

**CONROE FAMILY MEDICINE RESIDENCY PROGRAM
RESIDENT POLICY MANUAL**

2009-2010

“RULES OF THE ROAD”

RESIDENCY RULE CHANGES

In order to avoid inconsistent application of regulations, all changes are to be subject to approval by the full faculty. The Director, however, will maintain the necessary authority to make allowances for emergency situations if justification is properly documented. All changes to this document will then be recorded in an Appendix to be distributed within 10 working days for all residents and faculty. Updates to the pertinent pages and Table of Contents will be provided as needed.

Changes to be suggested by resident physicians should be presented through the monthly Resident Meetings by the Chief Resident. These may be discussed as needed in the subsequent monthly Resident/Faculty meetings.

Date Prepared: March 23, 2009

A. **ABFP DEFINITION OF FAMILY MEDICINE**

Family Medicine is the medical specialty that is concerned with the total health care of the individual and the family. It is the specialty in breadth that integrates the biological, clinical, and behavioral sciences. The scope of Family Medicine is not limited by age, sex, organ system, or disease entity.

B. **MISSION STATEMENT AND RESIDENCY GOALS AND OBJECTIVES**

1. To train family physicians who will pursue excellence in providing compassionate patient care.
2. To train well-qualified family physicians, thus increasing the supply of practitioners available to meet the health care needs in Texas and the United States;
3. To provide the medical student with role models so as to encourage interest in family medicine;
4. To stimulate intellectual pursuit and research by faculty, residents and family physicians in practice;
5. To provide continuing medical education for the graduates of this program and other physicians in private practice.

B. 1.0 FAMILY MEDICINE RESIDENCY LEARNING OBJECTIVES

The Residency Program has developed advancement criteria for each year level of training. These are appended to this document at Appendices A, B, C. At the conclusion of each year of training, the resident should have met criteria for advancement to the next year of training and for graduation. In addition, the Residency Program has developed a list of procedures that each resident is required complete prior to graduation. This list is appended to this document at Appendix D. It also contains a recommended number that do not necessarily ensure competence, but are the minimum suggested if residents intend to request the privilege to do the procedure in practice. Completion certificates will not be awarded to residents not meeting criteria for graduation.

At the completion of the three-year training program, a resident should be able to:

1. Demonstrate competence in the following areas:
 - a. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;
 - b. Medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences, evidence-based medicine, and the application of this knowledge to patient care;
 - c. Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care;
 - d. Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals;

- e. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population; and
 - f. System-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.
2. Demonstrate competence in the fundamental and evolving principles of family medicine, including the contextual understanding of health and illness and the role of the doctor/patient relationship in this understanding;
 3. Demonstrate excellent skills and knowledge in internal medicine, general surgery, obstetrics and gynecology, pediatrics, psychiatry, community medicine and any other specialties and subspecialties needed to prepare one to provide definitive care for the majority of the health problems encountered in practice;
 4. Demonstrate understanding and skill in the application of comprehensive care: preventive care, health education, acute care, anticipatory guidance, functional management of chronic illness, rehabilitation, adjunctive psycho/social services, environmental health and general health maintenance;
 5. Demonstrate this knowledge by providing the services needed by each family unit under his/her care in a coordinated manner;
 6. Identify and use community resources to implement effective treatment planning for individuals in a family unit;
 7. Request appropriate consultations and effectively coordinate these among medical specialists and allied health care providers;
 8. Demonstrate confidence in their understanding of the organization and economics of private practice, medico-legal issues, medical ethics, and community needs such that they are enabled to practice effectively and efficiently;
 9. Demonstrate use of electronic health records (EHR) and PDA software at the point of care;
 10. Successfully pass the examination for Board Certification and meet all the other requirements for Certification by the American Board of Family Medicine and understand the need and process for recertification/maintenance of certification.

B.2. PORTFOLIOS

A resident portfolio is a formal record of goals, growth, achievement and professional attributes obtained during a physician's residency. Resident Portfolios illustrate goals and development over time, with the main goal of demonstrating competency at the end of the three years of family medicine residency. The portfolio contains objective documentation as well as examples of self-reflection and assessment.

Family Medicine residents work with their faculty advisors over three years to build and refine their portfolios.

The Resident Portfolios at Conroe Medical Education Foundation have two parts – (1) the required component and (2) the personal choice component (*Individual Competency Reflections*). The personal choice component contains exhibits that demonstrate evidence of competence for the six ACGME outcomes: (1) patient care, (2) medical knowledge, (3) professionalism, (4) interpersonal and communication skills, (5) practice-based learning and improvement, and (6) systems-based practice.

Portfolios are kept in the office of the Program Coordinator. The resident is responsible for constructing and maintaining the Resident Portfolio with consultation from his or her faculty advisor. Portfolios will be reviewed during each quarterly resident meeting between the resident and her or her advisor.

C. CONROE FAMILY MEDICINE RESIDENCY PROGRAM

C. 1.0 GRADUATE MEDICAL EDUCATION COMMITTEE

CMEF Board of Directors:

Shashi Bellur, M.D. President, Armand Martel, M.D., Secretary, Peter Bigler M.D.
Designated Institutional Official: Stephen McKernan, D.O.
Program Director Core Residency: Stephen McKernan, D.O.
Program Director Sports Medicine Fellowship: Scott Rand, M.D.
Co-Chief Residents: Kevin Fite, M.D., and Alyssa Molina, M.D.
Administrator: Paul Tannos

Designated Institutional Official Designee: Jennie Faulkner

C 2.0 CONROE PROGRAM FACULTY AND STAFF

2.1 Full Time Faculty

William Brown, M.D., Family Physician
Catherine Browne, D.O., Obstetrics and Gynecology
Yvette Gordon, M.D., Obstetrics and Gynecology
Adel Ibrahim, M.D., Family Physician & Geriatrics
Lata Joshi, M.D., Family Physician
Stephen McKernan, D.O., Family Physician
Kim Norris, M.D., Family Physician
Scott Rand, M.D., Family Physician & Sports Medicine Director

2.2 Part Time Faculty

Edward Davidson, Ph.D., Behavioral Scientist
Louis Harman, M.D., Orthopedic Surgeon
Amit Parikh, D.O., Family Physician & Sports Medicine Faculty
Angelica Harrell, M.D., Psychiatrist
Angela Thomas, M.D., Family Physician
Tri-County MHMR LPC's

2.3 Clinical Instructors

Christine Pospisil, RD, LD, CDE
Valerie Powell, PharmD., Pharmacist
Hollie Stallings, R.Ph., Pharmacist

2.4 Support Staff

Paul Tannos, Administrator
Jennie Faulkner, Residency Coordinator
Gretchen Smith, Assistant Residency Coordinator

D. **ROTATION SCHEDULES**

The Residency Program’s curricular elements have been developed to prepare the resident to become certified by the American Board of Family Medicine and to meet the requirements of the Residency Review Committee. The curriculum is designed to prepare the resident to be a competent and capable physician. The chart below reflects the overall three-year curriculum with thirteen four-week rotations each academic year. There is some flexibility as to the year during which some rotations may be taken. Residents are encouraged to review rotation schedules and chosen electives with their faculty advisor.

D.1.0. Year 1	D.2.0. Year 2	D.3.0. Year 3
Inpatient Adult Medicine 16 weeks	ICU 8 weeks	Inpatient Adult Medicine 8 Weeks
Pediatrics/Nursery 8 weeks (Incl. Community Medicine)	Private Pediatrics 4 weeks	Sports Medicine 4 weeks
Obstetrics 8 weeks	Gynecology 4 weeks	Psychiatry 4 weeks
Night Float 7 weeks	Women’s Health 2 weeks	Radiology 2 weeks
Emergency Medicine 2 weeks	Night Float* 6 weeks	Geriatrics 2 weeks
	Emergency Medicine * 6 weeks	Ambulatory Care 4 weeks (Incl. Community Medicine)
	OB/Pedi (including NICU) 8 weeks	Night Float 1 week
Practice Management 100 hours (longitudinal over 3 years), including 2-week seminar in year 3		
Approved combinations of the following rotations may be completed during years 1, 2 or 3 but must be completed prior to graduation:		
Emergency Medicine (8 weeks)		
General Surgery (8 weeks)		
Surgical Subspecialties		
Orthopedic Surgery (4 weeks)		
Otolaryngology (2 weeks)		
Ophthalmology (2 weeks)		
Urology (2 weeks)		
Internal Medicine		
Pulmonology (4 weeks)		
Cardiology (4 weeks)		
Nephrology (4 weeks)		
Dermatology (4 weeks)		
Electives 16 weeks when these rotations are not combined		
Family Medicine 2 half-days per week	Family Medicine 3 half-days per week	Family Medicine 4 half-days per week

D. 4.0 ROTATION AND CLINIC SCHEDULE REQUESTS

Requests for next year's rotations are made in writing and must be turned in by the end of April to the Residency Coordinator. The rotations are assigned on a first come first serve basis for first year residents. Second and third year residents should decide as a class on their desired rotation schedules. These are due as requested by the Residency Coordinator. The clinic schedule is established by the Residency Coordinator and approved by the Program Director. Any significant deviations of this must be approved by the Program Director or Coordinator.

D. 5.0 ELECTIVES

Residents may use electives in part to remove identified deficiencies in knowledge or skills. No more than three months of elective time may be used for remedial purposes.

Electives should be used to gain experience relevant to the resident's future practice plans. Electives must be made with the advice and consent of the Program Director. Most electives will be in subspecialized areas of major primary specialties. A rural rotation in the State of Texas is encouraged.

D. 6.0 SCHOLARLY ACTIVITY

1. In compliance with RRC guidelines, the Conroe Family Medicine Residency requires that all residents complete at least one scholarly project during residency.
2. The goal of this requirement is for residents to gain exposure to critical thinking, data collection, evidence-based theory, and research collaboration.
3. Scholarly projects may include original research, case presentations, or literature reviews and may produce articles, state or national presentations, or another approved project.
4. Residents may work together on team projects. Ideally, teams should be comprised of physicians in different states of training.
5. All scholarly projects will include the following: (1) a written summary to be turned in to the resident's faculty advisor, (2) a review of applicable medical literature, and (3) a formal presentation of their project to the program.
6. Residents are encouraged to present their projects at national, state, and local meetings.
7. Residents are required to complete and present their scholarly activities during the third year of residency.
8. Scholarly projects will be kept on file in the Resident Portfolios maintained in the office of the Coordinator.
9. A completion certificate will not be awarded until the resident has completed the scholarly activity requirement outlined in # 5, above.

Interested residents may complete a research elective where a paper must be submitted for publication. If a paper is published in a non-peer reviewed journal, \$100.00 is added to the resident's discretionary account. If it is published in a peer reviewed journal, \$200.00 is added to the resident's discretionary account.

E. **EVALUATIONS**

To maintain the high quality of our rotations and electives, each resident is required to submit his or her own confidential evaluation of each rotation and of supervisors for each rotation in New Innovations. Once each year the Program conducts 360-degree evaluations of residents. These are completed by staff members from the pharmacy, nursing and front office departments, and by two continuity patients each residents selects. Residents are also required to complete self-evaluations in New Innovations as requested.

F. **FACULTY ADVISORS**

Each resident is assigned to a faculty advisor. You are required to meet with your advisor on at least a quarterly basis. You may schedule a meeting time or a meeting time may be scheduled by the Residency Coordinator. The advisor helps review your evaluations with you, helps you choose the appropriate electives and is available to listen or give advice as you request regarding the program, your future plans or personal problems.

F. 1.0 IN-TRAINING EXAMINATIONS

Each year on the first Friday in November, all Family Medicine Residents at all levels in the United States are required to sit for an In-Training Examination. This is a great rehearsal for the Family Medicine Board Exams and helps us to assess our program's strengths and weaknesses as well as provides an assessment tool for individual resident evaluation. Faculty takes over the Call Schedule at 10 PM the evening prior to the exam. The exam begins at 7:30 or 8:00 AM and ends early in the afternoon. All scores will be sent to the Program in January. Attendance at the In-Training Exam is mandatory. Results of the exam may be used to direct remediation. If a resident's composite score is below 400 during the PGY1 year, there is a 20% chance that they will not pass the Board Exam; if they again score below 400 during PGY2, there is a 40% chance that they will not pass the Board Exam; if during PGY3 they again score below 400, there is a 60-65% chance that they will not pass the Board Exam.

Bonuses will add to resident discretionary accounts as follows:

1. Score above 50 percentile for postgraduate year level \$50.00
2. Score above 90 percentile for postgraduate year level \$100.00
3. Any improvement in score compared with the prior year's score \$50.00

G. **DRESS CODE**

Dress at all times is to be professional and in compliance with the Lone Star dress code. Clothing is to be neat and clean. No jeans are to be worn except on Friday and on weekends. Jeans should be neat and in good condition. Keep in mind that the physician's appearance can affect the patient's view of their physician. Always wear a lab coat over surgical scrubs. **SCRUBS ARE NOT CONSIDERED APPROPRIATE ATTIRE FOR CLINIC EXCEPT FOR DELIVERIES, WHILE IN SURGERY, ON CALL, AND ON THE WEEKENDS.** Hospital policy states that a physician may leave the

Operating Room or Labor and Delivery Room with scrubs, but a lab coat must be worn over them. *Residents should never re-enter the Operating or Delivery Rooms without changing their scrubs (if time allows).*

H. FAMILY MEDICINE CLINIC

The **Lone Star Family Health Center** is the site of each resident's "private practice" for the three years. The facilities include two Residents' Rooms and mailboxes, two minor procedure rooms, fetal dopplers, colposcope, LEEP machine, tympanometer, spirometer, flexible sigmoidoscope, ultrasound equipment, EST cardiac equipment, PFT equipment, and computer equipment/Internet access.

An electronic health record is used to document patient encounters. All patient visits, phone messages and prescription refills are to be made in the electronic record. When a piece of paper must be created for a patient, that paper must be scanned into the record. Residents will have access to the electronic record from the hospital and through the internet from home. When used appropriately, this system can enhance patient care, but just like a paper record, the information must be updated and accurate. All providers are to use default exams and other lists.

Residents are required to check Healthmatics on a daily basis to answer questions, review labs, and refill medications.

HOURS: Morning arrival time 8:00, first appointment 8:15, last appointment 11:15, and Afternoon arrival time 1:00 p.m., first appointment 1:15 last appointment 4:15, Monday through Friday. After hours and during lunch, the telephone is answered by the answering service that transmits the calls to the upper level resident on call.

Clinic is one of each resident's highest priorities and responsibilities in training. If a resident feels that (s)he must be late to clinic, the tardiness MUST be approved by the Clinic Faculty, and the resident must notify his/her nurse prior to the start of clinic.

H. 1.0 ASSIGNMENT OF PATIENTS AND FAMILIES

1. Continuity of care is a top priority for resident clinics. Residents should make an effort to see their own patients for chronic problems if at all possible.
2. In July, patients and families from the previous year's graduates are assigned to other residents. **THE FIRST RESIDENT TO SEE THE PATIENT BECOMES THAT PATIENT'S PHYSICIAN, WHETHER NEW OR REASSIGNED.**
3. After this, patients are assigned generally in rotation, although first year residents cannot handle as many new patient assignments as more experienced residents.
4. New obstetrical patients are assigned as equitably as possible by rotation.
5. Residents build their practices primarily from following-up previously unassigned hospital patients, but they should seek to provide medical care for the entire family.
6. Requests for PCP reassignment will be handled by the Clinical Medical Director.

H. 2.0 RESIDENT AND PATIENT SCHEDULING

Appointment Schedules: Clinic appointment schedules are made by trying to balance the needs of the clinic patient population with the resident's education. Just like any other clinic, this Clinic's first priority is to care for its patients. Clinic schedule demands increase as each resident's experience increases.

In general, the following chart will be used to determine how many patient slots each patient will be assigned. Appointments may be for 2 slots.

New patient	2 slots
Well Woman Exam	2 slots
EPSDT/Texas Health Steps Exam	2 slots
New OB	2 slots
Routine OB	1 slot
Hospital Discharge Follow-up	2 slots, when available
Follow-up Appointments	1 slot

First Year: Two, occasionally one, half-days per week. During July and August, a minimum of 3 patients will be scheduled per session. Beginning in September and on a regular basis thereafter, additional patients will be scheduled in each session. This will allow the residents to become progressively more efficient and prepare them for advancement to second year. In addition, the resident on Pediatrics rotation also sees the infants with the neonatologist in their weekly high-risk infant clinic (Teddy Bear Clinic) after the first six months.

Second Year: Three, occasionally two, half days per week, 11-12 patients per session with 2 slot appointments as described above. The resident on Pediatrics rotation will do Teddy Bear Clinic for the first six months.

Third Year: Four half-days per week, some rotations have three clinics per week. 12-13 patients per session with 2 slot appointments as described above.

All residents are expected to add walk-in patients to their schedules as flow permits. It is best to be proactive and take the walk-in patients early if there are patients who do not show up for scheduled appointments, or if there are open slots in the schedule.

Procedures: Residents are responsible for identifying patients who need procedures and for scheduling them in their continuity clinic. Residents should note that procedure clinic is assigned to the resident on Ambulatory Care to provide specialized teaching, training and honing of skills, as well as for procedures that require longer time slots than are available in a reasonable time. Procedure clinic should not be viewed as the sole source of procedures for residents to perform or the place to send all procedures. Residents are strongly encouraged to perform procedures at the time of presentation and to coordinate this with their faculty. If the procedure cannot be done at the time of presentation, the resident should schedule the procedure in their own clinic. Some procedures must be scheduled for a time when a faculty member experienced in the procedure will be available (flexible sigmoidoscopy, colposcopy, OB ultrasound, and vasectomy), and when the resident has appointment slots available. All residents are

encouraged to seek opportunities for procedures and be proactive in finding faculty who can provide supervision for the procedure. A list of procedures done by specific faculty member will be provided.

The Residency Review Committee, the body that accredits family medicine residencies states: "The primary setting for training the knowledge, skills, and attitudes of family practice is the model office or FPC." Residents meeting the following standards of excellence in the Family Medicine Center will receive a discretionary account bonus as outlined below.

Year Level			
1	\$25: Average 3 patients per session per quarter (through October)	\$50: Average 4 patients per session per quarter	\$75: Average 7 patients per session per quarter
2	\$50: Average 8 patients per session per quarter and see at least 100 patients per month*	\$75: Average 10 patients per session per quarter and see at least 225 patients per quarter*	\$100: Average 12 patients per session and see a total of 225 patients per quarter*
3	\$50: Average 9 patients per session per quarter and see at least 100 patients per month*	\$75: Average 11 patients per session per quarter and see at least 300 patients per quarter*	\$100: Average 13 patients per session per quarter and see at least 300 patients per quartermonth*

While some rotations, such as night float, have fewer clinic sessions, all residents complete these rotations. Therefore, opportunities to achieve these standards of excellence are equal among all residents.

* - Total patient numbers per quarter will be appropriately adjusted to account for other responsibilities for the Chief Resident(s).

H. 3.0 WORK-IN PATIENTS

The business of a family physician is patient care. We are a large group practice and function as any group should. Quite regularly, residents may be asked to see a patient who usually sees another resident or faculty, as a "Work-In" or "Same Day Appointment" (SDA). These are not always emergencies, but are visits that are important to the patient. Many times, a resident scheduled in the clinic is called away for delivery or surgery or other emergency. When necessary, the office staff calls that providers' patients to reschedule the appointment, but many times that is not possible or the patient is already in the Family Medicine Center. In those circumstances, every effort is made to have the patient seen so that they are not inconvenienced. Residents may also see other providers' patients if their patients do not show up ("DNKA", Did Not Keep Appointment), or are canceled. Residents should expect to see a full clinic of patients every time the residents are scheduled to be in the Family Medicine Clinic.

Residents are to check-out with their assigned or the lead preceptor prior to leaving the building at the end of their scheduled clinic.

H. 4.0 SPECIALTY CLINICS

Appointments for procedure, Ortho, EST and vasectomy clinic are made through the clinic nurse supervisor. Appointments are made for OB, gynecology, behavioral science specialty clinics and diabetes education through the appointment clerk. As with any Consultation, your referral form in the chart should be specific as to the reason for the referral. If no referral form is found, you will be paged to come fill one out. Appointments to Coumadin Clinic are arranged by the Clinical Pharmacist in charge of that clinic. (I am not sure how they make this happen)

H. 5.0 PRECEPTING PATIENTS

All referrals generated by residents, both in clinic and at the hospital, other than on emergency basis should be discussed with a teaching faculty. This is for your education in deciding when to refer as well as the possibility of keeping some procedures within the clinic where they can be teaching cases. All patients should be precepted in accordance with clinic, insurance, Medicare and Medicaid guidelines, and state and federal laws. **All Medicare and Medicaid patients must be precepted with faculty at the time of the visit and documented appropriately in compliance with both state and federal laws. All Medicaid and Medicare patients must be seen by faculty during the first six months of the internship year and until the intern is approved for independent patient evaluation with check out. Faculty must see all patients whose visit is coded 99214 or 99215. It is not acceptable and violates CMS rules to down code a patient visit to avoid this supervision requirement All Medicare and Medicaid charts, as well as all other precepted charts, particularly if the faculty has seen the patient, must be submitted to the preceptor for review.**

Chart audits are required for documentation adequacy. Residents will randomly be asked to send all charts for a given day to faculty to sign off and review. Residents will intermittently be assigned to have a faculty member shadow them. See H.11.0.

All procedures done in the hospital and clinic must be precepted in person by faculty for a substantial part of the procedure in order to be billed.

H. 6.0 CHAPERONES

Male residents doing breast or pelvic or rectal examinations on female **patients MUST HAVE A FEMALE CHAPERONE IN THE ROOM** during that examination! Female residents doing genital or rectal examinations on male patients, or pelvic examinations on female patients, **MUST HAVE A CHAPERONE**. It is also recommended that all residents have a chaperone whenever they are doing these exams on persons of the same sex.

H. 7.0 TELEPHONE CALLS, MESSAGES, MAILBOXES

All residents and faculty are to check the EHR for telephone messages and prescription refills on a daily basis and respond to them. If a resident is not going to be in the clinic for a period of time (vacation, CME, away rotation, illness) the resident must notify their nurse so that patient messages can be referred to their buddy. The telephone message and the resident's noted response, including advice to the patient, prescriptions,

etc., is placed in the record as a permanent part of the record. First year residents should precept most messages with faculty or a third year resident. **It is discourteous, unethical, and may be actionable under the law (residents may be sued) to ignore telephone messages from patients. Unsuccessful attempts to reach a patient should be documented in the chart.** Procedures for documenting this will be covered in EMR training.

Personal long distance calls from the Family Medicine Center are not allowed. Internet access is available on the computer in the resident's mail room. Please use discretion when using the internet and use only appropriate web sites. Please also note that there is a policy prohibiting forwarding non work related messages through the Lone Star Family Health Center server.

H. 8.0 CORRESPONDENCE

Periodically residents will have to write letters for patients, sign orders on patients for visiting nurses, nursing home patients, etc. All of these communications must be approved and co-signed by a faculty member. They should all be done promptly, within one to two days of receipt. Patients bringing lengthy forms for the physician to fill out will be asked to schedule an appointment time for that purpose. All correspondence must be maintained in the patient's permanent record. If a resident is uncomfortable signing a request or form for a patient, this should be promptly discussed with a faculty member. You should let the faculty member know about your concerns. Since the resident may know the patient best, you should be aware of their needs and provide information that will help decide on an appropriate course of action.

For any correspondence involving risk management issues, residents must follow the policies outlined in *CMEF General Information for Residents*.

H. 9.0 PATIENT FINANCIAL MECHANISMS AND BILLING THIRD PARTIES

While LSCHC and CMEF have contractual obligations to care for a number of uninsured and/or under funded patients admitted to Conroe Regional Medical Center who have no physician, LSCHC and CMEF must pay our overhead and is not tax-supported for deficits. All patients are charged for our services. Faculty are both Medicaid and Medicare participating physicians, but all other patients must arrange to pay fees. The clinic fee schedule is available at the front office. We are not a free clinic and are prohibited from telling patients that we are. Lone Star has many programs to provide care, but we are not always able to see all patients under these programs.

If a patient has no third-party funding ("Self-Pay"), physicians should be sensitive to the patient's ability to pay for tests and obtain medications. The Clinic operates as a Federally Qualified Health Center (FQHC) and as such accepts all patients without regard to ability to pay as provided in federal guidelines. Please be aware that the ability to pay is not the same as willingness to pay. Patients who indicate they may have financial difficulty or inability to pay for their health care services should be referred to the eligibility office to work with a financial counselor to determine if they qualify for Medicaid, Public Assistance, one of our state grants, or a sliding fee discount. Patients who do not fall into these categories are expected to pay. Residents should encourage patients to use the Lone Star Pharmacy. Our pharmacy can provide medications on a sliding fee scale to qualified persons and can assist some patients in qualifying for low cost or free medications through pharmaceutical manufacturers' patient assistance

programs. It is not appropriate to have patient use our pharmacy only for free services as that is outside the guidelines of the FQHC. All attempts to assist the patient with their care should be documented in the care plan for the patient. In addition, our pharmacists provide excellent patient education and assist patients in obtaining needed medications, and will assist residents in gaining a more complete knowledge base of prescription medications.

H. 9.1 HOW TO CHARGE

Charge according to level or complexity of service following the RBRVS schedule. LSCHC and CMEF are reimbursed according to what the physician indicates supported by diagnoses. Everything done must be properly documented. An appropriate interval history, review of systems, past history and physical exam must be documented for the level of service charged

Never charge for more than is done. There should be only rare indications at the FMC for charging LESS than the "Expanded Problem Focused" (99213) visit, and these must be approved by the faculty. Residents should ask questions about charges, when precepting the patient visit with a faculty member. All Medicare and Medicaid rules must be followed. All 99214, 99204, 99215 and 99205 visits must be seen by faculty before the patient leaves the clinic.

Instruction and training on coding and billing are given frequently during didactics. The electronic record is also equipped with an E&M calculator tool to help residents code appropriately. Billing is done electronically when the visit is signed of, so it is imperative that you sign off your charts in a timely manner, usually within 48 hours if sent to faculty, or at the end of the session when signed off without review by faculty.

H. 9.2 WORKMAN'S COMPENSATION

Patients being seen for injuries they allegedly sustained on their jobs must all be precepted by a faculty member (even third year residents' patients), and all communications regarding the patient must be faculty-approved. All work related injuries should be reported to the front office manager to get permission for the patient to be seen at Lone Star Family Health Center.

H. 10.0 INTERPERSONAL RELATIONS

LSCHC employs over 90 people, including a number of office and nursing personnel, and a substantial number of resident and faculty physicians working in the program. If a resident has a problem with someone, the resident should discuss it calmly with the individual but should feel free to come to a preceptor or Program Director for advice. All LSCHC staff are expected to treat everyone, including patients, with courtesy, respect and professionalism at all times, and in compliance with CMEF and Lone Star Policies. This is important training for employee relations in the residents' future practice.

H. 11.0 CHART AUDITS

Residents' charts will be audited on a random basis as they are submitted electronically for preceptor review. Chart audits are used as a teaching tool. Residents may be asked for more information from their faculty reviewer. This may include appropriateness of care, adequacy of documentation or other issues as deemed appropriate by the faculty

preceptor. Residents are encouraged to ask questions about the comments or to support their opinion with the medical literature. An official form may be completed by the faculty which will become part of the resident's training record. **Please ask for help in areas that you feel that you need it. The faculty will not know your strengths and weaknesses unless you tell them. This is the best way to optimize your time in residency.**

H. 12.0 CONROE FAMILY MEDICINE PATIENT CARE CHECKLIST

(For self evaluation and chart audit)--"Continuing, comprehensive, compassionate care"

1. Charges: Patient charged appropriately
Procedures charged
Diagnoses and procedures coded correctly
2. Patient Care: Pertinent history
Appropriate P.E.
Lab data acted upon
Problems assessed
Family/Psychosocial considerations
Preventive maintenance
Proper therapy/counseling
Logical investigations planned
Follow-up plan
Patient education
3. Charting: Initial Database, filled out
Problem list (acute and chronic), up to date
Medication List, up to date
Dictation in SOAP format
Well-documented, succinct notes
4. Pediatrics: Immunizations
Growth/Weight curve
Development (use of R-PDQ and flowchart)
Health risks guidance
5. Adult men: Health maintenance/hazards appraisal, e.g., smoking, blood lipid levels, alcohol intake, exercise, genital and rectal exams, etc.
6. Adult women: Health maintenance/hazards appraisal, e.g., same as above for men, plus self and yearly breast exams, Pap smears.
7. Obstetrics: Complete check list; adequate or excessive weight gain; appropriate fetal growth; assessment and management of risk factors; completion of OB Ultrasound form.
8. Special: Appropriate consultation
Coordination of ancillary services
Dealing with financial constraints

H.13.0 CONTROLLED SUBSTANCES

The purpose of the controlled substance policy is to avoid prescribing medications and amounts that put patients at risk for substance abuse or diversion. Please be aware that residencies and physicians new to practice are targets of those that use controlled substances inappropriately. This does not mean that we do not treat pain, but you are required to do so judiciously.

H.13.1 Controlled Substance Prescription Policy.

1. **Oxycontin** will not be prescribed by providers in the Lone Star Family Health Center. The Lone Star Family Health Center Pharmacy will neither stock, nor dispense this medication.
2. **Hydrocodone (Vicodin[®], Norco[®], Lorcet[®])** prescriptions will be limited to a **maximum of 90 tablets per month with no refills**. Prescriptions may be refilled at the discretion of the provider at one month intervals. If patients experience pain that is not controlled by this, other medications, including long acting opiates, should be considered.
3. **Alprazolam (Xanax[®])** will not be prescribed by providers at the Lone Star Family Health Center. The Lone Star Family Health Center Pharmacy will neither stock, nor dispense this medication.
4. **Clonazepam (Klonopin[®])** will be substituted for Alprazolam (Xanax[®]) for long term use. Other benzodiazepines available at Lone Star Family Health Center include Diazepam (Valium[®]), Lorazepam (Ativan[®]), Temazepam (Restoril[®]), Oxazepam (Serax[®]) Clorazepate (Tranxene[®]) Chlordazepoxide (Librium). Due to the risk of seizure with overuse of these medicines, the pharmacists will contact providers when these are refilled early or prescribed in amounts inconsistent with proper use. These are limited to a 30 day supply with not refills
5. All controlled substance prescriptions require adequate documentation for their use in the patient's medical record and are limited to a 30 day supply with no refills. Patients should be seen in no less than **90 days. Refills for schedules other than schedule II may be done by phone between visit.**
6. It is the responsibility of speaking directly with a preceptor when a schedule II prescription is needed. Delegating this responsibility to a member of the staff is not acceptable.

NOTE: Prescribing outside of this policy requires a non-formulary request through the Lone Star P & T Committee. If prescriptions outside of this policy are not approved by the P & T Committee, the pharmacy will not fill the prescription and you are not authorized to write it.

The complete Controlled Substance Prescription Policy is available in the Lone Star Family Health Center Manual, section PS 51-100.

H.13.2 Controlled Substance Maintenance Therapy Contract

Patients maintained on controlled substances must sign the Controlled Substance Maintenance Therapy Contract. This contract is available in Healthmatics and in each exam room. By signing this contract, the patient gives informed consent to controlled substance therapy and states they understand certain risks associated with such. The patient also agrees to certain personal responsibilities and states that they understand circumstances under which their provider may discontinue prescribing these medications or discharge them from the practice.

I. **RISK MANAGEMENT/NO CODE ORDERS**

When problems concerning a patient's competence or the need to write a "no code" (Do Not Resuscitate) order arise, several resources are available for consultation. Such cases should always be discussed with the Attending faculty. Social Service and Risk Management are always of assistance. The resident should document the patient's and family's wishes at the time the resident first sees the patient. Once a decision regarding DNR status is determined, the resident obtains patient/power of attorney signature on the DNR form and counter-signs the form. All DNR forms or powers of attorney should be prominently documented in the record.

J. **URGENT PATIENT MESSAGES OR LAB**

Urgent patient messages will be paged to the patient's doctor. Critical lab values will be paged to the provider who ordered the test. If the physician is unable to be reached, critical information will be given to the preceptor. All laboratory results, except for those coming from the state lab, are automatically sent to the patient's electronic chart. These results should be checked daily and handled appropriately.

Residents carrying the second year pager will be paged for questions or problems related to continuity nursing home patients. After hours and on the weekends, pages will go to the resident on call. Nursing home labs will be put in the EHR as a scanned document.

K. **PATIENTS BEING SEEN IN CLINIC BY THE LONE STAR FACULTY OB/GYN**

If a patient of the Lone Star OB/GYN presents to the Emergency Department, the Emergency Department is to notify the Family Medicine resident carrying the second year call pager. If the patient is in need of admission or further evaluation. The Family Medicine resident will evaluate the patient and will discuss the patient with the Lone Star OB/GYN, if available, or with the Family Medicine faculty on call. If the patient needs to be admitted, she will be admitted under Family Medicine to OB/Pedi. When the Lone Star OB/GYN is unavailable and there is an urgent surgical or management issue that requires an OB/GYN, the OB backup physician who is contracted with Lone Star is to be called for any management issues that cannot be handled by the Family Medicine attending.

K.1.0. OUTPATIENT RESPONSIBILITIES

- Outpatient surgeries ("day surgeries") will be admitted and discharged completely by the Lone Star OB/GYN and the resident on the GYN Rotation. Questions on these patients will go directly to the Lone Star OB/GYN. Any resident involved in surgical cases or procedures are expected to provide proper documentation, including dictation of the surgical report, unless the attending physician chooses to do the documentation his or her self.

K.2.0 INPATIENT RESPONSIBILITIES

- Inpatient surgeries will be admitted directly to the family medicine OB/Peds service with the Lone Star OB/GYN consulted as the gynecologist on the case.
- At the time of admission, the Lone Star OB/GYN will speak to the OB/Peds resident about the case. Complicated cases will be discussed attending to attending.
- The OB/Peds team will round on the patient daily and document a progress note in the chart.

- The Lone Star OB/GYN will round on the patient as the surgical consultant.
- Medical issues during the day and at night will be handled by the OB/Peds resident and the family medicine OB/Peds attending or OB/GYN attending as appropriate. If the patient is admitted to or will be rounded on by the family medicine faculty, they should be aware of plans made with the OB/GYN faculty.
- Surgical issues that cannot be handled by the family medicine attending during the day and at night will be handled by the OB/Peds resident and the Lone Star OB/GYN or the attending gynecologist covering in the Lone Star OB/GYN's absence.

L. RESIDENT RESPONSIBILITIES

L. 1.0 GENERAL RESPONSIBILITIES

1. ATTENDANCE: Prompt attendance at all conferences is required. The curriculum covered in these conferences is designed to enhance the resident's learning experience, prepare the resident for the in-training and Board examinations, and establish a lifelong pattern of continuous learning. Prompt attendance demonstrates professionalism as well as respect and appreciation for those lecturing.
 - Any resident who forgets to present their assigned lecture at the scheduled time will be required to make up the lecture by immediately completing Challenger modules related to the topic of the missed lecture. Completion of these modules will be monitored by the resident's faculty advisor.
 - One unexcused absence from an afternoon conference will result in one night of call assigned to the resident; the call will be in-house and will be at the Program's discretion and/or in the resident being required to round with the Medicine team the following Saturday and Sunday or at the Program's discretion.
 - Three unexcused absences from individual lectures will result in the resident being required to round with the Medicine team the following Saturday morning or at the Program's discretion. Urgent patient care is an excused tardy.
 - More than five unexcused tardies will result in one extra night of in-house call to be assigned at the Program's discretion. Tardy is defined as being more than five minutes late to any lecture presented during the afternoon.

Only residents on night float, an away rotation not requiring clinic time, vacation, sick or administrative leave are excused from attending conferences. If a resident is going to be late or absent for any reason, they should contact the program coordinator or chief resident in advance of the conference. Attendance will be taken by the Chief Resident or his/her designee. Excused absences and excused tardies will be granted on a case-by-case basis by faculty.
2. RELIABILITY: Residents will assume responsibility for long term patient care and become **the family physician** for a segment of the clinic population for the three years the resident is here. The resident is expected to be in the clinic during assigned hours, and should not have to be paged. If a resident must miss clinic for emergencies, obstetrical deliveries or other reasons, the program director, residency coordinator and front office supervisor in the clinic must be notified, and the program director or designee must approve the absence.
3. CONTINUITY: Having the upper level continuity physician involved in a patient's hospital course is most critical at the start of the hospital stay.

1. The upper level continuity physician will be notified of their patient's admission, see the patient before morning rounds, and meet with the attending faculty member at 8:00 a.m. for verbal checkout, or, if the resident's rotation schedule precludes waiting to leave the hospital at 8 AM, give a detailed verbal checkout to the 3rd year medicine resident. During that first morning visit the resident can describe that the inpatient team will be around to see them later that day and continue to provide their day-to-day care (or similar).
 2. Care of the patient will be absorbed by the team on rounds.
 3. The upper level continuity physician may continue to see the patient if they choose, but otherwise will be available to the inpatient team by phone, be available for important family meetings, etc. (i.e. assist the team as needed to provide high-quality care for their patient and family).
 4. The discharging physician will schedule the patient in the continuity physician's clinic for follow up at an interval that is appropriate for the clinical circumstances, even if this requires overbooking. The inpatient team must therefore make sure the continuity physician gets a discharge summary or provides a good verbal hand-off when the follow-up appointment is made (for example, "they diuresed well, their discharge wt. was X on new lasix dose Y, I need you to review their home daily wts, check their volume status, listen to their lungs and check a BMP").
 5. Definition of a continuity patient: a patient who has been seen by a resident at least once during regular office hours and identifies that resident as their doctor.
4. CARE OF CONTINUITY OB PATIENTS: Each resident is expected to achieve five (5) continuity deliveries each year. Residents not on call should be available for their OB patients in labor. Continuity patients, by RRC definition, are to be managed in labor by their continuity resident. The team may provide initial assessment of all patients, but the management of that patient during labor remains the responsibility of the resident claiming the patient as a continuity patient. If unavailable at any time during the week, the resident must make arrangements in advance with residents on call or another resident to care for patients and this must be indicated in writing on the completed leave request form. Residents who are away Friday evening through Sunday afternoon may be excused from attending the delivery of a continuity patient. If the delivery is missed, the resident will not get credit for that continuity delivery. Residents should make their home and or cell phone number available to the Labor & Delivery staff and keep their pager on whenever they are not on away rotations during which the resident has no clinic responsibilities.
5. READING: Residents are expected to read about their patients. This is the best way to remember disease processes and management. This is also necessary to stay current and to develop good study habits for a lifetime. Use well known texts in various areas, management guides, the American Family Physician and other well known journals. There are available PDA resources, computer access to Medline and The Texas Medical Center (TMC) Library, Challenger and Infopoems which you should learn to use. Texts are available in the Call Room and Resident Precepting

rooms as well as through TMC Library. *Up To Date* is available on all hospital computers.
See Section O.

6. DOCUMENTATION OF EXPERIENCE: Minimum required procedure numbers are attached to this document as Appendix D. Residents should note that procedure clinic is assigned to the resident on Ambulatory Care to provide specialized teaching, training and honing of skills. Procedure clinic should not be viewed as the sole source of procedures for residents to perform. Each resident is responsible for documenting in a timely manner all pediatric patients, critically ill patients, and procedures performed in the hospital and the clinic. All procedures must be precepted by Family Medicine Faculty. Residents are to log procedures in the New Innovations software in a timely manner. The faculty member is automatically notified that they have procedures to review and the faculty will validate the resident's performance of and competency in performing that procedure. Residents must request that they be credentialed by the faculty to perform or teach a procedure. At the next faculty meeting, the resident's request will be approved or denied. If approved, the Program Coordinator will enter the information in the Hospital's Meditech system for access by selected nursing staff. Applications for privileges after graduation require documentation of procedures performed during residency. To become credentialed for a procedure, residents must be able to document previous experience. Different hospitals will require different numbers for credentialing. It is important to document all procedures performed. Neither the Program nor the Faculty will certify competence for procedures not recorded.
7. TIME LOGS: Turn in your time logs to the Assistant Residency Coordinator at the end of each rotation. Residents should list all times they are in Conroe Regional Medical Center Hospital, HealthSouth Surgery Center, Tomball Hospital, any other hospital, any physician office, and any other location. The location should also be listed on the form. A completion certificate will not be awarded until all required time logs are received by the residency office.
8. HOSPITAL DUTY: When on primary hospital services, team members not in clinic provide hospital coverage for inpatients and admissions. Residents are required to be in the hospital during these times.
9. RECRUITING: The chief resident, one resident from each class, faculty members and the program coordinator serve on the Recruitment Committee. However, all residents are required to attend the Program's annual recruitment meeting. Also, all residents are required to actively participate in recruiting faculty members and residents for the program. Examples of recruitment activities include but are not limited to: interviews, tours, meals, post-interview follow up, attendance at residency fairs, procedure workshops, Family Medicine Interest Group activities, and other activities as requested. Some of these activities occur after hours.

L. 2.0 NIGHT CALL/WEEKEND CALL

1. Up to the first three weeks of the year, all residents will take in-house call.
2. We have implemented a night float system for call.
 - a. The first year night float schedule is:

Call: Sunday – Thursday 5:00 p.m. – 7:00 a.m.

FMC: Friday Mornings

Friday Call: 5:00 p.m. – Saturday 6:00 a.m. by resident not on Night Float

First Year Residents begin Night Float the fourth week of the year.

b. The second year night float schedule is:

7:00 p.m. to 9:00 a.m. with rounds at 8:00 a.m with team

Saturday Call: 6:00 a.m. – Sunday 6:00 a.m. by resident not on Night Float

Sunday Call: 6:00 a.m. – 7:00 p.m. by resident not on Night Float

Holiday Call: Residents assigned to Night Float will take call the night before the first regular work day. The holiday will be considered the night before the holiday.

3. Third Year Residents take one week of in-house call for each second year residents.
4. Each Second Year Resident takes 6 weeks of Night
5. Checkout of patients must occur whenever there is a transfer of patient care or a change in shift.
6. Outside of the required in-house calls, third years will be allowed home call as back up coverage. Third years will be required to come in-house for CCU/ICU admissions, if needed by the first or second year resident on call and overflow. Residents taking at-home call must be able to arrive at the hospital within 20 minutes of being called.
7. All first and second year residents are required to be in the hospital at all times while on call.

L. 3.0 CALL DUTIES OF FIRST YEAR RESIDENT

The first year resident on the Night Float team works closely with the upper level resident and under their supervision and direction to care for patients in L&D, admissions in the ER and Family Medicine patients on the floor. When the first year night float resident arrives (s)he physically meets (finds as necessary) the leaving first year AND the upper level covering the hospital to receive sign-outs on all of the patients on the medicine service and take the “floor” patient pager. Their duties at night will be under the supervision and direction of the upper level night float resident and may include:

1. Follow in labor and delivery OB patients. These patients require H&P’s. Patients in active labor require a note every 1-2 hours until delivery.
2. Faculty must be notified of patients who are cared for in L&D, any complications, and for delivery
3. Evaluation of newborns, including completing newborn physical examination forms
4. Doing admissions/admission H&P’s on patients in the ER, direct admits, transfers to our service, or consults.
5. Be first assistant in C/Sections as experience and situation warrants.
6. Notify FMC continuity residents when their patients are admitted in labor or with complications. The FMC resident will provide further management instructions and prepare to come in for the delivery. **Residents are expected to manage their own patients in labor with faculty consultation and input.**
7. During the first six months of training, first year residents must discuss ABG’s, critical values, changes in therapy or condition, and all written or verbal orders, other than orders for diet, discontinuing Foleys, admission status and social work, with an upper level resident.
8. It is absolutely essential that notes be made in the medical records of patients in L&D to document discussions with other physicians and that these notes be made in a

timely manner. All patients for whom a change in therapy is ordered should have a note documenting the reason for the change.

9. All orders given during the first three months must be reviewed by the upper level resident.

L.4.0 CALL DUTIES OF UPPER LEVEL RESIDENT (IN-HOUSE)

The role of the upper level resident is to serve as leader of the night float team to accomplish all tasks occurring on that shift. This resident will direct and supervise the first year resident on night float in the care of all patients in L&D, admissions of all types, consults, and Family Medicine patients on the floor. When the upper level night float resident arrives (s)he physically meets the afternoon upper level resident that is being relieved AND the first-year night float resident. The upper level resident takes the medicine/ER pager and the OB pager. When the third year resident on Medicine arrives in the morning, that resident will take the "floor" pager from the second year night float resident who has held the pager since the first year resident left.

1. Be the first to evaluate all L&D patients for FMC and drop-in and unassigned patients, and other patients (with permission from attending). All OB patients sent home are to be checked out to Faculty on call and must have a billing card filled out. Must be physically present during the initial evaluation of all patients in L&D, subsequent re-evaluations and at all times of major decision making.
2. Take primary responsibility for all admissions. Evaluate ER patients to determine if admission is warranted. All admissions are discussed with the third year resident on call. See that admit order and note are written and H&P is dictated
3. Check out ICU admissions to third year resident on call.
4. Residents are to call the third year resident on home call if they have any questions regarding non-ICU admissions before calling the faculty member on call but are otherwise not obligated to do so.
5. Receive phone calls from the nursing home.
6. Round on all ICU/CCU patients in the evening and make brief note.
7. Evaluate, make adjustments to care and consult faculty on patients already in the hospital if significant change in status occurs.
8. Approve/Disapprove ER visits and admissions by managed care patients. The billing office must be notified of such approvals in a timely fashion.
9. Respond to all Code Blues.
10. Receive calls from the answering service and from Lone Star Clinic.
11. Night float residents caring for medicine patients who have been overflowed to the OB/Pedi teams should make every effort to provide a verbal checkout to the faculty member on that team at 8 AM in the dining room.
12. Be available to round with the inpatient medicine team from 8-9 AM.

L.5.0. UPPER LEVEL BACK-UP CALL (PGY-3)

1. Be available to come in promptly if residents in-house become overloaded or needs help. **TAKING CALL AT HOME IS A PRIVILEGE, NOT A RIGHT!**
2. If second year resident requests, assist as the primary physician for the neonate on babies of C/S if not participating in C/S. A second year resident, a third year resident, or faculty must be in-house to care for C/S babies.
3. Third year residents who have not completed their 30 required deliveries (in addition to 10 of their 15 continuity deliveries) will complete this requirement while on back-up call from home. The R3 will check with the OB resident at the beginning of the call night and will come to the hospital when the labor patient is 6-8 cm to supervise

the labor and subsequent delivery until the resident has a total of 30. The faculty on call will also be present to supervise the delivery.

4. All admissions by the second year resident are discussed with the third year resident.

L. 6.0 WEEKEND AND HOLIDAY ROUNDS

1. The standard times are: Pediatrics and OB Rounds routinely begin at 8:00 AM; Medicine rounds at 9:00 AM. Faculty members deviating from this schedule should discuss this with the residents.
2. The third year and second year residents on Medicine will split weekend coverage of rounds. That is, each will assist at rounds for two (2) weekends of each medicine rotation.

L. 7.0 CHIEF RESIDENT

Appointed by the Director after consulting the faculty and residents. Generally begins April 1st in his or her second year and ends one year later, and includes up to four half-days of administrative time each block and an additional \$2,000 in salary. DUTIES include:

1. Residents' Call Schedule and Vacation Schedules.
2. Conference Schedule, attendance and tracking of conferences.
3. Liaison between resident and faculty.
4. Help resolve conflicts between residents or between resident and faculty.
5. Assist with teaching activities.
6. Helps coordinate extra-curricular activities that reduce stress and improve morale.
7. Coordinate applicant dinners during interview season.
8. Coordinate evaluation of the conferences.
9. Attend required meetings.

M. **RESIDENCY ROTATIONS & SERVICES**

SUPERVISION OF RESIDENTS - First Three Months

1. First year residents must discuss ABG's, critical values, changes in therapy or condition, and all written or verbal orders, other than orders for diet, discontinuing Foleys, admission status and social work, with an upper level resident.
2. Residents covering the Pedi/OB service in the afternoon should check out all items as above to the upper level resident covering medicine.
3. It is absolutely essential that notes be made in the medical records of patients in L&D to document discussions with other physicians and that these notes be made in a timely fashion.

EIGHT FACTORS REQUIRING RESIDENT TO NOTIFY ATTENDING

1. Admission to the hospital
2. Transfer of the patient to the intensive care unit
3. Need for intubation or ventilatory support
4. Cardiac arrest or significant changes in hemodynamic status
5. Development of significant neurological changes
6. Development of major wound complications
7. Medication errors requiring clinical intervention
8. Any significant clinical problem that will require an invasive procedure or operation

IN-PATIENT PAGERS

936-525-1086 Medicine Floor Pager
936-525-1103 Medicine Admission Pager
936-525-1075 Labor and Delivery Pager
936-525-1087 Newborn Nursery/Post-partum/Pediatric Floor Pager

M. 1.0 INPATIENT MEDICINE SERVICE

The inpatient family medicine/adult medicine service involves a team consisting of at least two interns, two upper-level residents, and one faculty. The Family Medicine faculty member in charge of the service acts as the first consultant to the third year resident in charge of the team. That faculty member is ultimately responsible for the care of the patients.

Each resident is required to read about their patients' diseases in texts and/or journals and share their updated information with the entire team on rounds. This keeps rounds stimulating and educational.

During the day, the present members of the medicine team do admissions of all types, without distinction, (i.e, ER, transfers, consults, etc.); answer questions about patients already admitted; and accomplish all other work under the leadership, direction, delegation, and responsibility of the upper-level resident.

STRUCTURE OF MORNING ROUNDS.

- 8:00 a.m.: Entire medicine team meets in Dining Room A. Interesting admissions will be discussed at this time.
- X-ray rounds are accomplished using the PACS system in Dining room A
- Priority is for night float patients to be seen between 8:00 and 9:00 with the team

- See ICU patients
- See Floor patients
- Patients having procedures/leaving should be seen first

THIRD YEAR RESIDENT:

1. Supervises and acts as Team Leader Consultant for the first and second year residents.
2. (S)he is responsible for the care of all the patients on the service and will see patients as needed with the lower level residents on daily working rounds during which time treatment plans will be decided and appropriate testing ordered.
3. (S)he is encouraged to consult with the faculty at any time.
4. Has right of first refusal for any procedures done to patients, (Central lines, chest tubes, etc.), but is encouraged to help the resident directly responsible for the patient's inpatient care to learn the procedure. The faculty member or an appropriate specialist will be physically present to staff the procedure.
5. Receives the "floor" pager from the second year night float resident when rounds convene at 8 AM and carries this pager until the completion of morning rounds. This pager is then carried by the first year resident assigned to cover the hospital that afternoon.
6. Will make brief "patient status" rounds prior to morning report so that important changes and events can be evaluated and order written in a timely manner. Must see all new admissions as well as ICU patients with second year resident prior to rounds.
7. Will see patients in the emergency room on request of the Emergency Department physicians and, after appropriate evaluation, determine an appropriate course of treatment either as an outpatient or inpatient. Consultation with the faculty is mandatory if the patient is to be discharged from the ER in opposition to the ER doctor's desire for the patient to be admitted. The ER will require faculty attending to see patients when there is disagreement.
8. Organizes and runs rounds daily with Attending Faculty and other residents on the team, ensuring that patients having procedures or leaving the hospital are seen first. (On call Faculty and upper levels on medicine team round Saturday, Sunday and holidays.)
9. When patients are transferred from the ICU/CCU to the floor, the second year resident will write a transfer note and will continue to supervise the care of the patient (to provide continuity) until the point that 8 total patient units are reached according to the formula below. At that point, patients stepped down from ICU/CCU can be transferred to one of the first year residents on the medicine team.
 - a. ICU patient = 2 units
 - b. Floor patient = 1 unit

The above rule notwithstanding, the third year resident has the discretion to determine the distribution of patients amongst the members of the team while keeping in mind the spirit of continuity and what is best for our patients and also observing the rules regarding maximum patient numbers/units as separately outlined.
10. Delivers short relevant didactic lectures and assigns others to do so.
11. Reads EKG's with the assigned family medicine faculty member alternating with the second year resident.
12. Coordinates Grand Rounds.
13. Ensures that the continuity doctor has been notified of their patients' admission.
14. Responsible for initial billing documentation which must be reviewed with the attending to assure proper coding.

15. Checkout with resident on night float prior to the end of the night float shift.
16. May act as team leader for OB/Pedi team in afternoons.
17. Receive report on all upper level continuity patients on the service

SECOND YEAR RESIDENT:

1. Cares for the patients in the ICU/CCU and assists interns with critical floor patients. With the supervision of the faculty, the third year resident and the appropriate specialist consultant, (s)he will manage the care of the most critically ill patients including appropriate invasive monitoring and ventilator management. Will round on patients they admitted on the day prior. Continuity physician will see patients every day and maintain contact with the patient's family as applicable to the particular clinical situation.. See section L.1.3.
2. Occasionally, when the third year is not available, may have to assume some of the third year responsibilities. When complex patients are identified on the service, a second year resident also needs to be involved in the patient's care (coordinate consults, ensure appropriate care and documentation has been done, ensure problem notes are written prior to rounds by interns).
3. The second year resident will write an extensive admitting history and physical on patients admitted to the ICU/CCU, and daily or more frequent progress notes. These notes should review events since the last note by an upper level resident, changes in and current laboratory and vital signs, physical examination and plans. They will also make reference to consultant's recommendations where appropriate.
4. When patients are transferred from the ICU/CCU to the floor, the second year resident will write a transfer note and will continue to supervise the care of the patient (to provide continuity) until the point that 8 total patient units are reached according to the formula below. At that point, patients stepped down from ICU/CCU can be transferred to one of the first year residents on the medicine team.
 - a. ICU patient = 2 units
 - b. Floor patient = 1 unit

The third year resident has the discretion to determine the distribution of patients amongst the members of the team while keeping in mind the spirit of continuity and what is best for our patients and observing the rules regarding maximum patient numbers/units as separately outlined.

5. Will make "status rounds" on all ICU/CCU patients or critical floor patients prior to morning report so that appropriate status changes and orders may be noted and planned. Notes may be written on later rounds.
6. Will see patients in the emergency room on request of the Emergency Department physicians and, after appropriate evaluation, determine an appropriate course of treatment either as an outpatient observation or inpatient. Consultation with the faculty is encouraged and is mandatory if the patient is to be discharged from the ER in opposition to the ER doctor's desire for the patient to be admitted.
7. New admissions from ER need to be seen prior to morning report or prior to rounds when their status is critical or unstable.
8. Read EKG's with the assigned family medicine faculty member alternating with the third year resident.
9. Answer questions from nursing home(s) regarding our patients and notify the primary providers of any problems.
10. Does ER admissions until 7:00 pm and rounds on those patients the next day unless they are another upper-level's continuity patient and the patient has been checked out to the continuity resident.
11. May act as the OB/Pedi team leader in the afternoons.

12. Permitted and encouraged to leave morning rounds to attend code blue events.

FIRST YEAR RESIDENT:

1. The first year resident is the primary physicians for patients on our inpatient medical service and will see all new admissions assigned daily after rounds. Patients for whom they will assume responsibility at the conclusion of rounds will be assigned/divided by the upper-level resident that morning before rounds begins.
2. If a new patient admission presents between 8:00 AM and 7:00 PM, the Medicine team will do a complete evaluation including comprehensive history and physical. This will be recorded promptly as a pertinent admission note (Problem Oriented) and a dictation will be done at the same time.
3. When the patient has been admitted during the night, the resident on call will do the comprehensive history and physical, including a dictated H&P, and round on the patient the next morning with the team. The first year resident on the medicine service will perform his/her own evaluation of the patient (typically accomplished as part of rounds with the attending) as assigned by the third year resident and assume care of the patient after rounds.
4. All X-rays, EKG, CT's, MRI's, and all laboratory studies, will be reviewed daily, or if appropriate, more frequently. Notes detailing changes since the last note, changes in plans and orders, and notations of consultant's or faculty recommendations will be made in a timely manner. Residents are encouraged to view all imaging studies personally and not to rely on emergency department physicians or radiologist readings.
5. "Status rounds" are to be made on all patients prior to morning report. They can be brief, but must be detailed enough that the first year resident can discuss changes in each patient if called upon to do so.
6. Present patients to the third year resident and faculty attendings on formal rounds. Be prepared to present changes in pertinent studies, physical condition or history, and to make appropriate recommendations for therapy and management.
7. After the completion of morning rounds, the intern working in the hospital that afternoon takes the "floor pager" from the third year on the team.
8. Also present the patient to consultants when consultation is requested, contact other hospitals or physicians when necessary for additional information, contact social service agencies and mental health professionals as appropriate and when approved by faculty. All consultations must be approved by the third year resident or faculty.
9. Learn to insert central lines, chest tubes and other procedures necessary for patient management during the course of the rotation.

M. 2.0 INPATIENT OB/PEDI SERVICE

M.2.1 OB RULES OF THE ROAD

CONROE MEDICAL EDUCATION FOUNDATION

OB RULES OF THE ROAD

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- 7. Continuity OB Patients**
- 8. Weekend Coverage**

1. COMMUNICATION

This handout is designed to facilitate optimal obstetrical care for the patients of Lone Star Family Health Center throughout the pregnancy, intrapartum, and post-partum periods. In addition, it addresses appropriate care for the large number of “unassigned” obstetrical patients encountered in labor and delivery at Conroe Regional Medical Center.

The following, with the exception of certain hospital policies, are merely recommendations/guidelines for care. There are always circumstances that present as exceptions or unusual cases. The key is always *communication*. Communication must be complete and thorough between all parties involved – patients, residents, faculty, OB/GYN, nurses, and anesthesiologists.

2. PRENATAL CARE AT LONE STAR

- Phone calls from pregnant women wishing to become established clinic patients will be screened by the Lonestar OB nurse. New OB patients should be scheduled for an appointment within 72 hours. While the comprehensive intake H&P does not necessarily have to occur at this visit, it must be completed and documented by the third visit. Routine OB appointments may be overbooked with their provider if no open appointment is available.
- New OB appointments will be divided evenly between all residents, with preference given to the 1st and 2nd year residents. Initial OB visits that are 30 minutes in length should provide the resident with enough time to complete the initial assessment and complete the forms as appropriate.
- A designated nurse will coordinate the appointments and care of residency continuity OB patients. This nurse will fax OB records to L&D at 28 and 36 weeks. OB records will have documentation which includes the dates the records are faxed to L&D. This nurse will also be responsible for obtaining charts for the mandatory weekly OB conference/ chart review.
- The OB charts will be reviewed will be attended by the Lonestar OB nurse, the OB resident, and the available FP-OB faculty. All OB patients should be checked out with the preceptor prior to the patient leaving the clinic.
- The OB resident is ultimately responsible for guaranteeing that patients due that week have a copy of the clinic chart on L&D.
- Residents are responsible for delivery of prenatal care to their continuity patients. A designated buddy system will be used.
- If residents are unavailable to provide care for their continuity patients, designated coverage must be arranged. The continuity provider is responsible for arranging the coverage and informing the necessary faculty, residents and staff in a timely fashion.

- At the present time, ACOG prenatal forms will be used, i.e., “paper charts”. These forms must be completed by the patient’s third visit. In the future we will start using EHR for prenatal patients. In the interim, all orders including labs, imaging, procedures and other studies must be entered into the EHR. Residents are encouraged to document in the EHR as completely as possible.
- 100% of OB visits will be precepted, by a faculty member with OB privileges at CRMC. The preceptor will then sign off on these charts, indicating that they have reviewed the case and agree with the resident's management.
- A progress note *is not* required at every visit, but progress notes are often helpful to document instructions to patients or to clarify the plan of care. The column on the right of the chart is available to make notes if a full progress note is not indicated.
- All prenatal charts will be clearly labeled with the continuity provider's name.
- OB consult visits with an OB/GYN do not take the place of routine OB visits with the residents.
- A specific plan of care should be in place for each and every patient and visits scheduled accordingly. For example, an insulin requiring diabetic at 10 weeks should not go 4 weeks between visits. Plans of care will be developed at the beginning of the patient’s prenatal care via consultation with FP-OB faculty and OB/GYN faculty. It is the responsibility of the resident to clearly document this plan of care in the chart. It is recommended that residents inform their nurse or medical assistant of the frequency of prenatal visit for their patients so that these patients can get priority when schedules become available.

3 RECOMMENDATIONS FOR INITIAL OB VISITS

For patients presenting between 4 and 9 weeks EGA

Confirm pregnancy with urine hCG

Perform detailed history to stratify patient's obstetric risk status

Perform physical exam

Determine if ultrasound and/or OB/GYN consultation is indicated. While a consult may be indicated during the initial visit, most can wait until the complete OB work-up has been performed by the resident.

Provide prenatal counseling, prenatal vitamins, and literature

Schedule follow-up visit at 10-14wk EGA, at which time a complete physical exam, OB profile and other indicated blood work are done. Address acute problems such as hyperemesis gravidarum, UTI or bleeding.

For patients presenting initially after 9 weeks EGA

Confirm pregnancy with urine hCG

Perform detailed history and physical, identifying high risk factors

Provide prenatal counseling, vitamins, and literature

Auscultate FHTs with Doppler

If FHTs are present, obtain prenatal labs and any other indicated blood work.

Perform appropriate physical exam

Determine if ultrasound and/or OB/GYN consultation is indicated

Schedule a follow-up visit within 2-4 weeks. If a comprehensive prenatal physical exam has not yet been performed, it should be done during this follow-up visit

4. OB CONSULTS (outpatient prenatal care consults)

- Consults will be requested and scheduled once the resident has evaluated the OB patient and completed the ACOG prenatal record form. The patient should be discussed with the FP-OB faculty before a decision is made that an OB consult is indicated.
- Routine, uncomplicated OB patients can be followed throughout their pregnancies without consultation from an obstetrician.
- Consultation visits for OB patients do not substitute for routine prenatal visits with the continuity resident.

5. LABOR & DELIVERY CARE

- Everyone must be familiar with mandated hospital policies, particularly those that require consultation.
- All L&D patients will be evaluated by the on-call OB resident within 20 minutes and reviewed with the FM-OB on call
- The faculty on primary call for L&D is the admitting physician.
- Once a history and ***focused*** physical exam has been performed, the resident will contact the FP-OB on call to formulate a plan of care. If a consult is indicated, a formal written request for OB/GYN consultation will be entered into the chart at this time.
- The resident covering OB will make sure the appropriate form for billing is completed.
- Patients on L&D require close observation and monitoring. Written progress notes are expected every two (2) hours for patients in active labor and those undergoing induction. Observation patients may need progress notes less frequently.
- If a consulting physician changes the plan of care initiated by the admitting physician, the consultant will discuss the changes with the admitting physician and document agreement with the change in therapy. If agreement cannot be reached between the admitting and consulting physicians, the admitting physician may opt to transfer care to the consultant and sign off the case.

- All inductions will be discussed with the FP-OB attending who will be on call during the time of induction.
- A timely progress note will be placed in the record by the FP-OB attending confirming the indication for induction.
- Once the patient is admitted to L&D, the admission forms should be filled out in their entirety. (orders, H&P, plan of care) The EDC should be determined and recorded based on the best clinical criteria. Review of previous records should be used to verify how dating was established.
- Any change of care for L&D patients requires a progress note and notification of the FP-OB attending. Before performing AROM, placing an FSE or an IUPC, starting an induction or augmentation, or ordering an epidural, the resident must discuss this with the FP-OB. If a resident is uncomfortable with any procedure or plan, he/she should contact an upper level resident, FP-OB, or OB/GYN for assistance.
- With every shift change, the oncoming resident should check-in at L&D to familiarize him/herself with each patient's case and inform the nurses of the change in coverage. Both Lonestar and non-continuity patients should be discussed at check-out. The outgoing FP-OB faculty will contact the incoming FP-OB faculty in a similar fashion.
- Continuity OB patients do not require a note from the FP-OB attending in order to get an epidural.
- It is the resident's responsibility to confirm prenatal records are on the L&D chart. While this may be difficult for non-continuity patients, every attempt should be made to obtain these records. These attempts should be documented in the chart. Past records should be reviewed to ensure that the dating criteria used to determine the EDC are reasonable.

6. OB/GYN BACK-UP

- Consultation by OB/GYN does not transfer care unless agreed upon by the OB/GYN and the admitting FP-OB.
- Risk stratification forms will be used by the L&D nurse to determine which patients require an OB/GYN consult. The FP-OB must be notified as soon as the patient is risk-stratified as requiring an OB/GYN consult.
- It does not matter who notifies the FP-OB or OB/GYN on call. It can be the resident, the nurse, or the FPC faculty.
- All requests for consultation will be documented in the medical record.

- Only under very unusual circumstances should the OB/GYN consultant be contacted without the knowledge of the FP-OB faculty. These patients are admitted to the FP-OB attending and they must be aware of everything going on with the patient. Should a resident or nurse feel uncomfortable with a plan of care, or changes in the plan of care, they should first contact the FP-OB faculty on call. If a degree of discomfort persists, they may contact the OB/GYN consultant on call without hesitation. If a nurse is similarly uncomfortable with the plan from OB/GYN, he/she should continue to follow the chain of command set forth in hospital policy.
- The OB/GYN will not decline a consult or refuse to assume primary management of a high risk patient upon the request of the FP-OB faculty.

7. CONTINUITY OBSTETRICAL PATIENTS

- A resident scheduling an induction for his/her continuity OB patient should be available during the patient's labor and be able to be physically present on L&D within 20 minutes. If the resident is unable to manage the patient, the FP-OB must be informed about who will be covering by the continuity physician.
- All continuity OB patients require progress notes every two (2) hours when in active labor or undergoing induction.
- The responsibility for management of a continuity patient lies with the patient's primary resident physician. When a continuity patient is admitted from the clinic, the resident will send orders and an admission H&P to L&D. This resident will also make sure the prenatal record has been sent. The resident covering L & D will assume management for another resident's continuity patient on L&D until that resident can take over.
- When a resident is unavailable to manage his/her continuity patient, he/she must either arrange for a resident to manage the laboring patient or notify if the patient will go to the team. *This resident should preferably be from the same class year as the continuity provider.*
- When a resident is unavailable because of vacation or scheduled rotation, he/she must designate either the OB/Pedi team or another resident to cover his/her patients who present to L&D. This arrangement must be communicated to the FP-OB faculty and to the Program Director via the residency coordinator who will be informed in writing and will provide updated schedules for Labor and Delivery.
- *If a resident is unavailable and has not arranged coverage, the continuity patient is managed by the on-call resident of the same PGY level as the continuity resident.* A buddy system will be implemented by July 1st each year.
- FP-OB faculty on call will be notified if a resident is unavailable to care for a continuity patient and no coverage arrangements have been made. The Program Director will also be notified if this occurs.

- The initial evaluation of the continuity OB not sent from clinic will be done by the OB resident covering L&D. This resident will then call the patient's continuity resident OB provider and the FP-OB faculty on call. Responsibility for this patient then reverts to the continuity resident provider unless previous arrangements have been made. Communication with the faculty also is the continuity provider's responsibility, except in an emergency. All communication should be accomplished by the resident seeing and examining the patient.
- The resident who manages the patient's labor will have priority for performing the delivery or assisting in an operative delivery.

8. WEEKEND COVERAGE

- If the FP faculty on call is covering obstetrics as well as Med/Peds, the OB/GYN faculty on call will provide primary coverage of L&D during weekend and holiday mornings. After rounds conclude, the FP-OB will notify the OB/GYN on call.

M.2.2 OB/PEDI SERVICE

STRUCTURE OF MORNING ROUNDS

- 8:00 AM: Meet in Dining Room A to discuss interesting admissions with the medicine team. L & D Rounds. Review charts, data, strips, etc., see patients, write timed note, bill for nighttime evaluations already discharged.
- Before 9:00 AM: See babies and speak to patients.
- Post-partum rounds
- See Medicine Team overflow patients
- Circumcisions are worked in (must be done with faculty present).

UPPER LEVEL RESIDENT

The upper level resident serves as the team leader of the OB/Pedi team and is responsible for directing and supervising first year residents on the team. With the assistance of the interns on the OB/Pedi service, the upper level resident manages patients in L&D, newborns in Level I nursery, women in the post partum ward and pediatric patients. The upper level resident is exclusively responsible for babies in the Level II Nursery. It follows that the upper-level on the OB/Pedi team knows the normal newborns, the post partum patients, and the pediatric patients. The upper level resident, with the first year resident, is the first to evaluate all L&D patients for FMC and drop-in and unassigned patients, and other patients (with permission from attending). All OB patients sent home are to be checked out to Faculty on call and must have a billing card filled out. The upper level resident must be physically present with the first year resident during the initial evaluation of all patients in L&D, subsequent re-evaluations and at all times of major decision making.

The upper level resident will see NICU follow up patients with the neonatologist in "Teddy Bear" clinic and will provide a didactics lecture once during each OB Pedi rotation.

FIRST YEAR RESIDENT:

First year residents on the OB/Pedi team provide care under the direct supervision of the upper level resident on the team to care for patients in L&D, for babies in the Level I nursery, follow postpartum patients on the floor and care for pediatric inpatients.

SPECIAL NOTES FOR OB PATIENTS

1. PIH: Refer to protocol in L&D for treatment of toxemia.
2. Vaginal Bleeding: Unless at term, **do not** perform digital cervical exams on OB patients. Consult with staff or senior resident.
3. PROM: (PREMATURE RUPTURE OF MEMBRANES) implies that the patient is not or was not in active labor when the membranes ruptured.

Do **only** sterile speculum exams on patients presenting with PROM and not in labor. Obtain Group B Strep, Chlamydia and GC cultures. Note pooling, test with nitrazine paper and check for ferning. Notify the Faculty of the admission and discuss management.

DO NOT DO DIGITAL EXAM ON PATIENT WITH RUPTURED MEMBRANES UNLESS SHE IS AT TERM AND IN ACTIVE LABOR.

READING: You are expected to supplement your experience by reading relevant texts and articles during your OB rotations. Consult your faculty and available curriculum for good study materials.

M.3.0 GYN ROTATION

Clinic Responsibilities:

1. Responsible for seeing patients in the FM Gynecology/Colposcopy Clinic.
2. Other Clinic responsibilities remain the same.

Other Responsibilities

1. Care for the GYN patients on the service as primary physician.
2. Assist in training of first year on service by brief didactic sessions based on topical readings.
3. See patients in Gynecology clinics with the Family Medicine and/or Gynecology faculty.
4. Assist in surgery with all GYN patients whose primary doctor is not assisting.

M. 4.0. SURGERY ROTATIONS

The 8 weeks of general surgery rotations involve assignment to work with one or more of the private attending surgeons at Conroe Regional Medical Center, at the Surgery Center, and at the private physician's office. Typically, four weeks will be spent in an inpatient setting, and four weeks will be spent in an outpatient setting. Time will be spent with the surgeon in the operating room, making rounds on inpatients, seeing inpatient and emergency room consultations with the surgeon, and observing patients in the surgeon's office. Responsibilities will include patient evaluations and H&Ps. Residents are required to attend didactic sessions and to be present in the Family Medicine Center during scheduled clinic times. Residents may not be excused from clinic without prior approval of one of the Program director or designee. Continue to share night call responsibilities with the other first year residents.

Second and third year residents rotating on the surgical subspecialties have much the same responsibilities. They will assist the subspecialist at surgery, in making rounds, in doing consultations and in seeing patients in the surgeon's office. Residents are required to be at didactic sessions and in clinic when they are scheduled. Residents may not be excused from clinic without prior approval of one of the FPC faculty.

On Surgery, due to the duty hour requirements, weekend rounds are not made unless the resident is on call.

Surgical subspecialty rotations include ENT, ophthalmology, urology and orthopedics.

M. 5.0 EMERGENCY MEDICINE ROTATION

During the two months of required rotations through the Emergency Department at CRMC, the resident will be under the supervision of one of the full time ED physicians. The ED schedule is structured by the supervising ED physician, which includes time in the fast track, as well as the emergency department. It allows the resident to see patients on the Service at several different times of day in different parts of the week. This allows the opportunity to perform quite a few procedures under the supervision of the ED physician faculty. During the ED rotation, the resident will not usually take night call rotation with the other residents.

M.6.0 ELECTIVE ROTATIONS

1. Residents should contact their attending physician prior to the start of a given rotation. At this time, they will give the attending physician their own clinic schedule in the FMC so that they may coordinate to the benefit of all concerned when and where to report for duty. It is important to remember that the Residency Review Committee and the American Council of Graduate Medical Education (ACGME) stresses continuity of care and the resident's prime responsibility to their continuity patients in the FMC.
2. The resident should request from their attending a suggested reading list or reading materials for that rotation.
3. Residents should round with the attending, see clinic patients, do H&Ps, do consults and procedures, etc., as prescribed by the attending. However, the Program's didactics, meetings and Continuity clinic are the resident's first priorities (unless excused by the Program Director).
4. Other specific duties should be discussed with the attending at the start of the elective.
5. If any conflicts arise, they should be discussed with the Program Director.
6. A research elective is encouraged.

M. 7.0 NURSING HOME PATIENTS/GERIATRICS

Nursing Home patients are also a part of each resident's patient panel. Continuity nursing home patients will be assigned by the Program to each resident. All third year residents will complete a Geriatric rotation.

1. Nursing Home rounds are made the first Tuesday afternoon of each month. Medicare guidelines dictate the frequency of routine nursing home visits depending on the patient's level of care (skilled or unskilled). The third year resident on the Medicine service will round on their continuity nursing home patients on Monday before the Tuesday of nursing home rounds. The resident's continuity clinic will begin at 2 PM that Monday. The 3rd year resident on medicine will also be responsible for patient admitted to the short term SNF (Park Manor) and will see those patients with the Adult medicine faculty attending at the conclusion of rounds.

2. Residents carrying the second year call pager are on call for nursing home patients. The faculty covering medicine admissions will be the available preceptor for all nursing home calls.
3. All residents have a “buddy” to take call for them while on vacation. These buddies are identified by the residents and the information will be supplied by the Program.
4. Responsibilities: Primary Physician for two nursing home residents:
 - a. Initial and yearly H&P
 - b. Monthly PN
 - c. Arrange call coverage when not available with buddy
 - d. Read modules as assigned
 - e. Evaluate assigned patients as needed
6. You are expected to see your “buddy’s” continuity nursing home patient during nursing home rounds if (s)he is unable to attend.

M. 8.0 HOME VISITS

1. In compliance with RRC guidelines, the Conroe Family Medicine Residency requires that all residents perform at least two home visits each year on a continuity clinic patient.
2. At least two afternoons each academic year will be designated for home visits with faculty members.
3. A special home visit “doctor’s bag” containing a blood pressure cuff and thermometer is available for check-out from the middle nursing station.
4. The Home Visit Documentation Worksheet (attached) is to be completed for the visit and then scanned into the electronic health record upon returning to the clinic.
5. The resident is to complete a fee ticket for each home visit from the billing department upon returning to the clinic.
6. Unique features of the home visit – including assessment of falls risk, home and bathroom safety, ability to perform ADL’s (Activities of Daily Living), available food, transportation, and sanitation – are to be evaluated and documented by the visiting team.

M. 9.0 SCHEDULED TIME OFF

M.9.1 All Residents

While away from the program but not on vacation, residents are to keep their pagers on. This allows urgent calls which may have been made by mistake **to be corrected**. It also allows the resident to be available should one of their continuity obstetric patients need you for delivery.

M.9.2. First Year Residents

1. Work such as finishing a History and Physical on a newly admitted patient will have been completed.
2. Covering for another first year resident on a service will require that the resident covering has satisfactorily completed a month on that service. It will also require that the patient census is low enough for the covering resident to handle. This will require approval of the Program director or designee.
3. On Medicine Service, each intern receives four weekend days off. Also, one upper level resident on medicine will always be at weekend rounds to teach and facilitate getting rounds finished. When an upper level is covering rounds for a first year resident, they will be considered “the upper level at rounds.” Second years will do two weekends. Third years will do two weekends. The second and third year residents on the Medicine Service will cover for interns’ patients four weekend days

per block. If there is only one upper level resident, they will cover two weekends; the upper level on call will cover the other two weekends.

4. Upper level residents on OB and Ped rotations will provide the first year on their service with weekend coverage once during the rotation for the first six months. After the first six months, the first year Pedi and OB first years will cross-cover for each other.
5. Other: On surgery weekend rounds with the surgeon are not made unless you are on call. On Emergency Medicine, the schedule is arranged by the ED liaison. Rural rotations are at the discretion of the rural preceptor.

N. **LECTURE CURRICULUM GUIDE**

(Generally Tuesday 12:30-5:00 p.m. and the Last Friday of Each Block 2:00-5:00 p.m.)

PURPOSE:

1. To cover the breadth of problems presented to the Family Physician.
2. To emphasize the Family Medicine perspective and philosophy.
3. To emphasize the Family Physician's role in today's medical community and prepare for the future.
4. To cover the most frequent problems and procedures essential to the practice of Family Medicine, as well as some of the more uncommon problems.

METHOD:

1. Lectures in an 18 month format, allowing time to cover all the material and repeat it twice during a resident's three years of training.
2. Stresses active participation by the residents.

ATTENDANCE: This is an integral part of the education process therefore attendance is required. See L.1.0 General Responsibilities.

O. **FACULTY RESPONSIBILITIES**

1. To see that all areas of resident responsibilities are carried out and to take corrective action if they are not. For example, if a resident on call the night before makes an error that is discovered at morning rounds, the faculty member will usually ask the resident at the same level to notify the person involved and explain the error or ask them to take remedial action. (See also *Conroe Medical Education Foundation General Information for Residents*, "Corrective Action.") Be available to answer questions, direct to resources, provide guidance, stimulate discussion, precept or model procedures or behaviors for residents and ancillary health care providers according to their assigned duties as needed.
2. Perform their scheduled duties as coordinated by the Faculty coordinator.
3. Stay informed concerning Residency policies and policy changes.
4. Provide immediate and long-term feedback to the residents about their performance.
5. Support the residents, staff and each other in whatever ways are possible.
6. Stay medically up to date and work to continually improve teaching skills.
7. Provide conferences from a Family Physician perspective as requested and scheduled by the Curriculum Coordinator, also to assist residents as needed in providing their post-rotation noon conferences.

8. Work with the Director to see that the program meets and/or exceeds all requirements of the ABFM and RRC.
9. Complete chart audits in a timely manner using the guidelines of the Patient Care Checklist.
10. Develop research projects and grant proposals.
11. Provide letters of reference as appropriate for current and prior residents who are interviewing for a position. Letters of reference will not be given until the personnel file has been reviewed.

P. Access to Academic Resources

P.1.0 Houston Academy of Medicine Texas Medical Center Library. Each resident is provided with library access, including remote and off-campus access. Residents are responsible for any library fees they incur, including but not limited to library card replacement fees.

P.2.0 Moody Library. Article retrieval is available through the Moody Library in Galveston. The process for retrieval follows.

1. Start at the PubMed website at <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>.
2. Down the left side, under PubMed Services, click on SINGLE CITATION to search for your article.
3. Enter the search terms for your article like the author's name or date of publication.
4. Once you have found your article, at the top of the abstract there will be a drop down menu next to the Send To button. Choose ORDER and then click on SEND TO.
5. User ID: hcahealthcare Password: ewhaley
6. Select GO.
7. ACCEPT the copyright.
8. Under Delivery Information, enter the fax number or e-mail address of choice. The default option is Elaine Whaley's fax number and e-mail address.
9. Click on SEND ORDER.
10. **Log the article in the red folder next to the computer in the 1st/2nd year call room.**
 - The articles may get to you within one day, but the older the article the longer it will take to retrieve (up to 3-4 days).
 - If you need a rush placed on the article, call Janet Burk (409) 772-2386 at the Moody Library.
 - These articles cost \$9.00. So be sure the article you are retrieving is the article you need.

P.3.0 Up-to-Date. Up-to-Date is located on all hospital computers.

P.4.0 InfoRetriever. All residents receive a subscription to InfoRetriever. This is to be loaded on PDA's and you should receive daily evidence by Lone Star e-mail.

P.5.0 Med-Challenger. All residents have access to Med-Challenger modules. Residents are encouraged to use this valuable resource for added reading on rotations.

**RESIDENT ADVANCEMENT FORM
Conroe Family Medicine Residency
PGY 1 TO PGY 2**

Resident's Name: _____ **Date:** _____

Advisor's Name: _____ **Date:** _____

	YES	NO	COMMENTS
PATIENT CARE			
The Resident has received satisfactory evaluations in all clinic rotations, or has completed remediation.			
The Resident is able to perform with limited independence in clinical situations.			
The Resident shows developing clinical judgment in patient care.			
The Resident has established and maintained documentation of procedural competence/experience and has met the minimum number of suggested procedures.			
The Resident has maintained required patient logs.			
The Resident has recorded: 150 continuity visits in the Lone Star Family Health Center 5 continuity deliveries this academic year 2 home visits this academic year 2 continuity nursing home patients this academic year			
Comments:			
MEDICAL KNOWLEDGE			
The Resident has an adequate level of medical knowledge for PGY level.			
The Resident is aware of limitations in his/her knowledge base.			
The Resident has developed an analytical approach to clinical situations and care.			
The Resident has satisfactorily completed all required exams or has adequately completed remediation.			
The Resident has satisfactorily completed the most recent in-service exam with scores > 400, or has completed assigned Academic Rx.			
The Resident has attended 80% of the required lectures or has adequately completed remediation.			
Comments:			
SYSTEMS-BASED PRACTICE			
The Resident has proposed a scholarly project.			
The Resident has maintained a current Curriculum Vitae on file.			
The Resident is competent to teach and supervise medical students.			
The Resident is able to use technology and access data to support their own education.			
Comments:			

INTERPERSONAL AND COMMUNICATION SKILLS		
The Resident has developed appropriate interpersonal and communication skills that result in teaming with patients, their families and professional associates		
Comments:		
PROFESSIONALISM		
The Resident has developed time management and organizational skills.		
The Resident conducts him/herself in a professional manner while performing his/her duties.		
The resident demonstrates sensitivity to culture, age, gender, disabilities.		
The Resident's medical record keeping is thorough, complete and timely.		
The Resident regularly attends and actively participates in academic and community activities sponsored by the Department of Family Practice.		
The Resident has kept residency portfolio up-to-date.		
The Resident has given lectures/presentations as assigned.		
The Resident is also up-to-date on the following: Hospital medical records Clinic medical records including review of labs & x-rays Medicare time sheets (pink sheets)		
Comments:		
SYSTEMS BASED PRACTICE		
The Resident allocates resources, coordinates services, and advocates for quality, cost-effective care.		
Comments:		

COMMENTS: Has met PGY-1 competencies and recommend advancement from PGY-1 to PGY-2.

Resident's Signature: _____

Date: _____

Faculty Advisor's Signature: _____

Date: _____

Program Director's Signature: _____

Date: _____

RESIDENT ADVANCEMENT FORM
Conroe Family Medicine Residency
PGY 2 TO PGY 3

Resident's Name: _____ Date: _____

Advisor's Name: _____ Date: _____

	YES	NO	COMMENTS
PATIENT CARE			
The Resident has received satisfactory evaluations in all clinic rotations, or has completed remediation.			
The Resident is able to perform with limited independence in clinical situations.			
The Resident shows developing clinical judgment in patient care.			
The Resident has established and maintained documentation of procedural competence/experience and has met the minimum number of suggested procedures.			
The Resident has maintained required patient logs.			
The Resident has recorded: Minimum of 650 continuity visits in the Lone Star Family Health Center 10 continuity deliveries 2 home visits this academic year 2 continuity nursing home patients this academic year			
Comments:			
MEDICAL KNOWLEDGE			
The Resident has an adequate level of medical knowledge for PGY level.			
The Resident is aware of limitations in his/her knowledge base.			
The Resident has developed an analytical approach to clinical situations and care.			
The Resident has satisfactorily completed all required exams or has adequately completed remediation.			
The Resident has satisfactorily completed the most recent in-service exam with scores > 400, or has completed assigned Academic Rx.			
The Resident has attended 80% of the required lectures or has adequately completed remediation.			
Comments:			
SYSTEMS-BASED PRACTICE			
The Resident has developed and implemented a scholarly project.			
The Resident has maintained a current Curriculum Vitae on file.			
The Resident is competent to teach and supervise medical students and junior residents.			
The Resident is able to use technology and access data to support their own education.			
Comments:			

INTERPERSONAL AND COMMUNICATION SKILLS		
The Resident has developed appropriate interpersonal and communication skills that result in teaming with patients, their families and professional associates		
Comments:		
PROFESSIONALISM		
The Resident has developed time management and organizational skills.		
The Resident conducts him/herself in a professional manner while performing his/her duties.		
The resident demonstrates sensitivity to culture, age, gender, disabilities.		
The Resident's medical record keeping is thorough, complete and timely.		
The Resident regularly attends and actively participates in academic and community activities sponsored by the Department of Family Practice.		
The Resident has kept residency portfolio up-to-date.		
The Resident has given lectures/presentations as assigned.		
The Resident is also up-to-date on the following: Hospital medical records Clinic medical records including review of labs & x-rays Medicare time sheets (pink sheets)		
Comments:		
SYSTEMS BASED PRACTICE		
The Resident allocates resources, coordinates services, and advocates for quality, cost-effective care.		
Comments:		

COMMENTS: Has met PGY-2 competencies and recommend advancement from PGY-2 to PGY-3.

Resident's Signature: _____

Date: _____

Faculty Advisor's Signature: _____

Date: _____

Program Director's Signature: _____

Date: _____

RESIDENT ADVANCEMENT FORM
Conroe Family Medicine Residency
Graduation of PGY-3

Resident's Name: _____ Date: _____

Advisor's Name: _____ Date: _____

	YES	NO	COMMENTS
PATIENT CARE			
The Resident has received satisfactory evaluations in all clinic rotations, or has completed remediation.			
The Resident is able to perform with limited independence in clinical situations.			
The Resident shows developing clinical judgment in patient care.			
The Resident has established and maintained documentation of procedural competence/experience and has met the minimum number of suggested procedures.			
The Resident has maintained & completed required procedure logs.			
The Resident has recorded: Minimum of 1650 continuity visits in the Lone Star clinic Minimum of 40 deliveries (10 continuity + 30 other deliveries) 2 home visits this academic year 2 continuity nursing home patients this academic year			
Comments:			
MEDICAL KNOWLEDGE			
The Resident has an adequate level of medical knowledge for PGY level.			
The Resident is aware of limitations in his/her knowledge base.			
The Resident has developed an analytical approach to clinical situations and care.			
The Resident has satisfactorily completed all required exams or has adequately completed remediation.			
The Resident has satisfactorily completed the most recent in-service exam with scores > 400, or has completed assigned Academic Rx.			
The Resident has attended 80% of the required lectures or has adequately completed remediation.			
Comments:			
SYSTEMS-BASED PRACTICE			
The Resident has developed & presented a completed scholarly project.			
The Resident has maintained a current Curriculum Vitae on file.			
The Resident is competent to teach and supervise medical students and junior residents.			
The Resident is able to use technology and access data to support their own education.			
Comments:			
INTERPERSONAL AND COMMUNICATION SKILLS			
The Resident has developed appropriate interpersonal and communication skills that result in teaming with patients, their families and professional associates.			

Comments:			
PROFESSIONALISM			
The Resident has developed time management and organizational skills.			
The Resident conducts him/herself in a professional manner while performing his/her duties.			
The resident demonstrates sensitivity to culture, age, gender, disabilities.			
The Resident's medical record keeping is thorough, complete and timely.			
The Resident regularly attends and actively participates in academic and community activities sponsored by the Department of Family Practice.			
The Resident has kept residency portfolio up-to-date.			
The Resident has given lectures/presentations as assigned.			
The Resident is also up-to-date on the following: Hospital medical records Clinic medical records including review of labs & x-rays Medicare time sheets (pink sheets)			
Comments:			
SYSTEMS BASED PRACTICE			
The Resident allocates resources, coordinates services, and advocates for quality, cost-effective care.			
Comments:			

COMMENTS:

This resident has demonstrated the core competencies of family medicine and is able to perform independently. He/she has met the requirements for graduation.

Resident's Signature: _____

Date: _____

Faculty Advisor's Signature: _____

Date: _____

Program Director's Signature: _____

Date: _____

PROCEDURE EXPECTATIONS AND REQUIREMENTS FOR TRAINING
Conroe Family Medicine Residency
2009-2010

- Residents are encouraged to seek out opportunities for procedures on their rotations and while on call.
- Residents will complete procedure grid below for each quarterly meeting with faculty advisor.
- By March 1, third year residents will submit total procedure numbers to the program in anticipation of graduation.

EXPECTED PROCEDURES	1ST YEAR MINIMUM GOAL	1ST YEAR ACTUAL	2ND YEAR MINIMUM GOAL	2ND YEAR ACTUAL	3RD YEAR MINIMUM GOAL	3RD YEAR ACTUAL	<u>SUGGESTED NUMBER DURING RESIDENCY</u>	<u>MINIMUM REQUIRED FOR GRADUATION</u>
Circumcision	5		5		2		25	10
Biopsy-Punch	0		2		3		10	5
Biopsy-Excisional	0		2		3		10	5
Cryotherapy/Liquid Nitrogen	2		3		5		10	10
Laceration Repair	2		2		1		30	5
Toenail Wedge Resection	0		1		1		10	2
Tympanogram	0		1		1		25	2
Paracentesis	0		1		0		20	1
Pap smear	5		5		5		25	15
ICU Patients	NA		15		0		25	15
NICU Patients	NA		2		0		10	2
Family Meeting (coordinate & facilitate)	0		1		0		5	1
IV insertion	1		2		0		10	2

Central venous line insertion	0		2		0		10	2
Arterial line insertion	0		2		0		30	2
Endotracheal intubation	0		5		0		30	2
Endometrial Biopsy	0		2		2		10	2
Exercise Stress Test	0		3		2		50	5
Colposcopy	0		5		1		25	5
Dilation & Curettage	0		1		0		30	1
Lumbar Puncture -- adult	1		1		0		10	2
Lumbar Puncture -- child	1		1		0		15 including infants	2
Joint injection	0		3		2		15	5
Casting	0		3		2		15	5
Neonatal Resuscitation	2		2		0		10	4
Flexible Sigmoidoscopy	0		2		2		50 flex sigs or 50 colonoscopies	4 flex sigs or 4 colonoscopies
Colonoscopy	0		5		0			
OB Deliveries	25		5		5		75 with evidence of complication management + forceps or vacuum extraction	25 (total of 40 deliveries including continuity deliveries)
Continuity OB Deliveries	5		5		5		20	15
Vasectomy	0		0		1		10	1
IUD	0		1		1		10	1
Home Visits	4 (2 in the fall; 2 in the spring)		4		4		6	6 total = 2 per academic year

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