

## **Ambulatory Medicine Educational Goals & Objectives**

The Ambulatory Medicine rotation will provide the resident with an opportunity to become skilled in the prevention, evaluation and management of acute and chronic medical conditions commonly seen in the outpatient setting. Residents will rotate through their Ambulatory Clinic, spending increasing amounts of time throughout their 3 years in the program. They will grow their own patient panel, with patients ranging from newborns through geriatrics. The focus will be on the doctor-patient relationship, continuity of care, and the effective delivery of primary care. Residents will gain exposure to a broad spectrum of medical conditions, ranging from core internal medicine issues to conditions requiring knowledge of allergy and immunology, nutrition, obstetrics and gynecology, ophthalmology, orthopedics, otolaryngology, preventative medicine, and psychiatry as they pertain to the general care of their outpatients in the community. This exposure will complement directed subspecialty-based experiences on other rotations. They will also learn about billing and coding, insurance coverage, Patient Centered Medical Home, and other concepts pertinent to systems-based practice in the outpatient setting.

Faculty will facilitate learning in the 6 core competencies as follows:

### **Patient Care and Procedural Skills**

- I. All residents must be able to provide compassionate, culturally-sensitive care for their clinic patients.
  - PGY2s should seek directed and appropriate specialty consultation when necessary to further patient care.
  - PGY3s should be able to coordinate input from multiple consultants and manage conflicting recommendations.
  
- II. All residents will demonstrate the ability to take a complete medical history and incorporate information from the electronic medical record.
  - PGY1s should be able to differentiate between stable and unstable symptoms and elicit risk factors for the development of chronic disease.
  - PGY2s will independently obtain the above information and identify barriers to patient compliance and care.
  - PGY3s should be able to independently obtain the above details for patients with complex medical histories and multiple comorbid conditions.
  
- III. Residents should be able to perform a physical exam appropriately focused on the patient's presenting complaint.
  - PGY1s should become competent in routine newborn, healthy child, breast, pelvic, bimanual, and thyroid exams.
  - PGY2s should be able to focus on and characterize abnormal exam findings pertinent to the presenting complaint.
  - PGY3s should be able to independently perform a complete exam and understand the sensitivity and specificity of physical findings.

IV. Residents will understand the indications, contraindications, complications, limitations, and interpretation of the following procedures, and become competent in their safe and effective use:

- PGY1s: biopsy of dermal lesions, cerumen removal, cryosurgery of skin, curettage of skin lesion, EKG interpretation, excision of subcutaneous lesions, incision and drainage of skin abscesses, minor laceration repair, office microscopy, pelvic examination and PAP smear, spirometry, splinting, suture removal, wet mount exam
- PGY2s: joint and trigger point injections, toenail removal
- PGY3s: will perform all procedures required for graduation independently.

Residents will receive additional training in procedural medicine on other required rotations.

### **Medical Knowledge**

I. Given the broad nature of Ambulatory Medicine, this curriculum is not intended to be an ever-growing list. Rather, it is designed to highlight skills critical to the core of the practice of outpatient medicine. Appropriate sections of the subspecialty curricula will supplement the learning goals and objectives listed in this ambulatory curriculum

II. PGY1s will become skilled in the timely triage of and approach to acute changes in health status, including:

- Anxiety/depression
- Abdominal pain
- Cough
- Chest pain
- Diarrhea
- Electrolyte abnormalities
- Elevated blood pressure
- Fever
- Headache
- Heart murmur in adults and children
- Hematuria
- Lymphadenopathy
- Insomnia
- Mental status change
- Obesity
- Oliguria
- Palpitations
- Rash
- Rhinorrhea
- Shortness of breath
- Sore throat

- Vomiting

PGY2s should be able to incorporate presenting information into the context of past medical history and a risk assessment to generate a differential diagnosis and a more thorough plan of care.

PGY3s should be able to understand statistical concepts such as pretest probability, number needed to treat, etc. and their effect on diagnostic workup and treatment.

III. PGY2s will also develop an understanding of the pathophysiology, clinical presentation, natural history, and therapy for common diagnoses, including:

- Allergic rhinitis
- Anemia
- Anxiety
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Benign prostatic hypertrophy
- Bronchitis and/or pneumonia
- Celiac disease
- Cellulitis
- Chronic kidney disease
- Chronic liver disease
- Chronic pain
- Conjunctivitis
- Coronary artery disease
- COPD
- Congestive heart failure
- Croup
- Depression
- Dermatitis
- Diabetes mellitus
- Down's Syndrome
- Eating disorders
- GERD and dyspepsia
- Headache
- Hyperlipidemia
- Hypertension
- Hypothyroidism
- Learning disorders
- Low back pain
- Obesity
- Osteoarthritis
- Osteoporosis
- Sinusitis

- Urinary tract infection
- IV. PGY3s will gain a better understanding of the above conditions within the setting of comorbidities.
- V. Residents will understand the effective use and interpretation of the following tools:
- AMA Guidelines for Adolescent Preventative Services (GAPS)
  - APGAR score
  - Breast Cancer Risk Assessment Tool (National Cancer Institute)
  - Brief Patient Health Questionnaire (PHQ-9) and Depression Inventory
  - CAGE questionnaire
  - Cockcroft Gault and MDRD calculators
  - PQH9 for adolescents
  - Developmental screening tests
  - ACC/AHA ASCVD Risk Calculator
  - FRAX (WHO Fracture Risk Assessment Tool)
  - HEADSSS questionnaire (Home, Education, Activities, Drugs, Sex, Suicide/Depression, Safety)
  - MELD score
  - MOCA
- V. Residents will become familiar with frequently used complementary and alternative medicine treatments for common outpatient problems.
- VI. Residents will become knowledgeable about evidence-based national screening and care guidelines and become comfortable counselling their patients on a broad spectrum of issues, including those revolving around growth and development, parenting, disease prevention and wellness promotion, and elder safety:
- Age appropriate cancer screening
  - Advance directives
  - Contraception and safe sex
  - Domestic violence
  - Driving safety
  - Exercise and prevention of cardiovascular disease
  - Injury prevention
  - Nutrition and weight loss
  - Oral care
  - Smoking cessation
  - Substance abuse
  - Vaccination
- VII. Residents will understand indications for ordering and interpretation of results from laboratory and imaging studies relevant to the diagnosis and treatment above conditions.

### **Practice-Based Learning and Improvement**

- I. All residents should be able to access current clinical practice guidelines from USPTF, ADA, JNC, NCEP and other sources to apply evidence-based strategies to patient care.
- II. PGY2s and PGY3s should develop increasing independence in evaluating studies in published literature, through Journal Club and independent study.
- III. Residents will learn to use the electronic medical record effectively and understand the definition of meaningful use.
- IV. All residents should learn to function as part of a team, including the primary care physician, nurse, midlevel provider, medical assistant, and social worker to optimize patient care within the context of a Patient-Centered Medical Home.
- V. All residents should respond with positive changes to feedback from members of the health care team.

### **Interpersonal and Communication Skills**

- I. PGY1s must demonstrate organized and articulate electronic and verbal communication skills that build rapport with patients and families, convey information to other health care professionals, and provide timely documentation in the chart.
- II. PGY2s must also develop interpersonal skills that facilitate collaboration with patients, educate patients, and where appropriate, promote behavioral change.
- III. PGY3s should demonstrate leadership skills to build consensus and coordinate a multidisciplinary approach to patient care.
- IV. PGY3s must be able to elicit information or agreement in situations with complex social dynamics, for example, identifying the power of attorney or surrogate decision maker, and resolving conflict among family members with disparate wishes.

### **Professionalism**

- I. All residents must demonstrate strong commitment to carrying out professional responsibilities as reflected in their conduct, ethical behavior, attire, interactions with colleagues and community, and devotion to patient care.
- II. All residents should be able to educate patients and their families in a manner respectful of gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation on choices regarding their care.
- III. PGY2s should be able to use time efficiently in the clinic to see patients and chart information.
- IV. PGY3s should be able to provide constructive criticism and feedback to more junior members of the team.

### **Systems-Based Practice**

- I. PGY1s must have a basic understanding that their diagnostic and treatment decisions involve cost and risk and affect quality of care.

- II. PGY2s must be able to discuss alternative care strategies, taking into account the social, economic, and psychological factors that affect patient health and use of resources.
- III. PGY2s should understand the impact of insurance status on patient access to care and be aware of the availability of case workers, counseling services, and other community resources to maximize care.
- IV. PGY3s must demonstrate an awareness of and responsiveness to established quality measures, risk management strategies, and cost of care within our system.
- V. Residents must be aware of current quality issues in ambulatory care, such as cancer screening.
- VI. Residents will become familiar with the concept of the Patient-Centered Medical Home as well as other issues pertinent to the practice of outpatient medicine, such as coding and reimbursement, liability, and the costs and legal issues involved in running a practice.

### Teaching Methods

- I. Supervised patient care in the clinic
  - Residents will initially be directly observed with patients, to facilitate the acquisition of excellent history taking, physical exam, and procedural skills.
  - As residents become more proficient, they will interact independently with patients and present cases to faculty.
    - For PGY1s, initial emphasis will be on diagnosis and basic management.
    - For PGY2s and PGY3s, focus will be on medical decision-making, and residents will work with supervising physicians to finalize a care plan.
- II. Conferences
  - Specialty-specific didactics
- III. Independent study
  - Reading as recommended by Attending physician
  - Online educational resources
    - The Stanford 25 <http://stanfordmedicine25.stanford.edu/>
    - Up To Date
    - Clinical Key
    - ACP Caring with Compassion [https://www.acponline.org/cme-moc/online-learning-center/caring-with-compassion?\\_ga=2.256224523.1688184499.1553800570-2014796693.1533929003](https://www.acponline.org/cme-moc/online-learning-center/caring-with-compassion?_ga=2.256224523.1688184499.1553800570-2014796693.1533929003)
    - NEJM Case Studies in Social Medicine <https://www.nejm.org/case-studies-in-social-medicine>
    - Dementia and Diversity in Primary Care- Latino Population: <https://stanford.cloud-cme.com/default.aspx?EID=20687&P=3000&CaseID=25>

- US Prevention Services Task Force Recommendation Statement on Screening For Hepatitis C Virus Infection in Adolescents and Adults: <https://jamanetwork.com/journals/jama/fullarticle/2762186?referringSource=articleShare>
- Resources for pain management and addiction
  - CDC: <https://www.cdc.gov/drugoverdose/prescribing/resources.html> and <https://stacks.cdc.gov/view/cdc/38025>
  - California Bridge Program: <https://www.bridgetotreatment.org/resources>
  - NIDA: <https://www.drugabuse.gov/drugs-abuse/opioids>
  - AAFP: <https://www.aafp.org/afp/2019/1001/p416.html>
- Social Determinants of Health Screening Tools
  - National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool <http://www.nachc.org/research-and-data/prapare/>
  - AAFP The EveryONE Project <https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html>
  - Centers for Medicare & Medicaid Services Accountable Health Communities Health-Related Social Needs Screening Tool <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>
- Trans and gender diverse resources:
  - <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>
  - <https://transcare.ucsf.edu/guidelines>
  - <http://transhealth.ucsf.edu/trans?page=guidelines-terminology>
  - <https://stanford.cloud-cme.com/default.aspx?EID=20959&P=3000&CaseID=26>

## Evaluation

- I. Case and procedure logs
- II. Mini-CEX bedside evaluation tool – residents must complete a required number in PGY1 and PGY2 year in the venue of their choice
- III. Combank
- IV. Verbal mid-rotation individual feedback
- V. Continuity Clinic Evaluation – twice per year
- VI. 360 Evaluation – twice per year
- VII. Attending written evaluation of resident at the end of the year, based on observations and chart review.

## Rotation Structure

- I. Residents will be assigned to a preceptor and location at the beginning of their PGY1 year. They will meet with their attendings to review expectations to optimize patient care and resident learning in the clinic.
- II. Residents should notify the attending physician as well as the Program Director promptly if on any occasion they cannot be in clinic at their assigned time.
- III. Residents will spend increasing amounts of time in their Continuity Clinics.
  - Residents are the primary care providers for their patients. Residents will be involved in discussion of patient presentation, generation of a differential diagnosis, development of a treatment plan, and patient follow up. In addition, residents will be involved in surgical procedures as is appropriate.
  - Case-based learning is most effective. Nightly reading/study should be based on patients seen during the day.
  - When doing outpatient family medicine consults, the resident should understand the question asked and provide a concise answer.
  - When doing referrals, please consider the appropriate work up prior to a specialty clinic visit. For Orthopaedic clinic referrals, please see the attached addendum.
- IV. Residents will review TIPS (clinical pearls) each month in clinic with their preceptor. Residents may also be asked to do focused literature searches or presentations by their preceptor.
- V. Residents will be required to do one quality improvement project each year under the supervision of the attending physician. The project will be shaped by the resident's interests but will require applying principles of quality improvement to their own medical practice.
- VI. Call and weekend responsibilities TBD by the attending physician.
  - Hours worked must be consistent with ACGME requirements and are subject to approval by the Program Director.
- VII. Residents have specialty-specific didactics and should be excused in a timely fashion to attend.



## **Ortho Referral Work-Up Guidelines**

### **X-rays required:**

- include weight bearing AP pelvis for hips and WB bilateral knees
- if normal then PT or advanced imaging should be ordered first before referral
- always do x-ray before MRI or CT, especially if patient is over 40

### **Advanced imaging:**

- if you suspect a tear of meniscus, ligament, labrum, any soft tissue injury or a disc rupture get an MRI
- many insurances (mostly private) require a course of PT before they will pay for an MRI unless instability or neurologic deficit can be documented (this applies particularly to spine)

### **NSAIDS:**

- most people with an acute injury and no contraindications will benefit (we often use rule of 3: 3 OTC ibuprofen 3 times a day for 3 weeks)
- a lot of people with OA will benefit as well, remember topicals for knees and hands

### **Total joints:**

- CMS requires failure of conservative treatment (weight loss, NSAIDs, steroid injections, physical therapy, and possibly HA injections)
- we require BMI < 35, HgbA1c < 7.0, smoking cessation for 2 months or greater, optimization of medical issues

### **Ankle sprains:**

- most just need Aircast for 1-2 weeks and will improve rapidly by around 2 weeks
- need to fail 2 months PT or have an MRI before referral

### **Toe fx:**

- most just need hard soled shoe and buddy taping for 3 weeks (no Ortho needed)

### **Finger fx:**

- if non-displaced and not intra-articular then finger splint or buddy tape for 2-3 weeks then repeat x-ray (no Ortho needed for most)

**orthobullets.com is a great free website to consult**