Rotation Goals and Objectives

Table of Contents

Behavioral Science

Preamble

Resident training includes training in the biopsychosocial model of illness and health. Residents will appreciate the impact of psychiatric illness on the individual and his/her family, normal and abnormal lifespan development, medical ethics, rapport building techniques, the principles of behavioral change, and social and cultural determinants of health status. Residents will identify and treat common behavioral and emotional problems in children and adults and will utilize community services to improve care for their patients. They will also learn about the difficulties and options for treating substance abuse disorders.

The Behavioral Science Rotation is typically completed during PGY 1. Additionally, residents receive instruction and training from community faculty members including psychiatrists, psychologists, and allied health professionals.

In addition to the Behavioral Science rotation, residents will consult with on-site Psychologists to determine appropriate treatment plans for patients with mental health problems. Didactic training is provided throughout residency training. Residents will also participate in resident support group throughout residency training.

Goals

- An appreciation of the complexity of use of psychoactive medications
- Expertise in the availability of community resources to support patients with mental health problems
- Competence in the diagnosis and treatment of mood, neurobehavioral, substance abuse, sleep, and developmental disorders
- Recognition of personal limitations and the need for appropriate consultation

Objectives

- Identify and manage psychiatric problems commonly presenting in primary care
- Understand diagnostic and treatment concerns in special populations (e.g., substance abusers, pediatric and geriatric patients) and situations (e.g., postpartum adjustment, bereavement)
- Understand psychosocial and psychiatric treatment for patients with mental health concerns and describe these specialty services as part of a comprehensive treatment plan
- Assess high risk behaviors including substance use and unsafe sexual practices
- Increase knowledge of brief supportive or solution-focused counseling techniques for use in the context of typical primary care encounters
- Increase familiarity with community resources and referral process for specialty mental health and related services including psychology, psychiatry, pain management, and sleep medicine
- Increase familiarity with, and appreciation of, social and cultural determinants of health status

Rotation Schedule

FMR Clinic – Monday, Wednesday, Thursday AM
Agassiz Associates (Dr. Nikki Anvinson) – Tuesday All Day
Suedel Therapeutics and Wellness – Wednesday PM
Inpatient Psych – Thursday PM and Friday All Day

Contact for Rotation: Shyla Muse, PhD, shyla@grandforkstherapy.com

Revised and approved by Faculty 2021

Cardiology

Preamble

Cardiovascular disease is a leading cause of morbidity and mortality and the family physician should be proficient in the diagnosis and management of the commonest pathologies and knowledgeable of the others. They should be expert in preventive and lifestyle modifying strategies and interpretation of the electrocardiogram and appropriate interpretation of diagnostic tests. Residents, who will be involved in rural care, or working in smaller hospitals, will need to consider available resources, transport capabilities, and availability of consultation, as it applies to their chosen practice site.

Goals

- An appreciation of the important role of care of the patient with cardiovascular disease in full spectrum family medicine practice
- Expertise in primary and secondary prevention in cardiovascular disease
- Competence in the diagnosis of cardiovascular disease incorporating interpretation of common laboratory and ancillary testing
- Recognition of personal limitations and the need for appropriate consultation

Objectives

- An understanding of cardiovascular anatomy and pathophysiology
- Ability to perform appropriate cardiac history and physical examination and develop appropriate differential diagnosis and evaluation and management plans
- Knowledge and understanding of basic diagnostic procedures:
    - Mechanics and interpretation of ECG
    - Interpretation of chest radiographs
    - Stress test monitoring and interpretation
    - Ambulatory ECG monitoring and interpretation
- An evidence-based knowledge of primary and secondary prevention and risk management
- Knowledge and understanding of therapeutics and procedures:
    - Risk management
    - Cardiopulmonary resuscitation (CPR), both basic life support (BLS) and advanced cardiac life support (ACLS)
    - Treating dysrhythmias and conduction disturbances
    - Use of external temporary pacemakers
    - Management of acute myocardial infarction, post-infarction care, and complications
    - Congestive heart failure
    - Hypertensive emergencies
- Knowledge of cardiovascular rehabilitation:
    - Psychosocial issues
    - Sexual functioning
    - Depression
    - Family dynamics
- Knowledge of management of patients after an intervention:
    - Lifestyle adjustments
    - Coronary artery bypass surgery
    - Catheter-related interventional procedures
- Ability to appreciate the role of, and cooperate with, other disciplines including nursing, pharmacy and dietetics in cardiovascular disease
- Ability to communicate in compassionate, knowledgeable manner and address complex psychosocial issues in cardiology with patients and families

FMR Clinic Schedule: Two to four half days in the afternoon
Contact for Rotation: Dawn Smith, dcsmith@altru.org

Revised and approved by Faculty 2021

Critical Care

Preamble

Family physicians, particularly those involved in rural care or working in smaller hospitals, need to be able to provide care to the critically ill patient. However, the extent to which each resident will be involved will include the anticipated site of eventual practice and the facilities and support available at that site. Nevertheless, all residents should become adept at the diagnosis and management of the critically ill patient, particularly as regards ascertaining signs and symptoms and interpreting laboratory abnormalities. The comprehensive care of the critically ill patient also involves medical ethics and end-of-life care, and crosses boundaries with the care of the surgical patient.

The Critical Care rotation is completed in the third year of residency training.

Goals

- An appreciation of the important role of care of the critically ill patient in full spectrum family medicine practice
- Expertise in the pre-crisis recognition of fluid, pressor and ventilatory support in those who may become critically ill
- Understanding of the ethical dilemmas, and the interplay with end-of-life care, in the management of the critically ill patient
- Familiarity with the resources and facilities required in the care of the critically ill patient

Objectives

- Ability to perform a comprehensive critical care assessment and develop acute treatment plans
- Understanding of pathophysiology, diminished homeostasis, altered metabolism and effects of drugs in the critically ill patient
- Knowledge of strategies to prevent deep venous thrombosis and hospital-acquired infections, and to maintain normoglycemia
- Knowledge of IV fluids and uses, and aggressive correction of hypovolemia
- Understanding of indications for, and appropriate use of, ventilatory and circulatory support
- Ability to optimize care using a systematic approach to medical decision-making, combining scientific evidence and clinical judgment
- Ability to communicate effectively with patients, families, and other members of the health care team
- Awareness of personal limitations and timely recognition of need for consultation
- Effective and compassionate communication with patients and families in difficult and/ or emotionally charged circumstances

FMR Clinic Schedule: Three to four half days in the afternoons
Contact for Rotation: Dr. Mudireddy, umudireddy@altru.org

Revised and approved by Faculty 2021

Dermatology

Preamble

As much as 20% of family physician consultations are dermatologically related. Residents' dermatology education occurs mainly through individual experience gained encountering patients with skin disease in the continuity clinic with faculty assistance at point-of-care. This allows the self-directed resident to acquire the fundamental dermatology concepts relevant to the practice of family medicine. Additionally, the four- week dermatology rotation teaches the capabilities of a health system dermatology department and to apply dermatology to daily practice. The cognitive and behavioral objectives for the dermatology rotation are comprehensive and should thus be viewed as skills that develop throughout the residency experience.

Goals

- Acknowledgment of the impact of dermatologic conditions on the practice of family medicine
- Awareness of the importance of diagnosing and dermatologic conditions in family medicine practice
- A firm grasp of the basic principles, recognition and treatment of common disorders, initial management of dermatologic emergencies, and indications for specialist referral
- A willingness to manage the majority of dermatologic conditions
- A positive approach to psychosocial issues in patients who have skin disorders
- A willingness to learn and perform common dermatologic procedures
- A constructive collaboration with dermatologists when appropriate

Objectives

- Proficiency in diagnosis and treatment of common dermatologic diseases and in performing common dermatologic procedures
- Recognize common skin diseases and skin tumors
- Recognize important cutaneous signs of systemic disease or adverse reactions to drugs
- Appreciate the impact of skin diseases on patients and their families
- Possess knowledge about dermatologic emergencies, including the concept of skin failure (e.g., toxic epidermal necrolysis, erythema multiforme, acute urticaria, angioedema) and perform competent triage
- Ability to describe eczema, psoriasis, scabies, fungal infection and urticaria
- Understand the principles of topical treatment, including choice of base (e.g., cream versus ointment or lotion) and use of occlusion
- Understand basic principles of wound healing
- Recognize and distinguish between melanoma and non-melanoma skin cancer
- Ability to discuss complex dermatology issues with clarity, sensitivity, and compassion

FMR Clinic Schedule: Monday, Tuesday, Wednesday mornings and Friday all day
Contact for Rotation: Dr. Alyssa Hoverson, alyssa.hoverson@sanfordhealth.org

Revised and approved by Faculty 2021

Emergency Medicine

Preamble

Emergency Medicine, like Family Medicine, is a specialty of breadth and includes other specialties, but while continuity of care is central to Family Medicine, it is incidental in the emergency setting. Consequently, the goal is not to re-learn that which is common to both, but to learn from contrasting practice styles, observe the difference between diagnosing and "ruling out", and draw conclusions about cost-effectiveness, and where care may be most effectively rendered. Effective triage, resuscitation and stabilization, with prerequisite technical skills, are invaluable and cannot be learned outside the ER. As the resident considers practice in smaller communities, these skills assume vital importance.

Minimal rotation requirements are fourteen 12-hour shifts for the first emergency medicine rotation and twelve 12-hour shifts for the second rotation. These shifts must be made up with a combination of days, evenings, nights and weekends. Must include two weekends.
Time schedules should be arranged with Dr. Lohstreter via google calendar (log in altruedrotation, password AltruED123) who is the ER Coordinator. Schedules should be posted in the ER prior to the start of the rotation. Residents cannot schedule shifts with Dr. Schanzenbach.

Residents must record meaningful encounters for all patients they have seen during the ER rotation. Resident must see, at minimum, 125 adults and 50 pediatric patients during the two rotations.

Goals

- A capacity to effectively and efficiently assess according to the urgency of the problem
- An awareness of the importance of cost containment and appropriate utilization of medical resources
- An awareness of the appropriate use of the laboratory and imaging department in the emergency setting
- An awareness of those conditions that may deteriorate suddenly and critically and the supportive/resuscitative measures needed
- Practical experience of those procedures needed in the support/resuscitation of patients with unstable presentations
- An awareness of the emergency department role in community disaster planning

Objectives

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in urgent and emergent situations and develop treatment plans appropriate to the resuscitation, stabilization and disposition of these patients
- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary and consultative services
- Educate and elicit patient and family participation in medical decision-making
- Effective and compassionate communication with patients and families in difficult and/or emotionally charged circumstances

Suggested Reading:

- "Rosen's Emergency Medicine: Concepts and Clinical Practice" 6th Edition - 3 Volume Set Editor in Chief John A. Marx. NY, NY: McGraw-Hill (2006)
- Tintinalli, JE (2004). "Emergency Medicine A Comprehensive Study Guide." NY, NY: McGraw-Hill, 6th Edition
- Reichman EF, Simion RR (2004). Emergency Medicine Procedures NY, NY; McGraw-Hill
- 5 Minute ER Consult
- 5 Minute Toxicology Consult

FMR Clinic Schedule: One to two full days per week
Contact for Rotation: Dr. Samuel Lohstreter, slohstreter@altru.org

Revised and approved by Faculty 2021

Endocrinology

Preamble

The diagnosis and treatment of endocrine diseases are guided by laboratory tests to a greater extent than for most specialties. Some diseases are investigated through excitation/stimulation or inhibition/suppression testing. Consequently, a family physician confronted with a potential endocrine problem needs knowledge of clinical chemistry and biochemistry to understand the uses and limitations of the investigations. A second important aspect of endocrinology is distinguishing human variation from disease.

Atypical patterns of physical development and abnormal test results must be assessed as indicative of disease, or not, and diagnostic imaging of endocrine organs may reveal incidental findings which may or may not represent disease.

Most endocrine disorders are chronic diseases that need life-long care and are close to the heart of family medicine. Some of the most common endocrine diseases, including diabetes mellitus, hypothyroidism and the metabolic syndrome, are seen weekly, if not more frequently, in the family physician's office. Care of these chronic diseases requires understanding the patient at the personal and social level as well as the molecular, and the physician–patient relationship can be an important therapeutic process.

Goals

- Learn efficient outpatient management of patients with endocrine disorders
- Learn inpatient and outpatient management of patients with diabetes mellitus including:
- ketoacidosis and non-ketotic hyperosmolar coma
- simple glycemic control
- management and prevention of diabetic complications
- adjusting insulin and/or oral hypoglycemic therapy for procedures or surgery
- Efficiently evaluate the endocrine systems of acutely and chronically ill patients, including the role of stimulation and suppression testing and imaging studies
- Understand indications and timing of referral to endocrinology subspecialist

Objectives

- Demonstrates ability to obtain an accurate history with regard to:
    - symptoms of DM and complications
    - symptoms of hypo and hyperthyroidism, hypercalcemia and osteoporosis
    - risk factors for diabetes and osteoporosis
- Demonstrates the ability to perform a routine:
    - screening thyroid exam
    - screening diabetic foot exam
    - neurologic exam for evidence of stocking glove neuropathy
- Interpret results of:
    - Fasting and post-prandial glucose
    - Cholesterol panel
    - TSH determination used for screening
    - Microalbumin
- Understands the indications for:
    - Thyroid ultrasound
    - Thyroid uptake scan
    - Thyroid biopsy
- Recognizes, initiates management for, and outlines goals for:
    - uncontrolled DM (hyperosmolar states, DKA, asymptomatic hyperglycemia)
    - new onset DM in an outpatient with monotherapy
    - dyslipidemia
    - hypothyroidism in the young and in the elderly
    - osteoporosis using FRAX score

These goals and objectives are achieved through a combination of structured inpatient/ outpatient experience, together with didactic instruction. In addition to an elective endocrinology rotation, the overlap with general medicine should be apparent.

Suggested Reading:

- Polycystic ovary syndrome - Ann Int Med in the clinic - February 1, 2011 Hyperthyroidism - Ann Int Med in the clinic - July 3, 2012
- Primary hypothyroidism - The Endocrinologist 2006;16:203-207 Corticosteroid use preoperatively - Dr. Ryan
- Clinical use of anion gap - Medicine 1977;56:38-54 Important formulas in DKA - Dr. Ryan

FMR Clinic Schedule: Three to four half days per week
Contact for Rotation: Jessica Strand, jmstrand@altru.org

Revised and approved by Faculty 2021

Ear, Nose & Throat (ENT)

Preamble

A Queen's University study of epidemiology of disease placed ear, nose & throat complaints second only to dermatologic complaints in frequency. Consequently, the family physician must be knowledgeable in the diagnosis and treatment of common presentations, alert for the possibility of the atypical or treatment refractory, and competent in the first aid of ENT emergencies. Care may be carried out predominantly by the family physician, or shared with the consultant ENT specialist, or mainly managed by the ENT specialist with the family physician providing support.

Goals

- Acknowledgment of the impact of ear, nose and throat disease on the practice of family medicine
- Awareness of the importance of diagnosing and treating ear, nose and throat disease in family medicine practice
- A firm grasp of the basic principles, recognition and treatment of common disorders, initial management of ENT emergencies, and indications for specialist referral

Objectives

- Enhanced history taking skills relative to head and neck pathology
- Ability to conduct essential components of a basic ear, nose and throat review of systems and physical examination
- Ability to describe the applied anatomy of the ear, nose, mouth, pharynx, larynx, and neck
- Understanding of, and ability to describe, assessment procedures including audiologic tests, laryngoscopy and nasal cautery
- Diagnosis and treatment of common infections including acute sinusitis, epistaxis, pharyngitis and otitis media
- Understanding of the causes of stridor and ability to describe emergency airway management techniques
- Recognition of the causes of dysphonia and indications for referral
- Ability to identify abnormal examination findings of the oral cavity and pharynx including malignant lesions and lesions resembling malignancy
- Ability to describe and explain the work-up and treatment for otolaryngologic emergencies such as airway obstruction, tracheotomy care, caustic ingestion, deep neck abscesses and maxillofacial trauma
- Ability to communicate in compassionate, knowledgeable manner and address complex psychosocial ENT issues with patients and families
- Develop knowledge of ENT guidelines commonly encountered in family medicine, such as AOM, Pharyngitis, Sinusitis, etc.

Suggested Readings:

- ENT (aafp.org): Acute Otisis Externa, Adult Sinusitis, Allergic Rhinitis, Antibiotics for Acute Otitis Media, Antibiotics for Sinusitis, Cerumen Impaction, Hearing Loss, Deafness & Hard of Hearing, Hoarseness, Oral Cancer, Otitis Media, Speech and Language Delay, Tonsillectomy, Vertigo
- ENT Clinical Recommendations & Guidelines
- Primary Care Otolaryngology 3rd Edition by the American Academy of Otolaryngology
- Oto-Primary-Care-WEB.pdf (entnet.org)

FMR Clinic Schedule: One to two mornings per week.
Contact for Rotation: Anne Gerszewski, agerszewski@altru.org

Revised and approved by Faculty 2021

Family Practice Teaching Service (FPTS)

Preamble

The Residency Program expects that those residents wishing to develop the knowledge, practical skills, and judgment necessary for "full spectrum practice" will recognize the contribution of competent inpatient care. At the same time, it is recognized that these attributes are acquired incrementally which is challenging when patients present randomly with differing degrees of diagnostic and management complexity. The rate at which these competencies will be acquired is outlined for each month of family practice teaching service experience, with corresponding adjustments in responsibility and supervision. The Family Practice Teaching Service is regarded as the heart of the Program's general medical service.

Definitions

Direct supervision – the supervising physician is physically present with the resident and patient
Indirect supervision with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision
Indirect supervision with direct supervision available - the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to provide Direct Supervision.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members. Faculty members functioning as supervising physicians will delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Senior residents or fellows will serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

In general, the emphasis in the first year is on maturation of history taking, physical examination, assessment, and presentation. The first-year resident will be guided toward a practical understanding of the current electronic medical record and its operation. Organization, presentation, and documentation of clinical material will be demonstrated and modeled. Throughout, direct supervision will be provided. It is anticipated that resident progress will have occurred to permit "indirect supervision with direct supervision available" by the second year and is a program requirement for advancement.

Residents will have at least 600 hours and 750 patient encounters dedicated to the care of hospitalized adult patients with a broad range of ages and medical conditions. Teaching Service experience will include two blocks in PGY-1, five blocks in PFY-2, and one 6-8 weeks in PGY-3.

Goals

- An appreciation of the important role of inpatient medicine in full spectrum family medicine practice
- An understanding of the pathophysiology in common medical conditions requiring hospitalization
- Competence in the diagnosis and management of common inpatient medical presentations
- The development of management and therapeutic skills based on recognized pathophysiology and the correction of its causes

Objectives

- Ability to perform a concise history and physical examination without errors of omission
- Competence in the recognition and management of the pathophysiology involved in common conditions requiring hospitalization
- Ability to integrate laboratory, imaging, and advanced investigations in the diagnostic and therapeutic process
- Ability to present concisely and demonstrate integration of all pertinent information, with appropriate selection of diagnostic and therapeutic options
- Demonstration of ability to research current clinical problems and incorporate the best literature into therapeutic options
- Ability to function effectively as a member of a complex team
- Awareness of personal limitations and timely recognition of need for consultation
- Effective and compassionate communication with patients and families

Procedure

General

1. Patients placed on a teaching service are managed by the service residents and attending physician. Orders should be written by residents. Admissions to the teaching service must be accepted by the Chief Resident or the resident on call after 5:00 pm. Staff physicians may not admit to the teaching service without clearing through one of the above-named parties. If problems arise, it should be handled by the Program Faculty or the Chief Resident. Adult medical and clinical admissions to FPTS must be accepted by the attending physician.
2. FPTS "teaching rounds," which function as "sign-out rounds" for the post-call resident, occur from 8:30-10:30 am and includes the Chief Resident, junior residents on the FPTS, medical student(s), attending physician, and pharmacist. All new patients will have a history and physical presented during morning teaching rounds. Patients currently on the service will have an updated history, physical exam, and plan of care presented. Teaching rounds offer an opportunity to discuss patient management, learning issues and to perform formal rounds on the patient floors.
3. Unless circumstances are unusual, you should see your patients on your own before morning rounds. If discharge is planned for that day, residents should contact the attending physician and enter discharge orders prior to teaching rounds, time permitting.
4. Patients are to be assigned to a specific resident as soon as possible after admission. The patient's chart should be designated to the FPTS in EPIC.
5. All admissions to the FPTS prior to 4:30 PM will be carried out by the designated in-house resident. Such resident will also admit pediatric patients when the pediatric resident is unavailable. Admissions at or after 4:30 PM will be carried out by the resident responsible for overnight call. Patients with ongoing care needs on the FPTS will receive a face-to-face evaluation by his/her resident prior to sign-out rounds. The Chief Resident, the PGY-3 resident on-call, and all residents on the FPTS will be present at sign-out rounds at 5 PM on weekdays, in the common area by the resident call rooms, with the exception of any resident on post-call respite. Any resident who will be unavoidably delayed will notify the Chief Resident and the resident on-call and will be responsible for his/her patients' care until such time that formal handover has taken place. Prior to sign-out rounds, each resident will complete the standardized electronic log that contains pertinent patient information and specifically indicates whether a patient will require an evening visit by the resident responsible for overnight call, or not.
6. PGY3 residents providing call coverage for FPTS are responsible for rounding on patients admitted to the hospital during their call coverage. The resident is then required to attend teaching rounds allowing satisfactory transition of care.
7. Meaningful encounters on the FPTS include: H&Ps, daily progress notes, afternoon round notes that results in a change of plan of care, documentation of the care of an unstable patient, and discharge summaries. Each meaningful encounter must be sent to the attending physician for co-signature.
8. When requesting a consultation, be sure that the request is clear and specific (i.e. advice on patient's problem, assume total care, etc.) Consultations must be requested in EPIC and a phone call to the physician and/or their office. The patient's primary physician should be notified of these plans.
9. Some patients on the FPTS require procedures to be done while they are hospitalized such as an LP, etc. which the resident is permitted to perform with the discretion and proper supervision of the attending physician. The individual resident is responsible to take the initiative to coordinate this.
10. Only residents can write orders on service patients unless there is an emergent situation.
11. Schedule:
12. The chief resident is responsible for its construction
13. Requests for time off while on call should be submitted 40 days prior to the first day of the month on call
14. Any call schedule changes must be coordinated between residents. Changes must be given to the residency coordinator no later than the 15th of the preceding month
15. Any changes must conform to the Program policies on vacation
16. Service attendings rotate in two-week blocks from Monday am to Monday am.
17. Patients are received from the following:
18. Service attendings private patients
19. Patients of other Altru physicians considered to have educational value to the service

20. All patients of the Family Medicine Residency physicians (It is the individual resident's responsibility to assume care)
21. Consults
22. Residents are required to verbally communicate with a specialist when a hospital consult order is placed. The consultant should be paged to the call back number plus *77*2. If the consulting physician does not return the call within 15 minutes, the resident will send a message via "Secure Chat" in EPIC notifying the physician of the consult and asking that they page the resident for verbal communication. If the resident is post-call and will not be available to speak with the consulting physician, the team pager beeper number should be left in the Secure Chat message. If there are consultants who don't routinely return pages, a Clarity should be submitted, or the Program Director should be notified.

Chief Resident

A chief resident plays a critical role in the educational mission of residency program. Duties involved as the chief resident including managing administrative, educational, and clinical tasks of the residency. Serving as the chief resident provides an excellent opportunity for a third-year resident to continue to develop and model leadership and teamwork. A framework of expected duties and expectations for managing the FPTS is as follows:

Chief Duties

- Maintain the call schedule for FPTS.
- Organize the monthly chief conference. Chief Conference will be noon conference on the last Thursday of each block.
- Take attendance at noon conferences. Excused absences are only for a resident who is away on vacation, post-call respite, sick-leave, or attending to patient care duties.
- Manage evening/night phone calls. Calls should only be taken for FMR patients and Life Skills Transitional Center.
- Arrange call coverage if a resident is unable to provide it.
- Arrange post resident education support group and bring concerns to faculty.
- The chief resident will provide a list of cases appropriate for a root-cause and apparent cause analysis to the Program Director.
- Attend "hospitalist huddle" 1:00-1:20 pm M-F by phone
- PGY-3 resident on-call is required to check-in with in-house resident on-call at approximately 10 pm as a wellness check and giving the in-house resident the opportunity to answer questions.

Chief Expectations

- Update the FPTS list including, at a minimum, the patient room number, MRUN, name, code status, attending physician, PCP, admission date, vital sings and resident comments which will include all the following: hospital diagnosis, expected discharge date, significant PMH, diet, IVF pertinent labs and plan. All list updates include anticipated follow-up required following the transition of care.
- All patients on the FPTS will be designated as "visit required" or "visit not required". All patients designated as "visit required" will be seen by the day or night shift resident.
- Monitor resident notes on FPTS with special attention to 1st year residents
- Develop presentation skills with individual residents
- Check in with post call resident to evaluate their level of fatigue and provide relief if necessary. The chief resident should use discretion to round on patients when a resident appears to be overwhelmed. PGY-1 residents should have no more than 8 patients and PGY-2 residents should have no more than 10 patients.
- Encourage meaningful encounter data entry.
- Reinforce professional behavior to all residents, including on-time arrival for morning rounds.
- **The chief resident will encourage residents to submit Clarity reports when appropriate.**
- Monitor compliance with 80-hour work week for residents on the FPTS. Check-in with academic coordinator the third week of each block to establish if junior residents need work hours adjusted the last week of the block to maintain compliance with duty hours less than 320 per block.

- The chief has the responsibility of demonstrating POCUS on appropriate FPTS patients.
- Attend hospitalist huddle via phone daily
- Provide constructive feedback to the residents two weeks into each block, acknowledging strengths and providing opportunities for growth

Admissions:

- Chief is expected to notify residents of admissions or consults.
- The chief resident will notify residents for admission during daytime hours. If the resident is overwhelmed with other patient care obligations, the chief may choose to assign the patient to a different resident. Ultimately, there is joint discussion but not joint decision regarding patient assignment to residents.
- Assign cases to medical students (approximately 2 patients per 3rd year student and 3 patients per 4th year student). Patients followed by medical students need to have a resident follow with the patient as well. Residents may copy the medical student note and paste into their daily progress note, acknowledging the original author.
- Admissions after 4:15 PM should be done by the on-call resident.
- Admissions from 6-8:30 AM should be done by the chief resident who may then reassign the patient to a junior resident.
- If the PGY-1 resident has 3 or more admissions in 2 hours or the PGY-2 resident has 4 or more admissions in 2 hours, the chief resident will be in-house to assist.
- In-house PGY-3 resident on-call will round on all admits occurring between 8 PM and 7 AM. Admits occurring before 8 PM will be reassigned to residents on the FPTS.
- The FPTS will not take admissions from 11-5 PM on resident education days. Attending physicians will write admission orders and document H&P during this time. The attending physician may contact the Chief Residents if they would prefer the patient to be followed by the FPTS.
- When the teaching service census is greater than 20 at 8 am for 2 consecutive days, Sanford patients will not be admitted to the teaching service. If a Sanford physician is the attending on the teaching service, he/she may continue to admit patients to the teaching service when they are on-call or have a personal patient that requires hospital admission
- When the teaching service census is greater than 30 with four residents, or greater than 35 with five, residents the following protocol will be followed:
    - ~~o~~ If there is a resident(s) on inpatient pediatrics, they will see family medicine newborns and pediatric patients.
    - If there is a resident on the pharmacology rotation, they will join the FPTS. They will not be assigned call but will assist with rounds, daytime admissions, and managing the inpatient needs.
    - If there is no resident on pharmacology, we will ask for a volunteer to join the service from any residents on non-required, non-call rotations. If no volunteers, a resident will be assigned by the program.
    - The back-up resident will stay on the teaching service until the teaching service census at 8 am is less than 30 for two consecutive days
    - The back-up resident will help round on the weekend (if available, if not another resident will be brought in to assist on the weekend) if teaching service census is greater than 30 at 5 pm Friday.
    - Residents will be compensated an additional 2 days of comp time if they provide weekend coverage.
    - If the chief resident establishes that the acuity of patients on the teaching service exceeds the resident's ability to provide quality and safe care, the above protocol will be implemented at lower than above-stated numbers after discussion with the Program Director, Associate Program Director, or Faculty Member.

Morning Rounds:

- Actively guide learning issues on morning rounds. Each resident should have four learning issues per block. If junior residents are busy with patient care, the Chief resident should present learning issue. At least one learning issue should be presented daily.

- Post round with 1st year residents for the first two weeks they are on the FPTS.
- The chief will encourage residents to read attestations prior to calling the attending physician.

Evening/Sign Out Rounds:

- Chief resident and the third-year resident on-call are required to attend sign-out rounds.
- In-house residents will see their patients as well as the post call resident's patients for evenings rounds. Otherwise, residents do their own PM rounds and can write their PM notes after rounds, if needed.
- Encourage the use of "read-back" technique during sign-out rounds

Revised and approved by Faculty August 2, 2023

Geriatrics

Preamble

It is not even noteworthy to encounter an elderly patient on 20 medications, or an anti-coagulated patient whose risk of injury and hemorrhage outweighs any potential benefit. Examples in which altered pharmacokinetics and obvious organ senescence are ignored are numerous and if inappropriate hospitalization is added, then the seriousness of the problems that are confronted with the care of the elderly are compounded.

Reliance on traditional diagnostic methodology such as auscultation, in place of assessment of special senses and cognitive function, oral hygiene, proper shoe wear and ambulation, together with care of bladder, bowel and skin, will make it almost certain that the elderly patient will not achieve his/her goal of continued independence. Consequently, a curriculum addressing the care of the elderly should be include experiences within the acute hospital (where the effects of poly-pharmacy and isolation from familiar surroundings are most obvious), the continuity clinic, the long-term nursing facility, the transitional care unit, and ideally, the patient's home.

The support of social services, and proper utilization of those services, is essential to determine the adequacy of home support, delineation of potential hazards, identification of needed services, and recognition of the vulnerable adult.

Residents must be primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities and inpatient care facilities. Long-term care experiences must occur over a minimum of 24 months. Residents are required to complete 125 geriatric encounters.

Residents will be following with Dr. Chris Henderson in the transitional care unit and nursing home setting for two weeks in their second year and two weeks in their third. Residents will be expected to follow a panel of patients and round on patients, co-signing notes to Dr. Henderson. A main goal has been for residents to follow all the patients on TCU (transitional care unit) or the rest of the nursing homes that are family medicine patients and/or have been on the teaching service in the hospital.

Goals

- An awareness of the effects that a physician's attitudes and stereotypes related to aging, disability and death can have on the care of elderly patients
- Compassion and humanism, balancing realism and practicality in the consideration of inevitable decline and loss
- The promotion of the patient's dignity through self-care and self-determination

Objectives

- Understanding of physiology of organ senescence including:
    - Diminished homeostatic abilities
    - Altered metabolism and effects of drugs
    - Normal psychological, social and environmental changes of aging
    - Reactions to stress of retirement, bereavement, relocation and ill health
- Knowledgeable of changes in family relationships affecting care
- Expertise in recognition of risks and adverse effects of:
    - Polypharmacy
    - Iatrogenic illness
    - Immobilization and its consequences
    - Inappropriate institutionalization
    - Overtreatment
    - Inappropriate use of technology
- Knowledgeable of services available to promote rehabilitation or maintaining/ assessing an independent lifestyle, increasing the ability to continue in family, home and social environments

FMR Clinic Schedule: Tuesday and Thursday AM and Wednesday PM

Contact for Rotation: Dr. Chris Henderson, chenderson@altru.org or 701-899-1157

Revised and approved by Faculty 2021

Gastroenterology

Preamble

Symptoms that may arise from the GI tract present - abdominal pain, diarrhea, constipation, nausea, swallowing difficulty, heartburn, jaundice and bleeding - arise frequently and the family physician needs to acquire expertise in their diagnosis and management. To this should be added screening for malignancy of the GI tract of which colorectal cancer is the second most lethal in the United States. At the same time, ancillary testing, from breath tests to ultrasound to CT, offers an ability to assist diagnosis. Some diagnoses imply a lifetime burden and long-term support and commitment.

Goals

- Acquire history and physical exam skills, develop expertise in diagnostic testing, and learn management of gastroenterology disease
- Understand the range of gastroenterology problems and pathology
- Demonstrate the ability to complete a gastroenterology diagnostic workup
- Demonstrate the ability to communicate effectively with patients and others involved in their care
- Understand and utilize appropriate gastroenterology resources, including other health care providers

Objectives

- Perform a GI-focused history and physical examination
- Understand the indications and contraindications of EGD, colonoscopy, ERCP
- Understand the indications and contraindications of GI tract radiology including ultrasound, CT and MRI
- Be able to diagnose and treat GERD
- Be able to diagnose peptic ulcer disease and understand role of H pylori & NSAID use
- Understand diagnosis and treatment of cholelithiasis and its complications
- Understand the diagnosis and management of acute and chronic pancreatitis
- Understand the diagnosis and management of celiac disease
- Be able to diagnose inflammatory bowel disease & recognize indications for urgent referral
- Understand the indications and implications of chronic NG tubes, percutaneous gastrostomy and parenteral hyperalimentation
- Have expertise in colon cancer screening
- Understand the diagnosis & management of irritable bowel syndrome
- Understand the diagnosis & management of acute and chronic GI bleeding
- Understand the indications & contraindications and complications of bariatric surgery

These goals and objectives are achieved through a combination of structured inpatient/ outpatient experience, together with didactic instruction. In addition to a GI rotation, the overlap with general medicine should be apparent.

FMR Clinic Schedule: Afternoons
Contact for Rotation: Jodi Stauss, jodi.stauss@altru.org

Revised and approved by Faculty 2021

Gynecology

Preamble

The majority of women with gynecologic complaints consult a family physician. Indeed, unless a young female physician takes active steps to prevent it, her practice will be dominated by obstetrics, gynecology and pediatrics. Consequently, fundamental gynecology is learned in the resident's continuity clinic with faculty assistance at the point-of-care. During the Social Determinants of Health Rotation, half of your time will be dedicated to gynecology, specifically to compare and contrast management styles of common gynecologist disorders, to understand the role of nurse practitioners, and to develop an appreciation of gynecologic pathology in referral practice, indications for referral, and outpatient gynecologic procedures. However, key elements remain the investigation of abnormal bleeding, infertility, and pelvic floor abnormalities with altered urodynamics. The required experience at a federally-subsidized health clinic provides experience in diagnosis and management of sexually transmitted disease, contraception, and colposcopy. The cognitive and behavioral objectives for the gynecology rotation are comprehensive and should thus be viewed as skills that develop throughout the residency experience.

Goals

- To gain an understanding of the care of the female patient, with particular emphasis from adolescence onwards, it is important to understand the pathology, presentation, and management of common gynecologic disorders. You should also gain an understanding of the importance of the care of this population to family medicine practice.
- Residents will have at least 100 hours dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options for unintended pregnancy. The resident experience will occur through two blocks of the social determinants of health rotation. The resident will spend 12 half- days at Valley Health in each block.

Objectives

- Competent performance of routine gynecologic exam
- Knowledge of disease prevention, health promotion and periodic health evaluation
- Knowledge of physiology of menstruation
- Diagnosis and management of abnormal uterine bleeding
- Management of amenorrhea
- Management of abnormal pap test including HPV
- Diagnosis and management of pelvic inflammatory disease
- Diagnosis and management of endometriosis
- Diagnosis and management of peri-menopausal/menopausal problems
- Knowledgeable of pelvic floor dysfunction and urinary incontinence
- Discuss complex issues with clarity, sensitivity, and compassion

The goals and objectives are achieved through a combination of structured experience and didactic instruction.

FMR Clinic Schedule: Three to four half days anytime during the week
Contact for Rotation: Dr. Pierre Barbot, pbarbot@altru.org

Revised and approved by Faculty 2021

Hematology

Preamble

Hematologic problems are common in both hospital and outpatient settings. They may be primarily hematologic or secondary to other conditions and the family physician should be knowledgeable of appropriate workup and available therapies. Some hematologic problems are life threatening, and in others, the opportunity for intervention is time limited and these situations should be recognized. Additionally, hematologic abnormalities frequently indicate primary disease elsewhere in the body.

End-of-life issues, aggressiveness of care issues in patients with incurable malignancies, use of Hospice programs and discussion of pain control are regularly encountered when hematologic disorders are addressed. Universal precautions and the handling of blood products, complications of blood transfusions, including antibody reactions and infectious complications such as HIV and Hepatitis C are not only logically classified as hematologic problems, they are also part of the practice of general medicine an family medicine.

Goals

- Understand the clinical presentations and rationale workup of:
    - anemia
    - bleeding disorders
    - clotting disorders
    - hemoglobinopathies
    - multiple myeloma
    - myeloproliferative disorders
    - platelet disorders
    - acute leukemias and hematologic effects of chemotherapeutic agents
- Understand the mechanism of iron transport and storage

Objectives

- Able to recognize indications for, and complete workup of, iron deficiency anemia
- Able to recognize indications for, and complete workup of, anemia of chronic disease
- Able to recognize indications for, and complete workup of, macrocytic anemia
- Able to recognize hemolysis and complete initial workup
- Understand role, interplay, and interpretation of basic hematologic parameters:
    - red cell distribution width
    - mean corpuscular volume
    - reticulocyte index and reticulocytosis
    - peripheral smear
    - erythrocyte morphology
- Ability to appropriately order and interpret serum iron, total iron binding capacity, and ferritin

These goals and objectives are achieved through a combination of structured experience, together with didactic instruction. Daily opportunities to manage hematology problems present themselves on the family practice teaching and internal medicine services.

FMR Clinic Schedule: Three to four half days per week
Contact for Rotation: Heidi Panos, hpanos@altru.org

Revised and approved by Faculty 2021

Nephrology

Preamble

As the population ages and other at-risk populations increase, end stage renal disease incidence is sharply on the rise. The U.S. incidence is the highest in the world, 210 per million. Diabetes accounts for more than 40% of all new cases and hypertension for 26%. Disease processes leading most frequently to chronic renal disease - hypertension, diabetes and senescence - dominate family medicine practice.

Goals

- Evaluation and management of patients with fluid and electrolyte disorders and understanding of acid base pathophysiology and management
- Familiarity with mechanisms, clinical manifestations, and diagnostic strategies for patients with acute and chronic diseases of the kidney
- Understanding of reno-protective strategies
- Recognition of indications for timely nephrology subspecialist referral
- Familiarity with principles, indications, and complications of acute and chronic hemo- and peritoneal dialysis, renal biopsy and vascular access placement

Objectives

- Demonstrates ability to document an accurate and complete history from patient, caretaker or outside resource
- Understands risk factors for ARF, nephrotoxic drugs and etiology of CRF
- Demonstrates ability to perform a routine exam for volume status
- Assesses vascular access for appropriate bruit and signs of infection
- Initiates diagnostic testing for:
- sodium disorders
- hypokalemia and hyperkalemia
- acute renal failure
- calcium and phosphate disorders
- metabolic acidosis and alkalosis
- Identifies reasons for urgent dialysis
- Applies relevant clinical and basic science knowledge to:
- acid base disorders
- fluid and electrolyte disorders
- acute and chronic renal failure
- indications for emergent dialysis
- Interprets results of urinalysis, urine culture and sensitivity
- Understands the indications for renal ultrasound and catheter placement
- Effectively establishes rapport with patients and families and communicates complex issues understandably

Goals and objectives are achieved through a combination of structured inpatient/ outpatient experience, together with didactic instruction.

FMR Clinic Schedule: Three to four half days per week
Contact for Rotation: Jodi Stauss, jodi.stauss@altru.org

Revised and approved by Faculty 2021

Neurology

Preamble

Neurologic problems comprise about 15% of a family physician's work. Many are marked by slow degeneration, and for some, there is only palliation. Some such as seizure, amyotrophic lateral sclerosis, and Huntington disease may have social stigma attached. The opportunity to practice the neurologic examination should be taken whenever presented, and to correlate imaging findings with abnormal examination.
Care may be carried out predominantly by the family physician, or shared with the consultant neurologist, or mainly managed by the neurologist with the family physician providing support.

Goals

- Acknowledgment of the impact of neurological disease on family practice
- Awareness of the importance of diagnosing and treating neurological disease in family medicine practice
- An understanding of the role of treatment, prevention, and support in recurrent or progressive neurologic disease
- Knowledge of multi-system care and support
- Knowledge of appropriate pain management and referral in chronic pain

Objectives

- To be able to take an appropriate focused and comprehensive history (including necessary information from others) and communicate this verbally or in writing and in summary form
- To be able to perform a neurological and mental status examination, Glasgow coma scale and communicate verbally or in writing and in summary form to other providers
- To assess the acuity and prognosis of the clinical problem as it relates to the need for immediate management and the requirement for expert assistance
- Knowledge of indications, contraindications, risks and significance of ancillary tests
- Lumbar puncture
- Electroencephalogram
- Visual, brain stem auditory and somatosensory evoked potential
- Nerve conduction study and electromyography
- Muscle and nerve biopsy
- Advanced imaging techniques (CT, MRI, angiography, carotid ultrasound)
- Genetic testing
- Manage emergent neurology problems and obtain urgent consultation appropriately
- Develop systematic approach to investigation of headache
- To communicate in compassionate, knowledgeable manner and address complex psychosocial issues in neurology
- To recognize personal practice limitations and seek consultation with as appropriate

Suggested Readings:

- Evidence-based Guideline: Management of an Unprovoked First Seizure in Adults (aan.com)
- Evaluating a First Nonfebrile Seizure in Children (aan.com)
- Practice Guideline Update: Acute Treatment of Migraine in Children and Adolescents (aan.com)
- Practice Guideline Update: Pharmacologic Treatment for Pediatric Migraine Prevention (aan.com)
- Update: Pharmacologic Treatment for Episodic Migraine Prevention in Adults (aan.com)
- Primary Care of Adult Patients After Stroke: A Scientific Statement From the American Heart Association/American Stroke Association (aan.com)
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (aan.com)

FMR Clinic Schedule: Three to four mornings per week
Contact for Rotation: Renee Riskey, rriskey@altru.org

Revised and approved by Faculty 2021

NICU

Preamble
Common problems include perinatal asphyxia, major birth defects, sepsis, neonatal jaundice, and infant respiratory distress. The family physician must recognize the threat of delivery of a compromised infant, be skilled in its resuscitation and initial stabilization, knowledgeable about the transport and support capabilities within the area of practice and committed to supporting the family under stress.

Goals
- To know the capabilities available to support the distressed infant
- To understand the hazards of prematurity and strategies to reduce its occurrence
- To understand the problems involved in preparation for, and transport of, the compromised newborn
- To understand the family stressors of the intensive care environment and support and communicate effectively and compassionately
- To be prepared to look after the "graduate" from the intensive care unit

Objectives
- Perform initial assessment and evaluation of newborn infants
- Accompany the neonatal transport team when appropriate
- Perform the following procedures under supervision:
    - Attended deliveries
    - Bag-mask resuscitation
    - PIV insertions
    - Umbilical catheter
    - Intubation attempts
    - Lumbar punctures
- Evaluate laboratory results and correlate pathophysiology
- Develop neonatal resuscitation abilities including:
    - Positioning and tactile stimulation
    - Thermal regulation
    - Airway management (suctioning, ET intubation, g-tube insertion)
    - Ventilation, bag valve mask device and/or anesthesia bag
    - Establish vascular access including UVC line placement
    - External chest compressions
- Develop knowledge of stabilization of the critically ill neonate
- Demonstrate understanding of pathophysiology associated with prematurity and principles of management
- Recognize physical findings of the normal perinatal transition
- Integrate the basic principles of fluid, electrolytes, and nutrition
- Summarize mechanical ventilation and various modes of ventilation
- Observe complex neonatal care and appropriate convalescent management
- Discuss complex issues with parents with clarity, and sensitivity

Encounters will count towards the required 75 dedicated to the care of the ill child.

FMR Clinic Schedule: Three to four afternoons per week
Contact for Rotation: Dr. Durga Panda, dpanda@altru.org

Revised and approved by Faculty 2021

Obstetrics

Preamble

The Residency Program expects that those residents wishing to develop the knowledge, practical skills and judgment necessary for "full spectrum practice" will recognize the contribution of obstetrical care. These attributes are acquired incrementally which is challenging when patients present randomly with differing degrees of diagnostic and management complexity.

The resident will have five blocks (28 days) dedicated to participating in deliveries and providing prenatal and post-partum care.

The resident must complete one ABFM Part II obstetrics module during his/her first or second obstetrics rotation.

Goals

- An appreciation of the important role of obstetrics in full spectrum family medicine practice
- An understanding of the physiology in normal pregnancy, labor and delivery, and the pathophysiology in common disorders of same
- Competence in the diagnosis and management of common obstetrical presentations
- Competence in the procedural skills associated with pregnancy and labor
- Recognition and appropriate triage of high-risk pregnancies, labor and delivery and postpartum care

Objectives

- Ability to perform a concise obstetrical history and physical examination without errors of omission
- Ability to recognize normal labor curve with associated progressive changes on examination and to expeditiously recognize departures from same
- Competence in the recognition and management of disease processes associated with pregnancy and labor
- Competence in the performance of standard procedures associated with labor and delivery
- Competence in the provision of analgesia for the laboring patient
- Competence in the care and assessment of the newborn
- Awareness of personal limitations and timely recognition of need for consultation
- Effective and compassionate communication with patients and families

The goals and objectives are achieved through a combination of structured inpatient/outpatient experience, together with didactic instruction.

Procedures

The OB schedule is arranged by the OB fellow or chief resident in coordination with those residents on OB rotations. Care is provided by those residents who are on OB rotations and the OB fellow(s) with supplemented care from a second or third-year resident when necessary to provide adequate coverage.

The resident is responsible for the obstetrical floor in the hospital including triaging possible admissions, actively being involved with laboring patients, first assisting with C-sections, and providing post-partum care. OB fellows may also be available on Labor and Delivery to precept patients.

Weekdays - Rounds in the morning will be divided between the post-call resident and the new resident starting a shift. The post-call resident will stay until 7 am to assist with rounds. The incoming resident will arrive at 6 am to allow time for rounds. Rounds should be completed by 7:00 am. If no resident was on call the night before, find the charge nurse for update on patients.

Weekends - If there was no resident on the previous night, the resident coming on call will have to round on all patients with attending so that he/she is aware of any potential problems. Before going off call, the resident will round on all patients.

The attending physician will be responsible for dictating H&P's for scheduled elective C-sections. The resident on the floor will do those on patients on the floor for which they are caring. The resident assisting with a C-section, will be responsible for the discharge summary.

The resident must complete one ABFM Part II obstetrics module during his/her first or second obstetrics rotation.

Continuity Obstetrical Care
The goal of all Family Medicine residents is to follow **eight (8)** obstetrical continuity patients. After residency, each individual may personally determine whether to practice obstetrics. However, in residency everyone will obtain the necessary training and represent our program well.
Residents must accept OB patients during their training, regardless of total number of deliveries, for due date one month prior to anticipated graduation date. Residents who will continue in group practice in Grand Forks may accept OB patients with due date post-graduation so long as patient coverage can be provided in the graduate's absence.

During residency, each resident is required to provide continuity care to obstetrical patients through the prenatal, perinatal, and post-partum course. Residents are required to:

- Staff the initial OB with the preceptor in the Clinic. The patient may designate a faculty member, or you may precept with the preceptor that day.
- Staff with the preceptor in the Clinic again at 28 and 36 weeks and at any time a resident determines the prenatal course is deviating from routine care.
- Staff any contemplated consultations with the preceptor in the clinic prior to arranging for these consultations.
- Any inductions **MUST** be staffed with a faculty member prior to admission.
- When admitting the patient, admit them under the name of the faculty member on call (if faculty member has not been previously assigned to this patient) or assigned faculty member.
- Notify the faculty member on call when a patient is admitted.
- If you have any problems or questions during labor, please discuss with the faculty member on call before seeking obstetrical consultation, unless it is a dire emergency.
- Residents are expected to be on the OB floor for the entirety of active labor for continuity OB patients

Obstetrical Competency
Any resident seeking comprehensive obstetrical care including vaginal deliveries upon completion of their residency training must complete five blocks of obstetrics and 80 vaginal deliveries.

SIGN-OUT TEMPLATE FOR OBSTETRICS

.

- Every patient list needs to include the following columns: Room/Bed; Patient Name; Attending Physician; Gestational Age; Dilation; Effacement; Station; Resident Comments
- Resident comments for postpartum patients need to include: postoperative/postpartum day number; type of delivery; gravida/para; other pertinent information; anything that needs to be followed up on; time at which patient needs to be re-evaluated
    - **Example:** PPD#1, NSVD, G3P2, induction for gestational HTN; F/U on blood pressures every 2 hours; Reassess patient tomorrow AM
- Resident comments for intrapartum patients need to include: gravida/para, reason for admission (active labor/induction), epidural/no epidural, other pertinent information; time at which patient needs to be evaluated
    - **Example:** G1P0, induction for post-dates, has epidural; received 1 dose Cytotec and now on Pitocin; Recheck cervix at 1400
- Resident comments for antepartum patients need to include: gravida/para; reason for admission; medications given/needed; other pertinent information; time at which patient needs to be evaluated
    - **Example:** G5P4, admitted on 7/15 for PPROM at 30w3d; received 2 doses betamethasone; received mag sulfate; received IV and oral abx; monitor for infection/labor; plan to delivery at 34 weeks; Reassess patient tomorrow AM
- Resident comments for triage patients need to include: reason for triage; pending lab results; other pertinent information; time at which patient needs to be evaluated

- **Example:** Rule-out labor; vaginitis pending; U/A negative; Cervix 1.5/60/-3; Reassess cervix at 1345

Residents/Fellows PLEASE update your lists (you can have additional columns but must have the ones listed above). Make sure resident comments are updated regularly. At a minimum, they must be updated prior to sign-out.

Revised and approved by Faculty 2021

OB Required Readings: (For ACOG sign on name, see Program Coordinator or on OB floor)

- Maternity Care (aafp.org): Read all the Maternity Care Guidelines and Recommendations
- Practice Bulletin No. 171: Management of Preterm Labor : Obstetrics & Gynecology (lww.com)
- Shoulder Dystocia | ACOG
- Practice Bulletin No. 183: Postpartum Hemorrhage : Obstetrics & Gynecology (lww.com)
- Antepartum Fetal Surveillance | ACOG
- Prelabor Rupture of Membranes | ACOG
- Gestational Hypertension and Preeclampsia | ACOG

Ophthalmology

Preamble

Sight is arguably the most important of the special senses and its impairment adds to the challenges of aging and retaining independence. Ocular dysfunction presents unique challenges to patients who can rightfully expect the family physician to be knowledgeable, capable of caring for those problems that can be simply managed in the office setting, and of recognizing and appropriately triaging ocular emergencies such as glaucoma and corneal ulceration or threatened ulceration. Finally, assisting with social intervention and securing necessary support when visual impairment creates hazard or threatens independence is central to the physician's responsibility to the family and community.

Goals

- Acknowledgment of the impact of diseases of the eye on the patient and family in all stages of the life cycle
- Awareness of the importance of diagnosing and treating disease of the eye in family medicine practice
- A firm grasp of the basic principles, recognition and treatment of common disorders, initial management of ocular emergencies, and indications for specialist referral
- Triage skills in ocular emergencies

Objectives

- Ability to perform physical examination in patients of all ages, with emphasis on understanding normal neurologic and motor responses as well as appearance of the eye
- Ability to generate a differential diagnosis and formulate a rational plan for investigation and management, including assessment of severity and the need for immediate expert assistance in ocular emergencies or potential emergencies
- Skill in performance of basic techniques used in eye examination including fluorescein staining, slit lamp examination, tonometry and superficial foreign body removal
- Knowledge of current surveillance practices relating to ocular health in certain systemic diseases such as diabetes
- Manage and coordinate psychosocial and family issues, including long-term care of debilitating ocular conditions, necessary environmental adaptation and use of community resources
- Knowledge of systemic effects of commonly used ocular medications
- Ability to communicate in compassionate, knowledgeable manner and address complex psychosocial ophthalmology issues with patients and families

The goals and objectives are achieved through a combination of structured outpatient and longitudinal experience, including experience in the Emergency Room and the continuity clinic, together with didactic instruction.

Clinic Schedule: Three to four half days per week
Contact for Rotation: Jodi Stauss, jodi.stauss@altru.org

Revised and approved by Faculty 2021

Orthopedics

Preamble

The burden of suffering from musculoskeletal disease often extends over decades and even lifetimes. Consequently, the commitment to diagnosis, management and ongoing support and guidance, is at the core of family medicine. Besides, the effects of musculoskeletal trauma - contusion, sprain, dislocation and fracture, often present first to the primary care physician who must be skilled in triage, management and recognition of needed resources. Finally, communication with consultants is frequently necessary and important and the descriptive language of fractures should be utilized fluently.

The resident will have two blocks of orthopedics, one in each the second and third year. They will have 200 hours dedicated to the care of patients with a breadth of musculoskeletal problems.

Goals

- Acknowledgment of the impact of musculoskeletal disease on the practice of family medicine
- Awareness of the importance of diagnosing and treating musculoskeletal injuries in family medicine practice
- Awareness of the role of lifestyle in the progression of degenerative disease
- Awareness of proper rehabilitation of acute musculoskeletal injuries
- Knowledge of prevention strategies in the care of the musculoskeletal system
- Development of expertise in office procedures in common orthopedic presentations

Objectives

- Perform an appropriate musculoskeletal history and physical examination
- Be proficient in joint and extremity examination and be knowledgeable about specific examination techniques
- Formulate an appropriate diagnosis and recommend treatment
- Distinguish intra-articular and extra-articular effusion
- Recognize joint instability
- Basic interpretation of radiography and advanced imaging of joints and extremities
- Understand the indications for consultation and referral and be able to communicate findings and needed assistance accurately and specifically.
- Develop practical skills in splinting and casting, joint aspiration, joint and trigger-point injection
- Knowledge concerning appropriate use of analgesic and anti-inflammatory agents
- Effective and compassionate communication with patients and families

Required Reading:

- University of California, San Diego, Online Musculoskeletal Exam Tutorial (detailed tutorial on Musculoskeletal exam by joint. Provides several anatomic and clinical photos and videos with step-by-step review of detailed examination): http://meded.ucsd.edu/clinicalmed/joints.htm
- University of California, Los Angeles, Online Library of Radiographic Signs (listing of radiographic signs by location and diagnosis, peer reviewed by the American Journal of Radiology): http://www.gentili.net/signs/
- University of West Alabama Department of Sports Medicine and Athletic Training, Online Musculoskeletal Exam List and Explanation with Video (joint-specific physical exam test listing with detailed explanations and short video clips of the exam being performed):http://at.uwa.edu/CurrHome/AH323/skillsshoulder.asp

FMR Clinic Schedule: Two to three afternoons per week
Contact for Rotation: Rhonda Enger, renger@altru.org or Michael.Kruger@sanforhealth.org

Revised and approved by Faculty 2021

Pediatrics

Preamble

The Residency Program expects that those residents wishing to develop the knowledge, practical skills and judgment necessary for "full spectrum practice" will recognize the contribution of care "from cradle to grave". It is recognized that these attributes are acquired incrementally which is challenging when patients present randomly with differing degrees of diagnostic and management complexity. The rate at which these competencies will be acquired is outlined for each month of pediatric experience, with corresponding adjustments in responsibility and supervision. Pediatric experience will be gained through two blocks of inpatient/outpatient experience at Altru, NICU rotation in the third year of residency.

Residents will have at least 200 hours AND 100 patient encounters dedicated to the care of ill child patients which will include:

- a minimum of 50 inpatient encounters with children
- a minimum of 50 emergency department patient encounters with children
- at least 40 newborn patient encounters
- at least 200 hours dedicated to the care of children and adolescents in an ambulatory setting
- Residents will also complete the Care of Children ABFM Part II Pediatric SAM module prior to completion of pediatric rotations

Goals

- An appreciation of the important role of pediatrics in family medicine practice
- An understanding of the physiology of growth and development and the pathophysiology in common disorders of same
- Competence in the diagnosis and management of common pediatric presentations
- Familiarity with community services provided to safeguard the infant or child at risk

Objective

- Ability to perform a concise pediatric history and physical examination including family and developmental history without errors of omission
- Ability to recognize normal growth and development with early departures from same
- Competence in the recognition and management of common diseases involving the pediatric population including weight/age-based administration of drugs and intravenous fluids
- Awareness of preventive health strategies and immunization policies and practices
- Recognition of the common behavioral and psychiatric conditions in childhood
- Competence in the care and assessment of the newborn
- Awareness of personal limitations and timely recognition of need for consultation
- Ability to communicate in compassionate, knowledgeable manner and address complex psychosocial pediatric issues with patients and families

Procedure

If you are sick or have another unexpected absence, you need to call the pediatrics floor at 780-5660 and let the HUC know so that they can indicate that on the calendar. Please ask her to inform the physicians. If you have vacation during the month, please remind the attendings at rounds the day before you are off.

Weekdays

Rounds: Pediatrics rounds begin at 8:00 am in the rounds room on the 4th floor. This is across from 414. Be prepared to present all patients admitted to pediatric physicians or being seen by pediatric physicians in consult. Exceptions include nursery or NICU babies who have been transferred to pediatrics, you will not see these.

To have enough time, you may need to call pediatrics or check EPIC the night before to find out how many patients are admitted so you can see them all prior to rounds.

Being prepared includes reviewing any orders written overnight, talking to the nurses for updates, reviewing the vital signs, labs, intake and output, examining the patient and talking with patients/parents and formulating a plan for the day.

When presenting on rounds, you should give the complete history and physical on the first day after the patient has been admitted. If you did not admit the patient yourself, please read the history and physical prior to rounds so you are familiar with the patient before presenting.
Subsequent days of hospitalization, the presentations can be started with a one to two sentence introduction of the patient's age, day of hospitalization and admitting diagnosis followed by the events overnight. (For example: Johnny is a 3-year-old male with a history of asthma. This is hospital day #2 and he is admitted for pneumonia and asthma exacerbation).
Be prepared with an assessment and plan for each patient. Even if you have not yet talked to the attending, you should have formulated your own plan for the day and be able to explain your reasoning behind it.
Make sure you talk to the hospitalist for every patient every day.
Medications should be presented in mg/kg dosing (example: a child who weighs 10kg and is receiving 400mg of Amoxicillin bid should be presented as 80mg/kg/day divided bid).
IV fluids should be presented as what proportion of maintenance the child is receiving and what fluids they are on. (Example: D5 ¼ normal saline at maintenance rate)
Urine output should be presented in cc/kg/hour for children on strict ins and outs.
Daily notes: You will write daily progress notes on all patients you round on. All notes should be **dated and have a title at the top**. Please sign all your notes.

Weekend
When you are on call on Friday or Saturday, you are responsible for seeing the pediatrics and nursery patients on Saturday (Friday and Saturday call) and Sunday (Saturday call). When you have completed rounding on the patients and are ready to discuss them, please page your on-call attending. Please check with your attending the day before to make a rounding plan.

Call
Call is from home. You will have 4-5 nights of home call depending on whether you have vacation on the rotation. One of these may be a Friday (you will come in and round on Saturday morning) and one may be a Saturday (you will round on both Saturday and Sunday mornings).
If you are on call, you are expected to be available to come in and do admissions for pediatricians who are admitting patients. The pediatrician, ER physician or floor nurse will page you to let you know there is an admission. When you are done taking your history and examining the patient, page the attending to discuss the admission.

Admin Time
To promote resident wellness, residents are allowed to take ½ day off (afternoon) once during the rotation. It would be preferable that this half day is not on a call day when you are expected to be around for inpatient duties. Please let Dr. Peterson know if you are planning to use a half day as admin time and which day you plan to do this.

Problem List
Problem lists should be updated with hospital problems at admission and kept up to date throughout hospitalization.

Computer patient list
Access the pediatrics team list on EPIC. Any patients admitted in the Nursery, or to NICU on the pediatrics floor are not your responsibility. Pediatric patients on psych or admitted to surgery are not seen by us unless there is a formal consult. If a patient is on another floor and admitted to pediatrics or we are consulted, you will round on them. For example, we are occasionally consulted on patients in the SCCU.

Discharge summaries
Discharge summaries must be completed within 24 hours of a patient's discharge. If it is also serving as their progress note for the day, it must include a discharge physical examination and be completed at the same time as the other progress notes that day. If a patient you have been following has been discharged after you are gone for the day, you need to complete the discharge summary the following day.

Clinic notes: When completing clinic notes, please leave your encounter unsigned so we can edit your notes. Make sure these are also dated. All clinic patients will be staffed with and examined by the clinic pediatrician.

Residents will also complete the ABFM Care of Children KSA modules prior to completion of pediatric rotations.

FMR Clinic Schedule: Two to three afternoons per week
Contact for Rotation: Dr. Jennifer Peterson, j_peterson@altru.org

Revised and approved by Faculty 2021

Point of Care Ultrasound

Preamble

The application of ultrasound in direct patient care has been expanding over the past 25 years. This is a current component of the MD and DO curriculum in most schools and within many residency programs.

Altru Family Medicine Residency has a well-established program with significant online resources, a curriculum which includes didactic and practical components, an elective rotation, and twice monthly interest group meetings.

The program in point-of-care ultrasound includes enhancing assessment of volume status and cardiac ejection fraction, exclusion of pneumothorax, and enhanced differentiation between pulmonary atelectasis, effusion and consolidation.

Exclusion of deep venous thrombosis has been common and helpful, detection of hydronephrosis, bilateral in case of lower urinary tract involvement and unilateral in suspected ureteral stone obstruction, has been rapidly accepted by residents.

Finally, the residency program also has an extensive combination of basic and advanced skills questionnaires which are currently implemented in the evaluation of residents.

Goals

- Ability to recognize common clinical situations in which point-of-care ultrasound is adjunctive in clinical decision making.
- Completion of relevant Basic Skills and Advanced Skills Questionnaires, appropriate to level of training.

Objectives and Requirements

- Performance of basic elements of ultrasound assessment
- Refinement of clinical assessment based on ultrasound findings.
- Completion of appropriate Basic Skills Questionnaire
- Completion of appropriate Advanced Skills Questionnaire
- Collection and retention of appropriate real-time imaging

The goals and objectives are achieved through a combination of structured experience together with didactic instruction.

FMR Clinic Schedule: Three to four mornings or afternoons per week

Contact for Rotation: Dr. William Mann, wmann@altru.org

Revised and approved by Faculty 2021

Pulmonology

Preamble
COPD is the third leading cause of death in the U.S. There is currently no cure, but it is both preventable and treatable. Clinical practice guidelines are available, and the major current directions of COPD management are to assess and monitor the disease, reduce the risk factors, manage stable COPD, prevent and treat acute exacerbations and manage comorbidity. The only measures shown to reduce mortality are smoking cessation and supplemental oxygen. COPD imposes a lifetime burden and the need for long-term support and commitment to the individual and that individual's family.

Goals
- Acquire history and physical exam skills, develop expertise in diagnostic testing, and learn management of pulmonary disease
- Understand the range of pulmonary problems and pathology
- Demonstrate the ability to complete a pulmonary diagnostic workup
- Demonstrate the ability to communicate effectively with patients and others involved in their care
- Understand and utilize appropriate pulmonary resources, including other health care providers

Objectives
- Completes a comprehensive history and physical examination with particular focus on the pulmonary examination
- Interprets PFTs, ABGs, and chest x-ray
- Understands diagnostic features of V/Q scans and chest CT
- Recognizes and responds to signs of impending respiratory failure
- Evaluates and manages obstructive and restrictive pulmonary diseases
- Manages asthma at various levels of severity
- Recognizes clinical presentations of exercise-induced asthma and pulmonary hypertension
- Appropriately manages patients with hemoptysis
- Describes the physiology of obstructive and restrictive pulmonary disease
- Understands pharmacology of bronchodilators and steroids
- Understands the use of invasive and noninvasive (including CPAP and NIPPV) ventilation and mechanical ventilation for patients with ARDS
- Understands evaluation for sleep disorders, solitary lung nodule, pleural effusion, interstitial pneumonia, and latent tuberculosis
- Communicates effectively with patients with severe pulmonary conditions, as well as with their families
- Supports pulmonary guidelines to enhance healthcare quality

These goals and objectives are achieved through a combination of structured inpatient experience, together with didactic instruction. In addition to a pulmonology rotation, the overlap with general medicine should be apparent.

FMR Clinic Schedule: Three to four half days per week
Contact for Rotation: Jodi Stauss, jodi.stauss@altru.org

Revised and approved by Faculty 2021

Radiology

Preamble

Numerous longitudinal experiences during residency allow the self-directed resident to acquire the fundamental radiology concepts relevant to the practice of family medicine. Additionally, the minimum two-week radiology rotation teaches the capabilities of a hospital radiology department and to apply radiology to daily practice. In the continuity clinic, the resident has faculty assistance with interpretation of all x-rays taken at the point of care, and radiologic topics are also covered on clinical rotations that include Obstetrics, Emergency Medicine, Pediatrics, Orthopedics, Sports Medicine, NICU and ICU. The cognitive and behavioral objectives for the radiology rotation are comprehensive and should thus be viewed as skills that develop throughout the residency experience.

Goals

- To gain an understanding of radiology to include the principles of radiology, basicprinciples of image interpretation, and the range, uses, limitations, and costs of diagnostic techniques.

Objectives

- Demonstrate a basic understanding of radiologic investigations of:
  - the chest, including heart
  - the head and spine, with emphasis on trauma
  - the abdomen, with emphasis on CT anatomy
- State the fundamental principles of the physics of
  - Radiography
  - CT
  - Ultrasound
  - MRI
- Describe the fundamentals of the physics of trauma radiology
- Describe and summarize for patients the basic principles of radiation, its effects, andradiation protection
- Discuss the value, indications, limitations, sequencing, and costs of diagnostic techniques
- Understand optimal sequencing of imaging tests and their specific preparation
- Be knowledgeable of the American College of Radiology Appropriateness Criteria

The goals and objectives are achieved through a combination of structured experienceincluding experience in the Emergency Room, together with didactic instruction.

Suggested reading:

- radiopaedia.org Radiologic Anatomy
- orthobullets.com Orthobullets
- Keats TE (1984) An Atlas of Normal Roentgen Variants That May Simulate Disease

FMR Clinic Schedule: Two to three afternoons per week
Contact for Rotation: Dr. Bernie Dallum, bdallum@altru.org

Revised and approved by Faculty 2021

Social Determinants of Health

Preamble

Family physicians can play an important role in addressing Social Determinants of Health (SDoH) and Health Care Disparities. We provide high-quality health care for underserved populations more so than other medical specialties. SDoH are defined as the conditions under which people are born, grow, age, work, and live, and include factors such as education, neighborhood characteristics, socioeconomic status, employment, and social support networks. Evidence shows that these factors have a greater impact on population health than biology, behavior, and health care. SDoH, especially structural racism, poverty, and discrimination, are the primary drivers of health inequities. It is important to reduce health inequities because they are pervasive, unfair and unjust. They affect everyone and individuals affected have little control over the contributing circumstances.

In this rotation residents will perform Halvorson Home Visits*, work at a federally-subsidized health clinic*, and see patients at the local county jail and a permanent housing facility for the homeless*. The cognitive and behavioral objectives for the Social Determinants of Health rotation are comprehensive and should thus be viewed as skills that develop throughout the residency experience. There will be overlap in the required Behavioral Health Rotation and the rural health care experience in Devils Lake. There are also elective rotation options in Roseau and Mayville. Throughout the year there are patient support activities like helping patient's move, garden, etc. which residents are encouraged to participate in. We help provide care for Life Skills and Transition Center which is a state-operated, comprehensive support agency for people with intellectual and developmental disabilities. We have a SDoH lecture series and ethics lectures which are a part of our daily noon lectures.

Goals

- Awareness of impact of SDOH on the practice of family medicine
- Awareness of a comprehensive care team in addressing SDOH in family medicine
- Awareness of the role of the family physician in this comprehensive care team
- Awareness of how to help change the system to decrease heath care disparities

Objectives

- Learn how patients are affected by SDoH by helping address their needs to improve their health
- Create a practice culture that values health equity by addressing implicit bias in one's practice and using cultural proficiency and health literacy standards
- Understand what health inequities exist within one's community and help raise the prominence of these issues among the public and policymakers.
- Know which organizations are working to improve health equity in one's community
- Advocate for public policies that address SDoH and reduce health inequities.

Suggested reading:

Sherin K, Adebanjo T, Jani A. Social Determinants of Health: Family Physicians' Leadership Role. Am Fam Physician. 2019 Apr 15;99(8):476-477. PMID: 30990299.

Community Health (Jail and LaGrave)

The CDC defines Social Determinants of Health as "life enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life."

Health Care Disparity is the difference that exists among specific population groups in the attainment of full health potential. Disparity occurs based on race, gender, sexual orientation, age, disability status, socioeconomic status and geographic location.

During the community medicine rotation residents will spend much of their time on Halvorson Home visits addressing health care disparities of the geriatric population in their own home. The resident will spend one half day per week at either the Grand Forks County Correctional Facility or LaGrave on First. At each facility, the resident will have clinic visits, care for the individual's medical needs, and be part of the team caring for these individuals.

LaGrave on First

Preamble
Housing First is an approach used by the federal government to end homelessness by offering immediate housing without pre-requisites like treatment or sobriety. By providing a safe place to live, Housing First allows tenants to stabilize and take opportunities to utilize available services.
Permanent supportive housing is a model that provides safe, decent, affordable housing with on-site support services to encourage and assist tenants remaining housed. These services include 24-hour staffing, substance abuse counseling, behavioral and medical health care, medication monitoring and job training. Tenants of LaGrave on First are chronically homeless individuals with mental health and substance abuse issues who are at least 18 years of age. There are 42 single bedroom apartments. Funding for the project which cost approximately 10 million dollars was through federal grants and headed by the Grand Forks Housing Authority.

Goals
- Gain knowledge and understanding of the social determinants of health and health care disparities
- Identify key social determinants that impact patient outcomes.
- Learn a different approach in the care of the chronically homeless population.
- Be able to identify three different approaches that will impact the patient's overall wellness.
- Gain empathy and foster an environment of caring for those in need.
- Independently implement strategies that foster a healing environment with each patient encounter
- Demonstrate comfort and flexibility with each patient encounter whether in the patient's home or in the clinic setting
- Build relationships with those who work with LaGrave individuals daily.
- Be able to name at least five resources that LaGrave has to offer the individuals that reside at LaGrave on First
- Understand the importance of care continuity and how relationships improve quality of care
- Be able to identify three community resources that positively impact patient outcomes
- Understand the value of having a residence like LaGrave on First and how it benefits a community health care system.
- Be able to list three ways LaGrave on First services positively impacts the community

Grand Forks County Correctional Center

Preamble
The Grand Forks County Correctional Center (GFCCC) is a grade one correctional facility located at 1701 North Washington Street, Grand Forks, ND. Services provided include ministry programs, work release, chemical dependence, life skills, Free Through Recovery, medical, commissary, food service, laundry, and library. The facility also provides the distribution of prescribed medicines, commissary, and meals are served from a full-service kitchen.
All offenders are housed based upon their needs and their respective levels of classification. GFCCC housing units include maximum, medium, and minimum custody classifications. Each pod has dayrooms with large glass windows, which restrict visibility from the inside of the unit and gives the secondary control stations a direct view into the pods. All the units have a dayroom located in the front of the housing pods and a private shower located at the left or right side in the lower or upper tiers of each of the housing pods. The design of each shower unit allows the offenders to have privacy for showering. The recreation area is in the center of the housing units, with a classroom in each of the housing units. Each cell has a washbasin and toilet in the immediate sleeping areas. Offenders assigned to a unit do have limited contact with offenders in other units during programming. Each cell is equipped with an intercom that allows offenders to communicate with staff. Each unit has basic furnishings, television, kiosks, phones, and multi-purpose areas. All housing units have adequate and appropriate seating for the number of inmates that make use of each unit. All housing units have access to natural lighting and illumination sufficient for comfortable reading in the living areas. The dayrooms allow offenders to congregate, watch television, use the telephone system, use texters, and have access to the kiosk system for visitation and ordering of commissary.

Goals

- Gain knowledge and understanding of the social determinants of health and health care disparities for the incarcerated patient.
- Identify key social determinants that impact patient outcomes.
- Learn a different approach in the care of the incarcerated patient.
- Be able to identify two different approaches that will impact the patient's overall wellness
- Gain empathy and foster an environment of caring for those in need.
- Implement strategies that foster a healing environment with each patient encounter.
- Build relationships with those who provide care for the incarcerated patients.
- Be able to state three key roles the community health nurse plays in the care of the incarcerated patient.

Halvorson Home Visits

Preamble

Physician home visits are no longer a routine part of the physician work schedule. Hospital stays have become shorter. Medical care has become increasingly complex resulting in patient non-compliance or inability to follow the outlined treatment plan. Further, the number of medical services available to patients is continually expanding; however, patients are unfamiliar with services available with consequent underutilization of resources. The goal of the Halvorson Home Visit program is to follow high-risk patients as they transition from the hospital to their home environment.

Home visits provide a unique interface between physician, patient and support system, allowing physicians to provide care in the patient's environment, observe barriers to care that has been outlined, and insure appropriate utilization of health care resources. This program will work closely with existing healthcare resources such as Home Health, Respiratory Services, Yorhom and Social Services to provide a comprehensive home plan. As the U.S. population continues to age, the demand for home visits will increase exponentially. Utilization of an effective home visit program will reduce the number of readmissions to the hospital by assessing home safety medication management and coordination of appropriate services, allowing patients to continue to live in their home environment. The Home Visit Program provides Family Medicine Residents an invaluable interface to increase knowledge regarding care medical care of complex patients in the home environment.

Goals

- Resolution of conflicting-confusing hospital discharge instructions
- Removal of unnecessary or conflicting medication
- Rationalization of medications with patient's economic resources
- Recognition of potential hazards at home
- Recognition of obstacles to further care
- Continuity of inpatient and outpatient services
- Utilization of appropriate health care resources
- Clarify advance directives
- Increased awareness of the 'total' patient, unobtainable from the most detailed hospital
- admission history, including an understanding of the patient's environment and support system.
- Improved, individualized care plans
- Strengthened sense of purpose and identity

Procedure

- PGY-3 residents will have a 6-8 week home visit rotation.
- Residents may take no greater than one week of vacation during their rotation. Halvorson Home Visits will not occur in the absence of the resident scheduled for the rotation.
- The FMR PCMH nurse is responsible for blocking the Halvorson Home Visit schedule in the anticipated absence of the resident.
- Predictive analytics and physician gestalt will determine which FPTS patients require a home visit.
- Home visits than cannot be accommodated utilizing the "Halvorson Home Visit" will be

- completed with an order placed for the “Hospital Transition Program.”
- Home visits will occur in a 15-mile radius of Grand Forks.
- The need for a home visit will be communicated to staff at IDT by the Chief Resident
- Order will be placed in EPIC: “Halvorson Home Visit”
- Appointment for the home visit will be scheduled by the HUC. Appointments will be available at 9, 10, and 11AM, Monday thru Thursday. Patients will be notified this is +/- 30 minutes.
- The chief resident will notify the FMR Medical Home nurse
- The medical home nurse and PGY-3 home visit resident will visit the patient in their home.
- The first two home visits performed by a resident will have direct supervision from FMR faculty
- Questions regarding medical care of the patient should first be directed to PCP. If PCP is unavailable, the resident should consult with a precepting physician at FMR
- Documentation for the home visit will occur via standardized EPIC template and sent to the PCP
- Venipuncture may be performed at the time of the home visit.
- BSQ certification for “venipuncture” must be completed prior to starting the Halvorson Home Visit rotation.

Suggested resident conduct

- Understand your position as a guest in the home
- Take off shoes
- Sit a patient’s bedside – move furniture as needed and replace when done
- Establish closeness and degree of intimacy
- Lay on hands and listen
- Comment on photographs and memorabilia that seem to be of significance
- Materials required for home visit
    - Alcohol hand rub
    - Gloves
    - Dressing change material if appropriate
    - Protective gowns
    - Masks
    - Infection Control Kit (refer to Home Care Infection Policy)
    - Canister Sani-Cloth
    - Stethoscope
    - Otoscope and tips
    - Tongue depressor
    - BP cuffs
    - Pulse oximeter
    - Copy of the after-visit summary (AVS)
    - Tablet with hot-spot

Rotation Schedule:

Monday – Thursday AM and 1st and 3rd Monday PM: Home Visits
2nd and 4th Monday PM, Thursday PM and Friday AM: MyAlly
Tuesday and Friday PM: FMR Clinic
1st, 3rd and 5th Wednesday PM: Jail
2nd and 4th Wednesday PM: LaGrave

Contacts for Rotation:

Home Visits: Bethany Abrahamson, babrahamson@altru.org
Jail: Dr. Jamie Roed, jroed@altru.org
LaGrave: Korrine Stephani, kstephani@altru.org
MyAlly: Kerry Anderson, kerry@myallyhealth.org

Revised and approved by Faculty 2021

Sports Medicine

Preamble

Sports medicine, defined as primary care of a population modified by specific behavior,provides general medical care in addition to addressing problems specific to the athleteand exercising population. While involvement with musculoskeletal problems includinginjury is substantial, practice includes the female athlete triad, overuse and abuse syndromes, exercise-induced asthma, screening for cardiac abnormalities, and the management of athletes with diabetes and seizure disorder. Of importance is knowledge of concussion, second impact and post-concessional syndromes and safe return to participation, together with communication skills and ability to work with athletic trainers, physical therapists, coaches, and parents. All residents are required to participate in monthly sports medicine conferences, pre-participation sports physicalsfor local schools and the University of North Dakota (UND), and injured UND athletes. In the residency program, opportunity exists to serve as team physician and acquire additional skill and experience with event coverage.

Goals

- Be able to confidently perform a musculoskeletal history and physical examination; formulate an appropriate differential diagnosis; and recommend treatment
- Demonstrate proficiency in care for acute and chronic musculoskeletal conditions
- Have the ability to prescribe exercise for prevention and rehabilitation
- Develop procedural experience in common musculoskeletal office procedures

Objectives

- **Exercise Basics**
  - List health benefits of exercise
  - Provide counseling to patients on exercise training techniques and injury prevention
- **Sports Medicine Basics**
  - Participate in training room, physical therapy, sporting events, and other experiences
  - Utilize both medical and physical therapy modalities to improve function and performance
  - Describe the benefits of a team-based approach to sports and activity injury prevention and rehabilitation
  - Perform preparticipation exams
- **Medical Management**
  - State a differential diagnosis and initial management plan for acute injuries including:
    - Trauma / Closed head injuries / Concussions / Spine Injuries
    - Sprains and strains
    - Fractures and dislocations
    - Arthritis (septic, osteoarthritis, rheumatoid)
    - Bursitis / tendonitis/ tendonosis/ tenosynovitis
  - Provide competent medical advice to patients who have chronic medical conditions such as:
    - Osteoarthritis and other arthritis
    - Bursitis, tendonitis, tendinosis, tenosynovitis
  - Provide return to learn/play instructions following concussion
- **Sports Medicine Technical Skills**
  - Demonstrate proficiency in performing:
    - Immobilization / splinting / casting / bracing
    - Evaluate plain film extremity radiographs and competently identify:
      - Fractures and Dislocations
      - Arthritis
      - Bone disease including osteopenia, bony metastasis, bone tumors
      - Inject and/or aspirate joints or bursa

FMR Clinic Schedule: Three to four mornings or afternoons per week
Contact for Rotation: Dr. Adam Quinn, aquinn@altru.org

Revised and approved by Faculty 2021

Surgery

Preamble

The Residency Program expects that those wishing to develop the knowledge, practicalskills and judgment necessary for "full-spectrum practice" will recognize the contributionof family medicine to the diagnosis of surgical conditions, together with pre- and post- operative care. The primary sources of education in the care of the surgical patient are the inpatient and outpatient services of the surgical residency program of the University of North Dakota School of Medicine and its faculty, together with longitudinal experienceat the family medicine residency program's continuity clinic. Residents will have a least 100 hours dedicated to the care of surgical patients.

Goals

- A commitment to the comprehensive care of the personal patient to includerecommendations for preoperative and peri-operative care
- The ability to assist in the postoperative medical management of personal patients
- The competence to guide patients to understand their appropriateness for surgery andthe risks and benefits of surgical procedures
- The willingness to guide patients to understand the nature of a surgical procedure
- The confidence and ability to appropriately refer patients for surgery, particularly inemergent or life-threatening situations
- The ability and willingness to safely perform minor procedures with adequate surgical technique

Objectives

- Ability to diagnose common surgical conditions in a primary care setting
- Ability to perform a surgical assessment and develop an appropriate treatment plan
- Development of skills necessary to assist and to perform minor surgery competently
- Development of proficiency in the preparation of the patient for surgery, and in thecare following surgery
- Ability to communicate effectively with surgical staff and consultants concerning signsand symptoms, test results, and proposed plan of care
- Proficiency in management of hypovolemia and administration of appropriateintravenous fluids
- Understanding appropriate use of diagnostic tests including imaging and skill ininterpretation of results from such tests
- Ability to communicate in compassionate, knowledgeable manner and addresscomplex psychosocial surgical issues with patients and families

FMR Clinic Schedule: Friday PM
Contact for Rotation: Lisa Steinbrink, gsresidency@altru.org

Revised and approve by Faculty 2021

Rural Rotation (Devils Lake and Elective)

Preamble

North Dakota is a predominantly rural state. Fifty-four percent of the population resides in 49 non-metropolitan areas. However, only 32% of physicians practice in rural areas. Abundant research has demonstrated that repeated educational experience in rural practices, at medical student and resident levels, significantly encourages young physicians to seek employment opportunities in rural areas.

Goals

- The introduction of the resident to the workload of a rural family physician
- The demonstration of the scope of practice of a rural family physician
- The ability to allow the resident to function as a member of a small, inter-dependent team
- The opportunity to familiarize the resident with the unique nature of the bond between a rural family physician and his/her patients with its special rewards
- The presentation of the advantages of living in a smaller community
- The understanding of the enhanced stature a physician has in a smaller community
- The recognition of the rural patient population as the largest health care disparity in the United States.
- Understanding how to provide medical care in an environment with limited resources and lack of immediate access to specialists.

Objectives

- Develop an increased self-awareness and become a better physician as a result of this experience
- Appreciate the rewards of the practice independence
- Understand the increased importance of his/her role, together with the special nature of the patient-physician relationship
- Ability to function effectively as a member of a team in a small community
- Awareness of personal limitations and timely recognition of need for triage to tertiary care center
- Begin to understand the complexity of providing medical care in a smaller community with limited resources

Procedure (Devils Lake)

- Resident will cover clinic hours (9 AM-5 PM) for family medicine department.
- Residents will have the option to choose certain types of patients they have a special interest in seeing, including pediatrics, internal medicine, diabetes, obstetrics, musculoskeletal, or urgent care.
- The clinic will do its best to provide the resident with the types of patients they feel would be most beneficial for their education.
- Each week, the resident will have a supervising physician to whom they will submit their notes. If the resident precepts a patient with a physician other than the one listed for the week, the note for that patient should go to the precepting physician.
    - Week 1 – Dr. Samson
    - Week 2 – Dr. Wayman
    - Week 3 – Dr. Martin
    - Week 4 – Dr. Foughty
- Residents will see patients every 20 minutes during clinic hours with no appointment type restrictions. Clinic will be from 9AM to 12PM and 1:20 PM to 5PM with the last scheduled appointment at 4:20 PM.
- Questions regarding patients should first be discussed with the PCP if available. If the PCP is unavailable, resident may discuss the patient's care with any of the attending physicians.
- Residents must notify an attending physician if they are doing any procedures. Attending physicians will observe most if not all procedures that the resident performs.
- procedures on Medicare patients must be observed in entirety for billing purposes.
- The residents will see a maximum of 10 patients per half day. Additional patients may be added at the resident's discretion.
- The resident nurse or phone nurse may ask if a resident is willing to see an extra patient during the day. The decision to see or not see extra patients is up to the discretion of the resident; however, we do ask that you keep the purpose of this rotation in mind when these requests occur.

- Residents will also spend part of one afternoon, tentatively during the first or second week of the rotation, with Dr. Martin touring the reservation and surrounding area. The resident will be blocked out of clinic during this time.
- Residents will spend one half-day with Home Health.
- For Residents Rotating in the Emergency Department:
    - Residents will take Family Medicine/C-Section Assist call one weekday each week of the rotation (usually Wednesday 7AM to Thursday 7AM) and one weekend (Friday 7AM to Monday 7AM)
    - Residents will be responsible for evaluating and admitting patients to the hospital under the supervision of the on-call attending physician. This includes completing documentation and entering orders.
    - Residents will be expected to assist with any C-sections that are performed during the hours they are on call
    - Resident will be responsible for rounding on any admissions that they participate in each day prior to the start of clinic. The care of these patients should be discussed with the attending physician for that patient.
    - Residents are NOT expected to round on patients they did not admit.
    - Residents will be responsible for a 6-hour shift in the Emergency Department each weekday they are on call. They will also need to do a total of 24 hours in the Emergency Department over the weekend they are on call. This can be divided over the weekend as the resident sees fit.
    - Residents will not be responsible for entering orders while working in the Emergency Department. If a resident desires to put in orders, they can work with supervising provider to do this.
    - Documentation requirements will be determined by the supervising provider in the emergency department during each shift.
    - Residents are expected to be active in-patient care at the direction of the supervising provider (i.e. residents cannot just choose to see “interesting patients”)
    - At the end of each shift, the attending provider will complete a brief evaluation of the resident’s performance. They will also be able to complete E-Value evaluations if desired.
    - There is a sleeping room in the basement of the clinic that is available for each resident during the entire duration of their rotation.
    - If there are community events occurring while the resident is on their rotation, attending these events during an ED shift will count toward the total hours needed for that shift.
- For residents taking obstetric call:
    - Residents will take Family Medicine/C-Section Assist/OB call one weekday each week of the rotation (usually Wednesday 7AM to Thursday 7AM) and one weekend (Friday 7AM to Monday 7AM)
    - Residents will be responsible for evaluating and admitting patients to the hospital under the supervision of the on call attending physician. This includes completing documentation and entering orders.
    - Residents will be expected to assist with any C-sections that are performed during the hours they are on call
    - Resident will be responsible for rounding on any admissions that they participate in each day prior to the start of clinic. This includes intrapartum, postpartum, newborn infants and pediatric patients. The care of these patients should be discussed with the attending physician for that patient.
    - Residents are NOT expected to round on patients they did not admit.
    - While on call, residents will be expected to see all triage and active labor patients, evaluate them, and precept them with the on call attending physician or the patient’s primary care physician. This includes documentation and inputting orders.
    - Triage patients do not need to be evaluated in person by the attending physician.
    - The attending physician must be present at all deliveries.
    - There is a sleeping room in the basement of the clinic that is available for each resident during the entire duration of their rotation.
    - During the last week of the rotation, the resident will do a brief presentation with the family

medicine physicians. This presentation should review and interesting case, social situation, etc. that was encountered during the rotation.
    - If you have any concerns or questions regarding your rotation, please contact Dr. Foughty. If she is not available, please contact any of the attending physicians you feel comfortable speaking to.

**If you are planning to arrive the night before your rotation starts, please notify our Clinic Manager, Amber Stokke.

FMR Clinic Schedule: First Friday and last Friday of block all day in clinic at FMR
Contact person for Rotation: Amber Stokke, astokke@altru.org and Dr. Stephanie Foughty, sfoughty@altru.org

Procedure (Rural Rotation Elective)

- Arrangements are made for rural elective rotations in Mayville, ND and Roseau, MN. In addition, Residents may choose to do an elective rural rotation in a novel setting if the following conditions are met:
- The rotation is granted with approval from the faculty.
- Graduating third-year residents may not be absent from continuity of care obligations in the final month of their training.
- Residents are free to have exploratory discussions with clinics in rural sites but may not enter into agreements until program faculty have reviewed the request. In general, the requested rotation should have some obvious unique educational value to the residents
- The resident is responsible for ensuring that all legal requirements, such as licensure, are met before the rural experience is initiated. Evidence of meeting such requirements must be presented to faculty for approval.
- Rural rotations in non-contiguous states may not be approved unless the circumstances provide a unique educational experience which cannot be replicated elsewhere.

Revised and approved by Faculty 2021

Urology

Preamble

Urogenital tract complaints are frequent in family medicine. The subject includes urodynamics, a resource in diagnosis and therapy of voiding problems. The acute scrotum represents an emergency with short timeline for testicular salvage in torsion requiring foundational knowledge and decisive clinical problem skills when this presents. Hematuria is a frequent urinalysis finding with significance varying from trivial to serious. Again, sound knowledge and judgement is needed to resolve the finding with stone disease, infection, and neoplasia potentially involved. The complaint of erectile dysfunction is epidemic and management has evolved from procedural to pharmacologic and may potentially require management of cardiovascular abnormalities. Finally, urinary tract infection is a common presentation which may transcend the boundaries of general medicine, urology and nephrology.

Goals

- Acquire history and physical exam skills, develop expertise in diagnostic testing, and learn management of urologic disease
- Understand the range of urologic problems and pathology
- Demonstrate the ability to complete a urologic diagnostic workup
- Understand the principals of therapy
- Demonstrate effective communication with patients and others involved in their care
- Understand and utilize appropriate urologic resources, including other providers

Objectives

- Performance of basic elements of a urologic assessment
- Development of differential diagnosis based on testicular swelling
- Development of differential diagnosis based on hematuria
- Appropriate laboratory investigation and interpretation based on initial evaluation
- Understand clinical approach to lower urinary tract symptomatology
- Understand screening for prostate cancer, or not
- Understand management of elevated PSA
- Differentiate between simple and complicated urinary tract infection and their management
- Recognition of urgent presentations such as testicular pain and appropriate emergency management
- Diagnosis, investigation and management of erectile dysfunction
- Diagnosis of ureteral calculus together with indications for both expectant management and urgent referral
- Basic assessment male and female incontinence together with knowledge of indications for referral
- Communication to the patient and family regarding the proposed investigation, treatment and community resources available
- Inclusion of a multidisciplinary approach and appropriate referral to urology

The goals and objectives are achieved through a combination of structured experience together with didactic instruction.

FMR Clinic Schedule: Three to four afternoons per week
Contact for Rotation: Dr. Adam Nicholson, afnicholson@altru.org

Revised and approved by Faculty 2021