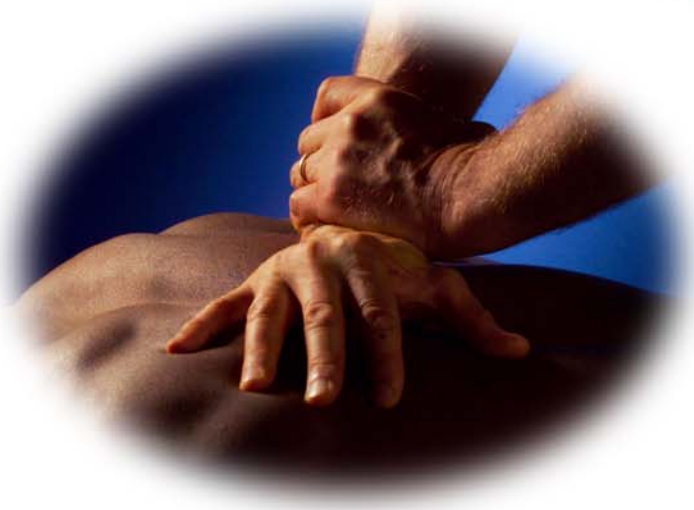
Logan

College of Chiropractic

Clinician Handbook



Revised 09/2010

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The purpose of this handbook is to supplement information provided in Logan's Faculty Handbook with information specific to Logan's Health Center Clinics. This handbook is not a contract, expressed or implied, guaranteeing any term of employment or employment for any duration. You may terminate your employment at any time.

Requirements for Eligibility as a Clinician

Doctor of Chiropractic degree and five years practice experience and/or training or the equivalent combination of education and experience. Must have a current Doctor of Chiropractic license in good standing with the State of Missouri, be acupuncture certified and must not have a delinquent status in any other State.

Overview of Duties and Responsibilities

A. First Clinician

1. Manages the Logan College Clinic of their charge, providing competent oversight of daily operations. Fiscal responsibilities include overseeing insurance reporting and inventory control.

2. Is responsible for all aspects of patient care and enforcement of Logan's policies and procedures. Demonstrates, supervises and assists interns in patient consultations, examinations, differential diagnosis, development of treatment protocols, and follow up care. Maintain a consistent pattern of expectations and evaluations of students in the clinical setting. Identify and bring to the attention of the students their strengths and weaknesses in any area of the clinical requirements. Utilizes senior intern assistants or group leaders in their defined roles whenever possible. Schedules Spinal Health Care classes at least once per week for new patients and their guests. Ensures that interns require all NP's attend spinal health care classes with them. Ensures that any unscheduled patients go to interns who are on a scheduled shift and according to the walk-in rotation schedule. Reports and/or addresses intern violations of health center regulations in a timely manner. Observes and/or reviews with the intern all documents related to patient care including the report of findings. Reviews and signs all documents in the patient chart related to patient care. Reviews and signs the travel slip at the same time as the SOAP notes and initials all performed procedures on travel slip.

3. Reports to the Chief of Clinical Services for patient care, clinical protocols, schedules, performance and delivery of clinical services, maintenance status of the facility and equipment. Assists in budget development for their clinic.

4. Keeps regular office hours and forwards all statistics as requested. Establish and track daily, weekly, monthly, and yearly goals. With the assistance of the Marketing Director, establishes a marketing strategy for each trimester (lectures, talks, screening's, etc.), and encourages intern participation.

5. Meets with interns at the beginning of each trimester to discuss, and provides a written list of expectations, rules, regulations and guidelines on performance in their clinic. Emphasizes utilization of the clinic model.

6. Oversee and facilitate Case Report and Clinical Lab Interpretation Modules conducted by interns under their supervision at their assigned clinic.

7. Meets monthly with interns to review goals and achievements, reviews clinical strengths/weaknesses, review patient files and discuss marketing plans for the month.

8. Sets up a file on each intern to facilitate evaluation and grading. Maintains accurate records on each intern that shall include attendance and evaluations of the clinical competencies and submits grades in a timely manner. Provides objective assessments of student's skills, utilizing the 16 Clinical Competencies as outlined in CCE Standards.

9. Is available to cover emergencies after hours and on weekends.

B. <u>Second Clinician</u>

1. Is responsible for all aspects of patient care and enforcement of Logan's policies and procedures. Demonstrates, supervises and assists interns in patient consultations, examinations, differential diagnosis, development of treatment protocols, and follow up care. Maintain a consistent pattern of expectations and evaluations of students in the clinical setting. Identify and bring to the attention of the students their strengths and weaknesses in any area of the clinical requirements. Utilizes senior intern assistants or group leaders in their defined roles whenever possible. Schedules Spinal Health Care classes at least once per week for new patients and their guests. Ensures that interns require all NP's attend spinal health care classes with them. Ensures that any unscheduled patients go to interns who are on a scheduled shift and according to the walk-in rotation schedule. Reports and/or addresses intern violations of health center regulations in a timely manner. Observes and/or reviews with the intern all documents related to patient care including the report of findings. Reviews and signs all documents in the patient chart related to patient care. Reviews and signs the travel slip at the same time as the SOAP notes and initials all performed procedures on travel slip.

2. Reports to the Chief of Clinical Services for patient care, clinical protocols, schedules, performance and delivery of clinical services, maintenance status of the facility and equipment. Assists in budget development for their clinic.

3. Keeps regular office hours and forwards all statistics as requested. Establish and track daily, weekly, monthly, and yearly goals. With the assistance of the Marketing Director, establishes a marketing strategy for each trimester (lectures, talks, screening's, etc.), and encourages intern participation.

4. Meets with interns at the beginning of each trimester to discuss, and provides a written list of expectations, rules, regulations and guidelines on performance in their clinic. Emphasizes utilization of the clinic model.

5. Oversee and facilitate Case Report and Clinical Alb Interpretation Modules conducted by interns under their supervision at their assigned clinic.

6. Meets monthly with interns to review goals and achievements, reviews clinical strengths/weaknesses, review patient files and discuss marketing plans for the month.

7. Sets up a file on each intern to facilitate evaluation and grading. Maintains accurate records on each intern that shall include attendance and evaluations of the clinical competencies and submits grades in a timely manner. Provides objective assessments of student's skills, utilizing the 16 Clinical Competencies as outlined in CCE Standards.

8. Is available to cover emergencies after hours and on weekends.

Clinician Performance Evaluation

Evaluation of the clinician's performance is based on the following items. All are based on a 1-5 scale with 5 considered Exceptional and one considered Not Effective. Items in Section One are weighted at 4.4 while items in Section Two are weighted at .9. Total score possible is 80

A. SECTION ONE:

1. J**ob Knowledge:** Understands all phases of the job and effectively utilizes job related information, technical skills, and procedures.

2. **Quality of work**: Produces presentable work with minimum supervision and follow-up.

B. SECTION TWO:

1. **Initiative**: Demonstrates self-reliance and resourcefulness. Takes initiative in identifying and accomplishing tasks. Aggressively seeks and acts upon new opportunities.

2. **Adaptability & Flexibility:** Grasps and adjusts to new ideas, procedures, and situations comfortably. Demonstrates ability to stand by decisions of the college and presents these decisions in a positive manner.

3. **Communication skills:** Communication is clear, concise and appropriate to produce results required of the job. Develops strong lines of communication with others. Willing to listen to others and their ideas.

4. **Working relationships**: Relates well with all levels of organization. Treats people with respect and integrity. Acts as a team player.

5. **Attendance:** Regular and punctual in attendance.

6. **Planning and organization**: Approaches work in an organized, logical and efficient manner. Determines priorities and follow-up is effective and timely.

7. **Problem analysis and decision making**: Diagnoses problematic situations, evaluates alternatives; develops and recommends realistic solutions.

8. **Personal development**: Initiates or accepts additional responsibilities; utilizes opportunities for training and development; displays interest in career growth**.**

9. **Continuing Education:** Has attended additional continuing education courses beyond what is required for re-licensure

10. **Clinical Education/Intern Assessment:** Demonstrates , through patient chart audits and Intern files reviews, an acceptable level of teaching and assessment of intern attitudes, knowledge and skills across the clinical competencies.

Intern Clinic Assignments

Intern assignments for all clinics start with a lottery-based selection process. This process is initiated near the end of Trimester 6 and Interns are encouraged to visit all Health Centers prior to the lottery. The Health Center Administration directs this process and has the final decision for all Intern assignments. The intern rotation and shift assignment schedule is available on SelfServe and is posted for the upcoming trimester 4 weeks prior to the first day of finals. Trimester 8 Interns are assigned rotations at the Adult Rehabilitation Center (A.R.C.). Trimester 8, 9, and 10 Interns are assigned rotations at St. Patrick's Center.

Effective with the class entering the Outpatient Health Center in the Fall 2010, Tri-8 interns will be assigned to three (3) clinic shifts at their assigned clinic and must obtain **all** of their quantitative requirements from their assigned clinic or assigned rotations through other sites. Effective for the January 2011 trimester, all Tri-8 and 9 interns will be assigned to three (3) clinic shifts at their assigned clinic. Effective for the May 2011 trimester, all interns will be assigned to three(3) clinic shifts at their assigned clinic.

Community Based Internship Program – CBI

The Logan College of Chiropractic CBI Program provides an enhanced clinical education experience for interns in privately owned chiropractic clinics to include the on campus BioFreeze Center. The program will provide under supervision, the intern opportunities with expert instruction to observe, acquire and practice the learning objectives and competencies necessary for entry level chiropractic practice as primary health care clinicians. The CBI Program is for students in Trimesters 8, 9 and 10 who have met all the requirements for participation. The CBI Program will allow those students who choose to participate to work and fulfill graduation requirements with a Doctor of Chiropractic in a private practice setting. Doctors of Chiropractic will be credentialed through an application process to become a CBI Doctor. Applications for interns will be posted on SelfServe during the 7th week of the trimester for CBI opportunities the following trimester.

Intern Orientation to Clinic

New trimester 8 interns shall receive an orientation to the assigned site prior to the first assigned rotation date. During this orientation, the interns will be provided a tour of the clinic and meet all office staff. The role of each staff member will be explained to the interns so they clearly understand the responsibilities of each person in the clinic. An overview of HIPAA and patient privacy rights and the patient intake process shall be presented along with review of the intern/patient assignment process. During the orientation it is imperative that the chain of command be clearly described. This process must include a discussion regarding the levels of interaction with staff and boundaries expected of the intern during these interactions. Interns must be made aware of the professional dress code and decorum expected within the clinical setting and how their behavior is a reflection of the clinic, College, and Profession. Meeting times for the entire intern pool as well as individual meeting times should be discussed.

Intern Duties and Responsibilities

Interns must realize their responsibility in obtaining patients and all credits necessary for Health Center course completion and graduation.

A. Interns are prohibited from:
   Engaging in social and/or intimate relationships with patients currently under their care or within 90 days of transfer or release from care; and/or treating patients with whom Interns have a pre-existing social and/or intimate relationship. It is the intent of the College that this policy be construed broadly to avoid even the appearance of improper activity. Interns having doubt or concern regarding whether specific conduct or activities are ethical or otherwise appropriate should contact the Chief of Clinical Services or his/her designate. Violation of this rule will result in punitive action and may be referred to the Professional Committee.
B. Interns must be present, available, properly attired and in possession of their diagnostic equipment for their assigned rotation shifts and for any patient appointments. This should include a thermometer, stethoscope, sphygmomanometer, penlight, combination opthalmoscope/otoscope, reflex hammer, small tape measure, goniometer, disposable specula for ears, and hand held eye chart.
C. Interns must complete all clinic related documents and forms according to current procedures as established in the Health Center Handbook or by policy.
D. Interns must follow the directions and instructions of Clinicians. Advising, consultation, history taking, examining, performing or ordering studies, establishing or altering treatment plans and treating patients are the purview of the licensed Clinician. Interns may not perform any service without the consent of the Clinician responsible for the care of the patient.
E. Patients are to be gowned during examinations and treatment. Robes are available for traveling to other areas. Patients should be instructed to wear socks and shoes when walking outside the treatment room.
F. All physical therapy and rehabilitation equipment must be returned to the appropriate storage area immediately following its use.
G. All treatment rooms must be clean and presentable manner prior to bringing the patient to the room. Following patient care, interns are expected to disinfect the surfaces of the treatment table that patients come into contact with. This should be done using the disinfectant spray and paper towels that are in the treatment room. Interns are expected to perform this duty after every patient encounter.

H. Discussion of examination findings, diagnosis and/or treatment must be discussed with the clinician in charge of the care of the patient prior to discussing this with the patient.
I. Patient files or records shall not be removed from a Health Center. for any reason, nor can a patient be seen at a different location unless the patient willingly transfers to that facility and the records are officially transferred.
J. Interns must comply with HIPAA and maintain confidentiality and privacy for their patients. Discussion with the patient regarding their diagnosis or how they are feeling must not occur in the waiting room or any other public area. No patient information (including personal notes) may be stored electronically on personal computers or removed from the clinic.
K. Confidentiality must be maintained by Interns when discussing cases in which the patient is not present.
L. Interns must be responsible for any educational task that is assigned by any attending Clinician or Health Center Administration.
M. Interns may not contact other physicians regarding their patients nor arrange for a referral to another health care professional. The attending Clinician will handle all communication with other physicians.
N. Interns may not advise patients regarding medications they are taking. Interns must obtain approval of their Clinician prior to recommending herbal, vitamin, or mineral supplements.
O. Falsifying Health Center records is a serious offense. Examples include but are not limited to forging signatures on the sign in/out sheets, vacation forms, patient records, travel sheets, laboratory and radiology impressions, narratives and research papers.
P. Interns are expected to treat fellow students, faculty, staff, and patients with respect. Unprofessional conduct (including negative actions, malicious gossip, and vulgar comments) will not be tolerated. Punitive measures will be taken and the incident will be referred to the Professional Committee.
Q. Interns may only use the adjustive techniques in which proficiency has been attained in the Logan specialized technique courses or eligibility for certification through selected Post-Graduate courses at Logan. The intern's unofficial transcript has that information available. Proficiency attained of an adjustive technique gained outside of Logan's curriculum, (i.e. Logan's post-graduate courses or other seminars) can not be used while attending patients in the Logan Health Center System.
R. Diversified and Basic techniques are the only two adjusting techniques that can be utilized in Student Health Center.
S. Interns are to treat all patients assigned or requested of them by their Clinician. Co-treating patients to provide procedure credit to another Intern is prohibited.
T. It is important that Interns maintain a professional environment for patient care at all times. Do not loiter in the waiting room, around the front desk, or the P.T./rehabilitation area.
U. No adjusting or manipulative procedure can be performed except under the present and direct supervision of a duly licensed and qualified instructor. Unauthorized adjusting procedures performed either on or off campus shall subject the individual(s) to a hearing before the Professional Committee and possible dismissal from Logan College.
V. Interns not involved in patient care during their shift are strongly encouraged to be engaged in other clinic related activities and/or completion of their module assignments (Case Report, Clinical Laboratory Interpretation)

Other responsibilities not specified in this section or elsewhere in this handbook, may be outlined for students by Clinicians or Health Center Administration and in the regular Logan Student Handbook.

Senior Intern Assistant Program

The Senior Intern Assistant Program enables motivated senior Interns to work in the Health Center System for personal and clinical skills enhancement. Interns interested in this program should speak with their Clinician regarding participation. Interns on academic probation are not eligible and participation is contingent upon continued fulfillment of both academic and consultation responsibilities.

Benefits of participation in the program include:

1. Interns are recognized with a certificate at the Tri 10 awards ceremony.
2. Additional clinical experience from working closely with an experienced Clinician.
3. Additional experience in patient management while working with a licensed Clinician and treating Interns.

Prerequisites:

1. Work study eligibility as determined by the Financial Aid office;
2. Minimum grade point average (cumulative) of 2.5; and
3. Recommendation from assigned Clinician.

Responsibilities of a Senior Intern Assistant:

1. Assists Interns with new patients in all functions such as consultation, report of findings, development of a treatment plan, and with the processes associated with patient examination and ordering x-rays and laboratory work.
2. Assists licensed Clinician with assisting Intern's utilization of physical therapy, and Intern record keeping.
3. Assists in case reviews and review of patient records
4. Assists Clinician in evaluating the clinical skills of Interns, identifying Interns who need special assistance, and provides tutorial training.

Group Leader Program

The Group Leader Program is designed to provide assistance to interns during the initial phase of outpatient clinic activities. The Group Leader will observe and assist the newer interns with patient intake procedures, documentation of the encounter, differential diagnosis strategies, treatment plan development, future scheduling, and completion of insurance reporting forms. In addition, the Group Leaders are to observe and assess the Report of Findings delivered to the patients by the interns. Any and all documents completed by the intern and Group Leader must be reviewed and approved by the Clinician. Intern performance in these various activities is assessed by the Group Leader and the strengths and weaknesses in the different tasks are reported back to the Clinician for review with the intern. Group leader training is done by the Clinician.

Course Syllabi and Requirements

Information regarding the requirements of each clinic level and grading of intern performance is listed in the course syllabi. This information should serve as a supplement to this handbook and each will be updated when the need arises.

Intern Self Evaluation, Mid-Term Meeting, and End of Term Evaluation

During the 6th or 7th week of the trimester, each supervising Clinician should provide each intern with a self evaluation document to be completed by the intern. A meeting should be scheduled with each intern in order for the clinician to review the interns self evaluation and compare that with the clinicians evaluation for intern performance. During meeting the strengths and areas in need of improvement should be discussed with each intern resulting in a formative assessment by the clinician. The evaluation documents completed by the intern and the clinician are the same allowing for an equivalent comparison of items. These documents are also are linked to the clinical competencies referenced later in this document. The summative document used for evaluating and grading intern performance at the end of the trimester is the same document as the self evaluation. At the end of the midterm meeting with the clinician, interns should be aware of what areas of the clinical competencies need improvement. Since interns must meet a level of performance sufficient to enter the practice of chiropractic as a graduation requirement, these formative assessments are valuable for helping interns identify what they need to focus on in order to be meet clinical eligibility for graduation. The next page lists the self-evaluation document.

LOGAN COLLEGE HEALTH CENTER INTERN SELF-EVALUATION

Intern Name: _____ Trimester: _____ Date:

Attending Physician: _____ Midterm Eval.___ Final Eval.

LEGEND: Scoring done based on the below attitudes, knowledge and skills
0 Unfamiliar with this competency
1 Minimal familiarity with this competency - Needs constant supervision/direction
2 Basic familiarity with this competency – Needs close supervision/direction
3 Clearly familiar with this competency – Needs some supervision/direction
4 Mastery of this competency – Needs minimal to no supervision

CATEGORY					ITEM
RECORD KEEPING					
0	1	2	3	4	SOAP notes accurate and complete
0	1	2	3	4	Treatment plans accurate and updated
0	1	2	3	4	Problem list complete and updated
0	1	2	3	4	Records, exams, patient Hx. done comprehensively
COMMUNICATION SKILLS					
0	1	2	3	4	Good communication between intern, patient & clinician
MARKETING SKILLS					
0	1	2	3	4	Outside marketing activities
0	1	2	3	4	Involved in Patient Health Care Workshop
0	1	2	3	4	Demonstrate ability to obtain patients from outside
CHIROPRACTIC SKILLS					
0	1	2	3	4	Palpation skills
0	1	2	3	4	Adjusting skills
0	1	2	3	4	Structural/functional evaluation of radiographs
0	1	2	3	4	Advise home care, stretches, nutritional support, etc.
0	1	2	3	4	Use of physiological therapeutics, rehab and nutrition
CLINICAL SKILLS					
0	1	2	3	4	Develop differential diagnosis
0	1	2	3	4	Proficiency in consultation, report of findings
0	1	2	3	4	Proficiency in physical/NMS exam procedures
0	1	2	3	4	Ability to elicit appropriate history
0	1	2	3	4	Ability to identify an emergency
0	1	2	3	4	Ability to evaluate lab results
0	1	2	3	4	Ability to apply diagnostic codes to condition
0	1	2	3	4	Case management proficiency (NP10)
PROFESSIONALISM					
0	1	2	3	4	Adhere to patient confidentiality
0	1	2	3	4	Professional attire and grooming
0	1	2	3	4	Assists in keeping clinic clean, tx. rooms organized, etc.
ATTITUDE/INITIATIVE /ATTENDANCE					
0	1	2	3	4	Volunteer, pt. recruitment, referrals
0	1	2	3	4	Rotation shift attendance & availability on non-shift days
0	1	2	3	4	Positive attitude and integrity

Interns Signature_____ Date_____

Clinician/Intern Relationship and Problem Resolution

In the event of a problem or conflict between a Clinician and an intern, it is suggested that all parties remain open minded during the resolution process. These conflicts are best resolved by following processes and procedures outlined within this document, the Health Center Handbook, and/or the Student Handbook. Should the conflict fall outside procedures identified in these documents, the Clinician and intern should work towards resolving the problem in a fair and equitable fashion. Should resolution not be accomplished through these means, the Clinic Administration should be contacted to assist in resolution. We will work with your in an attempt to identify strategies for resolution of the identified problem. If this is unsuccessful, we may meet with the parties, either together or independently to mediate and resolve the issue. Should the conflict be deemed not resolvable, Clinic Administration reserves the right to re-assign the intern to another site. This final strategy will only be considered if the above process has been followed without resolving the issue.

Assessment and Evaluation of Intern Performance

Attitude, knowledge, and skills:

In order to ensure that the educational program is effective, assessment and evaluation of intern performance is essential. This assessment should also ensure patient safety as well as the future success of interns meeting the educational goals. The assessment of intern performance must be across multiple domains and the intern must demonstrate that he/she meet the educational goals of the each domain and that of the entire education program. The attitude, knowledge, and skills of each intern in the program must be congruent with the expectations of the profession and that of the patients who will be receiving care from these individuals after they graduate. In order to ensure this occurs, interns are evaluated based on the Clinical Competencies as established by the Council on Chiropractic Education. Each competency has aspects of each of the aforementioned domains that must be included in the assessment of intern.

The process of intern assessment is challenging, yet provides considerable insight over time, as to how each intern will progress through the program. Some interns possess great intellect, but have limited social skills. Others may have strong social skills, but may lack technical ability. The wide variety of intern abilities makes the evaluation process challenging. Understanding this to be the case, you are encouraged to remain open and unbiased as you approach this task. Each intern is an individual and must be evaluated as such. The evaluation of new interns is almost exclusively formative and requires considerable patience. Interns approaching graduation should be assessed in a more summative way since they will soon be in charge of patients of their own. Finding a balance between these circumstances may be difficult, yet, it is essential. We have no room for error in the summative evaluation of an intern that will soon be functioning autonomously in a private practice. A more stringent process of intern assessment is necessary in the intern's final trimester of his/her clinical experience. It is at this point that you, the Clinician, need to be most critical of an intern's performance and clearly communicate any and all concerns to the soon to be graduate.

Clinical Competencies

The Council on Chiropractic Education has identified specific Clinical Competencies that must be by a candidate for the degree Doctor of Chiropractic. These candidates must meet a level of competence in these identified areas in order to be eligible for the D.C. degree as well as licensure. The next several pages list each individual competency and the items that must be assessed at a level of satisfaction in order for a candidate to eligible for the D.C. Degree. Interns that fail to meet the minimal level of competency in any of the CCE clinical competencies are not eligible for receipt of the D.C. degree. These interns, when identified, will be referred to Health Center Administration for development of an IEP to remediate the identified deficiency. See the following pages for the Assessment Forms related to the CCE Clinical Competencies.

HISTORY ASSESSMENT

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Recognizes professional and ethical boundaries expected of doctors by their patients.	❒	❒	❒	❒
2. Attention to patient comfort, recognizing patient apprehension/avoids exclamatory, misleading or inappropriate verbal or physical responses.	❒	❒	❒	❒
3. Recognizes the importance of and demonstrates ability in obtaining an organized, comprehensive case history relative to the patient's presentation. The various components of the history are included: patient demographic data, chief complaint, history of present illness, prior medical history, family history, psychosocial history, and review of systems.	❒	❒	❒	❒
4. Formulate and employ an organized and effective methodology of inquiry when taking the history. Communication is concise and clear, active listening is employed, and adapts to challenging situations.	❒	❒	❒	❒
5. Questions the patient with appropriate depth, pursuant to all relevant health concerns, complaints and symptoms.	❒	❒	❒	❒
6. Establishes an appropriate initial differential diagnosis and comprehends possible systems involvement.	❒	❒	❒	❒
7. Organizes and records patient/clinical information appropriately and develops problem list and differential diagnosis consistent with this information.	❒	❒	❒	❒

1 Minimal familiarity with this competency - Needs constant supervision/direction
2 Basic familiarity with this competency – Needs close supervision/direction
3 Clearly familiar with this competency – Needs some supervision/direction
4 Mastery of this competency – Needs minimal to no supervision

Additional Comments:

Intern: _____ Clinician: _____

Date: _____

EXAMINATION ASSESSMENT

_____ SCOPE

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Exhibits an understanding of the patient's presentation. The intern selects and performs appropriate examinations based on that presentation. (e.g., chief complaint, history, signs and symptoms)	❒	❒	❒	❒
2. Understands the importance of the physical examination to establish a differential diagnosis.	❒	❒	❒	❒
3. Demonstrates understanding of the professional and ethical boundaries expected of doctors by their patients.	❒	❒	❒	❒
4. Selects and properly utilizes instruments and equipment appropriate for the examination.	❒	❒	❒	❒
5. Clearly communicates with the patient for the purpose of efficiency and education while appropriately performing the examination(s).	❒	❒	❒	❒
6. Performs in an organized, efficient manner to acquire physical and neuromuscular examination data. (Using inspection, percussion, instrumentation, palpation, ROM, O/N)	❒	❒	❒	❒
7. Understands the mechanisms of the examination and is able to recognize, interpret and assess normal, variant and abnormal findings.	❒	❒	❒	❒
8. Organizes, interprets and assesses the pertinent, verbal and non-verbal, case history and physical and neuromuscular examination information and develops a differential diagnosis.	❒	❒	❒	❒

1 Minimal familiarity with this competency - Needs constant supervision/direction
2 Basic familiarity with this competency – Needs close supervision/direction
3 Clearly familiar with this competency – Needs some supervision/direction
4 Mastery of this competency – Needs minimal to no supervision

Additional Comments

Intern _____ Clinician: _____

Date: _____

PSYCHOSOCIAL ASSESSMENT

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Recognize and appreciate how psychosocial factors contribute to patient presentations, communication skills, and responses to care.	❒	❒	❒	❒
2. Willingness to explore and discuss the psychosocial environment and understand the influence of these factors on health.	❒	❒	❒	❒
Assess patient attitudes that negatively affect health and intervene appropriately. Identify and administer screening tools and recognize clues indicating the need for further assessment.	❒	❒	❒	❒
3. Recognize the clinical indications for referral or collaborative care and identify appropriate services, agencies and programs available to assist the patient.	❒	❒	❒	❒
4. Understand how pain and disability can affect patient behavior, be able to modify procedures when caring for the patient affected by psychosocial factors and deal effectively with aberrant behavior from patients in an office setting.	❒	❒	❒	❒
5. Obtain and record psychosocial information that is accurate, complete, and compliant with legal standards using family members or others as resources when indicated.	❒	❒	❒	❒
6. Recognize circumstances that require doctors to report information to appropriate authorities.	❒	❒	❒	❒

1 Minimal familiarity with this competency - Needs constant supervision/direction
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3 Clearly familiar with this competency – Needs some supervision/direction
4 Mastery of this competency – Needs minimal to no supervision

Additional Comments:

Intern: _____ Clinician: _____

Date: _____

DIAGNOSTIC STUDIES

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Recognize the necessity and importance of diagnostic studies in developing an accurate patient profile while considering the costs, benefits, and risks in the ordering and performance of the studies.	❒	❒	❒	❒
2. Understand s the clinical indications for and the significance of the findings, results, and ranges of values obtained from the studies and their relative values.	❒	❒	❒	❒
3. Understands the principles and procedural elements of equipment employed in diagnostic imaging, laboratory, and other diagnostic studies along with the federal and state regulatory guidelines governing their use.	❒	❒	❒	❒
4. Orders or conducts diagnostic studies (x-ray/clinical labs/other studies) with appropriate attention to patient safety, instruction, and comfort following professional protocols and preserving study quality.	❒	❒	❒	❒
5. Can accurately record data obtained from diagnostic studies.	❒	❒	❒	❒
6. Interprets imaging, labs, and/or other procedures as clinically indicated and can integrate the results with information from other components of the exam to formulate a diagnosis.	❒	❒	❒	❒

1 Minimal familiarity with this competency - Needs constant supervision/direction
2 Basic familiarity with this competency – Needs close supervision/direction
3 Clearly familiar with this competency – Needs some supervision/direction
4 Mastery of this competency – Needs minimal to no supervision

Additional Comments:

Intern: _____ Clinician: _____

Date: _____

DIAGNOSIS

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Understands and recognizes the importance of collecting sufficient clinical information and generating a diagnosis consistent with the history and exam prior to initiating care or additional diagnostic procedures.	❒	❒	❒	❒
2. Integrates the data facilitating formulation of a diagnosis and can identify the pathophysiology responsible and understand the natural history of the disorder.	❒	❒	❒	❒
3. Develops, records and conveys a diagnosis consistent with the history and exam findings and any other significant information.	❒	❒	❒	❒
4. Exhibits reasoning and understanding inn using sources to support the diagnosis.	❒	❒	❒	❒
5. Recognizes when routine diagnostic procedures are insufficient and can obtain appropriate advanced studies when indicated.	❒	❒	❒	❒
6. Develops and prioritizes a problem list.	❒	❒	❒	❒
7. Recognize circumstances that require doctors to report information to appropriate authorities.	❒	❒	❒	❒

1 Minimal familiarity with this competency - Needs constant supervision/direction
2 Basic familiarity with this competency – Needs close supervision/direction
3 Clearly familiar with this competency – Needs some supervision/direction
4 Mastery of this competency – Needs minimal to no supervision

Additional Comments:

Intern: _____ Clinician: _____

Date: _____

CASE MANAGEMENT

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Recognize the need and be able to develop, record, and communicate and appropriate care plan consistent with the diagnosis, pathophysiology, and disorders of natural history and modify the plan appropriately based on changes in the patient's clinical status.	❒	❒	❒	❒
2. Effectively communicate to the patient, through appropriate means, the diagnosis, suggested chiropractic care plan and alternative approaches while appreciating the need for informed consent and patient compliance to the plan.	❒	❒	❒	❒
3. Understand and integrate the patient's physical and psychosocial factors into the care plan and provide appropriate patient education in the development and communication of that plan.	❒	❒	❒	❒
4. Identify personal and professional care limitations recognizing when routine clinical procedures are insufficient and incorporate other procedures, including referral for consultation or collaborative care and be able to initiate that process.	❒	❒	❒	❒
5. Initiate the appropriate drugless health care regimen, selecting and employing clear outcome measures to evaluate the initial diagnosis, clinical progress, care plan effectiveness and to determine condition resolution or maximum therapeutic benefit.	❒	❒	❒	❒
6. Understand professional and legally acceptable methods of recording clinical and financial information and that these records are kept in a way that ensures accurate and current information of the patient's progress and financial obligations.	❒	❒	❒	❒
7. Compliance with requests for patient records and reports, being aware of the confidential nature of the doctor/patient relationship and releasing records only to those authorized to review them.	❒	❒	❒	❒

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Additional Comments:

Intern: _____ Clinician: _____

Date: _____

ADJUSTMENT ASSESSMENT

_____ AREA AND TECHNIQUE

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Demonstrates understanding of the need for advisement to the patient as to the nature of the adjusting procedure to be administered, and any inherent risks associated with the procedure.	❒	❒	❒	❒
2. The intern recognizes the indications and contraindications for adjusting procedures.	❒	❒	❒	❒
3. The intern effectively uses appropriate methods to identify spinal and/or extremity subluxations.	❒	❒	❒	❒
4. Able to modify methods/procedures to accommodate patient needs/body type.	❒	❒	❒	❒
5. The intern's performance reveals an understanding of articular anatomy and function.	❒	❒	❒	❒
6. Utilizes appropriate patient positioning.	❒	❒	❒	❒
7. Utilizes appropriate Doctor positioning.	❒	❒	❒	❒
8. Utilizes appropriate technique: Alignment, Contact, Speed, Force	❒	❒	❒	❒
9. The intern accurately records the method of determining the location of the subluxation, the method of treatment and the outcome of the adjustment.	❒	❒	❒	❒

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Additional Comments

Intern: _____ Clinician: _____

Date: _____

EMERGENCY CARE

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Recognize the responsibility to and legal implications of providing emergency care.	❒	❒	❒	❒
2. Recognize and emergency or life threatening situation, the need for prompt appraisal, response, and assistance and the need for effective communication and collaboration with other health care providers.	❒	❒	❒	❒
3. Understand and utilize current emergency care and first aid procedures and equipment in providing first aid and BCLS and perform appropriate reporting, recording and follow up.	❒	❒	❒	❒
4. Remain calm and reassuring while communicating with the patient, monitoring the effect of emergency care and eliciting additional help as needed.	❒	❒	❒	❒
5. Remain calm and reassuring while communicating with the patient, monitoring the effect of emergency care and eliciting additional help as needed.	❒	❒	❒	❒
6. Determine availability of local emergency care resources and select the appropriate services.	❒	❒	❒	❒

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Additional Comments:

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Date: _____

CASE FOLLOW UP

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Demonstrates recognition of the need to monitor the patient's clinical status, response to care and modify the care plan as needed.	❒	❒	❒	❒
2. Understands how and when to re-evaluate the patient's clinical status and demonstrates the ability to conduct an appropriate re-evaluation and record the data for case management in an organized fashion.	❒	❒	❒	❒
3. Possesses the ability to evaluate the patient's response to care through appropriate outcome measures.	❒	❒	❒	❒
4. Can identify the need to and consult with or initiate referrals to other providers and communicate this effectively to the patient and providers.	❒	❒	❒	❒
5. Appreciates the benefits of appropriate consultation/referral and can recognize/respond to patient concerns and apprehension regarding collaborative referral.	❒	❒	❒	❒

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Additional Comments:

Intern: _____ Clinician: _____

Date: _____

RECORD KEEPING

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Recognize the need and demonstrate ability to construct patient records in an accurate, legible, complete, current and non-judgmental fashion.	❒	❒	❒	❒
2. Know and understand the elements essential to developing complete patient records.	❒	❒	❒	❒
3. Recognize patient record confidentiality and the need to ensure that records are released only upon legal and/or written authorization and understand accepted procedures for requesting records/information from other providers or agencies.	❒	❒	❒	❒
4. Sensitive to patient interests in accessing records understanding legal guidelines for release recognizing what records must be released and those elements that can be legally withheld.	❒	❒	❒	❒
5. Willingness to respond to record requests in a timely manner through clear, concise professional correspondence.	❒	❒	❒	❒
6. Recognizes the need to stay current with trends and technology in record keeping and transfer/be aware of legally accepted methods of record maintenance, storage and security.	❒	❒	❒	❒
7. Enters pertinent clinical data, providers and care plans in a legible, organized and accurate manner reflective of the decision making process using accepted coding systems and abbreviation keys, when necessary.	❒	❒	❒	❒

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Additional Comments:

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Date: _____

DOCTOR/PATIENT RELATIONSHIP

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Recognize the importance and seriousness of the role D.C.s have in patient care and appreciate that this doctor/patient relationship is based on trust, confidence, respect and confidentiality.	❒	❒	❒	❒
2. Recognize the importance of the doctor and patient working together as partners managing care appropriately, preventing patient dependency and development of unrealistic expectations.	❒	❒	❒	❒
3. Recognize the importance of developing and maintaining professional attitudes and behavior both in and out of the office and be aware of the impact the doctor's positive or negative health behaviors may have on patients.	❒	❒	❒	❒
4. Understand and respond to the needs, concerns, and fears that a patient may have and appreciate the importance of compassion, empathy and touch as being vital components of healing and influential on outcomes of care.	❒	❒	❒	❒
5. Develop and exhibit behavior and a communication style (verbal and non-verbal) that projects a professional image.	❒	❒	❒	❒
6. Appreciate and adapt to cultural, social, religious, gender and age differences and use appropriate techniques when managing patients that exhibit inappropriate behavior.	❒	❒	❒	❒
7. Know what patient care and office procedures can be employed to reduce potential risks and professional liability.	❒	❒	❒	❒

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Date: _____

PROFESSIONAL ISSUES

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Recognize and appreciate the importance and need to support and participate in the affairs and activities of community and professional organizations.	❒	❒	❒	❒
2. Awareness and understanding of the professional obligation to produce and appreciate the importance of research in education, practice, and professional growth and the need to maintain knowledge and skills for practice through education.	❒	❒	❒	❒
3. Desire and have the ability to critically evaluate new and current knowledge, including clinical research literature.	❒	❒	❒	❒
4. Understand and demonstrate knowledge regarding; 1) following sound business practices involving finances personnel, consultants and liability insurance 2) ethical practice development strategies including marketing and demographics, billing and collection procedures, and patient care issues 3) realize the obligation to refrain from illegal or unethical procedures.	❒	❒	❒	❒
5. Develop effective patient rapport through communication skills, understand what patient care and office procedures can be employed to reduce risks and identify which community care or social service agencies can assist in meeting the patient's needs.	❒	❒	❒	❒
6. Awareness of professional reporting requirements of federal, state and local agencies.	❒	❒	❒	❒
7. Recognize circumstances that require doctors to report information to appropriate authorities.	❒	❒	❒	❒

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Date: _____

NON-ADJUSTING THERAPY

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Understand the principles, physiologic effect, and application of the various therapeutic procedures common to the practice of chiropractic along with understanding selection and use of equipment necessary in administering the therapy.	❒	❒	❒	❒
2. Recognize the clinical indication and rationale, contraindication and potential complications and be able to select and apply appropriate therapeutic procedures while accommodating patient privacy and modesty.	❒	❒	❒	❒
3. Appreciate the need for and demonstrate the ability to explain the application, clinical benefit, potential immediate or delayed reactions, and the risks of the therapies recognizing the potential for patient apprehension and concern.	❒	❒	❒	❒
4. Appreciate the need for and demonstrate the ability to explain the application, clinical benefit, potential immediate or delayed reactions, and the risks or therapies recognizing the potential for patient apprehension and concern.	❒	❒	❒	❒
5. Develop effective patient rapport through communication skills, understand what patient care and office procedures can be employed to reduce risks and identify which community care or social service agencies can assist in meeting the patient's needs.	❒	❒	❒	❒
6. Awareness of professional reporting requirements of federal, state and local agencies.	❒	❒	❒	❒

1 Minimal familiarity with this competency - Needs constant supervision/direction
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Additional Comments:

Intern: _____Clinician: _____

Date: _____

WELLNESS

ATTITUDES, KNOWLEDGE AND SKILLS COMPETENCIES

	1	2	3	4
1. Appreciates the multidimensional characteristics of wellness, and how multiple factors interplay in overall health and wellness, and accepts and promotes active patient care participation as an essential component of health care.	❒	❒	❒	❒
2. Appreciates the broad social determinants of health including community-level health care issues, and the significant impact that environmental influences may have on a patient's overall well being.	❒	❒	❒	❒
3. Is able to describe and discuss basic principles, perspectives, and concepts of health promotion appropriate for the needs of the public and the patient in the context of chiropractic care.	❒	❒	❒	❒
4. Understands the role of the doctor of chiropractic in health promotion and is able to relate lifestyle changes promoting increased quality and years of healthy life to patients and the public.	❒	❒	❒	❒
5. Is able to identify minimum screening activities for health promotion, and the resource materials available to educate patients and the public; and to describe the principal trends and demographics for each of the leading health indicators	❒	❒	❒	❒
6. Communicates effectively and uses appropriate techniques to encourage active patients' participation in their own health promotion.	❒	❒	❒	❒
7. Implements and performs preventive and common screening procedures and wellness assessments along with providing patient counseling for health promotion.	❒	❒	❒	❒

1 Minimal familiarity with this competency - Needs constant supervision/direction
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Additional Comments:

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Date: _____

Recording of Intern Credits

The number of adjustment, physical examinations, physiological therapeutic treatments, and all other clinic requirements are tracked by Health Center personnel. The clinical requirements needed for graduation are updated daily. Accumulated totals for each Intern are published on a weekly basis and made available to all Interns via the Health Center Web based intern data tracking system. Effective with the class entering the Outpatient clinic April 2009, 7 of the 10 required Case Management credits (NP10s) and 120 of the required 200 adjustments MUST come from the clinic to which the intern is assigned. Effective with the entering Tri 8 class in the Fall 2010, all 10 of the case management and all 200 of the adjusting credits required for graduation must come from the intern's assigned clinic. Credit and hours will be given for all eligible clinical and Red Badge activities.

Verification of Clinic Hours Worked

Interns are expected to sign in/out using the fingerprint tracking system that is located at each fee for service clinic site. At the Community service clinics, interns should sign in/out on the attendance sheet at that site. When an Intern signs in, it indicates that the Intern is present, properly dressed, equipped, and available to treat patients. Interns are not to sign in for clinic hours during scheduled class time. Interns should not schedule patients during scheduled class times. It is considered unprofessional for Interns to sign in and not be available. Likewise, it is unprofessional for Interns to sign out early. Credit is given only to Interns who sign in and remain available for the entire duration of their shift. Please be advised that the public address system cannot be heard in the library. Interns will not be contacted on personal pagers by the front desk.

Health Center Grades – Benchmarks

The three trimester clinical internship is graded as a Pass or Fail. The established benchmarks listed below serve as a guide of clinical expectation. The intern's transcript will simply denote continuation of this internship by the letters IP (In Progress) at the end of the 8th and 9th trimesters.

The following cumulative benchmarks are trimester 8 expectations:

3rd week of trimester	5 outpatient encounters 1 new patient/case management credit
6th week of trimester	15 outpatient encounters 2 new patients/case management credits
9th week of trimester	30 outpatient encounters 3 new patients/case management credits
12th week of trimester	50 outpatient encounters 4 new patient/case management credits
15th week of trimester	65 outpatient encounters 5 new patients/case management credits

The following cumulative benchmarks are trimester 9 expectations:

3rd week of trimester	85 outpatient encounters 7 new patient/case management credit
6th week of trimester	110 outpatient encounters 8 new patients/case management credits
9th week of trimester	135 outpatient encounters 10 new patients/case management credits
12th week of trimester	160 outpatient encounters 11 new patient/case management credits
15th week of trimester	185 outpatient encounters 13 new patients/case management credits

If, in the opinion of a Clinician, an Intern demonstrates a lack of proficiency in the performance of any aspect of their clinical duties (consultation/patient history, patient examination, differential diagnosis, adjusting or other patient care procedures), the Intern may be referred to Student Services for integration into an Individualized Educational Plan with specific recommendations from the Clinician and Health Center Administration.

Intern Vacations/Sick Time

The first day a new intern is eligible to begin working in outpatient clinic is the first day of finals in Trimester 7. Because this is the first official day of Trimester 8, the three week vacation rule begins on this day. The vacation rule stipulates that an Intern is entitled to:

1. Three (3) weeks of vacation time during the three semesters (Trimester 8, 9, and 10) of their Outpatient_Health Center practica. No more than two (2) weeks vacation may be taken in succession.

2. All vacation must be pre-approved by the assigned Clinician and the signed request submitted to the Health Center secretary. The Intern is responsible for finding coverage from within the assigned clinic for their rotation shift(s) and for scheduled patients and needs approval of the Clinician responsible for the patients. Attendance by the covering Intern is mandatory for all assigned clinical rotations and for all scheduled patients under the scheduled Intern's care.

3. In the event of illness, Interns may be examined to insure that they are well enough to treat patients. Sick days or other absences shall apply to the three (3) week vacation rule in that the three (3) weeks of vacation includes three (3) absences from out-patient rotation.

New Patient Processing

A new patient is defined as any person not previously evaluated at any Logan Health Center or an existing patient who has not been evaluated or treated in the prior 12 months. (See the New Patient Flow Chart.) Logan Health Centers provide the patient with a comprehensive evaluation, and therefore, Interns should allow 1 to 1-1/2 hours for the first visit. This should be explained to the patient by the Intern and the front desk personnel.

The last new patient schedule time is 6:00 p.m., Monday through Thursday, 5:00 p.m. on Fridays and 10:00 am. on Saturdays. This allows adequate time to process new patients before clinic closure.

The Consultation is done by the intern under the direction and supervision of the Clinician. The level of participation by the Clinician in actually conducting the consultation is determined by his/her comfort with the intern's skills in conducting a consultation. Typically, there is more Clinician involvement with newer interns until the Clinician is satisfied that the intern has the knowledge and skills to collect the necessary information.

When the consultation is complete and the information has been reviewed by the Clinician, the Clinician will explain to the patient the examination format that is appropriate for the patient (i.e. a regional exam of the area of chief complaint, physical examination and necessary radiology and laboratory procedures). Patients should be informed of the costs of the recommended procedures. Questions regarding payment or insurance matters should be handled by the financial office.

After the examination has been completed, the Intern must consult with the Clinician and review the findings from the exam. The Clinician may chose to double-check the Intern's examination findings as well as explain to the patient the need for x-rays, lab work, and/or referral.

If the Clinician determines x-rays are needed, Interns will be asked to complete a Radiology Information Sheet which is then signed by the Clinician. Female patients must sign an additional form stating they are not pregnant. The Radiology Department that serves all the Logan Health Centers, adheres to the 10-day rule.

The Intern escorts the patient to radiology. At this time, the Intern will type a flash card for their patient's films. Once the films are obtained, a preliminary interpretation of the films will be provided.

The ordering of laboratory studies and x-rays are for the purpose of diagnosis. This responsibility falls onto the Clinician and requires a written order for performance. The order must include the patient name, diagnostic test to be performed, date of the order and signature of the Clinician ordering the study. These orders are done on a duplicate sheet. The person performing the study will initial the order at the time the procedure is performed. The lab/x-ray department will keep the original for their files. The duplicate copy will be entered into the patient file to provide evidence that the study was performed. When the results are obtained, they will be forwarded to the ordering Clinician for review and entry into the patient file. The results will be reviewed with the Intern and determination will be made at the time whether to review with the patient at the current or next visit or call the patient for discussion of the results if the patient has already departed.

If it is determined that a phone call to the patient regarding abnormal lab or x-ray findings is necessary, the Clinician ordering the study, not the Intern, should contact the patient. If the result is of a nature that requires referral to another health care provider, the Clinician will inform the patient of this. If the result indicates additional testing to determine a diagnosis, the Clinician will discuss this with the patient and arrange for the testing to be performed. These conversations must also be recorded in the patient chart and should include the date, time and content of the conversation.

The Clinician and Intern will formulate a working diagnosis and a treatment plan at this time based upon the consultation and examination findings. Interns are encouraged to provide input and ask questions during all aspects of patient care, however, the Clinician will make the final decisions regarding patient care.

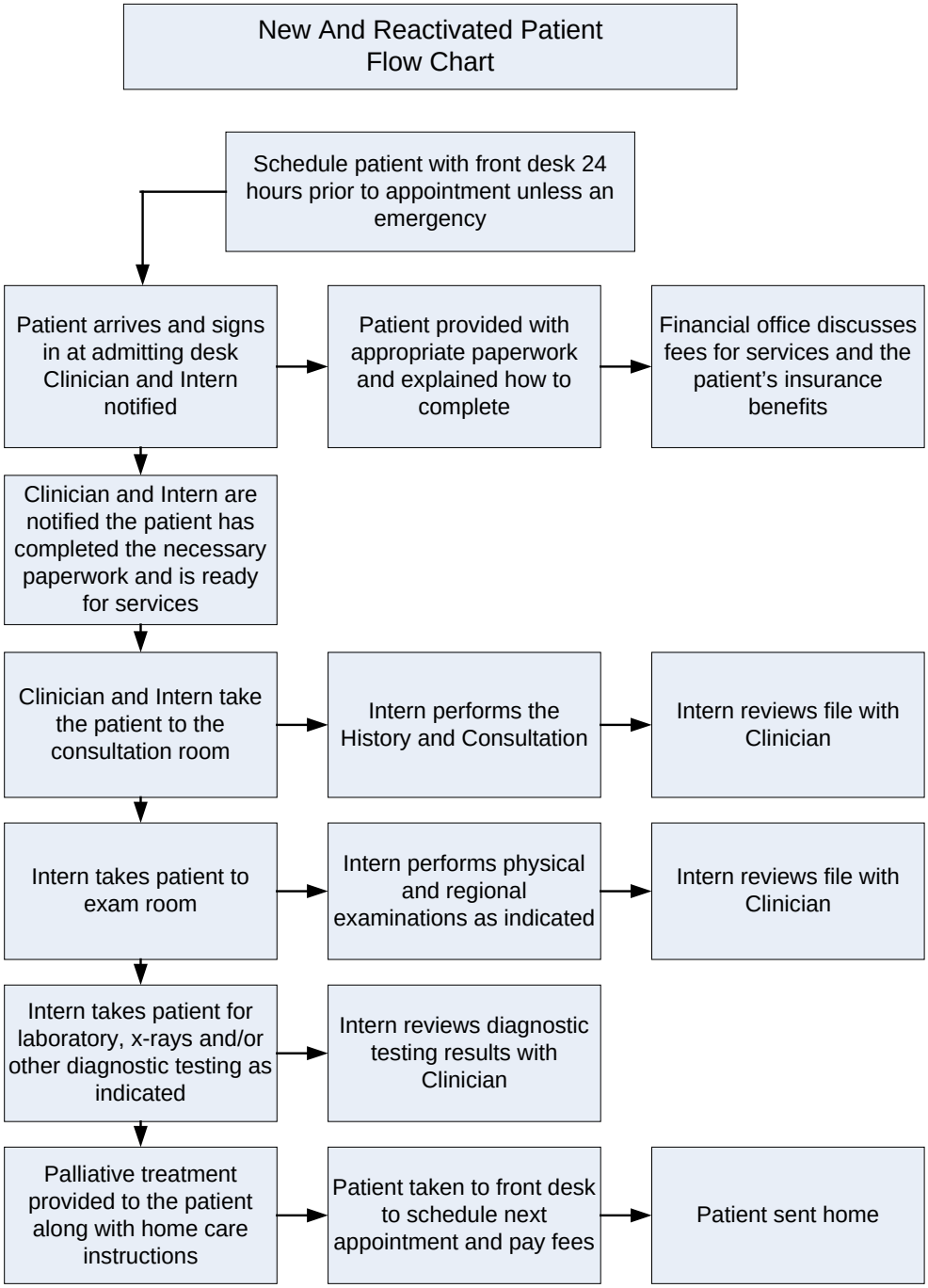
On the second visit, the Intern and Clinician will present the report of findings, the recommended treatment plan, discuss benefits/risks/alternatives and obtain informed consent for care, and answer any questions the patient may have. Once again, questions regarding payment or insurance should be directed to the financial office. Once the patient gives consent for treatment, the Intern evaluates the patient, reviews the findings with the Clinician, has the patient complete the appropriate Outcomes Assessment instrument and care is delivered. The Clinician observes and directs, as necessary, the adjusting procedures. At the conclusion of the treatment, the patient is provided instructions for home care and any questions are answered. The Clinician discusses the Patient Education Workshop with the patient and encourages attendance. At this point, the Intern and the patient arrange an appointment schedule for the Workshop and the first two weeks of care. The patient is escorted to the front desk, appointments booked, fees paid and the patient departs.

The travel sheet must be accurately marked and thoroughly completed. The travel sheet is given to the Patient Services person who then can collect payment, give the patient a receipt, and schedule the patient for their next visit.

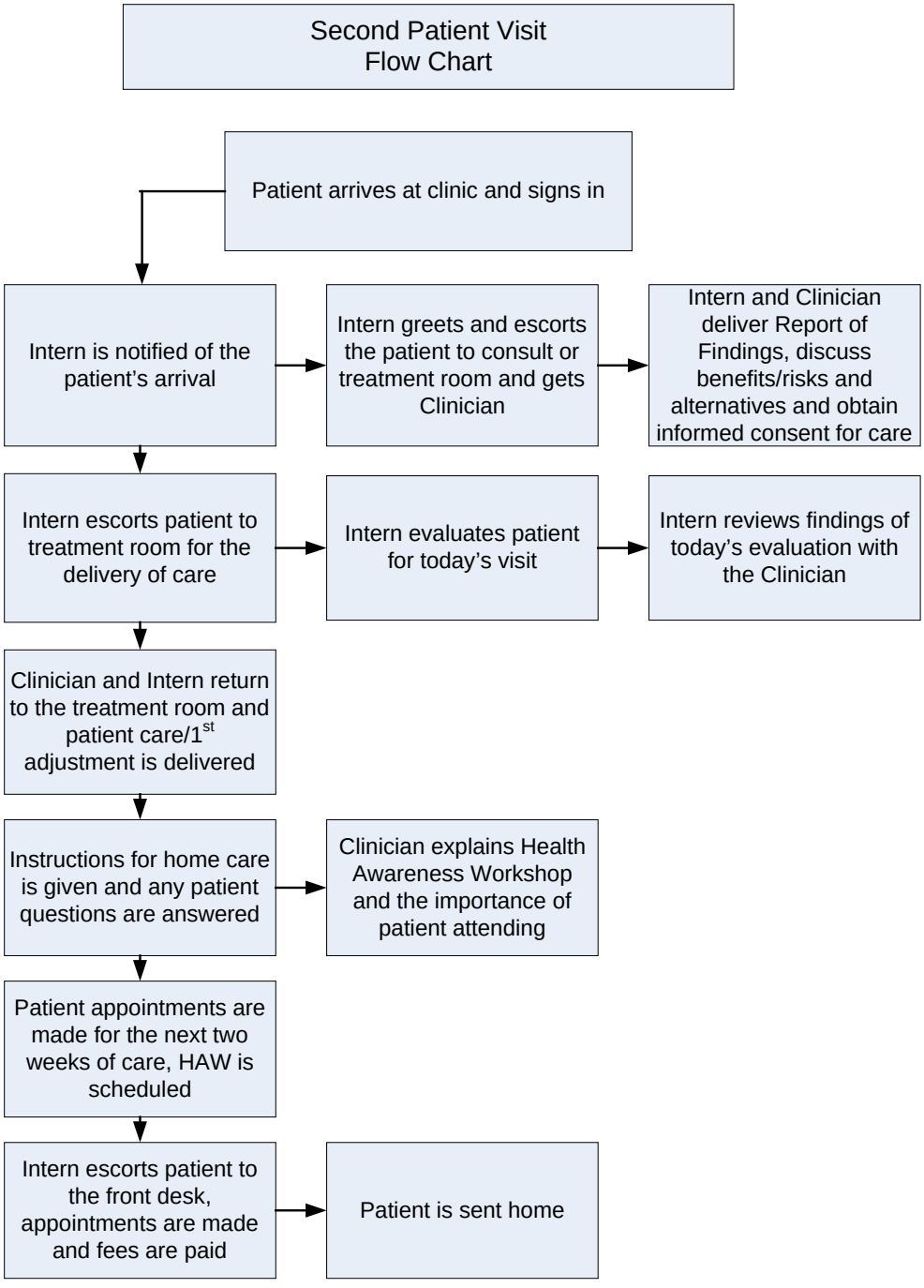
The Clinician is expected to interact with the new patient and the intern during every aspect/phase of the new patient visit. It is during this encounter that the Clinician establishes the Doctor/Patient relationship and secures the trust and confidence of the patient. Clinicians should review the history with the intern and confirm items as well as inquire deeper with the patient if necessary. The Clinician is also expected to confirm the physical exam findings to ensure the appropriate testing strategies are employed to arrive at an accurate diagnosis. Below are the flow charts for the 1st and 2nd patient visits.

New and Reactivated Patient Processing Flow Chart

A. First Visit



B. Second Visit



Patient Assignments to Intern

Whenever possible patients will be distributed equally among the Interns assigned to a given location.

1. Established patients:

    a. Trimester 10 Interns will meet with the Clinician(s) prior to leaving the Health Center System to participate in a preceptorship or to graduate. The Clinician(s) will assign new Interns for each patient, distributing them between the Trimester 9 and Trimester 8 Interns.

2. "Walk-in" patients:

    a. A "walk-in" patient is a patient who either does not have an assigned Intern, or, comes into the Health Center for treatment at a time when their assigned Intern is not present. The Clinician will assign an Intern on shift to care for "walk-in" patients. The front desk staff/C.A.'s will keep a rotation list of Interns on shift at any given time. Two separate rotations will be tracked – "walk-in" adjustments, and "walk-in" new patients. The "walk-ins" will be assigned to the next Intern on the list. After an Intern receives the opportunity for a "walk-in" the next Intern on the list will be given the next opportunity. If an Intern misses an opportunity due to absence, other patient appointments, failure to bring appropriate equipment, declining the opportunity, or any other reason, he/she is skipped. He/she will not receive another opportunity until the shift list cycles back to his/her name.
    b. If, at the discretion of the Clinician, an Intern is skipped due to technique requirements, the Intern skipped will receive the very next opportunity for a "walk-in".

Note: Because Trimester 10 Interns typically have a full day shift, they will receive two opportunities (morning and afternoon) for each one (morning or afternoon) given to Trimester 8 and 9 students. Example:

AM Shift	Adjustments				NP's		PM Shift	Adjustments				NP's	
Wendy Tri 10	X				X		Wendy Tri 10	X				X	
Rob Tri 10	X						Rob Tri 10	X				X	
Lori Tri 10	X						Lori Tri 10	X				X	
Sue Tri 9	X						Todd Tri 8						
Andy Tri 9	X						James Tri 8						
Michael Tri 8	X						Eric Tri 8						

In this example, a "walk-in" established patient needing to be adjusted would be assigned to Wendy during the morning shift or Todd during the afternoon shift. A walk-in new patient would be assigned to Rob during the morning shift or Todd during the afternoon shift. If a "walk-in" came in the afternoon and Todd was unable to take the patient an "X" would be placed in his slot and the patient assigned to James instead.

Documentation and Record Keeping

The patient file is a permanent legal document that may be called as evidence in a court of law. Files must be accurately maintained, written in legible handwriting, and follow the standards of care regarding documentation. The patient record must justify the need for initial or continued care of the patient or referral to the appropriate provider. To accomplish this, the record must be complete and accurate. The record should be written in ink, legible, organized, and complete. Entries into the patient chart should be dated and signed by the person making the entry. The records of patients seen by interns MUST be countersigned by a licensed clinician. The patient record must include the following items:

Informed Consent documents signed by the patient or in the case of a minor, the parent/legal guardian.

A description of the patient's current condition including date and mode of onset, past and current treatment received with response to that treatment.

A description of current and past conditions that the patient has or is currently receiving treatment for AND the treatment being received.

A description of the patient's social and family history

A Review of Systems to be considered for other undetermined co-morbid illnesses

Examinations performed, including laboratory and/or x-ray studies and the results of those examinations leading to the documented working diagnosis which is supported by the H & P and other tests

A Problem List that identifies all current and resolved problems. Each problem listed should have the ICD-9 code listed

Daily notes which contain the subjective complaints, objective findings, the ICD-9 code for the condition being treated, an opinion noting the status or change in the patient's condition, a listing of all procedures performed on the visit, and all recommendations given to the patient. If therapeutic modalities or Rehabilitation procedures are performed on the visit, the duration/length of treatment noting beginning and ending time must be listed in the treatment note.

A treatment plan identifying the type, frequency, and duration of care along with recommendations given to the patient for self or home care. This plan should include short and long term treatment goals.

Results of any re-examinations to evaluate the interval change regarding the patient's condition

Outcome Assessment instruments prior to beginning care and at all re-examination intervals

Logan's Family Educational Rights and Privacy Act (FERPA) Policy

Overview

The Family Educational Rights and Privacy Act of 1974 (FERPA), 20 U.S.C. §1232g, as amended, is a federal law giving certain rights to parents or students regarding education records at schools of every level receiving funding from the U.S. Department of Education. At the postsecondary school level, the rights afforded by FERPA belong, in general, to the student rather than the parent. The five rights, as summarized in the Department of Education regulations, 34 CFR §99.7, are as follows:

1. The right to inspect and review the student's education records.
2. The right to request the amendment of the student's education records that the student believes to be inaccurate, misleading, or otherwise in violation of the student's privacy rights.
3. The right to consent to disclose personally identifiable information contained in the student's education records, except to the extent that FERPA and the regulations authorize disclosure without consent.
4. The right to file with the U.S. Department of Education a complaint concerning alleged failures by the institution to comply with the requirements and regulations of FERPA.
5. The right to obtain a copy of the institution's student record policy.

I. RIGHT TO INSPECT AND REVIEW. Students may inspect and review their education records upon request to the appropriate record custodian. (See list of types, locations and custodians of student records at the end of this policy)

The regulations define "education records" as meaning, subject to the few exceptions, those records that are (1) directly related to a student and (2) maintained by an educational institution or by a party acting for the institution.

A student should submit to the record custodian a written request, which identifies, as precisely as possible, the record or records s/he wishes to inspect. The office of the record custodian will make the needed arrangements for access as promptly as possible and notify the student of the time and place where the records may be inspected. Access must be given within a reasonable time, but in no event more than 45 days from the receipt of the request. When a record contains information about more than one student, the student may inspect and review only that part of the record that relates to him or her.

Logan reserves the right to refuse to permit a student to inspect the following records:

1. Financial records of the student's parents.

2. Confidential letters and statements of recommendation for which the student has waived his or her right of inspection and review.

3. Records connected with an application to attend Logan if the application was denied.

4. Those records which are excluded from the FERPA definition of education records.

Logan reserves the right to deny copies of transcripts or copies of records (but not access to the record) in any of the following situations:

1. the student has an unpaid financial obligation to Logan, or

2. the student has failed to comply with disciplinary sanctions.

II. RIGHT TO SEEK AMENDMENT. If a student believes the education record(s) relating to the student contain information that is inaccurate, misleading, or in violation of the student's privacy rights, s/he may ask Logan to amend the record. The procedures for amendment of records are the following:

1. Students should submit to the office of the record custodian (see list at the end of this policy) a written request for amendment of the record, identifying the part of the record requested to be changed and specifying why it is inaccurate, misleading, or in violation of their privacy rights.

2. Logan will decide whether to amend the record as requested within a reasonable time after receiving the request.

3. If Logan decides not to amend the record as requested, it shall inform the student in writing of its decision and of his or her right to a hearing.

4. If the student requests a hearing, Logan shall hold the hearing within a reasonable time after receiving the request. Logan shall give the student reasonable advance notice of the date, time and place. The hearing may be conducted by an individual without a direct interest in the outcome, including a Logan official. At the hearing, Logan shall give the student a full and fair opportunity to present evidence relevant to the issues.

5. Logan shall make its decision in writing within a reasonable period of time after the hearing. The decision will be based solely on the evidence presented at the hearing and will include a summary of the evidence and the reasons for the decision.

6. If, as a result of the hearing, Logan decides that the information is inaccurate, misleading, or otherwise in violation of the privacy rights of the student, it will amend the record accordingly and inform the student of the amendment in writing.

7. If, as a result of the hearing, Logan decides that the information is not inaccurate, misleading or otherwise in violation of the privacy rights of the student, it will inform the student of the right to place a statement in the record commenting on the contested information and stating why s/he disagrees with Logan’s decision.

8. If a statement by the student is placed in the record, Logan shall maintain the statement with the contested part of the record for as long as the record is maintained and disclose the statement whenever it discloses the portion of the record to which the statement relates.

III. RIGHT TO CONSENT TO DISCLOSURE. Logan will not disclose personally identifiable information from a student's educational record without the prior written consent of the student, except:

1. to comply with a federal grand jury subpoena or any subpoena issued for a law enforcement purpose, in which case the court or other issuing agency orders, for good cause shown, that the existence or contents of the subpoena or any information furnished in response to the subpoena not be disclosed.

2. to parents or legal guardians of students under 21 regarding a disciplinary violation involving a Logan rule or policy governing the use or possession of alcohol or a controlled substance, and,

3. to school officials within Logan who Logan has determined to have a legitimate educational interest in the records.

The definition of a school official includes but is not necessarily limited to:

a. A person employed by Logan in an administrative, supervisory, academic or research, or support staff position.
b. A person employed by or under contract to Logan to perform a special task, such as an attorney or auditor.
c. A person serving on the Board of Trustees.
d. A student serving on an official committee, such as a disciplinary committee, or assisting another school official in performing his or her task.

A school official, in most cases, will have a legitimate educational interest if the official is carrying out the duties or responsibilities of his or her position. A school official has a "legitimate educational interest" if the official is:

a. Performing a task that is specified in his/her position description or by a contractual agreement.
b. Performing a task related to a student's education.
c. Performing a task related to the discipline of a student.
d. Providing a service or benefit relating to the student or student's family, such as health care, counseling, maintenance of the safety and security of the campus or students, job placement or financial aid.

Without prior consent by the student, FERPA authorizes releases of personal information to third parties as follows:

a. To certain officials of the U.S. Department of Education, the Comptroller General, and state and local educational authorities in connection with the audit or evaluation of certain state or federally supported education programs.
b. In connection with a student's request for or receipt of financial aid as necessary to determine the eligibility, amount, or conditions of the financial aid, or to enforce the terms and conditions of the aid.
c. Institutions from which the student has received or applied to for financial aid.
d. As required by state law.
e. To organizations conducting certain studies for or on behalf of Logan.
f. To accrediting organizations to carry out their functions.
g. To parents of an eligible student who claim the student as a dependent for income tax purposes.
h. To comply with a judicial order or a lawfully issued subpoena.
i. The results of any disciplinary proceeding conducted by Logan against an alleged perpetrator of a crime of violence to the alleged victim of that crime.
j. At a time of emergency defined in terms of the following considerations:

- The seriousness of the threat to health or safety.
- The need for access to the record in meeting the emergency.
- Whether the person requesting the records is in a position to deal with the emergency.
- The extent to which time is of the essence in dealing with the emergency.

In these instance, a record of access will be kept by Logan which indicates (a) name and signature of person who requested or examined the file; (b) the purpose for which the file was accessed; (c) date on which access to record occurred; and (d) clear notice that the information must not be released by a third party without the consent of the student. Logan will keep notification of releases made to third parties in the student's record.

Logan designates the following as directory information:

> name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received (including Dean's list), and the most recent previous educational agency or institution attended by the student.

Directory Information is information that Logan may disclose but is not required to be disclosed without prior consent by the student.

In accordance with the requirements of FERPA, Logan annually will give public notice to students in the Student Handbook, Catalog and website of the types of personally identifiable information that Logan has designated as directory information. Furthermore Logan will give the student the opportunity to refuse to let Logan designate any or all types of information about him or her as directory information. Copies of forms to request non-disclosure of directory information are available in the Registrar's Office.

RECORD OF REQUESTS FOR DISCLOSURE. Subject to certain expectations set forth in FERPA regulations, the record custodians within Logan will maintain a record of all requests for and/or disclosure of information from a student's educational records. The record will indicate the name of the party making the request, any additional party to whom it may be redisclosed, and the legitimate interest the party had in requesting or obtaining the information. The record may be reviewed by the student.

IV. RIGHT TO FILE A COMPLAINT. Students have a right to file a complaint with the U.S. Department of Education if they believe that Logan has failed to comply with the requirements of FERPA. The complaint should be in writing and contain specific allegations of fact giving reasonable cause to believe that a violation of FERPA has occurred. The complaint should be sent to:

Family Policy Compliance Office
U.S. Department of Education
Washington, D.C. 20202-4605

V. TYPES, LOCATION AND CUSTODIANS OF STUDENT RECORDS

All students have records in one or more of the following offices, maintained by the custodian listed.

Type	Location	Custodian
Admissions Records	Admissions Office	VP of Enrollment
Advising Records	Advisor's Office	Academic Advisor
Counseling Records	Counselor's Office	Counselor
Credential Files	Registrar's Office	Registrar
Academic Records	Registrar's Office	Registrar
Disability Records	Student Services	Dean of Student Srvcs.
Disciplinary Records	Student Services	Dean of Student Srvcs.
Accounting Records	Business Office	CFO
Financial Aid Records	Financial Aid Office	Financial Aid Director
Clinical Education Records	Clinic	Clinic Data Entry