CONROE FAMILY MEDICINE RESIDENCY PROGRAM
RESIDENT POLICY MANUAL

2017-8

“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 Revised: February 10, 2016
A. **ABFM 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 successful private practice, medico-legal issues, medical ethics, and community needs such that they are enabled to practice effectively and efficiently;

9. Demonstrate mastery of electronic health records (EHR) and point of care informatics;

10. Successfully pass the examination for Board Certification and meet all the other requirements for Certification by the American Board of Family Medicine and/or the American Osteopathic Board of Family Physicians 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 360-degree evaluations, 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 Director of Medical Education. 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. Chairman, Peter Bigler M.D., Darshan Tolat, M.D., Jennifer Chilek, M.D.
Designated Institutional Official: Stephen McKernan, D.O.
Program Director Core Residency: Lata Joshi, M.D.,
Co-Chief Residents: Brian McNelis, M.D., Cristina Hamme, M.D.
Administrator: Karen Harwell, CPA
Designated Institutional Official Designee: Jennie Faulkner, C-TAGME

C 2.0 CONROE PROGRAM FACULTY AND STAFF

2.1 Full Time Faculty
Lata Joshi, M.D., Program Director, Family Physician with Obstetrics
Marwan Al-khudhair, M.D., Family Physician
Pamela Ferry, M.D., Family Physician with Obstetrics
Yvette Gordon, M.D., Obstetrics and Gynecology
Adel Ibrahim, M.D., Family Physician & Geriatrics
Mark Nichols, M.D., Obstetrics and Gynecology
Daniel Porter, M.D., Family Physician with Obstetrics
Jonathan Santos, M.D., Family Physician with Obstetrics
Ra Nae Stanton, M.D., Family Physician with Obstetrics

2.2 Part Time Faculty
Edward Davidson, Ph.D., Behavioral Scientist
Iqnoor Bains, M.D.
Tri-County MHMR LPC’s

2.3 Clinical Instructors
Valerie Powell, PharmD., Pharmacist
Hollie Stallings, R.Ph., Pharmacist

2.4 Support Staff
Jennie Faulkner, C-TAGME, Medical Education Director
Derick Dennis, Assistant Education Coordinator
Gretchen Smith, Assistant Education 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 Family Medicine Review Committee (RC). 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.

<table>
<thead>
<tr>
<th>D.1.0. Year 1</th>
<th>D.2.0. Year 2</th>
<th>D.3.0. Year 3</th>
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</thead>
<tbody>
<tr>
<td>Inpatient Adult Medicine</td>
<td>ICU</td>
<td>Inpatient Adult Medicine</td>
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<tr>
<td>16 weeks*</td>
<td>8 weeks</td>
<td>8 Weeks</td>
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<tr>
<td>*-One week of NF may count toward Inpatient Adult Medicine at the Director’s discretion</td>
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<tr>
<td>Pediatrics/Nursery</td>
<td>Private Pediatrics</td>
<td>Sports Medicine</td>
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<tr>
<td>8 weeks (Incl. Community Medicine)</td>
<td>4 weeks</td>
<td>4 weeks</td>
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<tr>
<td>Obstetrics</td>
<td>Gynecology</td>
<td>Psychiatry</td>
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<tr>
<td>8 weeks</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Night Float</td>
<td>OB/Pedi (including NICU)</td>
<td>Radiology</td>
</tr>
<tr>
<td>5 weeks*</td>
<td>8 weeks</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Emergency Medicine</td>
<td>Geriatrics</td>
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<tr>
<td>2 weeks</td>
<td>6 weeks</td>
<td>2 weeks</td>
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<tr>
<td>Night Float</td>
<td>Night Float</td>
<td>4 weeks</td>
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<tr>
<td>4 weeks</td>
<td>2 Weeks</td>
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<tr>
<td>Practice Management</td>
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<tr>
<td>100 hours (longitudinal over 3 years), including 2-week seminar in year 3</td>
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<tr>
<td>Ambulatory Care</td>
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<tr>
<td>4 weeks: 2 weeks in year 1 and 2 weeks in year 2 or year 3</td>
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<tr>
<td>Approved combinations of the following rotations may be completed during years 1, 2 or 3 but must be completed prior to graduation:</td>
<td></td>
<td></td>
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<tr>
<td>General Surgery (8 weeks)</td>
<td>Internal Medicine</td>
<td></td>
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<tr>
<td>Surgical Subspecialties</td>
<td>Pulmonology (4 weeks)</td>
<td></td>
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<tr>
<td>Orthopedic Surgery (4 weeks)</td>
<td>Cardiology (4 weeks)</td>
<td></td>
</tr>
<tr>
<td>Otolaryngology (2 weeks)</td>
<td>Nephrology (4 weeks)</td>
<td></td>
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<tr>
<td>Ophthalmology (2 weeks)</td>
<td>Dermatology (4 weeks)</td>
<td></td>
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<tr>
<td>Urology (2 weeks)</td>
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<tr>
<td>Electives</td>
<td></td>
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<tr>
<td>20 weeks</td>
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<tr>
<td>Family Medicine</td>
<td>Family Medicine</td>
<td>Family Medicine</td>
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<tr>
<td>2 half-days per week</td>
<td>3 half-days per week</td>
<td>4 half-days per week</td>
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</tbody>
</table>
D. 4.0 ROTATION AND CLINIC SCHEDULE REQUESTS

The rotations are assigned to first year residents. Second and third year residents will meet with the Medical Education Director to develop their desired rotation schedules. The clinic schedule is established by the Medical Education Director and approved by the Program Director. Any significant deviations of this must be approved by the Program Director or Medical Education Director.

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. The Conroe Family Medicine Residency requires that all residents complete at least two scholarly projects during residency, one which must be a quality improvement project completed under the direction of a core faculty member.
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. Residents must email their scholarly projects to the Medical Education Director. Copies will be kept on file in the Resident Portfolios maintained in that office.
9. A completion certificate will not be awarded until the resident has completed the scholarly activity requirement outlined in #1 and #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. Twice 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. In addition, twice each year each resident will be evaluated by the Clinical Competency Committee using the ACGME Family Medicine Milestones.

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 Medical Education Director. 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 AND IN-SERVICE EXAMINATIONS

Each year 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. All scores are sent to the Program. 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 390, they are expected to have a 50-50 chance of passing the examination. A score of 440 would increase the possibility of passing to over 90%.

Bonuses will be added to the resident discretionary accounts as follows:

<table>
<thead>
<tr>
<th>Year Level</th>
<th>$50.00</th>
<th>$100.00</th>
<th>$50.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Score &gt; 500</td>
<td>Score &gt; 600</td>
<td>Raised score from last year and score is &gt; 390.</td>
</tr>
<tr>
<td>2</td>
<td>Score &gt; 460</td>
<td>Score &gt; 500</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Score &gt; 420</td>
<td>Score &gt; 440</td>
<td>N/A</td>
</tr>
</tbody>
</table>

All AOA residents must also sit for the In-Service Examination.

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. 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. Hospital policy requires that residents wear a white jacket at all times in the hospital, regardless of whether scrubs or business attire is worn. Additionally, physicians must wear a hospital ID badge while at CRMC. 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. When on outside rotations, especially with private attendings, scrubs should not be worn except on the general surgery rotation or unless approved by the attending.

**H. FAMILY MEDICINE PRACTICE (FMP)**

The **Lone Star Family Health Center** is the site of each resident’s “private practice” for the three years. The facilities include Residents’ Rooms, procedure rooms, fetal dopplers, colposcope, LEEP machine, tympanometer, spirometer, flexible sigmoidoscope, ultrasound equipment, EST cardiac equipment, PFT equipment, other equipment appropriate for broad scope family medicine, 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 Allscripts on a daily basis to answer questions, review labs, and refill medications.

**HOURS:** Morning arrival time by 8:00, first appointment 8:00, last appointment 11:15, and Afternoon arrival time by 1:00 p.m., first appointment 1:00 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. If a resident must be absent they must personally notify the Program Director and the Medical Education Director.**

**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.

7. Continuity patients are defined as the physician whom the patient identifies as “their doctor” and who has seen the patient in clinic.

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.

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>New patient</td>
<td>2 slots</td>
<td></td>
</tr>
<tr>
<td>Well Woman Exam</td>
<td>2 slots</td>
<td></td>
</tr>
<tr>
<td>EPSDT/Texas Health Steps Exam</td>
<td>2 slots</td>
<td></td>
</tr>
<tr>
<td>New OB</td>
<td>2 slots</td>
<td></td>
</tr>
<tr>
<td>Routine OB</td>
<td>1 slot</td>
<td></td>
</tr>
<tr>
<td>Hospital Discharge Follow-up</td>
<td>2 slots, when available</td>
<td></td>
</tr>
<tr>
<td>Follow-up Appointments</td>
<td>1 slot</td>
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</tbody>
</table>

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 every two months 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.

Second Year: Three, occasionally two, half days per week, 11-12 patients per session with 2 slot appointments as described above.

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. All procedures must be done with a faculty member present.

The Family Medicine 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 FMP.” Residents meeting the following standards of excellence in the Family Medicine Center will receive a discretionary account bonus as outlined below.

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

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 WALK-IN PATIENTS**

The focus 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 “Walk-In”. 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 clinic. In all 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, PFT, 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.

**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 while they are still in the clinic 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**

- All 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 IN THE ROOM.**
- 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 clinic are not allowed. 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 staff 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 off; 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. Providers are not permitted to waive charges without the permission of Lone Star’s CEO, CFO or COO.

H. 9.2 WORKMAN’S COMPENSATION

All patients being seen for injuries they allegedly sustained on their jobs must 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 COO to get permission for the patient to be seen at Lone Star Family Health Center.

H. 10.0 INTERPERSONAL RELATIONS

LSCHC employs over 100 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®) Clonazepate (Tranxene®) Chlordiazepoxide (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 or a maximum of 90 tablets for 30 days supply with no 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 visits.
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 Allscripts. 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. This contract must be completed at the time of the first prescription being written.

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. 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 OR LAB MESSAGES**

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 first with the Family Medicine faculty member on call and with the Lone Star OB/GYN, if needed. 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 (in-house and will be at the Program’s discretion) and/or in the resident being required to round with the Medicine team on a 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 medical education director 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. POLICY ON CONDUCT. All residents sign a policy on conduct agreeing to return pages to any patient care area within 15 minutes. Pages to the ER must be returned within this timeframe.

3. 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, medical education director and director of clinic operations in the clinic must be notified, and the program director or designee must approve the absence.

4. **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/OR identifies that resident as their doctor.

5. **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 FM-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.
6. **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 electronic resources, computer access to UNTHSC-TOM 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 TCOM Library. *Up To Date* is available on all hospital computers. See Section O.

7. **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 procedures. At the next faculty meeting, the resident’s request will be approved or denied. If approved, the Medical Education Director will notify CMRC’s Medical Staff Office. 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.

8. **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, 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.

9. **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.

10. **RECRUITING:** The chief residents, one resident from each class, faculty members and the Medical Education Director 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. Residents calling in sick on call should arrange for coverage by another member of their class. When no one in their class is available, the attending faculty member must provide approval for the third year resident on call to cover the call shift.

2. We have implemented a call system incorporating night float as follows:
   a. **First Year Residents:**

   **Night Float:** Monday-Friday (inclusive) 8:00 PM-12:00 Noon or completion of attending rounds and patient work, whichever is earlier. One abbreviated clinic session/week.
   They will round on either ob/pedi or medicine patients on Saturday morning, depending on who the Day Call intern is.

   **Weekday Long Call:** Monday – Friday until 8:00 PM
   This will be taken by an intern on the Medicine and Ob/Peds service and will be maximum once a week on a rotational basis. When the medicine intern takes long call, they will pick up and round on these patients the next day (up to their maximum # of patients). If they are already at their max or if the OB/Peds intern is taking long call, then the upper level on long call (Pgy 3 or 2) will determine who sees these patients the following day. This will be relayed to the night float team at 8 pm checkout as they may also have to see a few patients admitted that day. Attempts will be made to have the Ob/Peds intern to have long call on Fridays to alleviate some of this.

   **Saturday and Sunday Day Call:** 6:00AM-8:00PM
   Intern will be from the medicine team, and will round on medicine floor patients Saturday and Sunday morning. This intern can only take a maximum of one call weekend a block if on medicine.
   If there are more than 4 interns on medicine, one weekend will be covered by an intern from OB/Peds team.

   **Saturday and Sunday Night Call:** 8:00 PM – 12:00 Noon the next day or completion of attending rounds, whichever is earlier.
   Intern should be from the ob/pedi team and round on ob/pedi Sunday and Monday morning.
   Intern must leave by 12:00PM the day following call.

   * Intern not on Medicine or Ob/Peds may be required to take one night call weekend per block.

   **Residents must have 4 days free each block.**

   b. **Second Year Residents:**

   **Night Float:** Monday-Friday (inclusive) 8:00PM-12:00 Noon or completion of attending rounds and patient work, whichever is earlier. One abbreviated clinic session/week.
Will round on overnight admits on Saturday morning and some floor patients to help evenly distribute patient load.

**ICU Resident: Long Call:** Upper level long call (5-8 PM) is divided among ICU and third year FM residents as assigned by the Medical Education Director. This resident also rounds on their patients one weekend out of their two week rotation.

**Saturday and Sunday Day Call:** 6:00AM-8:00PM
Resident will round on ICU patients, and possibly some floor patients to evenly distribute patients on both days (when 3rd year is the rounding resident), and only floor patients when ICU resident is rounding. Patient distribution will be made keeping in mind that this resident may be called to do admits and attend to L&D.

c. **Third Year Residents:**

**Long Call:** Upper level long call (5-8 PM) is divided among ICU and third year FM residents as assigned by the Medical Education Director.

**Weekday Home Call:** Monday-Thursday, 5:00 PM – 6:00 AM the next day (never done by the 3rd year on Medicine) See section L5.0 for details.

**Weekend Call:** Friday 5:00 PM - Monday 12:00 Noon
Fri 5:00PM - Sun 8:00 PM will be home call with the same duties as above.
Sun 8:00PM – Mon 6:00AM will be in-house call by the same resident. (This resident attends to their morning responsibilities for whichever rotation/service they are on starting at 8:00 AM Monday after checking out to upper level on medicine and finish for that day at 12:00PM).

*The third year on medicine will be not be able to take any weekend call or overnight weekday call during that month except for long call or weekend home call.

d. **Notes/FAQ’s:** 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.

Rounds begin at 8 AM typically (or at the discretion of the attending). Barring emergencies, it is assumed that rounds will begin with the night float residents’ (or the overnight residents on the weekends) patients and continue until they are seen. After they are all seen the night float/overnight residents will leave rounds and work independently, accomplishing tasks specified on rounds or others as necessary to facilitate the patients’ care. Patients who will be staying in the hospital are transferred to the care of the daytime team as otherwise outlined. The night float residents are then able to leave the hospital.

As outlined below, the night float/night residents will round on patients they assumed the care of and any subsequent admissions they had during their shift in the morning before attending rounds. The night float residents
should review previous patients in detail to become thoroughly familiar with them.

Checkout of patients must occur whenever there is a transfer of patient care or a change in shift. See Section L.7.

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, and as needed by the first or second year resident on call for help and overflow. Residents taking at-home call must be able to arrive at the hospital within 20 minutes of being called.

All first and second year residents are required to be in the hospital at all times while on call. The only exception to this is when PGY3 residents are on the NF rotation. During those times the PGY2 resident may take home call and is subject to the requirements above.

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:

Following labor and delivery patients- These patients require H&P’s. Patients in active labor require a note every 1-2 hours until delivery.

Evaluation of newborns, including completing newborn physical examination forms.

Doing admissions: admission H&P’s on patients in the ER, direct admits, transfers to our service, or consults.

Being first assistant in C/Sections as experience and situation warrants.

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).

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.
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.

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); See section L.2**

The role of the upper level resident is to serve as the leader of the night 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 resident arrives (s)he physically meets the afternoon upper level resident that is being relieved AND the first-year resident. They will:

1. Be the first to evaluate all L&D patients. 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 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. See that admit orders and notes are written and H&P is dictated. Take over ER admissions at 4:45 p.m.
3. Check out ICU admissions to third year resident on call in advance of calling faculty.
4. 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. Round on all ICU/CCU patients in the evening and make brief notes.
6. Evaluate, make adjustments to care and consult faculty on patients already in the hospital if significant change in status occurs.
7. Approve/Disapprove ER visits and admissions by managed care patients. The billing office must be notified of such approvals in a timely fashion.
8. Respond to all Code Blues.
9. Be available to round with the inpatient medicine team as outlined above.
10. See pediatric patients (not nursery) before bedtime. This could be as simple as a brief chart review, check-in with the nurse regarding the patient’s status, an assessment of the child in the room to detect anything untoward or needing attention, and a brief not in the chart, i.e., for a stable patient. A child whose status is changing or more tenuous will require more.

**L.5.0. UPPER LEVEL BACK-UP CALL (PGY-3); See Section L.2**

1. Be available to come in promptly if residents in-house become overloaded or need help. **Third year residents taking call must be able to get to the hospital with in 20 minutes from the time they are called. TAKING CALL AT HOME IS A PRIVILEGE, NOT A RIGHT! All of those taking home call must be prepared with necessary arrangements. Anyone living outside of the required distance must stay in-house or close by.**
2. Take phone calls from the nursing home.
3. Receive calls from the answering service and Lone Star Clinic.
4. If second year resident requests, serve as the primary physician for the neonates of C-sections. A second year resident, a third year resident, or faculty must be in-house to care for C/S babies.
5. 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.

6. Come to the hospital to participate in new admissions to the ICU/CCU.

L.6.0. SIGN-OUTS

Good sign-outs provide concise, yet adequately complete information on patients (i.e. “every single thing I need to know about the patient and nothing else”) so that there is a seamless transition in their care and caregiver. There should not be unanticipated patient developments to the new caregiver that could have been anticipated had the sign-out been of good quality. The caregiver at all times should be able to answer nursing questions over the phone with reasonable patient familiarity. With an interval history and exam and a brief review of the chart at the bedside they should be able to do everything from evaluate a change in status of the patient to initiate patient-specific critical-care.

The upper-level resident in the hospital is at all times ultimately responsible for all of the patients under our service’s care. Junior residents are given duties to participate in this care to a very significant degree but must be supervised carefully by the upper-level as determined by their skill level and the supervisory requirements of the FM-RC.

Upper-level to upper-level sign-outs and transitions are critically important. This should happen after completion of morning rounds for the afternoon hospital resident(s), between the afternoon resident(s) and the evening call residents when they arrive, and to the night float residents at 7:45 PM. First year residents must attend these when on duty or coming on duty in order to prepare then to do a good job while carrying the “floor” pager and the “newborn nursery/post-partum/pediatrics floor” pager. First year residents are certainly encouraged to participate in sign-outs with vigor, but this will always be in the presence of the upper-level(s) so that they are equally aware of all patient issues (for which, again, they are ultimately responsible). This is not optional - find each other - signouts can occur anywhere (call room, ICU, ER, nurses’ station, etc.), except in patient rooms, while respecting patient confidentiality. Increasing transitions-in-care must lead to serious rigor and attention to detail in signouts.

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.
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

RESPONSIBILITY FOR PENDING ADMISSIONS
Residents must complete two floor admissions or one ICU admission received in the hour before shift change up to thirty minutes before shift change (i.e. 2 floor admissions after 6 PM, all admissions after 6:30 PM will be the responsibility of the incoming resident).
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 up-to-date 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.

No pre-printed standing orders should be used unless they are hospital-mandated as part of the patient record based on a certain condition. The only other exception to this is the ICU TPN form, which should be completed with great attention and learning.

All medication dosing/pharmacokinetics/drug level assays must be determined and ordered by the resident, i.e. “Vancomycin 1g IV q12 hours, pharmacy to follow and dose” is not acceptable.

STRUCTURE OF MORNING ROUNDS.

• 8:00 AM.: Entire medicine team and OB/Pedi team meets in Dining Room A. A case will be presented from 8-8:30AM by the night residents under the direction and guidance of the medicine-team third-year resident. Note well: All residents on the teams should be in the conference room and seated at 8AM, the ONLY exceptions being an admission in the ER, a delivery, or a critically-ill patient that needs immediate attention. If this educational tool is to be maintained consistently these guidelines must be followed closely.

• Pertinent X-rays are reviewed using the PACS system in Dining Room A.

• Excepting situations where patients need more urgent attention, patients of the night residents are seen first to facilitate their timely departure as outlined above in the call section of this document.

THIRD YEAR RESIDENT:

1. Acts as the team leader and supervises the first and second year residents.
2. 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.
3. Is encouraged to consult with the faculty at any time.
4. Has the right of first refusal for any procedures performed for patients (central lines, chest tubes, etc.), but is encouraged to help the resident directly responsible for the patient’s care to learn the procedure.
5. Receives the “floor” pager from the 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 orders written in a timely manner. Must see all new admissions as well as ICU patients prior to rounds.

7. See patients in the emergency department at the request of the ED 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.

8. Perform/supervise admissions to the service. Please note: Interns are expected to participate in ER admissions with the understanding that the upper levels will actively participate as a teacher, guide, evaluator, and collaborator.

9. On afternoons covering the hospital: perform ER admissions of which they are notified until 7:45 pm and round 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. The upper level “long call” resident covers ER admissions received after 7:45 p.m.

10. Facilitates morning case presentation from 8-8:30AM.

11. The third year resident has the full 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.

12. Delivers short relevant didactic lectures and assigns others to do so.

13. Read EKG’s with the assigned family medicine faculty member alternating with the second year resident.

14. Ensures that continuity physicians have been notified of their patient’s admission.

15. Responsible for billing (please see billing section).

16. May act as team leader for OB/Pedi team in afternoons.

17. Receive report on all upper level continuity patients on the service.

18. Round the first and third weekends of each block, unless other assignments have been agreed to by the ICU resident.

SECOND YEAR RESIDENT:

1. Cares for the patients on our service in the ICU/CCU and assists interns with critical floor patients. With the supervision of the faculty, the third year resident, and the appropriate consultants, (s)he will manage the care of the most critically ill patients, including appropriate invasive monitoring and ventilator management.

2. Occasionally, when the third year is not available, may have to assume some of the third year responsibilities.

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, changes in and current laboratory and vital signs, physical examination and plans.

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 10 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. (Note: this rule is
not intended to preclude the second year from seeing all ICU patients of any number
but to allow a guideline for them to follow step down patients).
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. See patients in the emergency department at the request of the ED 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.

6. Perform/supervise admissions to the service. Please note: Interns are expected to
participate in ER admissions with the understanding that the upper levels will
actively participate as a teacher, guide, evaluator, and collaborator.

7. On afternoons covering the hospital: perform ER admissions of which they are
notified until 7:45 pm and round 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. The upper level “long call” resident covers ER admissions
received after 7:45 p.m.

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. May be required act as the OB/Pedi team leader in the afternoon.

11. Attend all “code blues.”

12. Round the second and fourth weekends of each block, unless other arrangements
have been agreed to by the third year on the team.

FIRST YEAR RESIDENT:

1. The first year resident is the primary physicians for patients on our inpatient medical
and OB/Pediatric services under the supervision of the teams’ upper level resident.

2. When patients are admitted during the night, the resident on call will do
comprehensive history and physical exams, round on and write notes on the patients
before attending rounds and participate in attending rounds. The first year residents
on the medicine service will participate in the patient’s evaluation and team
discussion on attending rounds then assume care of the patients after rounds as
assigned by the third year resident.

3. 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.

4. “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.

5. 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.
6. 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.

7. Present patients 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.

8. Learn to insert central lines, chest tubes and other procedures necessary for patient management during the course of the rotation.

9. Interns are to participate in ER admissions; however, this is with the understanding that the upper level will actively participate as a teacher, guide, evaluator, and collaborator.
M. 2.0 INPATIENT OB/PEDI SERVICE

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.

Interns are to participate in ER admissions; however, this is with the understanding that the upper level will actively participate as a teacher, guide, evaluator, collaborator

The upper level resident provide a didactics lecture at least 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 WITHOUT CHECKING WITH THE UPPER LEVEL RESIDENT/FACULTY.

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.
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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.

- 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, we use the EHR for prenatal patients. 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.

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
  patients. 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 pages should be answered immediately.

- All L&D patients will be evaluated by the on-call OB resident within 20 minutes and
  reviewed with the FM-OB on call.

- All patients presenting to L&D must have an upper level as part of their initial
  evaluation, not an unaccompanied first year. This is a bylaws regulation, the
  violation of which could result in grave consequences.

- 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 faculty member on primary OB 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 FM-OB attending who will be on call during the time of 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 FM-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 FM-OB. If a resident is uncomfortable with any procedure or plan, he/she should contact an upper level resident, FM-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 FM-OB faculty will contact the incoming FM-OB faculty in a similar fashion.

- Continuity OB patients do not require a note from the FM-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 FM-OB.

- Risk stratification forms will be used by the L&D nurse to determine which patients require an OB/GYN consult. The FM-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 FM-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 FM-OB faculty. These patients are admitted to the FM-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 FM-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 FM-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 FM-OB must be informed about who will be covering for 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 FM-OB faculty and to the Program Director via the medical education director who will be informed in writing and will provide updated schedules for Labor and Delivery. Patients should also be notified.

• *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.
• FM-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 FM-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.

M.3.0 GYN ROTATION

Clinic Responsibilities:
1. Responsible for seeing patients in the FM Gynecology/Colposcopy Clinic, and surgical cases with the OB/GYN faculty member(s).
2. Other Clinic responsibilities remain the same.
3. When not in continuity clinic, the resident should shadow the OB/GYN faculty member(s).

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 Practice 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 program director or designee.

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 blocks of required rotations through the Emergency Department at CRMC, the resident will be under the supervision of one of the full time ED physicians. For every two weeks on the rotation, regardless of whether or not vacation is taken, 50 hours must be completed. Shifts should be 10 hours and must include night/weekend shifts. 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. No call shifts may be scheduled concurrent with ED shifts. Resident must contact the ED staff prior to the start of the rotation to ensure that the resident is able to write notes and prescriptions in the ED EHR system.

**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 FMP 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, the American Council of Graduate Medical Education (ACGME), the American Osteopathic College of Family Physicians (ACOFP) and the American Osteopathic Association (AOA) stress continuity of care and the resident’s prime responsibility to their continuity patients in the FMP.

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 residents will complete a Geriatric rotation.
1. Nursing Home rounds are made every Wednesday afternoon of every week. Residents carrying the second year call pager are on call for nursing home patients during work hours to cover for residents on vacations, or night float. The faculty covering medicine admissions will be the available preceptor for all nursing home calls, should consulting with the attending is needed during work hours. **If a resident is unable to attend nursing home rounds, they must have their absence approved in advance by Dr. Ibrahim. If the resident does not attend nursing home rounds and does not have an approved absence, the resident will have to use vacation time to cover their time away from their assigned responsibility.**

2. Responsibilities: Primary Physician for at least two long term patients:
   a. Initial and yearly H&P
   b. Monthly PN
   c. If you will be away on the first Wednesday of the month, you must inform Dr. Ibrahim one week in advance of vacation, CME or sick leave and one week in advance of night float
   d. Notify Dr. Ibrahim in advance if you will be unavailable for call coverage
   e. Read modules as assigned
   f. Evaluate assigned patients as needed

3. You are expected to see your “buddy’s” continuity nursing home patient during nursing home rounds if (s)he is unable to attend.

4. New Admissions: **All patients must have an H&P within 48 hours of admission.**
   a. Daytime Admissions. All new admissions during work hours go to Dr. Ibrahim.
   b. After Hours Admissions. All the new admissions will be called to and reviewed by the third year on call. If the resident is concerned about a certain patient, he or she should call the attending on call to discuss the issue with the attending.
   c. Weekend Admissions. Admissions from Thursday - Sunday will be taken care of by the third year resident on call for the weekend.
      1. Patients admitted Thursday or Friday must be seen on Saturday morning.
      2. Patients admitted Saturday and Sunday, should be seen before the resident arrives for Sunday evening call. If this is impossible, the resident must see the patient(s) before 8 AM on Monday.

5. Protocol to triage new admissions:
   1. Get all demographics Name, room No#, DOB, insurance (medicare/medicaid/TXHS).
   2. Get Admission diagnosis + other diagnoses.
   3. Get BMP especially creatinine.
   4. Review all medications and adjust doses based on their estimated GFR.
   5. Call the attending on call and check out to them your plan of care.
   6. Send Dr. Adel Ibrahim an email with demographics/diagnoses/important updates, so that he can assign the patient ASAP.
   7. **If the email is not sent, the resident taking the call will continue to take care of the patient until the patient is assigned to another resident.**
   8. **As a consequence of not reporting an admission to Dr. Ibrahim in a timely manner, the resident will be assigned to round on a Saturday or Sunday on medicine service.**
M. 8.0 HOME VISITS

1. In compliance with RC guidelines, the Conroe Family Medicine Residency requires that all residents perform at least two home visits on continuity clinic patients, one of whom is an elderly patient.
2. Home visits should be held during the second Ambulatory Care block.
3. A special home visit “doctor’s bag” containing a blood pressure cuff and thermometer is available for check-out from the orange pod.
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. 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 and third year residents will divide the 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. Rural rotations are at the discretion of the rural preceptor.
N. **LECTURE CURRICULUM GUIDE**
(Generally Wednesday 12:15-4:00 p.m. and the third Friday of Each Block 1:00-5:00 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.

**PAGERS:** During didactics, pagers will move to the upper level residents with the third year resident on medicine will do admissions. The OB pager will be held by the upper level on OB/Peds unless the intern on the service is taking care of an active labor patient and they want to continue with that patient.

**ELECTRONICS:** Cellphone and laptop use will be limited to looking up clinical information pertinent to the topic being covered by the speaker.

**PAGERS:** Demonstration of professionalism and good manners is expected by all residents.

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.
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 FM-RC.
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.
12. Serve as faculty advisor to assigned residents.
13. Participation in faculty development.
15. Oversight of quality improvement projects.

P. Access to Academic Resources

P.1.0 University of North Texas Health Science Center. 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 Up-to-Date. Up-to-Date is located on all hospital computers.

P.3.0 Essential Evidence. 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.4.0 Challenger. All residents have access to Challenger modules. Residents are encouraged to use this valuable resource for added reading on rotations.

P.5 Prescriber’s Letter.
Appendix A.

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

Resident’s Name: ____________________________ Date: _________________
Advisor’s Name: ____________________________ Date: _________________

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 continuity nursing home patients this academic year

ACGME Milestones: Level 2

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.

ACGME Milestones: Level 2

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.

ACGME Milestones: Level 2

Comments:
<table>
<thead>
<tr>
<th><strong>INTERPERSONAL AND COMMUNICATION SKILLS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Resident has developed appropriate interpersonal and communication skills that result in teaming with patients, their families and professional associates</td>
<td></td>
</tr>
<tr>
<td>ACGME Milestones: Level 2</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PROFESSIONALISM</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Resident has developed time management and organizational skills.</td>
<td></td>
</tr>
<tr>
<td>The Resident conducts him/herself in a professional manner while performing his/her duties.</td>
<td></td>
</tr>
<tr>
<td>The resident demonstrates sensitivity to culture, age, gender, disabilities.</td>
<td></td>
</tr>
<tr>
<td>The Resident's medical record keeping is thorough, complete and timely.</td>
<td></td>
</tr>
<tr>
<td>The Resident regularly attends and actively participates in academic activities sponsored by the Department of Family Medicine.</td>
<td></td>
</tr>
<tr>
<td>The Resident has kept residency portfolio up-to-date.</td>
<td></td>
</tr>
<tr>
<td>The Resident has given lectures/presentations as assigned.</td>
<td></td>
</tr>
<tr>
<td>The resident has participated in at least 1 community activity sponsored by the Department of Family Medicine.</td>
<td></td>
</tr>
<tr>
<td>The Resident is also up-to-date on the following:</td>
<td></td>
</tr>
<tr>
<td>Hospital medical records</td>
<td></td>
</tr>
<tr>
<td>Clinic medical records including review of labs &amp; x-rays</td>
<td></td>
</tr>
<tr>
<td>Medicare time sheets (pink sheets)</td>
<td></td>
</tr>
<tr>
<td>ACGME Milestones: Level 2</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SYSTEMS BASED PRACTICE</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>The Resident allocates resources, coordinates services, and advocates for quality, cost-effective care.</td>
<td></td>
</tr>
<tr>
<td>ACGME Milestones: Level 2</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
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</tbody>
</table>

**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: _________________

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
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<tr>
<td></td>
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</table>

**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 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 activities sponsored by the Department of Family Medicine.

The Resident has kept residency portfolio up-to-date.

The Resident has given lectures/presentations as assigned.

The resident has participated in at least 1 community activity sponsored by the Department of family Medicine.

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: _________________

<table>
<thead>
<tr>
<th>PATIENT CARE</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>The Resident has received satisfactory evaluations in all clinic rotations, or has completed remediation.</td>
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<tr>
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<tr>
<td>The Resident has maintained &amp; completed required procedure logs.</td>
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<tr>
<td>The Resident has recorded:</td>
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<tr>
<td>Minimum of 1650 continuity visits in the Lone Star clinic</td>
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<tr>
<td>Minimum of 40 deliveries (10 continuity + 30 other deliveries)</td>
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<tr>
<td>2 home visits during training</td>
<td></td>
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<tr>
<td>2 continuity nursing home patients this academic year</td>
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<tr>
<td>ACGME Milestones: Level 4</td>
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<td>Comments:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL KNOWLEDGE</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Resident has an adequate level of medical knowledge for PGY level.</td>
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<td>The Resident has satisfactorily completed the most recent in-service exam with scores &gt; 400, or has completed assigned Academic Rx.</td>
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<tr>
<td>The Resident has attended 80% of the required lectures or has adequately completed remediation.</td>
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<tr>
<td>ACGME Milestones: Level 4</td>
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<td>Comments:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SYSTEMS-BASED PRACTICE</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Resident has developed &amp; presented a completed scholarly project.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Resident has maintained a current Curriculum Vitae on file.</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>The Resident is competent to teach and supervise medical students and junior residents.</td>
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<tr>
<td>ACGME Milestones: Level 4</td>
<td></td>
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<tr>
<td>Comments:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL AND COMMUNICATION SKILLS</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Resident has developed appropriate interpersonal and communication skills</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

46
that result in teaming with patients, their families and professional associates.

ACGME Milestones: Level 4

Comments:

<table>
<thead>
<tr>
<th>PROFESSIONALISM</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>The Resident has given lectures/presentations as assigned.</td>
</tr>
<tr>
<td>The resident has participated in at least 1 community activity sponsored by the Department of family Medicine.</td>
</tr>
<tr>
<td>The Resident is also up-to-date on the following:</td>
</tr>
<tr>
<td>Hospital medical records</td>
</tr>
<tr>
<td>Clinic medical records including review of labs &amp; x-rays</td>
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<tr>
<td>Medicare time sheets (pink sheets)</td>
</tr>
</tbody>
</table>

ACGME Milestones: Level 4

Comments:

<table>
<thead>
<tr>
<th>SYSTEMS BASED PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Resident allocates resources, coordinates services, and advocates for quality, cost-effective care.</td>
</tr>
</tbody>
</table>

ACGME Milestones: Level 4

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
2015-16

- By March 1st, third year residents are responsible for submitting their total procedure numbers to the program in anticipation of graduation.
- All residents are required to submit their total procedure numbers and their New Innovations Procedure log to their May/June advisor meeting.
- At least 50% of all procedures should be completed before the start of year 3.
- 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.

<table>
<thead>
<tr>
<th>EXPECTED PROCEDURES</th>
<th>SUGGESTED NUMBER DURING RESIDENCY</th>
<th>MINIMUM EXPECTED FOR GRADUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumcision</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Biopsy-Punch</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Biopsy-Excisional</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Cryotherapy/Liquid Nitrogen</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Laceration Repair</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Toenail Wedge Resection</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Tympanogram</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Paracentesis</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Pap smear</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>Care of Hospitalized Adults</td>
<td></td>
<td>750</td>
</tr>
<tr>
<td>ICU Patients</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>Procedure</td>
<td>Adult</td>
<td>Child</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Family Meeting (coordinate &amp; facilitate)</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Abscess I&amp;D</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Central venous line insertion</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Arterial line insertion</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Endotracheal intubation</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Endometrial Biopsy</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Exercise Stress Test</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Dilation &amp; Curettage</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Lumbar Puncture -- adult</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Lumbar Puncture -- child</td>
<td>10 including infants</td>
<td>2</td>
</tr>
<tr>
<td>Joint injection</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Casting &amp; Splinting</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Flexible Sigmoidoscopy</td>
<td>10 flex sigs or 10 colonoscopies</td>
<td>2 flex sigs or 2 colonoscopies</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB Deliveries</td>
<td>60 with evidence of complication management + forceps or vacuum extraction</td>
<td>25 (total of 40 deliveries including continuity deliveries)</td>
</tr>
<tr>
<td>Continuity OB Deliveries</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Ill Child Visits in Hospital and/or ER</td>
<td></td>
<td>250</td>
</tr>
<tr>
<td>Inpatient Child Visits</td>
<td></td>
<td>75</td>
</tr>
<tr>
<td>ER Child Visits</td>
<td></td>
<td>75</td>
</tr>
<tr>
<td>Newborn Encounters</td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>IUD</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Home Visits</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>EKG Interpretation</td>
<td></td>
<td>15*</td>
</tr>
<tr>
<td>X-Ray Interpretation</td>
<td></td>
<td>15*</td>
</tr>
</tbody>
</table>

*Should be sent to the preceptor promptly to confirm.
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