding resident work hours.

**DUTY HOURS**

For resident physician health and patient well-being, new guidelines regulate resident workload as follows:

- Residents will not be scheduled for more than 80 hours per week, averaged over a 4-week period. This includes time spent on in-house call, but does not include home-call except for the hours actually spent in the hospital. Residents taking home call will be expected to keep accurate records of time spent in-hospital.
- Continuous time on duty is limited to 24 hours, with an additional 6 hours being allowed for continuity patient care.
- There will be a minimum of 10 hours rest period between duty periods.
- Residents will have one day in seven completely free of duties, averaged over a 4-week period.
- Moonlighting counts towards the 80 hour maximum.

On the average, family practice residents spend less than 80 hours per week on hospital-based duties. Night call averages no more than every 3 nights while on other services. Family Medicine residents should have one continuous day out of seven free from clinical duties while on other rotations and while on the family practice inpatient service. Occasionally, vacation schedules and unanticipated absences may interfere with time away if patient care demands are great.

The Department of Family Medicine Duty Hours Policy will also include the following:
1. Educational goals and objectives of the program will not be compromised by excessive reliance on residents to fulfill service obligations.

2. Duty hours and schedules will be monitored by the Program Director on a monthly basis, and adjustments will be made to address any excessive service demands or resident fatigue.

3. Residents may remain on duty in the event that patient care could be compromised, if a resident were to leave at a designated time.

4. If patient care responsibility becomes too difficult or prolonged, the resident will contact their attending physician and notify him/her of the situation. If the attending physician cannot be contacted, the resident will contact the Program Director or Chairman, who are available at all times by phone or pager.

5. Departmental duty hours will be in compliance with those set forth by Charleston Area Medical Center and on-call schedules will focus on the needs of the patient, continuity of care, and the educational needs of the resident.

6. The Program Director will monitor moonlighting hours and comply with the institution’s moonlighting policy. Permission for moonlighting will be given in writing to residents and their hours will count toward the 80-hour weekly limit.

7. Residents and faculty will attend a didactic session each year to review the signs of fatigue. If a resident is found to be suffering from fatigue, he/she will be sent home to rest, and their work duties and patient responsibilities will be re-assigned.

8. The program will provide a written report annually to the GMEC to review compliance with the duty hour policy.

9. Residents will meet annually with the Program Director and Department Chairman to discuss the issues of duty hours, resident safety and well being. A written summary of this meeting will be included in the annual report and forwarded to the GMEC.

10. At any time, residents may express their concerns with duty hours, patient or on-call responsibilities to the Program Director or other faculty member in the department.
CRITERIA FOR PROMOTION
FROM PGY1 TO PGY2

1.) The resident must successfully complete all PGY1 rotations (see criteria for successful rotation completion) or receive advanced credit for twelve months from the American Board of Family Medicine.

2.) The resident must demonstrate achievement of competency in the Core Competencies required in the PGY1 (see Competency Based Goals and Objectives for each level of training in Family Medicine). In order to show achievement of these competencies, PGY1 residents are expected to demonstrate the following:
   a.) Identifies purpose of visit.
   b.) Gathers complete and realistic history.
   c.) Develops an appropriately ordered, reasonable differential diagnosis for presenting problem.
   d.) Orders appropriate labs/tests for presenting problem.
   e.) Presents working diagnosis to patient.
   f.) Discusses appropriate follow-up and/or discharge planning.
   g.) Prescribes medications appropriately.
   h.) Considers the ramifications of treatment including interactions, side effects, and potential complications.
   i.) Educates patient about prescribed medication.
   j.) Documentation is legible, concise, in SOAP format for each problem and with a completed problem list for each patient.
   k.) Health maintenance information is updated, including medicine/allergy list and problem list.
   l.) Demonstrates a commitment to carrying out professional responsibilities.
   m.) Patients are billed appropriately.
   n.) The resident is able to take call independently.
   o.) The resident recognizes limitations and seeks help appropriately.
   p.) Accepts feedback well.
   q.) Uses instructional technology to determine best medical evidence.
   r.) Introduces self to patient and addresses patient with appropriate title.
   s.) Become competent in physical exam skills.
   t.) Demonstrates sensitivity to a diverse patient population.
   u.) Learns from experience.
   v.) Recognizes that patient’s needs supersede resident’s needs.
   w.) Documents all procedures performed during PGY1.
   x.) Begin to evaluate the medical literature for presentations.
   y.) Receives an evaluation and feedback for each outside rotation during PGY1.
   z.) Attends 75% of all conferences.
   aa.) Meets expected behaviors and knows content identified in resident manual.
   bb.) Resident responds to pages promptly and appropriately.
   cc.) Resident actively participates in research or scholarly activity.
3.) The resident must complete the annual ABFM In-Training Assessment Exam. The resident is expected to have a composite score in the 10th percentile for PGY1. The Education Committee will review residents with scores below the 10th percentile.

4.) The resident must meet with faculty advisor or program director on a quarterly basis and have proper documentation of this meeting in the resident’s file.

5.) The resident must be judged competent, by the faculty and fellow residents, to supervise junior residents.

6.) The resident must complete all administrative duties (rotation evaluations, procedure logs, and medical records, application for licensure {DO and American MD graduates}) in a timely fashion.

7.) The resident must have taken and passed the USMLE Step 3 (MD) or COMLEX Step 3 (DO).

8.) The resident must have completed one home visit and have documentation of this visit in his/her file.

**CRITERIA FOR PROMOTION**

**PGY2 TO PGY3**

1.) The resident must successfully complete all PGY2 rotations. (See criteria for rotation completion). Final decision about remediation will be made by the Director with input from the Residency Education Committee and the resident’s advisor.

2.) Demonstrates achievement of competency in the Core Competencies required in the PGY2 year. (see Competency based Goals and Objectives for level of training in Family Medicine) In order to show achievement of these competencies, PGY 2 residents are expected to demonstrate the following:
   a.) Implements a negotiated management plans with patient.
   b.) Addresses sensitive issues appropriately such as mental health or risk behaviors.
   c.) Tends to chronic problems when appropriate.
   d.) Incorporates health maintenance and preventative care where appropriate.
   e.) Arranges appropriate medical and ancillary referrals.
   f.) Manages clinic duties efficiently.
   g.) Discusses with patients end-of-life issues appropriately and in a sensitive way.
   h.) Performs the duties of senior resident on the Family Medicine ward service.
   i.) Responds appropriately in emergent/urgent situations.
   j.) Demonstrates ability to teach students and interns in clinic and on hospital service.
   k.) Works with non-physician professionals in a way that garners mutual respect and excellent patient care.
   l.) Documents all procedures performed during PGY2.
   m.) Receives an evaluation and feedback for each outside rotation during PGY2.
   n.) Attends 75% of all conferences.
   o.) Meets expected behaviors and knows content identified in updated/revised PGY2 resident manual.
p.) Critically evaluates the literature during presentations.
q.) Demonstrates active participation in research or scholarly activity.
r.) Receives appropriate evaluations on patient satisfaction surveys.

3.) The resident must complete the ABFM in Training assessment Exam. The resident is expected to have a composite score in the 10th percentile or above for PGY2. The Education Committee will review those residents that score below the 10th percentile on the In-Service Exam.

4.) The resident must meet with faculty advisor or Program Director on a quarterly basis and have proper documentation of this meeting in the resident’s file.

5.) The resident must complete all administrative duties (rotation evaluations, faculty evaluations, procedure logs, medical records etc.) in a timely fashion.

6.) The resident must document all deliveries in their procedure logs and have documentation of these in their file.

7.) The resident must have satisfactory performance during the previous year as demonstrated by satisfactory evaluations from family medicine faculty, off-service supervising faculty, peers (fellow residents), medical students, office staff, nursing staff, and patients

**CRITERIA FOR GRADUATION**

**PGY 3**

1.) The resident must successfully complete all PGY3 rotations. (See criteria for rotation completion)

2.) Demonstrates achievement of competency in the Core Competencies required in the PGY3 year. (See Competency based Goals and Objectives for level of training in Family Medicine) In order to show achievement of these competencies, PGY3 residents are expected to demonstrate the following:
   a.) Works with patient and family to develop a collaborative relationship and management plan that includes care of acute and chronic issues, health maintenance, disease prevention, and continuity of care.
   b.) Works with and motivates all staff in a way that garners mutual respect and efficient patient care.
   c.) Actively and appropriately manages clinic.
   d.) Able to function as a “Teaching Attending” in clinic and on hospital service.
   e.) Completes all patient care tasks in a timely, organized and professional manner (charting, phone calls and laboratory data).
   f.) Resident’s pattern of prescribing medications and ordering tests/ancillary services is cost-effective and appropriate for patient’s needs and resources.
   g.) Resident is seen as an advocate for the FMC and as such encourages patients to choose him/her and the clinic for their ongoing care.
   h.) Completes two house calls during residency and places documentation of these visits into his/her residency file.
   i.) Works with physician colleagues in a way that garners mutual respect and excellent patient care.
j.) Documents all procedures performed during PGY3 in procedure log.
k.) Receives an evaluation and feedback for each outside rotation during PGY3.
l.) Attends 75% of all conferences.
m.) Meets expected behaviors and knows content identified in updated/revised PGY3 Resident Manuel.
n.) Critically evaluates literature during presentation.
o.) Completes chart review and presented data.
p.) Resident must meet all six core competency requirements and receive documentation from the director to verify accomplishment.
q.) Resident is able to practice competently and independently in the field of family medicine.

3.) The resident must complete the ABFM In Training Assessment Exam. Residents are expected to score at the 10th percentile on the exam. The Education Committee will review residents that score below the 10th percentile.

4.) The resident must meet with faculty advisor or program director on a quarterly basis and have proper documentation of this meeting in the resident’s file.

5.) The resident must complete all administrative duties (rotation evaluations, faculty evaluations, procedure logs, medical records etc.) in a timely fashion.

6.) The resident must have ALL deliveries recorded in his/her procedure logs, indicating which deliveries were continuity patients).

7.) The resident must have the appropriate number of patient encounters as required by the ABFM and the ACGME. The resident must also follow continuity guidelines for patient care.

8.) If the resident is an MD (American graduate LCME School) or a DO, the resident must have an active license to practice Medicine in the state of West Virginia.

10.) The resident must complete an exit interview with the program director.

OSTEOPATHIC RESIDENTS

Membership in the AOA and ACOPF is REQUIRED during your residency. The Department will pay for your membership in these organizations.
# DEPARTMENT OF FAMILY MEDICINE
## CURRICULUM OUTLINE
### 2010-2011

## Internship Year

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<tr>
<th>Rotation</th>
<th>Allopathic Internal Medicine Service</th>
<th>Osteopathic Internal Medicine Service</th>
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### Year 3

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Curriculum Guide

BEHAVIORAL MEDICINE
Competency Based Goals and Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine.

Rotation Overview: This is a full-time 4-week required rotation. Aside from normal call and continuity clinic, the resident will receive a schedule for the month prior to the rotation.

Skill Objectives & Educational Experiences:
1. To enhance doctor-patient communication and interviewing skills through didactic instruction, role-play, and videotape review. Agenda setting, information gathering, assessment presentation, and instruction giving are specific areas of focus – emphasizing their impacts upon adherence individual differences in gender, race, age, sexual orientation, and culture as important dynamics affecting the doctor-patient relationship, working alliance, and clinical outcome. Medical ethics including respect for patient autonomy, privacy/confidentiality, and quality of life are underscored.
2. To increase breadth of psychiatric diagnostic knowledge and skill application through didactic instruction, readings, and participation in psychological evaluations and follow-up care. Educational and clinical activities take place primarily within the Family Medicine Clinic but also at additional designated ambulatory sites and/or nonambulatory (e.g. nursing home) sites. Biopsychosocial conceptualizations will be underscored as will normal psychosocial development (individual and family), stages of stress within the family life cycle, and the emotional aspects of nonpsychiatric disorders (e.g. uncomplicated bereavement).
3. To enhance basic counseling skills and be able to differentiate between common listening and action responses in counseling and utilize them readily. Readings and participation in psychological evaluations and follow-up sessions.
4. To become familiar with psychosocial (as well as medical) utilities of the genogram as both a history taking and intervention tool. Readings, construction of personal family genogram, construction of a patient genogram. Common family dynamics are underscored (e.g. intergenerational transmission) as is the critical issue of physician well-being.
5. To acquire basic cognitive-behavioral skills and intervention strategies – particularly to address common mood and anxiety disorders presenting in primary care. Didactic instruction, participation in counseling sessions.
6. To enhance physician skills in assessment and intervention with common patient behavioral health issues and psychosocial difficulties (e.g. smoking cessation, alcohol/substance use/abuse, domestic violence). Didactic instruction, use of educational/intervention materials, participation in counseling sessions.

Behavioral Sciences Syllabus
7. To acquire basic skills in accessing appropriate community resource and support services. The resident will utilize a community resource manual in identifying at least two appropriate referrals for each of several assigned biopsychosocial patient scenarios.
8. To acquire basic relaxation/stress management skills – both for personal use and to teach patients. Didactic instruction, limited readings, practice.
9. To research an area of interest with regard to psychiatric illness present in primary care and give a noon conference on the topic.
REQUIRED TEXTS:
CARDIOLOGY
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine.

KNOWLEDGE OBJECTIVES
The resident shall be able to:

1. Characterize the principles of cardiac physical examination, noninvasive examination and laboratory interpretation.
2. Identify indications and limitations of invasive examinations such as cardiac catheterization.
3. Identify the pathophysiology and management and rehabilitative measures for coronary artery disease, arrhythmias, hypertension, congestive heart failure, thromboembolic disease, congenital heart and valvular disease, and other cardiac disorders.

SKILL OBJECTIVES
1. Perform history and physical examination related to the cardiovascular system.
2. Order and interpret diagnostic tests such as EKG, chest x-ray.
3. Perform resuscitation using fluids, basic CPR and advanced life support, and antiarrhythmics and electrical cardioversion.
4. Manage patients with chest pain, acute myocardial infarction, arrhythmias, heart failure, cardiogenic shock, and conduction abnormalities.
5. Order to perform advanced diagnostic treatment measures as indicated and treatment regimens such as thrombolytics, Swan-ganz, echo and electrophysiologic studies, angioplasty.

IMPLEMENTATION
1. Residents are required to do a one month rotation in Cardiology which involves rotating with one of the local cardiologists. During the month, the resident will perform consults, read EKG’s, order appropriate lab/diagnostic tests and take cardiology call.
2. Residents also have Intensive Care Unit rotation which frequently involves intracardiac monitoring, and cardiac drugs and resuscitation.
3. Additional experience with cardiac problems is gained on Family Medicine Service, Adult Medicine Service and in the outpatient clinic.

EVALUATION
1. Performance evaluations by the attending cardiologist.
2. Board and in-service examinations.
4. Observation of patient presentations and review of charts of individual patients by faculty preceptors.
COMMUNITY MEDICINE
Competency Based Goals & Objectives

Residents should review the competency based goals and objectives for each level of training in Family Medicine

PURPOSE: To enable the resident to gain competency and knowledge of the community medicine resources available in our area.

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Be familiar with the resources available at the WIC program.
2. Understand the role of home health in the care of patients.
3. Understand the role of the local county health department and become familiar with the services offered.
4. Recognize and treat various sexually transmitted diseases that can be seen at a local walk-in clinic.
5. Become familiar with the services offered by the Women’s Shelter.
6. Become familiar with the services offered by Health Right – a local free clinic for indigent patients.
7. Become familiar with the services offered at the Occupational Lung Center and interpret Pulmonary Function Tests.

SKILL OBJECTIVES
The resident shall be able to:
1. Incorporate the knowledge learned at the WIC program into patient care of continuity patients.
2. Utilize the services of home health agencies in the care of their patients.
3. Treat and recognize sexually transmitted diseases and report them to the health department if required by the law.
4. Manage patients seen at Health Right.
5. Utilize the services of the Occupational Lung Center in patient care and the interpretation of PFTs.
6. Gain an understanding of the services offered at the Women’s Shelter.

IMPLEMENTATION
All residents will complete a one-month rotation in Community Medicine and attend 2 evening clinics at Health Right during the PGY 2 and PGY 3 years.

EVALUATION
The attending physician at the health department, Health Right, and other agencies will complete evaluations.

CONTINUITY CLINICS
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Follow and deal with a wide rage of medical and psychosocial problems among the total spectrum of patient age and demographics.
2. Take an efficient yet sufficient history to include pertinent positives and negatives.
3. Develop a complete differential diagnosis on common ambulatory problems.
4. Create an appropriate, thorough and cost-efficient diagnostic and treatment plan to include:
   a. The use of appropriate laboratory and imaging tests and the knowledge of when such tests are nonproductive, contraindicated, or not cost-effective.
   b. The appreciation of appropriate pharmacologic therapeutic modalities to include risks, benefits, compliance issues and cost issues.
   c. The appropriate use of nonpharmacologic therapeutic modalities and an awareness of alternative health care options.
   d. Familiarity of local community resources to aid patients.

**SKILL OBJECTIVES**

The resident shall:
1. Develop communication and interactive skills to attract and maintain a consistent patient panel.
2. Utilize behavioral skills to deal with nonorganic health problems.
3. Become competent in common office procedures, such as uncomplicated sprains and fractures, dermatologic minor surgery procedures and joint injections.
4. Be able to deliver prenatal and antenatal care for uncomplicated pregnancies.
5. Be familiar with common office laboratory procedures.
6. Develop an understanding of appropriate referral patterns to other specialists.
7. Be cognizant of Managed Care, medicolegal and other issues in the changing healthcare environment.

**IMPLEMENTATION**

1. PGY1 residents will spend two half-days per week in continuity clinic. All patients will be checked out and evaluated by the preceptor.
2. PGY2 residents will spend four half-days per week in continuity clinic, with allowances made for extremely demanding service obligations. One half day per month will be scheduled for nursing home. All patients will be checked out to the Preceptor. In addition, the beginning of some home visits is expected on several patients who would benefit (e.g. elderly, shut-ins, physically handicapped).
3. PGY 3 residents will spend four half-days per week in continuity clinics, with one half day per month scheduled for nursing home. All patients will be checked out to the attending.

**EVALUATION**

1. One-on-one interactions and feedback shall occur between resident and preceptor as appropriate for the level of training.
2. All transcribed charts shall be reviewed and where necessary commented on by the preceptor involved.
3. Preceptors will complete evaluations on the resident. These evaluations will be reviewed by the faculty advisor and discussed during the resident’s performance evaluation meetings or as necessary.
4. The resident shall have the opportunity to anonymously evaluate faculty on a regular basis.
DERMATOLOGY
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Characterize the normal anatomy and physiology of the skin.
2. Recognize risk factors and preventive measures for skin problems.
3. Identify dermatologic manifestations of systematic disease or toxicity.
4. Recognize dermatologic conditions requiring emergency treatment.
5. Recognize that the skin is a very important organ in mirroring the emotions and recognize that the patient who presents with Dermatologic complaints may have a serious disorder or has significant concerns even with what appears to be very minor problems.

SKILL OBJECTIVES
The resident shall be able to:
1. Develop a systematic approach toward categorizing skin lesions into by etiology i.e. infectious allergic, vasculitic, neoplastic.
2. Manage common skin problems utilizing topical, systematic, and physical agents.
3. Evaluate those skin disorders representing serious illness.
4. Perform skin culture, scraping, biopsy, curettage, excision, cautery, and cryosurgery and intralesional injection.
5. Counsel patient regarding skin problems.

IMPLEMENTATION
1. One month block rotation with a board certified dermatologist – office based practice.
2. Longitudinal experience in Family Practice Clinic during continuity clinic and clinic rotations.

EVALUATION
1. Evaluation by Dermatology Attending.
2. Evaluation by Family Medicine Faculty.

EMERGENCY MEDICINE
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Distinguish life-threatening emergencies from urgent situation or routine visits.
2. Identify appropriate diagnostic and treatment modalities for common emergency medical and surgical problems such as asthma, chest pain, abdominal pain, seizures, and trauma.
3. Characterize those patients requiring hospital admission versus outpatient care.
4. In addition to the medical problems the resident must learn to deal with the perceptions of the patient and family regarding the situation.
5. Recognize and deal with hostility, anxiety, grief and irrational behavior in emergency situations within himself and others.
SKILL OBJECTIVES

The resident shall be able to:
1. Recognize and treat shock, hemorrhage, respiratory distress, anaphylaxis, etc.
2. Provide initial management and stabilization and triage of patients.
3. Participate in resuscitation of cardiac arrest or multiple injured patients.
4. Perform suturing, peripheral and central venous access, intubation, chest tube insertion, and other procedures as needed.

IMPLEMENTATION

1. One month required rotation in the Emergency Department at CAMC, which includes shifts at General Division (Level 1 Trauma Center) or at Thomas Memorial Hospital.
2. Elective rotation in Emergency Medicine for upper level residents may be arranged at either facility.
3. Provision of emergency care services to Family Practice Center patients when "on call" for Family Medicine Service (longitudinal).
4. Formal ACLS training at orientation for all residents on entry.
5. Formal ATLS course offered as CME to residents.
6. Formal PALS course at orientation for all residents on entry.

EVALUATION

1. Emergency Medicine evaluation of resident
2. Board scores on in-service exam.
3. Check in rounds daily presentation of patients seen in ER by on-call resident.

WOMEN’S HEALTH
(GYNECOLOGY)

Residents should review the competency based goals and objectives for each level of training in Family Medicine

GOAL: To provide comprehensive health care specific to female patients from menarche through menopause.

KNOWLEDGE OBJECTIVES:

The resident will demonstrate a working knowledge of the following:
1. Sexuality and sexual dysfunction.
2. Menstrual disorders and abnormal vaginal bleeding.
3. Menopause and hormone replacement therapy.
4. Contraceptive methods.
5. Sexually transmitted diseases.
7. Pelvic inflammatory disease.
8. Ovarian cysts.
10. Endometriosis.
11. Neoplasms of the female genitourinary tract.
12. Abnormal pap smears.
13. Infertility.
14. Uterine prolapse.
15. Pelvic pain (acute & chronic).
16. Understand the normal growth and development of the female reproductive tract.
17. Amenorrhea.

PROCEDURES:

i. Perform pelvic exam.

ii. Obtain pap smear.

iii. Perform wet mount & KOH prep.

iv. Endometrial sampling.

v. Cervical biopsy.

vi. Colposcopy.

vii. Diaphragm fitting.

viii. IUD insertion.

ix. IUD removal.

x. Endocervical curettage.

ATTITUDES:

1. Provide appropriate contraceptive counseling.

2. Provide appropriate infertility counseling.

3. Discuss sexual dysfunction with patient.

4. Determine when referral to gynecologist is appropriate.

IMPLEMENTATION:

1. One-month rotation at Women’s Medicine Center in the Gyn Clinic.

2. Participation in gynecologic surgery and perioperative care.

3. Participation in colposcopy clinics.

EVALUATION:

1. Evaluation of month-long rotation by OB/Gynecology faculty.

2. Performance on in-service examination.

3. FMC precepting evaluation.

4. Nursing feedback.

5. Patient satisfaction surveys.

INTERNAL MEDICINE SUBSPECIALTIES

Competency Based Goals & Objectives

Residents should review the competency based goals and objectives for each level of training in Family Medicine

KNOWLEDGE OBJECTIVES

The resident shall:

1. Characterize the principles of history, physical examination and diagnostic interpretation of common problems encountered on these subspecialty ambulatory rotations.

2. Be able to develop an adequate differential diagnosis to include possibilities outside of subspecialty in question.

3. Be able to create and implement an appropriate, thorough and cost-efficient diagnostic and treatment plan for common problems within that subspecialty.

SKILL OBJECTIVES

The resident shall be able to:

1. Perform history and physical examination related to the individual subspecialty.

2. Order, perform and interpret appropriate diagnostic tests, both noninvasive and invasive (e.g. joint aspiration, pulmonary functions tests).

3. Manage patients with common problems related to the medicine subspecialties.
4. Know when to refer the complicated patient.

**IMPLEMENTATION**

1. Residents can spend 2 weeks or one month rotating on any of these subspecialties.
   a. Rheumatology
   b. Endocrinology
   c. Nephrology
   d. Pulmonary
   e. Resident's Choice

2. Additional experience as encountered on the Family Medicine inpatient and outpatient services.

**EVALUATION**

1. Performance evaluations by respective subspecialty faculty in appropriate ambulatory settings.
2. Board and In-Service examination performance.
3. Performance evaluation on Family Medicine inpatient and outpatient services.
4. Observation of patient presentations and review of charts of individual patients by faculty preceptors on appropriate services.

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**NEWBORN NURSERY**

**Competency Based Goals & Objectives**

Residents should review the competency based goals and objectives for each level of training in Family Medicine

**Purpose:** To provide competency in the care of the normal newborn and familiarity with the critical care of the ill newborn.

**KNOWLEDGE OBJECTIVES**

The resident shall be able to:
1. Identify congenital problems or perinatal infections in newborns.
2. Define screening and prophylaxis provided to newborns.
3. Identify fluid and caloric needs of newborns.
4. Define normal weight gain/loss in newborns.
5. Recognize the distressed neonate and provide for transfer.
6. Provide information or counseling to the mother concerning the infant.

**SKILL OBJECTIVES**

The resident shall be able to:
1. Diagnose and manage common congenital problems or refer as needed.
2. Perform a metabolic or septic work-up in the newborn.
3. Manage fluid and feeding problems.
4. Resuscitate and stabilize neonates whether in delivery room or nursery.
5. Perform venipuncture, blood gas, pulse oximetry, umbilical artery catheterization, respiratory support, and intubation as needed.

**IMPLEMENTATION**

One-month rotation in Newborn Nursery.
EVALUATION
Monthly performance evaluation by pediatric faculty and performance on in-service examinations.

NIGHTFLOAT
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

Purpose: The Nightfloat rotation provides night time coverage for the hospitalized Family Medicine patient. The Nightfloat resident will also be responsible for Emergency Admissions for the Emergency Room, direct admissions from home and nursing homes, as well as transfers from outlying physicians.

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Manage inpatients, after initial evaluation, with once or twice daily critical and succinct assessments, coupled with interim management from either the office or (after hours) home setting.
2. Maintain high quality of patient care, with reasonable outcomes, in an appropriate time frame.
3. Know when it is appropriate to seek specialty and subspecialty consultation for complex patient management.
4. Learn the sufficient, yet cost-effective, use of ancillary medical services.
5. Learn to work with Healthcare Professionals including those from other disciplines, to provide patient focused care.
6. Learn to use information technology to support patient care decisions and patient education.
7. Learn to counsel and educate patients and their families.
8. Develop and carry out patient management plans.
9. Make informed, decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence & clinical judgment.

SKILL OBJECTIVES
The resident shall be able to:
1. Evaluate, admit, and plan a strategy on the patient in a timely manner.
2. Take into account biopsychosocial aspects of the patient's problem(s), and appropriately use consultants, placement services, and discharge planning.
3. Become competent in the following common procedures:
   a. Lumbar puncture.
   b. Bone marrow aspirate/biopsy
   c. Paracentesis
   d. Thoracentesis
   e. Intravenous access
   f. Arterial puncture
   g. Resuscitation

   It is recognized that many of these skills will be learned on other inpatient services as well.
4. Create and sustain therapeutic and ethically sound relationships with patients.
5. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory questioning and writing skills.

6. Work effectively with others as a member, leader, Health Care Team or Professional Group.

7. Be an advocate for quality patient care and assist patients in dealing with system complexities.

8. Know how to partner with Health Care Managers and Health Care Providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

**IMPLEMENTATION**

These objectives will be achieved as follows:

1. Family Medicine patients are to be admitted from the FMC, KVFPC, Valley Nursing Home, Oakridge Nursing Home, Sissonville and Clendenin offices of Cabin Creek Health Systems and occasionally as referrals from outside Family Physicians.

2. The nightfloat resident will participate in morning report and be prepared to present a case/patient admitted to the Family Medicine Service from the prior night.

3. The nightfloat resident will also provide an update on the current patients to the day team.

**EVALUATION**

1. The resident's performance will be evaluated by the Attending Faculty, residents and medical students.
   a. Through daily interaction on Rounds and timely feedback.
   b. Through electronic evaluation at the end of the rotation.

2. Elements of evaluation shall include:
   a. Medical knowledge and judgment with regards to initial assessment, management plans, expected outcomes, and handling of unanticipated complications.
   b. Interpersonal relations with patients, peers and allied health professionals.
   c. Appropriate and cost-effective use of ancillary services and hospital length of stay.
   d. Appropriate discharge planning.
   e. Ability to take psychosocial factors into consideration when dealing with the hospitalized patient and the family.
   f. Expected outcomes, given the diagnosis constellation.
   g. Skills in performing common procedures.

**OBSTETRICS**

**Competency Based Goals & Objectives**

*Residents should review the competency based goals and objectives for each level of training in Family Medicine*  

**GOALS**

1. Each resident must be provided instruction in the biological and psychosocial impacts of pregnancy, delivery and care of newborns on the female patient and her family.

2. Each resident must assume responsibility of longitudinal provision of antenatal, natal and postnatal care during 3 years of training so as to achieve accomplishment of stated objectives.

**KNOWLEDGE OBJECTIVES**

1. The resident should obtain working knowledge of the following:
   a. Prenatal evaluation
   b. Prenatal screening tests
   c. Hyperemesis
   d. Bleeding during pregnancy
   e. Pre-eclampsia
   f. Eclampsia
   g. Indications for induction of labor
   h. Techniques for induction of labor
i. Post partum hemorrhage
j. Post partum depression
k. Spontaneous abortion and miscarriage
l. Identification of high risk pregnancy
m. Rh sensitization & prevention
n. Appropriate drug therapy during pregnancy

PROCEDURAL SKILLS

1. Provide pre-conceptual counseling.
2. Provide family-centered prenatal care utilizing medical and community resources.
3. Recognize and manage prenatal complications and emergencies, which may arise.
4. Identify and provide initial management of high-risk pregnant patients and utilize obstetrical consultation appropriately.
5. Receive training in genetic counseling.
6. Initially manage pre-term labor with utilization of consult services when necessary.
7. Manage first, second and third stages of labor.
8. Deliver uncomplicated obstetrical patients.
9. Perform vacuum extraction as needed.
10. Recognize indications and contraindications for induction of labor and implement when needed.
11. Perform amniotomy (AROM), episiotomy and repair, pudendal block, place internal monitors (fetal scalp and IUPC), amnioinfusion, manual removal of placenta, and repair perineal lacerations.
12. Manage post partum complications to include uterine atony and post partum hemorrhage.
13. Assist at c-sections and other operative deliveries, and postpartum tubal ligations as needed.
14. Utilize appropriate forms of obstetrical anesthesia as needed.
15. Provide counsel and advice on breastfeeding.
16. Appropriately interpret fetal heart rate tracings to include NST's and fetal monitoring during labor.
17. Perform and accurately determine cervical dilation.
18. Perform Leopold's maneuvers for fetal presentation.
19. Accurately determine pelvic size and adequacy for delivery.
20. Be able to handle complications: shoulder dystocia, post partum hemorrhage, umbilical cord prolapse, uterine inversion.

ATTITUDES

1. Communicate effectively with patient and family during labor and delivery.
2. Communicate with OB staff when consultation is necessary.
3. Provide clear and distinct orders and guidance to OB nursing staff.
4. Insure appropriate and continuous care to patient’s in labor.
5. Insure that the appropriate transfer of care has been communicated when going off duty.

IMPLEMENTATION

1. Two one-month rotations in obstetrics
2. Longitudinal experience in FM Clinic following continuity OB patients.
3. Mandatory attendance at ALSO course for all residents, beginning in 2007
4. Residents planning to practice obstetrics in the future are encouraged to augment their training with elective experience in rural obstetrics and high-risk obstetrics.
EVALUATION
1. Evaluation of month-long rotations by Obstetrical faculty and ongoing evaluation by Family Medicine faculty, OB residents and medical students.
2. Performance on in-service exam

OPHTHALMOLOGY
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

Purpose: To become familiar with common eye disorders and to distinguish those requiring ophthalmologic referral.

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Identify common eye disorders such as blepharitis, conjunctivitis, hordeolum, foreign bodies, and trauma.
2. Characterize appropriate screening methods to prevent sequelae from common conditions, such as amblyopia, glaucoma.
3. Recognize advanced forms of ophthalmologic testing and intervention e.g. fluorescein angiography, laser, etc.

SKILL OBJECTIVES
The resident shall be able to:
1. Conduct an appropriate history and physical examination of the eye and adnexal structures.
2. Diagnose and treat common eye problems.
3. Distinguish and refer those eye problems which require specialist care.
4. Interpret simple measures of visual health such as visual acuity, intraocular pressure, visual fields, etc.
5. Participate in ongoing care of patients being treated by ophthalmologists, i.e. diabetics, cataracts, glaucoma, etc.

IMPLEMENTATION
1. Residents will complete a two (2) week rotation with a local Board Certified Ophthalmologist.
2. Longitudinal experience in Family Practice Clinic and "on call" to ER for Family Practice patients.

EVALUATION
1. Formal evaluation by Ophthalmology faculty.
2. Part of experience in Family Practice Clinic.
3. Daily check in rounds in Family Medicine Department regarding on-call activities.
ORTHOPEDICS
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Identify sprains, fractures, congenital and other orthopedic problems.
2. Characterize those problems typically related to specific activities or lifestyles and their prevention.
3. Recognize the range of surgical or bracing procedures utilized for various disorders.

SKILL OBJECTIVES
The resident shall be able to:
1. Perform a complete examination of the back, joints, extremities, and musculoskeletal system.
2. Utilize and interpret imaging and other diagnostic studies of the musculoskeletal system.
3. Diagnose and manage simple fractures and sprains, etc.
4. Recognize and refer those musculoskeletal problems requiring specialist care.
5. Evaluate and stabilize the emergency patient with musculoskeletal injury.
6. Perform simple casting or splinting procedures.
7. Assist with operative procedures as desired.

IMPLEMENTATION
1. Minimum 140 hours block rotation in orthopedics to include on-call duties with the orthopedic surgeon.
2. Longitudinal experience in Family Medicine Clinic

EVALUATION
Formal rotation evaluation by Orthopedics faculty

OTOLARYNGOLOGY
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

PURPOSE: To become familiar with common ENT problems and indication for referral.

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Identify common problems related to the nose, throat, and pharynx, such as epistaxis, sinusitis, polyps, otitis, etc.
2. Characterize common head and neck masses and their causes.
3. Identify those head and neck problems requiring surgical treatment.
SKILL OBJECTIVES
The resident shall be able to:
1. Perform a complete head and neck examination including indirect laryngoscopy.
2. Diagnose and treat common ENT infections and other disorders.
3. Refer for timely surgical management as appropriate.
4. Participate in care of hospitalized and operative patients.
5. Assist in airway management of emergency patients as needed.
6. Interpret tympanograms, sinus films, audiograms, and other common ENT tests.

IMPLEMENTATION
1. A two (2) week rotation in ENT with one of the local board certified ENT specialists.
2. Longitudinal experience in Family Practice Center.

EVALUATION
Formal evaluation of rotation by ENT faculty

PEDIATRIC INPATIENT SERVICE
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

PURPOSE: To become competent in the inpatient management of common childhood illnesses and familiar with complex pediatric problems.

KNOWLEDGE OBJECTIVES
1. Identify causes of fever in children and its workup.
2. Define the need for fluid therapy for children and infants in various types of dehydration.
3. Define the pathophysiology and approach toward common disorders and infections of children.
4. Recognized manifestations and causes of serious illness or congenital diseases, e.g. metabolic or neurologic, in children.
5. Develop understanding of the adolescent's unique health care needs.
6. Develop a working knowledge of the following:
   a. Feeding and nutrition
   b. Immunizations
   c. Growth and development
   d. Safety issues
   e. Behavioral disorders
   f. Speech and learning problems
   g. Acute illnesses (Respiratory, GI, ENT, Dermatologic)
   h. Gait and musculoskeletal disorders
   i. Child abuse
   j. Emergencies (Asthma, Epiglotitis, Menigitis, Poisoning, Dehydration, Seizures)

SKILL OBJECTIVES
The resident shall be able to:
1. Manage fluid and electrolyte balance in children.
2. Work up an infant or child with fever.
4. Manage children with common disorders such as croup, pneumonia, gastroenteritis, bronchitis, seizures, meningitis, anemia, diabetes, etc.
5. Arrange appropriate referral for children with severe or unusual diseases.

IMPLEMENTATION
1. Two (2) months of Pediatric Inpatient Service at CAMC with faculty and residents from WVU Pediatric Department.
2. One month in the second or third year with a community based primary care pediatrician if desired.

EVALUATION
1. Evaluation by pediatric faculty, residents and medical students.
2. Performance on in-service examination.

PEDIATRIC OUTPATIENT CLINIC
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

PURPOSE: To enable the resident to provide care to sick and well children and adolescents in the outpatient setting and to provide preventive, counseling, and other appropriate support to children and families.

KNOWLEDGE OBJECTIVES
The resident shall be able to:
1. Define essentials of well childcare.
2. Identify the appropriate stages of growth and development at each age from newborn through adolescence.
3. Define appropriate immunizations at each age.
4. Recognize and understand common physical problems in children such otitis, pharyngitis, asthma, intoeing, etc.
5. Be comfortable treating young patients and their family.
7. Identify appropriate feeding practices.

SKILL OBJECTIVES
The resident shall be able to:
1. Examine children and differentiate normal and abnormal physical findings.
2. Provide age-appropriate counseling and anticipatory guidance to parents and patients.
3. Provide evaluation and/or referral of adjustment or learning problems.
4. Manage common pediatric outpatient problems.

IMPLEMENTATION
One-month rotation in Pediatric Outpatient Clinic as well as ongoing care of pediatric patients in FP Clinic.

EVALUATION
1. Evaluation by pediatric faculty.
2. Evaluation in FP Clinic by faculty preceptor.
3. Performance on in-service examination.

**PROCEDURAL SKILLS**

**Competency Based Goals & Objectives**

Residents should review the competency based goals and objectives for each level of training in Family Medicine

**PURPOSE:** To train the resident to be comfortable and competent in procedural skills likely to be encountered in practice. These include: colposcopy, nasopharyngoscopy, minor surgery, joint injection/aspiration, trigger point injection, excisional biopsy, cryotherapy, abscess I & D, etc., EKG interpretation, casting techniques, central line placement and intubation, etc.

**KNOWLEDGE OBJECTIVES**

1. Recognize indications for the above mentioned procedures.
2. Be aware of the risks involved with above mentioned procedures.
3. Understand proper follow-up for the above mentioned procedures.

**SKILL OBJECTIVES**

1. Competency in the above mentioned procedures.
3. Proper follow-up of above mentioned procedures.

**IMPLEMENTATION**

1. Opportunities with Family Practice Center continuity patients.
2. Dermatology rotation.
5. Office based procedure month.

**EVALUATION**

Monthly performance evaluations by appropriate faculty on the rotations.

**SPORTS MEDICINE**

**Competency Based Goals and Objectives**

Residents should review the competency based goals and objectives for each level of training in Family Medicine

**PURPOSE:** To enable the resident to gain competency in the management of sports related injuries.

**KNOWLEDGE OBJECTIVES**

The resident shall be able to:

1. Recognize and understand the mechanism of sports related injuries, including sprains, strains, and dislocations simple fractures.
2. Become familiar with common sports medicine procedures including joint aspiration and injection.
4. Become familiar with physical therapy modalities and treatments.
5. Become familiar with physical therapy evaluations.
6. Become familiar with cardiac and pulmonary rehabilitation.

**SKILL OBJECTIVES**
1. Apply splints or casts
2. Perform the following procedures:
   a. Joint aspiration
   b. Joint injection
3. Interpret simple radiographs.
4. Understand the role of physical therapy in the treatment of acute sports injuries.
5. Understand the role of cardiac and pulmonary rehab in the care of continuity patients.

IMPLEMENTATION
All residents will complete a one-month rotation in Sports Medicine during the PGY 2 or PGY 3 year. Those residents on the Community Medicine month will cover the sports medicine clinic.

EVALUATION
The attending physician covering the Sports Medicine Clinic will complete evaluations.

ELECTIVES
Competency Based Goals & Objectives
Residents should review the competency based goals and objectives for each level of training in Family Medicine

All may be elected for 1/2, one, or more months. All will be taught at CAMC or Thomas Memorial Hospital, with the exception of disciplines not available at this institution. In order to take an elective outside of CAMC, there must exist a written affiliation agreement between CAMC and the institution where the rotation will take place. This agreement must be approved by the DIO. The supervising physician of the rotation will complete a written evaluation, as well as examination of section data on in-service and board examinations.

Anesthesia
Offered at CAMC under the direction of the one of the board certified Anesthesiologists. The resident becomes acquainted with the basics in this field including techniques in general and regional anesthesia, and endotracheal intubation, and pain management acute or chronic

Allergy
Resident gains exposure to common and unusual allergic problems and their management. Training is under one of our local board certified Allergists. Includes allergy, asthma, urticaria and desensitization. Occasional inpatient consultation.

Emergency Medicine
This one month rotation can be completed at CAMC or Thomas Memorial Hospital. During the rotation, the resident will be able to refine their skills in Emergency Medicine, have the opportunity to master various procedures necessary in the stabilization of the patient such as intubation, central line insertion, chest tube insertion, or other procedures as they are available. It is expected that more responsibility be placed on the resident under supervision as they demonstrate competence as assessed by the ER attending.

Endocrine/Metabolism
This rotation, under the direction of a local board certified Endocrinologist. During this rotation, the resident is exposed to common and uncommon endocrine problems referred to that clinic and on occasions he may be called to see patients in the inpatient service. Includes diabetes, thyroid, adrenal, parathyroid, and some reproductive problems.

Gastroenterology
Emphasizes the ambulatory and inpatient management of common and uncommon GI problems. It is offered at CAMC or Thomas Memorial Hospital under the direction of one of the board certified Gastroenterologists. The resident is expected to perform inpatient consultations.

Geriatrics
A one-month rotation to be completed with Dr. Johnson and Dr. Jarrell at Oakridge Center, a skilled nursing facility. The resident will have the opportunity to refine their skills in the care of nursing home patients and the issues surrounding nursing home care. The resident will also gain exposure to Hospice Care and spend a few days at Hospice House.

Hematology/Oncology
Emphasizes the outpatient management of common hematologic problems. Also, it exposes the resident to the oncologist approach to the cancer patient. It is offered at CAMC with one of the board certified hematologists. Inpatient consultation will be included.

Infectious Diseases
Through working with the consultative service in infectious diseases, the resident learns the diagnosis and use of antibiotics for the control of infectious diseases and the approach to patients with fever. This rotation is offered at CAMC or Thomas Memorial Hospital with one of the board certified Infectious Disease Specialists.

Nephrology
A one-month elective, which will allow the resident to gain insight into the management of renal failure and the work-up of nephrologic diseases. This is primarily a hospital – based rotation at CAMC or Thomas Memorial Hospital.

Neurology
A one-month elective to be completed with one of the area neurologists at CAMC or Thomas Memorial Hospital. The rotation will include office and hospital based neurology. The resident will be able to improve neurologic diagnostic skills to gain more experience in the management of common neurological problems.

Obstetrics/Gynecology – Advanced
A one to three month elective designed to refine obstetrical skills. The resident will have the opportunity to function as a second year resident with the OB floor team. The resident will assist in caesarean sections, vacuum assisted deliveries and focus on development of their skills in the delivery suite.

Outpatient Cardiology
This one-month rotation is designed to emphasize the aspects of outpatient cardiology. Office management of cardiovascular problems as well as outpatient – based procedures are included in the experience. Stress testing, EKG interpretation, echocardiography and cardiac CT are some of the procedural skills emphasized.

Pain Clinic
A one-month elective designed to give additional exposure to the principles of pain management and the various modalities used in the field. Indications for referral are to be learned as well, along with other resources, which may augment patient care.

Plastic Surgery
This is a one-month elective offered with one of the plastic surgeons at CAMC. The resident will have the opportunity to refine their surgical skills, particularly dermatology procedures of suturing, lesion removal and skin biopsy.
Podiatry
A one-month office based rotation with a board certified podiatrist to learn refined techniques in the diagnosis and management of various foot disorders. The resident will also gain knowledge to gait disturbances as they relate to the foot. An exposure to orthotics as it relates to podiatry is covered as well.

Pulmonary Diseases
Resident gains exposure to acute and chronic pulmonary disorders and their management. It is offered at CAMC or Thomas Memorial Hospital with one of the local board certified Pulmonologists. Interpretation of pulmonary function testing is emphasized.

Radiology
A two-week or one month rotation at CAMC, Thomas Memorial Hospital or Mountaineer Imaging is available. This rotation serves to augment the exposure residents in radiology during their first year. The resident will have the opportunity to interpret various medical imaging techniques including x-ray, CT, MRI and ultrasound with the radiologist. The resident will also gain an understanding in the imaging tools available and appropriate use in patient care.

Rheumatology
Exposes the resident to the outpatient diagnosis and management of the arthritides and other rheumatologic or autoimmune problems. It is offered with one of the local board certified Rheumatologists. Joint aspiration and injection are skills commonly learned.

Pediatric Subspecialties
Offered as a combined elective or as an intensive one-month rotation in one of five outpatient Subspecialties (Pediatric Cardiology, Neurology, Endocrine/Metabolics, Hematology/Oncology, and Child Psychiatry). Residents gain exposure to common and uncommon problems likely to be referred to the pediatric subspecialist. If at all possible, the emphasis is on ambulatory management of such problems. This is offered at CAMC – Women and Children’s Hospital with the WVU faculty.

Neurosurgery
Resident learns the initial management and stabilization of the patient with head trauma. This is offered at CAMC with one of the board certified Neurosurgeons, and is primarily an inpatient service.

OBJECTIVES
At the end of the one-month elective rotation the resident will:
*choose an investigative topic (preferably from the identified needs)
*investigate that topic for current status
*report investigative results in professional forum
*be able to identify at least one strategy to assess reading level of patient and printed material
*Observe patient education individual and group instructional modalities
*review at least two articles or literature sources relative to adherence and physician role
*conduct a learning needs assessment with at least one patient
*establish life-style change goals with at least one patient
Research and Scholarly Activity

All family medicine residents are required to participate in a research project prior to graduation. Charleston Area Medical Center hosts a Resident Research Day typically in April. Residents from all disciplines are given the forum to present original research, case studies and poster presentations. Each category is judged and prizes are awarded to the winners. However if a resident wishes to pursue other research avenues they are encouraged to do so.