I. Educational Purpose and Goals

The TEACH (Transforming Education and Community Health) program trains internal medicine senior resident physicians to provide comprehensive, well coordinated, evidence-based, culturally competent care to underserved adults with chronic illness. This team of residents and faculty improve access to high-quality health services for the local underserved population. The program replaces the traditional third year of medicine residency.

II. Principal Teaching Methods

A. Supervised direct patient care:
Residents primarily learn through direct patient care with attending supervision in the inpatient and outpatient settings. Residents will be responsible for primary evaluation of patients and development of an assessment and plan that is discussed with the supervising attending. The resident will complete documentation of patient encounters (within the electronic health record or as specified by county, Kaiser or VA-based preceptors), order referrals or additional testing as discussed with the attending and follow up on test results. Case based teaching will center on data gathering, clinical examination skills, diagnostics and therapeutic plans, and use of the electronic health record.

Inpatient Experiences

1. TEACH wards: TEACH residents spend 8 months out of the year on a TEACH block. Each 4 week block consists of 7 days on continuous inpatient service (TEACH wards) and 3 weeks of clinics (see below for schedule details). The TEACH ward team is composed of one TEACH resident, one intern and one third year medical student. Residents admit up to 3 patients each day to a team cap of 12 patients. No more than 2 patients per week can be transferred to TEACH from the MICU.

2. Other inpatients rotations: Additional inpatient rotations include general medicine wards, cardiology wards, and medical/or intensive care unit and general medicine consult rotation.

Outpatient Experiences

1. TEACH Continuity Clinic: Located at the Sacramento County Primary Care Center, each TEACH resident will have 2-3 clinics per week during the outpatient weeks of the
TEACH rotation. During non-TEACH non-ICU rotations, residents will have 2 continuity clinics per week. Six patients will be scheduled per clinic, starting at 1:30 pm. TEACH residents inherit a small panel of patients; the majority of patients will be added from patients cared for on the inpatient TEACH service, walk-ins to the county clinic or referrals from other county providers.

2. University Continuity Clinic: Those residents who had a continuity clinic at the university clinic will continue to care for their panel of patients at the university clinic. On average, residents have 2 university clinics per month. The clinic is located in the UC Davis Ambulatory Care Center.

3. Hospital Discharge Clinic: Based on a contract between UCDMC and the Sacramento County Department of Health and Human Services, county uninsured patients discharged from UCDMC receive 60 days of follow up care in the UC Davis Ambulatory Care Center. After the 60 day period, patients obtain primary care from one of the TEACH residents in the TEACH clinic (see above). Patients who become eligible for Medi-Cal during their hospitalization may become part of the TEACH resident’s university continuity clinic following discharge from the hospital.

B. Didactic lectures:

1. The resident will participate in the mandatory weekly pre-clinic journal clubs.

2. TEACH has joined with Primary Care for ½ day didactic sessions each Tuesday during the outpatient blocks. Topics include journal club, lecture series in EBM, topics in Psychiatry, office-based procedures, medicine in the media and resident centered teaching sessions.

C. Learning modules:

The resident will complete:

1. the on-line Evidence Based Medicine Modules
2. the on-line Procedure Module
3. 5 ABIM Practice Improvement Module chart reviews

C. Clinical Question Board: Mounted in the outpatient clinic conference room, residents write clinical questions which arose, but were not answered during the day. By the next clinic week, residents write answers to those specific questions for all residents to review.

D. Independent Reading: The resident will read independently to answer questions about patient care. The residents may use UptoDate, primary literature or other sources suggested by preceptors.

III. Educational Content

A. Mix of diseases:

1. General Internal Medicine:
   The resident will encounter patients with a broad range of acute and chronic medical conditions, including but not limited to diabetes, hypertension, coronary
heart disease, congestive heart failure, arthritis, obesity, depression and anxiety disorders, hyperlipidemia, abnormal uterine bleeding, osteoporosis, upper and lower respiratory infections, allergic rhinitis, peptic ulcer disease and gastroesophageal reflux disease, anemia, chronic obstructive pulmonary disease, asthma, and chronic renal failure. During the subspecialty clinics, the most common illnesses include thyroid disease, osteoporosis, hormone deficiencies and excesses, arthritities, SLE, fibromyalgia, depression, personality disorders, schizophrenia, hepatitis C as well as a variety of sports related injuries.

2. Subspecialty clinics: Clinical care will focus on diseases specific to that specialty clinic and which are the most useful for general internists.

B. Patient Characteristics:

Through the experience in three different hospital systems (UC Davis, Kaiser, VA and Sacramento County), the residents care for patients with great diversity of age, gender, occupation, culture, socioeconomic status, and ethnicity. TEACH residents will primarily work with patients are from the Sacramento County system; these patients too represent diverse cultures, but are almost exclusively under 65 years old and uninsured.

C. Learning Venues:

1. Location: The residents will rotate with preceptors at the Sacramento County Clinics, UCD Ambulatory Clinics, UC Davis satellite clinics, Kaiser clinics, and VA clinics.
2. Types of clinical encounters: The resident will see patients for acute care visits, chronic disease management, preventative health services and consultations.
3. Longitudinal Conferences: the resident will continue to participate in regularly scheduled conferences including grand rounds and Monday core conferences.
4. Longitudinal Clinic: the resident will continue to participate in his/her weekly continuity clinic and add a second clinic at the Primary Care Center.
5. Procedures: availability of procedures will vary based on patient characteristics but may include:
   a. Vaginal KOH, wet mount and PAP smear collection
   b. Arthrocentesis/joint injection
   c. Removal or destruction of skin lesions
   d. Incision & drainage of abscesses
   e. Toenail removal extraction
   f. Lumbar puncture
   g. Paracentesis

D. Structure of rotation:

Below is a sample schedule. The actual schedule may vary from month to month.
<table>
<thead>
<tr>
<th>Week</th>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Sat/Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7 am</td>
<td>Inpatient</td>
<td>Inpatient</td>
<td>Inpatient</td>
<td>Inpatient</td>
<td>Inpatient</td>
<td>Inpatient</td>
</tr>
<tr>
<td></td>
<td>4 pm</td>
<td>Conference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>8 am</td>
<td>University Clinic</td>
<td>Conference</td>
<td>GR/clinic</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
</tr>
<tr>
<td></td>
<td>1 pm</td>
<td>Clinic</td>
<td>TEACH/PC</td>
<td>Self study</td>
<td>TEACH</td>
<td>clinic</td>
<td>clinic</td>
</tr>
<tr>
<td>3</td>
<td>8 am</td>
<td>Specialty Clinic</td>
<td>TEACH/PC</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
</tr>
<tr>
<td></td>
<td>1 pm</td>
<td>Conference</td>
<td>TEACH</td>
<td>TEACH</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
</tr>
<tr>
<td>4</td>
<td>8 am</td>
<td>University Clinic</td>
<td>TEACH/PC</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
</tr>
<tr>
<td></td>
<td>1 pm</td>
<td>Conference</td>
<td>TEACH</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
<td>Specialty Clinic</td>
<td>TEACH</td>
</tr>
</tbody>
</table>

### IV. Principal Ancillary Educational Materials

A. **Computer-based resources**: available for online texts, clinical guidelines, and literature searches at multiple sites in the hospital and clinics and available at [https://ucdcrc.ucdmc.ucdavis.edu/servlet/CRCsignin](https://ucdcrc.ucdmc.ucdavis.edu/servlet/CRCsignin)

B. **Textbooks** are available in most clinical settings. There is a full medical library on the UC Davis Medical Center campus.

C. The resident can review the following web-based resources:

1. Duke University Medical Center’s Introduction to Evidence Based Medicine available at: [http://www.mclibrary.duke.edu/subject/ebm?tab=overview&extra=tutorials](http://www.mclibrary.duke.edu/subject/ebm?tab=overview&extra=tutorials)
2. Duke University Supplement on diagnostic tests available at: [http://www.hsl.unc.edu/services/tutorials/ebm/Supplements/EvidDiagnosis.htm](http://www.hsl.unc.edu/services/tutorials/ebm/Supplements/EvidDiagnosis.htm)
3. The University of Nebraska Medical Centers module on Interpreting Diagnostic Tests at [http://gim.unmc.edu/dxtests/Default.htm](http://gim.unmc.edu/dxtests/Default.htm)
4. Michigan State University’s Introduction to Information Mastery available at: [http://www.poems.msu.edu/InfoMastery/default.htm](http://www.poems.msu.edu/InfoMastery/default.htm)
5. The Centre for Evidence Based Medicine at [http://www.cebm.utoronto.ca/](http://www.cebm.utoronto.ca/)
V. **Methods of Evaluation**

A. **Resident Performance**

1. **Clinical Evaluation Exercise (CEX)**
   Each resident will be directly observed in clinical encounters a minimum of three times. Each resident will ask faculty to observe and provide written and oral feedback on direct observation of the resident taking a history, performing a physical examination and/or providing counseling. Results will be turned in prior to completion of the block. Completion is required to receive a passing evaluation for the rotation.

2. **American Board of Internal Medicine Practice Improvement Module Chart Review**
   The resident will perform a chart review of 5 of their patients using the ABIM PIM on-line module.

3. **Competency Evaluations**
   Faculty provide formative feedback on clinical performance, including documentation, throughout the rotation. Preceptors provide summative feedback by completing web-based electronic resident evaluation forms provided by the Internal Medicine Residency office. The evaluation is competency-based, fully assessing core competency performance. The evaluation will be shared with the resident, is available for on-line review by the resident at their convenience and is sent to the residency office for internal review. The evaluation will become part of the resident file and will be incorporated into the semiannual performance review for directed resident feedback.

B. **Program and Faculty Performance**

1. Upon completion of the rotation, the resident will be asked to complete a service evaluation form commenting on faculty, facilities and service experience. These evaluations will be sent to the residency office for review and the rotation coordinator (Dr Fancher) will review anonymous copies of completed evaluation forms periodically.

VI. **Institutional Resources: Strengths and Limitations**

A. **Strengths**

1. Faculty: Faculty members are expert in their fields and have demonstrated that they are competent and enthusiastic educators.

2. Settings: Residents will be exposed to a mix of academic and county settings. The facilities are generally technologically sophisticated and appropriate to the field.

3. Patients: Residents will see patients from a variety of socioeconomic and ethnic backgrounds with a mixture of acute and chronic complaints.

4. Evaluation tools: Evaluations methods include written competency based assignments and self-evaluation exercises

B. **Limitations**

1. Settings: The resident must travel between practice settings. County settings may not have the same electronic resources available to residents.

2. Faculty: The resident may work with a preceptor only a few times.
VII. Rotation Specific Competencies

A. Patient Care: By the end of the rotation, the resident will be able to:

1. perform a problem-focused history and physical examination and develop a management plan in accordance with national guidelines (as available) for patients presenting to ambulatory settings with complaints of:
   a. hip, knee, shoulder and low back pain
   b. upper respiratory symptoms
   c. depression
   d. dyspnea
2. Perform a problem-focused history and physical examination and develop an evidence-based management plan for ambulatory chronic disease management of:
   a. hypertension
   b. diabetes mellitus
   c. hyperlipidemia
   d. obesity
   e. asthma
3. Develop longitudinal plans of care for patients with acute or chronic medical problems in accordance with national guidelines.
4. These skills will be demonstrated directly during patient encounters, discussions with preceptors and completion of assignments listed under “Methods of Evaluation.”

Procedures
- Inpatient - thoracentesis, paracentesis, lumbar puncture, central line, arterial line
- Outpatient - I&D, skin biopsy, arthrocentesis, joint injection

B. Medical Knowledge: By the end of the rotation, the resident will be able to:

1. List the differential diagnosis for acute complaints listed in the section above
2. Describe the risks and benefits of diagnostic and therapeutic strategies for the acute and chronic conditions listed above
3. This knowledge will be demonstrated directly during patient encounters, discussions with preceptors and completion of assignments listed under “Methods of Evaluation.”

C. Interpersonal and Communication Skills: By the end of the rotation, the resident will be able to:

1. Establish therapeutic doctor-patient relationships on ambulatory settings, including the ability to counsel patient regarding lifestyle behaviors.
2. Provide clear, concise oral presentations to preceptors
3. Complete patient charting using the forms in the electronic health record or paper record. The resident will update histories, problems lists and medication lists at each visit. All charts must be completed by the resident and send to the preceptors within 48 hours of care
4. Work as a productive member of the team with preceptors, nurses, medical assistants and other office staff.
5. These skills will be demonstrated directly during patient encounters, discussions with preceptors and completion of assignments listed under “Methods of Evaluation.”

D. Professionalism: By the end of the rotation, the resident will be able to:

1. Be timely
2. Treat all patients and their families with compassion and respect
3. Acknowledge errors when they are made and reveal them promptly to the preceptor
4. Tell the truth
5. Maintain patient confidentiality
6. Be honest and accurate in coding and referral practices
7. Demonstrate an interest in proving high quality care

E. Practice Based Learning By the end of the rotation, the resident will be able to:
   1. Identify personal areas of weakness in medical knowledge of ambulatory care and perform focused reading for self-improvement throughout the rotation.
   2. Complete the hypertension chart review previously described.
   3. This learning will be demonstrated directly during patient encounters, discussions with preceptors and completion of assignments listed under “Methods of Evaluation.”

F. Systems Based Practice By the end of the rotation, the resident will be able to:
   1. Prescribe medications and order additional testing in compliance with patients’ insurance coverage and medical standards of care.
   2. The resident will order ancillary services such as home health care, physical therapy and occupational therapy as medically necessary.
   3. Communicate with primary care physicians, consultant or referring physician to improve continuity and quality of care.

VIII. Work Hours

   A. During this rotations, shifts are 12 hours or less and there is no overnight call activity. The schedules are arranged so that there are greater than 10 hours between all shifts. Duty hours are limited to less than 80 hours per week.